

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G613	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 01/27/2012
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NAME OF PROVIDER OR SUPPLIER GIBSON COUNTY ARC 8TH ST	STREET ADDRESS, CITY, STATE, ZIP CODE 116 N 8TH ST PRINCETON, IN 47670
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W0000	<p>This visit was for investigation of complaint #IN00102589.</p> <p>Complaint #IN00102589: Substantiated, federal/state deficiency related to the allegation is cited at W149.</p> <p>Survey dates: 1/25, 1/26 and 1/27/12</p> <p>Facility Number: 001177 Provider Number: 15G613 AIM Number: 100245650</p> <p>Surveyor: Jenny Ridao, Medical Surveyor III</p> <p>This deficiency also reflects state findings in accordance with 460 IAC 9. Quality Review completed 2/6/12 by Ruth Shackelford, 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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W0149	<p>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. Based on record review and interview for 1 of 4 sampled clients (A), the facility neglected to implement written policy/procedures to prevent the neglect of the client in regards to leaving client A unattended in the home.</p> <p>Findings include:</p> <p>The facility reports were reviewed on 1/25/12 at 10:00 AM. The facility's Bureau of Developmental Disabilities Services (BDDS) reports indicated: _On 1/13/12 "Office staff noticed [client A] coming to the office alone around transport time. The office staff discovered [client A] was without staff at the home. The men's home uses two vans for work transport and sometimes the blue minivan is also used. A few minutes after staff discovered [client A] was alone the first van to leave for transport returned home. The second van was enroute to the workcenter at this time. [Client A] was ok and went to work."</p> <p>A follow up report to BDDS indicated: _ "Three staff were on duty at the time of the incident. Two staff have been suspended pending an investigation to why and how [client A] was left alone for</p>			W0149	<p>To Address W149: 1) To address the deficient practice Staff #1 and Staff #2 have been issued corrective actions for failure to implement the practice of using the Transport Occupancy Log during transport. Staff #1 and Staff #2 have also been retrained on use and implementation of the Transport Occupancy Log. 2). In order to prevent the same deficient practice from affecting the other Residents, all Staff at the North 8th. St. home has been retrained on the use and implementation of the Transport Occupancy Log. Note: The Transport Occupancy Log accounts for the whereabouts of all Residents during transport. 3). A systemic change to prevent recurrence at the North 8th St. home has been implemented: The Mileage Log and Transportation Occupancy log are no longer kept in separate binders on the vans and now share the same binder. 4). To ensure the deficient practice will not recur, the QMRP and Home Manager will make periodic inspections to ensure the Transportation Occupancy Log is ongoing and continually being implemented. Additionally, all new hires shall receive training on the Transport Occupancy Log. All the above shall be implemented no later than</p>		02/26/2012

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	<p>approximately 3-5 minutes. The vans monitor whereabouts of the residents using Transport Occupancy forms daily. Staff have been trained to use the transport occupancy log to account for all residents during transportation. Today there was a breakdown in communication and probable use of the occupancy log."</p> <p>Conclusion: "[Client A] was left unattended from somewhere between 3-5 minutes. [Client A] was discovered alone walking next door to the office. [Client A] is independent in pedestrian safety skills. The breakdown in communication happened when the Home Manager was taking another client on an appointment and [staff #3] was to take [client A] and [client B] to the workshop. [Staff #3] failed to follow the Transportation Occupancy form that morning."</p> <p>Review of the facility's Procedures, Protocol and Information to follow for Incident Reporting dated 11/18/11 on 1/25/12 at 11:45 AM indicated "Suspected abuse, neglect or exploitation are events characterized by risk or uncertainty resulting in or having the potential to result in significant harm or injury to an individual or death of an individual."</p> <p>Interview with the Home Manager (HM)</p>		February 26, 2012.				

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	<p>on 1/26/12 at 12:35 PM indicated client A was left unattended for approximately 3-5 minutes. The HM indicated client A had gone back to bed after breakfast and staff #3 did not use the transportation occupancy log. The HM stated "If the log was used, this incident would not have happened."</p> <p>This federal tag relates to complaint #IN00102589.</p> <p>9-3-2(a)</p>				