

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G134	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  01/13/2012
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NAME OF PROVIDER OR SUPPLIER  ARC OPPORTUNITIES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 0170 W 300 N HOWE, IN 46746
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W0000	<p>This visit was for a fundamental recertification and state licensure survey.</p> <p>Dates of Survey: January 9, 10, 11, 12, 13, 2012.</p> <p>Facility number: 000671 Provider number: 15G134 AIM number: 100234320</p> <p>Surveyor: Susan Reichert, Medical Surveyor III</p> <p>The following federal deficiencies also reflect state findings in accordance with 460 IAC 9.</p> <p>Quality Review was completed on 1/23/12 by Tim Shebel, Medical Surveyor III.</p>	W0000		

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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W0249	<p>As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan.</p> <p>Based on record review, observation and interview, the facility failed to implement 1 of 3 sampled clients (client #3's) dining plan as written.</p> <p>Findings include:</p> <p>The facility's reports to the Bureau of Developmental Disabilities Services and internal incident reports were reviewed on 1/9/12 at 3:50 PM and included a report dated 5/1/11 that indicated client #3 had choked after eating sausage prepared to bite sized consistency and required 3 back blows to dislodge the sausage. Client #3 was taken to the ER (emergency room) for evaluation and released with no further treatment/follow up recommended. The report indicated client #3 had a history of engaging in rapid rate of eating and "stuffing her mouth", and client #3's primary care physician and dietitian would be consulted for further recommendations for evaluation.</p>	W0249	<p>It will be the responsibility of the Nurse to train small group home staff on the choking/dining risk plan that will include: A. Correct meal set up B. The importance of verbal prompts and physical intervention when required for safe dining practices to be implemented. C. Proper positioning &amp; adequate hydration during meal times. D. The Nursing Dept. will contact the speech therapist to clarify recommendations &amp;/or suggestions in the documented swallow study to ensure staff are accurately trained on the intent of the recommendations to achieve the desired outcomes. In the future it will be the responsibility of the QDDP during random observations at varying meal times to observe &amp; document findings of the correct implementation of the choking/dining risk plan on an ongoing basis at least bi-monthly or more as required to progress toward desired outcomes.</p>	02/12/2012			

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	<p>Observations at the group home were conducted on 1/9/12 from 5:15 PM until 6:20 PM. During the evening meal, client #3 ate whole bread sticks, chicken noodle casserole, 1/2 an apricot sized pieces of fruit without direction or assistance from staff to cut the food into smaller pieces. Client #3 placed her face close to her plate and scooped food rapidly with her fork and with her hands, drank her beverages sporadically through the meal with the use of a lidded cup with straw and staff provided 2 prompts to take a sip of liquid, one prompt to take smaller bites during the meal, and failed to prompt client #3 to sit upright at a 90 degree angle or to place her chin down during swallowing.</p> <p>Client #3's Risk Plan dated 5/12/11 was reviewed on 1/10/12 at 9:35 AM and indicated "staff will assist by cutting food into 1/3 tsp (teaspoon) size pieces and limit sip of liquid to 1/2 teaspoon size. Staff will encourage [client #3] to alternate bite of solid with sip of liquid throughout meal and take two or three swallows after every bite or sip."</p> <p>Client #3's full record was reviewed on 1/12/11 at 1:31 PM and indicated a swallow study dated 5/12/11 with the recommendations "seated upright 90 degrees, chin down during swallow, sm</p>			
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	<p>(small) bites 1/3 tsp, sm sips, 1/2 tsp size, eat slowly, alternate bites of solids with sips of liquid, take 2 or 3 swallows for every bite of food."</p> <p>The Qualified Developmental Disabilities Professional (QDDP) was interviewed on 1/11/12 at 1:50 PM and indicated client #3's risk plan for eating should have been implemented.</p> <p>9-3-4(a)</p>				

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W0369	<p>The system for drug administration must assure that all drugs, including those that are self-administered, are administered without error.</p> <p>Based upon observation, record review and interview, the facility failed for 1 of 5 clients who received medication (client # 3) to ensure staff administered his medication without error.</p> <p>Findings included:</p> <p>During observation at the group home on 1/9/12 from 5:15 PM until 6:20 PM, client #3 received Ketoconazole 2% shampoo (medicated shampoo) from staff #2 at 5:55 PM. The label indicated she was to receive the shampoo 2 times weekly.</p> <p>Client #3's 1/12 Medication Administration Record (MAR) was reviewed on 1/10/12 at 5:50 PM. The record indicated client #3 was to receive the shampoo 3 times weekly, and indicated documentation she had received the shampoo three times weekly from 1/1/12 to 1/9/12.</p> <p>Client #3's record was reviewed on 11/11/12 at 1:31 PM and indicated a physician's order dated 10/24/11 with a note to use the shampoo twice a week.</p>	W0369	<p>It will be the responsibility of the nurse to correct the Medication Administration Record (MAR) to correctly match the Dr.'s orders. This will be done by 1/11/12. It will be the responsibility of the Nursing Dept. to evaluate the root cause of the issue and to develop a strategy to reduce or eliminate the potential for reoccurrence of the medication error. 2/12/12 It will be the responsibility of the Nurse to retrain the staff on the medication administration protocol. There is one staff effected staff currently on maternity leave who will be retrained prior to resuming her duties. 2/12/12 It will be the responsibility of the C.E.O. and the Director of Nursing to meet with the Medical Director concerning the issue and come up with a reasonable solution to reduce the risk or error. 2/13/12 note: Dr. Hershberger has been unavailable due to being on vacation until the 13 of February. The meeting is scheduled at his earliest convenience. In the future it will be the responsibility of the Nurse when preparing the MAR to check for continuity between the MAR and the Dr.'s orders. Before the Medications are administered it will be the responsibility of the person passing the medications to</p>	02/13/2012			

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	The Qualified Developmental Disabilities Professional (QDDP) was interviewed on 1/11/12 at 1:50 PM. She indicated the MAR had now been corrected to reflect client #3's physician's order.  9-3-5(a)		ensure that the medication label and the MAR match.If there are any discrepancies it will be immediately brought to the attention of the Q/Q on-call who will be responsible to with the Nursing Dept. for further clarification or correction if warranted.		

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W0382	<p>The facility must keep all drugs and biologicals locked except when being prepared for administration.</p> <p>Based on observation and interview for 1 of 3 sampled clients (client #2), the facility failed to ensure medications were locked when not in use.</p> <p>Findings include:</p> <p>During observation at the group home on 1/9/121 from 5:15 PM until 6:20 PM, staff prepared client #1's medication for administration at 5:55 PM, then left client #2 with the medications on the desk and the drawer containing medications unlocked while she retrieved water for client #2.</p> <p>Staff #1 was interviewed on 1/9/12 at 6:00 PM She indicated medications should be locked when not being administered.</p> <p>The Qualified Developmental Disabilities Professional (QDDP) was interviewed on 1/11/12 at 1:50 PM. She indicated medications should be locked when not being administrated.</p> <p>9-3-6(a)</p>	W0382	<p>It will be the responsibility of the Nurse to retrain the individual who made the Medication error on proper medication administration policy and procedure with emphasis on locking the med cabinet at all times except when medications are being prepared. In the future it will be the responsibility of the Nurse to document that proper protocols are being implemented by staff at random observations @ least quarterly. In addition at least two times a quarter the QDDP will also conduct unannounced observations of medication administration as well.</p>	02/12/2012
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W0460	<p>Each client must receive a nourishing, well-balanced diet including modified and specially-prescribed diets.</p> <p>Based upon observation, record review, and interview for 1 of 3 sampled clients (client #1), the facility failed to ensure her food was prepared to the consistency as specified in her risk plan.</p> <p>Findings include:</p> <p>The facility's reports to the Bureau of Developmental Disabilities Services and internal incident reports were reviewed on 1/9/12 at 3:50 PM and included a report dated 5/1/11 that indicated client #3 had choked after eating sausage prepared to bite sized consistency and required 3 back blows to dislodge the sausage. Client #3 was taken to the ER (emergency room) for evaluation and released with no further treatment/follow up recommended. The report indicated client #3 had a history of engaging in rapid rate of eating and "stuffing her mouth", and client #3's primary care physician and dietitian would be consulted for further recommendations for evaluation.</p> <p>Observations at the group home on 1/9/12 from 5:15 PM until 6:20 PM. During the evening meal, client #3 ate whole bread</p>	W0460	<p>It will be the responsibility of the Nurse to train small group home staff on the choking/dining risk plan that will include:A. Correct meal set up B. The importance of verbal prompts and physical intervention when required for safe dining practices to be implemented.C. Proper positioning &amp; adequate hydration during meal times.D. The Nursing Dept. will contact the speech therapist to clarify recommendations &amp;/or suggestions in the documented swallow study to ensure staff are accurately trained on the intent of the recommendations/suggestions to obtain the desired outcomes.In the future it will be the responsibility of the QDDP during random observations at varying meal times to observe &amp; document findings of the correct implementation of the choking/dining risk plan on an ongoing basis at least bi-monthly or more as required to progress toward desired outcomes.</p>	02/12/2012	

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	<p>sticks, chicken noodle casserole, 1/2 an apricot sized pieces of fruit without direction or assistance from staff to cut the food into smaller pieces.</p> <p>Client #3's Risk Plan dated 5/12/11 was reviewed on 1/10/12 at 9:35 AM and indicated "staff will assist by cutting food into 1/3 tsp (teaspoon) size pieces and limit sips of liquid to 1/2 teaspoon size.</p> <p>Client #3's full record was reviewed on 1/12/11 at 1:31 PM and indicated a swallow study dated 5/12/11 with the recommendations "sm (small) bites 1/3 tsp, sm sips, 1/2 tsp size."</p> <p>The Qualified Developmental Disabilities Professional (QDDP) was interviewed on 1/11/12 at 1:50 PM and indicated client #3's food should have been prepared as indicated in the risk plan.</p> <p>9-3-8 (a)</p>			
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