

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G313	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/21/2011
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NAME OF PROVIDER OR SUPPLIER ARC BRIDGES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 19038 MISSISSIPPI ST HEBRON, IN46341
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W0000	<p>This visit was a post certification revisit to a fundamental recertification and state licensure survey conducted on August 26, 2011.</p> <p>Dates of Survey: October 20 and 21, 2011.</p> <p>Facility number: 000832 Provider number: 15G313 AIM number: 100249150</p> <p>Surveyor: Christine Colon, Medical Surveyor III/QMRP-Team Leader</p> <p>The following deficiency also reflects state findings in accordance with 460 IAC 9.</p> <p>Quality Review completed 11/4/11 by W. Chris Greeney ICF-ID Surveyor Supervisor</p>	W0000		
W0436	<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 observation, record review and interview, the facility failed for 2 of 4 clients residing at the group home (client</p>	W0436	Service Coordinator retrained all staff on the importance of adaptive equipment and proper documentation. Community Services Nurse retrained staff on	11/19/2011

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>#2 and #3), to encourage/teach them to wear their prescribed eyeglasses.</p> <p>Findings include:</p> <p>An evening observation was conducted at the group home on 10/20/11 from 4:30 P.M. until 6:15 P.M.. During the entire observation period clients #2 and #3 were not observed to wear eyeglasses, nor were staff observed to prompt or teach the clients to wear their prescribed eyeglasses.</p> <p>A review of client #2's record was conducted on 10/21/11 at 12:02 P.M.. Review of client #2's "Annual Physical" dated 3/18/11 indicated client #2 wore "corrective lenses."</p> <p>A review of client #3's record was conducted on 10/21/11 at 12:15 P.M.. Review of client #3's most current vision exam dated 3/22/11 indicated he wore "corrective lenses."</p> <p>An interview with the Service Coordinator (SC) was conducted on 10/21/11 at 12:20 P.M.. The SC stated, "Staff should have prompted them (clients #2 and #3) to wear their glasses."</p> <p>This deficiency was cited on 8/26/11. The facility failed to implement a systemic plan of correction to prevent recurrence.</p>		<p>following the medication administration record and proper documentation. A form has been added to the medication book reminding staff to evaluate clients for using prescribed adaptive equipment. New objectives have been put in place for clients #2 and #3 for adaptive equipment desensitization. 11/19/11. To ensure future compliance, Service Coordinator and/or Community Services will observe the clients weekly for the next two months and at least bi-monthly thereafter to ensure they are offered individual adaptive equipment as prescribed.</p>		

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

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FORM APPROVED

OMB NO. 0938-0391

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	9-3-7(a)				