

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G623	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 09/18/2015
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NAME OF PROVIDER OR SUPPLIER KNOX COUNTY ARC - BICKNELL 2	STREET ADDRESS, CITY, STATE, ZIP CODE 410 LIBERTY BICKNELL, IN 47512
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(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 #IN00180209.</p> <p>Complaint #IN00180209 - Substantiated, federal/state deficiency related to the allegations is cited at W322.</p> <p>Survey Dates: September 16, 17 and 18, 2015.</p> <p>Facility Number: 001182 Aim Number: 100249470 Provider Number: 15G623</p> <p>This deficiency also reflects state findings in accordance with 460 IAC 9.</p> <p>Quality review of this report completed by #09182 on 9/23/2015.</p>	W 0000		
W 0322 Bldg. 00	<p>483.460(a)(3) PHYSICIAN SERVICES</p> <p>The facility must provide or obtain preventive and general medical care.</p> <p>Based on record review and interview, the facility failed for 1 of 3 sampled clients (A), and 1 additional client (E), to ensure the clients' received an annual</p>	W 0322	<p>All individuals in the house have received their annual physicals; The Medical Services Assistant is now tracking all annual appointments to ensure they are completed on</p>	10/07/2015

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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	<p>physical.</p> <p>Findings include:</p> <p>Record review for client A was done on 9/17/15 at 3:25p.m. Client A's most recent documented annual physical was dated 8/14/14.</p> <p>Record review for client E was done on 9/17/15 at 3:25p.m. Client E's most recent documented annual physical was dated 8/13/14.</p> <p>Interview of staff #2 (nurse) on 9/17/15 at 3:35p.m. indicated client A's most recent documented annual physical was 8/14/14 and client E's annual physical was dated 8/13/14. Staff #2 indicated it had been over a year since client A and E's last documented annual physical.</p> <p>This federal tag relates to complaint #IN00180209.</p> <p>9-3-6(a)</p>		time.		