

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G689	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  09/18/2015
--------------------------------------------------	-----------------------------------------------------------------	---------------------------------------------------------------------	---------------------------------------------

NAME OF PROVIDER OR SUPPLIER  KNOX COUNTY ARC	STREET ADDRESS, CITY, STATE, ZIP CODE 2918 E ARC AVE BLDG 101 VINCENNES, IN 47591
-----------------------------------------------------	-----------------------------------------------------------------------------------------

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 0000  Bldg. 00	<p>This visit was for the investigation of complaint #IN00180198.</p> <p>This visit was in conjunction with a post certification revisit (PCR) to the investigation of complaint #IN00178673 investigated on 7/29/15.</p> <p>Complaint #IN00180198 - Substantiated, federal/state deficiency related to the allegation(s) is cited at W154.</p> <p>Survey Dates: September 16, 17, 18, 2015</p> <p>Facility Number: 002939 Aim Number: 200333130 Provider Number: 15G689</p> <p>This deficiency also reflects state findings in accordance with 460 IAC 9. Quality Review of this report completed by #15068 on 9/28/15.</p>	W 0000		
W 0154	483.420(d)(3) STAFF TREATMENT OF CLIENTS			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G689		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  09/18/2015	
NAME OF PROVIDER OR SUPPLIER  KNOX COUNTY ARC				STREET ADDRESS, CITY, STATE, ZIP CODE 2918 E ARC AVE BLDG 101 VINCENNES, IN 47591			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
Bldg. 00	<p>The facility must have evidence that all alleged violations are thoroughly investigated.</p> <p>Based on record review and interview, the facility failed to thoroughly investigate 1 of 2 incidents reviewed for allegations of abuse/neglect (client H).</p> <p>Findings include:</p> <p>The facility's reportable incident reports were reviewed on 9/17/15 at 12:30p.m. A reportable incident report, dated 7/31/15, indicated a facility staff was impatient with client H and had yelled at her (client H) and had "pulled" her to the breakfast table. The facility's 8/3/15 investigation did not have documented client and staff interviews.</p> <p>Professional staff #1 was interviewed on 9/18/15 at 11:20a.m. Staff #1 indicated there were no documented staff/client interviews for the 7/31/15 allegation of abuse investigation. Staff #1 indicated the facility should have documented staff and client interviews.</p> <p>This federal tag relates to complaint #IN00180198.</p> <p>9-3-2(a)</p>	W 0154	<p>An investigation regarding the 7/31/2015 incident will be conducted.</p> <p>All administrative staff handling incident reporting and investigations will be retrained on reporting policies as well as proper investigation and follow-up.</p> <p>A staff has been put in place to track all incident reports that are filed and be sure investigations and follow-ups are completed and turned in.</p>	10/15/2015			

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/21/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G689	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 09/18/2015
NAME OF PROVIDER OR SUPPLIER  KNOX COUNTY ARC			STREET ADDRESS, CITY, STATE, ZIP CODE 2918 E ARC AVE BLDG 101 VINCENNES, IN 47591		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	