

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G693	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  04/13/2015
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NAME OF PROVIDER OR SUPPLIER  KNOX COUNTY ARC-ARC AVE (105)	STREET ADDRESS, CITY, STATE, ZIP CODE 2968 E ARC AVE BLDG 105 VINCENNES, IN 47591
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W 000  Bldg. 00	<p>This visit was for a recertification and state licensure survey.</p> <p>Dates of Survey: April 6, 7, 8, 9, 10 and 13, 2015</p> <p>Provider Number: 15G693 Aim Number: 200333060 Facility Number: 002937</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9.</p>	W 000		
W 104  Bldg. 00	<p>483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility. Based on observation and interview, the facility failed to exercise operating direction over the facility to provide a safe and clean environment for 8 of 8 clients (#1, #2, #3, #4, #5, #6, #7, #8) living in the group home.</p> <p>Findings include:</p> <p>An observation of clients #1, #2, #3, #4, #5, #6, #7 and #8 (at the group home)</p>	W 104	<p><b><u>W104</u></b> Plan of Correction: Maintenance ticket will be entered and maintenance will determine if new carpet, laminate or linoleum would be best. New flooring will be installed in the living room and back hall area. Preventive Action: KCARC will train all Group Home staff on proper procedures for reporting maintenance issues. Maintenance will complete monthly maintenance</p>	05/13/2015

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.

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W 125 Bldg. 00	<p>was done on 4/6/15 from 4:12p.m. to 6:07p.m. The observation included the following environmental condition: the living room and back hallway carpeting had stained and ripped areas.</p> <p>Interview of staff #1 on 4/10/15 at 10:34a.m. indicated the group home carpeting was in need of replacement. Staff #1 indicated they were not aware of any work orders in place to replace the carpeting.</p> <p>9-3-1(a)</p> <p>483.420(a)(3) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must allow and encourage individual clients to exercise their rights as clients of the facility, and as citizens of the United States, including the right to file complaints, and the right to due process.</p> <p>Based on record review and interview, the facility failed for 1 of 4 sampled clients (#1), to ensure the qualified intellectual disabilities professional (QIDP) monitored client #1's continued need for involved guardianship assistance.</p> <p>Findings include:</p>	W 125	<p>checklist.</p> <p>Monitoring: Assistant Program Coordinator or ProgramCoordinator will be in the home weekly to identify maintenance issues.</p> <p>Responsible Party: Manager, Assistant Program Coordinator, Program Coordinator and Maintenance.</p> <p>Date to be completed: Assessments and bids will be completed by May13th 2015. Installation will follow a timeline provided by vendorselected for installation.</p> <p>Plan of Correction: AnIDT meeting will be scheduled to discuss guardianship with participant onesmother. Documentation of the IDT meeting will be placed in participants file.</p> <p>Preventive Action: KCARCwill train administrative team to document all progress toward guardianship forparticipants in need of a guardian.</p>	05/13/2015

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	<p>Record review for client #1 was done on 4/9/15 at 12:14p.m. Client #1's 7/1/14 individual program plan (IPP) indicated client #1 did not have a guardian. Client #1's current 9/10/14 "Guardianship Assessment" indicated client #1 needed a guardian. The assessment indicated client #1 "cannot effectively communicate their wishes." Client #1 had a 6/2/13 "Guardianship Assessment." The 6/2/13 assessment indicated client #1 was unable to understand her rights and file grievances.</p> <p>Staff #1 (QIDP) was interviewed on 4/10/15 at 10:34a.m. Staff #1 indicated client #1 was currently assessed to be in need of guardian assistance. Staff #1 indicated client #1 had not had a guardian for over a year. Staff #1 indicated client #1's mother was pursuing guardianship but there was no documentation of this. Staff #1 indicated there was no documentation the facility had pursued guardianship for client #1.</p> <p>9-3-2(a)</p>		<p>Monitoring: ProgramCoordinator and Director of Residential and Community Support Services Responsible Party: ProgramCoordinator and Director of Residential and Community Support Services Date to be completed: May 13th 2015</p>		

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W 159  Bldg. 00	<p>483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL</p> <p>Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional. Based on record review and interview, the facility failed for 2 of 4 sampled clients (#1, #3), to ensure each client's active treatment program was coordinated and monitored by the facility's qualified intellectual disabilities professional (QIDP), by the QIDP not ensuring achieved client training programs were revised (#1, #3) and follow up to the identified need of a guardian (#1).</p> <p>Findings include:</p> <p>Client #1's record review was completed on 4/9/15 at 12:14p.m. Client #1's documented monthly training program data for 11/14 through 2/15 indicated client #1 had met at 100% every month the training programs to: tie shoes, toothbrushing, wipe off dining room table, and prepare a meal. It was documented, on the 11/19/14 review, "revisions needed."</p> <p>Client #3's record review was completed on 4/9/15 at 2:09p.m. Client #3's documented monthly training program data for 11/14 through 2/15 indicated</p>	W 159	<p>Plan of Correction: Assistant Program Coordinator/ProgramCoordinator will review current IPP's and make changes as needed.</p> <p>Preventive Action: AssistantProgram Coordinator/Program Coordinator will be retrained regarding when to update individuals IPP's or create new objective as they notice a need.</p> <p>Monitoring: Program Coordinator will review progress for goals during 90 day meeting period.</p> <p>Responsible Party: AssistantProgram Coordinator/Program Coordinator Date to be completed: May 13th 2015</p>	05/13/2015	

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	<p>client #3 had met at 100% every month the training programs to: choose a penny from different coins, count 4 strings, choose his birthday from 3 dates, and choose between a medication and a non medication. It was documented, on the 11/19/14 review, "revisions needed."</p> <p>Record review for client #1 was done on 4/9/15 at 12:14p.m. Client #1's 7/1/14 individual program plan (IPP) indicated client #1 did not have a guardian. Client #1's current 9/10/14 "Guardianship Assessment" indicated client #1 needed a guardian. The assessment indicated client #1 "cannot effectively communicate their wishes." Client #1 had a 6/2/13 "Guardianship Assessment." The 6/2/13 assessment indicated client #1 was unable to understand her rights and file grievances.</p> <p>Staff #1 (QIDP) was interviewed on 4/10/15 at 10:34a.m. Staff #1 indicated clients #1 and #3 did not have recent program revisions for the identified met training programs. Staff #1 indicated client #1 did not have a guardian. Staff #1 indicated she thought client #1's mother was pursuing guardianship but there was no documentation the facility had followed up on the recommendation for guardianship. Staff #1 indicated the QIDP was responsible for the</p>			

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W 255 Bldg. 00	<p>coordination and monitoring of the clients' programs.</p> <p>9-3-3(a)</p> <p>483.440(f)(1)(i) PROGRAM MONITORING &amp; CHANGE The individual program plan must be reviewed at least by the qualified mental retardation professional and revised as necessary, including, but not limited to situations in which the client has successfully completed an objective or objectives identified in the individual program plan.</p> <p>Based on interview and record review of 2 of 4 sampled clients (#1, #3), the Qualified Intellectual Disabilities Professional (QIDP) failed to revise the Individual Program Plan (IPP) in regards to the clients' (#1, #3) having successfully completed objectives identified in the IPP.</p> <p>Findings include:</p> <p>Client #1's record review was completed on 4/9/15 at 12:14p.m. Client #1's documented monthly training program</p>	W 255	<p>Plan of Correction: Assistant Program Coordinator/Program Coordinator will review current IPP's and make changes as needed.</p> <p>Preventive Action: Assistant Program Coordinator/Program Coordinator will be retrained regarding when to update individuals IPP's or create new objective as they notice a need.</p> <p>Monitoring: Program Coordinator will review progress for goals during 90 day meeting period.</p> <p>Responsible Party: Assistant Program Coordinator/Program Coordinator</p>	05/13/2015

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W 356 Bldg. 00	<p>data for 11/14 through 2/15 indicated client #1 had met at 100% every month the training programs to: tie shoes, toothbrushing, wipe off dining room table, and prepare a meal. It was documented, on the 11/19/14 review, "revisions needed."</p> <p>Client #3's record review was completed on 4/9/15 at 2:09p.m. Client #3's documented monthly training program data for 11/14 through 2/15 indicated client #3 had met at 100% every month the training programs to: choose a penny from different coins, count 4 strings, choose his birthday from 3 dates, and choose between a medication and a non medication. It was documented, on the 11/19/14 review, "revisions needed."</p> <p>Professional Staff #1 was interviewed on 4/10/15 at 10:34a.m. Staff #1 indicated clients #1 and #3's goals should have been considered met and revised by the QIDP.</p> <p>9-3-4(a)</p> <p>483.460(g)(2) COMPREHENSIVE DENTAL TREATMENT The facility must ensure comprehensive dental treatment services that include dental</p>		Date to be completed: May 13th 2015	

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W 436	<p>care needed for relief of pain and infections, restoration of teeth, and maintenance of dental health.</p> <p>Based on record review and interview, the facility failed for 1 of 4 sampled clients (#2), to ensure recommendations for follow up dental services were addressed/followed.</p> <p>Findings include:</p> <p>The record of client #2 was reviewed on 4/9/15 at 1:20p.m. Client #2's 12/8/14 dental exam indicated "severe plaque and calculus on most teeth." Client #2 had physician's orders on 1/16/15 that recommended client #2 have full tooth extraction and dentures. There was no documented follow up to this recommendation.</p> <p>Interview of staff #1 and #3 (nurse) was done on 4/10/15 at 10:34a.m. Staff #1 and #3 indicated client #2 did not have dentures. Staff #1 and #3 indicated the facility did not have documentation the follow up to the above recommendation had been addressed by the facility.</p> <p>9-3-6(a)</p> <p>483.470(g)(2) SPACE AND EQUIPMENT</p>	W 356	<p>Plan of Correction: IDT meeting will be held with participant to determine if he wants to follow through with the recommendation. If yes, KCARC will schedule an appointment to begin the process.</p> <p>Preventive Action: Assistant Program Coordinator/Program Coordinator/Nurse will be retrained regarding the need for IDT meetings to address health care recommendations.</p> <p>Monitoring: Program Coordinator/Nurse will review recommendations from appointments.</p> <p>Responsible Party: Program Coordinator/Nurse</p> <p>Date to be completed: May 13th 2015</p>	05/13/2015

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Bldg. 00	<p>The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client.</p> <p>Based on record review and interview, the facility failed for 1 of 4 sampled clients (#2) with adaptive equipment, to furnish the identified need of hearing aids.</p> <p>Findings include:</p> <p>The record of client #2 was reviewed on 4/9/15 at 1:20p.m. Client #2 had a 10/10/14 audiological evaluation that indicated client #2 had mild sloping to profound hearing loss. The evaluation indicated the recommendation was for bilateral hearing aids. The evaluation indicated the facility was to call the Audiological office to set up further treatment. There was no documentation the facility had followed up on this recommendation.</p> <p>Interview of staff #1 and #3 (nurse) was done on 4/10/15 at 10:34a.m. Staff #1 and #3 indicated client #2 did not have hearing aids. Staff #1 and #3 indicated the facility did not have documentation the follow up to the above recommendation had been addressed by</p>	W 436	<p>Plan of Correction: IDT meeting will be held with participant to determine if he wants to follow through with the recommendation. If yes, KCARC will schedule an appointment to begin the process.</p> <p>Preventive Action: Assistant Program Coordinator/Program Coordinator/Nurse will be retrained regarding the need for IDT meetings to address health care recommendations.</p> <p>Monitoring: Program Coordinator/Nurse will review recommendations from appointments.</p> <p>Responsible Party: Program Coordinator/Nurse</p> <p>Date to be completed: May 13th 2015</p>	05/13/2015

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

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