

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 11/30/2011
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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, IN47670
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W0000	<p>This visit was for investigation of complaint # IN00099912</p> <p>Complaint # IN00099912 substantiated: Deficiencies related to the allegation are cited at W149, W249 and W474.</p> <p>Survey dates: 11/23, 11/28 and 11/30/11</p> <p>Facility Number: 001177 Provider Number: 15G613 AIM Number: 100245650</p> <p>Surveyor: Jenny Ridao Medical Surveyor III</p> <p>These deficiencies also reflect state findings in accordance with 431 IAC 1.1.</p> <p>Quality Review was completed on 12/15/11 by Tim Shebel, Medical Surveyor III.</p>	W0000		
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</p>	W0149	<p>1. The corrective actions accomplished for the residents affected by this deficiency</p>	12/30/2011

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>neglected to implement written policy/procedures to prevent the neglect of the client in regards to leaving client A unattended during meal time which resulted in a client choking.</p> <p>Findings include:</p> <p>The facility records were reviewed on 11/23/11 at 10:00 AM. The facility's Bureau of Developmental Disabilities Services (BDDS) reports indicated: ___On 11/13/11 " (sic) Morning breakfast was being prepared. Staff in the dining room heard [client A] coughing. He (staff #1) immediately went to check and assist him. Noted sausage in the consumers hands. Felt consumer was choking. Performed Heimlich. got 2 pieces of sausage out of [client A's] mouth. No distress noted following procedure. Nurse updated and advised to take to ER for evaluation. No new orders from ER."</p> <p>Review of the facility's 11/14/11 investigation indicated "[staff #1] was assigned to [client A] for his one on one observation while in the home. [Staff #2] was in the kitchen with [client C] preparing breakfast. [Staff #3] was back in a bedroom helping a client get dressed. [Staff #2] sat a plate of sausage down on the counter and went back to assisting</p>		<p>resulted in the termination of employment affecting the two (2) staff assigned to observe and monitor Danny during meal prep and dining. All staff are trained on the consumers dining plans and staff are to be with consumers at all times during meal prep and dining, the latter is also stipulated on the MAR for each individual resident. The client also has 24/7 observation tracking. 2. In order to identify other residents having the potential to be affected by the same deficient practice, all group home residents will have supervision during meal prep and eating, this also includes snack time, and their individual dining plans will be implemented with staff supervision and assistance as needed. All residents also have updated swallowing evaluations and done as needed based on any changes such as symptoms of distress during dining. 3. To ensure the deficient practice does not recur again, all staff have been trained on an updated dining plan for the client affected. The client now has a personal dining (card table) area where he can not reach for foods from the tables. The client affected is in close proximity to staff and peers during meal time so he is not isolated from his peers, and staff are readily available to observe the client and provide adequate supervision for him during meal time. 4. In order</p>				

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	<p>[client C] cook. [Staff #1], who was supposed to be within arms reach of [client A], was in the living room with the other clients watching TV. While [staff #2] was assisting [client C], [client A] reached over and took several pieces of sausage and put them in his mouth. When [client A] began to cough, his one on one staff came into the kitchen to check on him. [Staff #1] felt [client A] was choking and performed the Heimlich maneuver. [Client A] coughed up two pieces of sausage and had a few pieces of sausage in his hand."</p> <p>Follow up to the facility's 7/14/11 investigation indicated staff #1 and staff #2 were immediately suspended that morning pending the results of the investigation. Results of the 7/14/11 investigation indicated staff #1 and staff #2 were terminated. The 7/14/11 investigation indicated staff #1 was to be within arms reach of client A and not in another room. Staff #2 should not have placed food within client A's reach, due to it not being in a puree form.</p> <p>Client A's record was reviewed on 11/23/11 at 2 PM. Client A's 5/10/11 Health/Risk Plan indicated client A was a potential for choking/aspiration, currently received a pureed diet, 1500 calorie, receive one portion, avoid red beverages,</p>		<p>to ensure the deficient practice will not recur all staff are trained on the consumers individual diet plans. Additionally, monthly home audits are conducted and meal prep and dining is monitored during the audits and corrections are made and any deficeincies are addressed through the home audits. 5. All of the above are to be implemented no later than 12/30/2011.</p>		

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	<p>small spoon and sipper cup. Staff should supervise all meals and snacks.</p> <p>Client A's 2/9/11 Nutritional assessment indicated client A was to have staff supervise meals and snacks. Client A's 7/11 Medication Administration Record indicated staff were to monitor all oral intake.</p> <p>Review of the Facility's Procedures, Protocol and Information to follow for Incident Reporting dated 7/14/09 on 11/23/11 at 9:45 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) on 11/28/11 at 4 PM indicated staff #1 should have been within arms reach of client A at all times in the home due to his food stealing and elopement. The HM also indicated staff #2 should have not placed food within client A's reach due to his food stealing and the food was not as client A's diet was prescribed. The HM stated "Both [staff #1] and [staff #2] did not follow [client A's] plan for dining, his plan to be within arms reach or his high risk plan."</p>				

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W0249	<p>This federal tag relates to complaint #IN00099912.</p> <p>9-3-2(a)</p> <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 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 during meal time which resulted in a client choking.</p> <p>Findings include:</p> <p>The facility records were reviewed on 11/23/11 at 10:00 AM. The facility's Bureau of Developmental Disabilities Services (BDDS) reports indicated: <u>On 11/13/11 " (sic) Morning breakfast was being prepared. Staff in the dining room heard [client A] coughing. He (staff #1) immediately went to check and assist him. Noted sausage in the consumers hands. Felt consumer was choking.</u></p>	W0249	. The corrective actions accomplished for the residents affected by this deficiency resulted in the termination of employment affecting the two (2) staff assigned to observe and monitor Danny during meal prep and dining. All staff are trained on the consumers dining plans and staff are to be with consumers at all times during meal prep and dining. When staff are noted to be deficient with practice they receive inservice training from the administrative staff that includes the QMRP and designees as well as nursing staff. Termination of employment can result when employees fail to	12/30/2011

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	<p>Performed Heimlich. got 2 pieces of sausage out of [client A's] mouth. No distress noted following procedure. Nurse updated and advised to take to ER for evaluation. No new orders from ER."</p> <p>Review of the facility's 11/14/11 investigation indicated "[staff #1] was assigned to [client A] for his one on one observation while in the home. [Staff #2] was in the kitchen with [client C] preparing breakfast. [Staff #3] was back in a bedroom helping a client get dressed. [Staff #2] sat a plate of sausage down on the counter and went back to assisting [client C] cook. [Staff #1], who was supposed to be within arms reach of [client A], was in the living room with the other clients watching TV. While [staff #2] was assisting [client C], [client A] reached over and took several pieces of sausage and put them in his mouth. When [client A] began to cough, his one on one staff came into the kitchen to check on him. [Staff #1] felt [client A] was choking and performed the Heimlich maneuver. [Client A] coughed up two pieces of sausage and had a few pieces of sausage in his hand."</p> <p>Follow up to the facility's 7/14/11 investigation indicated staff #1 and staff #2 were immediately suspended that morning pending the results of the investigation. Results of the 7/14/11 investigation indicated staff #1 and staff #2 were terminated. The 7/14/11 investigation indicated staff #1 was to be within arms reach of client A and not in another room. Staff #2 should not have placed food within client A's reach, due to it not being in a puree form.</p> <p>Client A's record was reviewed on 11/23/11 at 2 PM. Client A's 5/10/11 Health/Risk Plan indicated client A was a potential for choking/aspiration, currently received a pureed diet, 1500 calorie,</p>		<p>provide supervision for the residents. 2. In order to identify other residents having the potential to be affected by the same deficient practice, all group home residents will have supervision during meal prep and eating, this also includes snack time, and their individual dining plans will be implemented with staff supervision and assistance as needed. Staff are required to be seated at the dining table during meals to enhance monitoring as well as observation and assistance when needed. This same practice also applies during community outings and activities. 3. To ensure the deficient practice does not recur again, all staff have been trained on an updated dining plan for the client affected. The client now has a personal dining (card table) area where he can not reach for foods from the tables or from peers. The client affected is in close proximity to staff and peers during meal time so he is not isolated from his peers, and staff are readily available to observe the client and provide adequate supervision for him during meal time. 4. In order to ensure the deficient practice will not recur all staff are trained on the consumers individual diet plans and health risk plans. For quality assurance purposes the home manager and QMRP conduct periodic checks and monthly audits to ensure the consumers</p>		

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W0474	<p>receive one portion, avoid red beverages, small spoon and sipper cup. Staff should supervise all meals and snacks. Client A's 2/9/11 Nutritional assessment indicated client A was to have staff supervise meals and snacks. Client A's 7/11 Medication Administration Record indicated staff were to monitor all oral intake.</p> <p>Interview with the Home Manager (HM) on 11/28/11 at 4 PM indicated staff #1 should have been within arms reach of client A at all times in the home due to his food stealing and elopement. The HM also indicated staff #2 should have not placed food within client A's reach due to his food stealing and the food was not as client A's diet was prescribed. The HM stated "Both [staff #1] and [staff #2] did not follow [client A's] plan for dining, his plan to be within arms reach or his high risk plan."</p> <p>This federal tag relates to complaint #IN00099912.</p> <p>9-3-4(a)</p> <p>Food must be served in a form consistent with the developmental level of the client. Based on interview and record review for 1 of 4 sampled clients (A), the facility failed to provide client A with food in the form appropriate for his pureed diet.</p> <p>Findings include: The facility records were reviewed on 11/23/11 at 10:00 AM. The facility's Bureau of Developmental Disabilities Services (BDDS) reports indicated:</p>	W0474	<p>have adequate supervision and training. 5. All of the above is to be implemented no later than 12/30/2011.</p> <p>1. The corrective actions accomplished for the residents affected by this deficiency resulted in the termination of employment affecting the two (2) staff assigned to observe and monitor Danny during meal prep and dining. All staff are trained on the consumers dining plans and staff are to be with consumers at all times during</p>	12/30/2011	

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	<p>__ On 11/13/11 " (sic) Morning breakfast was being prepared. Staff in the dining room heard [client A] coughing. He (staff #1) immediately went to check and assist him. Noted sausage in the consumers hands. Felt consumer was choking. Performed Heimlich. got 2 pieces of sausage out of [client A's] mouth. No distress noted following procedure. Nurse updated and advised to take to ER for evaluation. No new orders from ER."</p> <p>Review of the facility's 11/14/11 investigation indicated "[staff #1] was assigned to [client A] for his one on one observation while in the home. [Staff #2] was in the kitchen with [client C] preparing breakfast. [Staff #3] was back in a bedroom helping a client get dressed. [Staff #2] sat a plate of sausage down on the counter and went back to assisting [client C] cook. [Staff #1], who was supposed to be within arms reach of [client A], was in the living room with the other clients watching TV. While [staff #2] was assisting [client C], [client A] reached over and took several pieces of sausage and put them in his mouth. When [client A] began to cough, his one on one staff came into the kitchen to check on him. [Staff #1] felt [client A] was choking and performed the Heimlich maneuver. [Client A] coughed up two pieces of sausage and had a few pieces of sausage in his hand."</p> <p>Follow up to the facility's 7/14/11 investigation indicated staff #1 and staff #2 were immediately suspended that morning pending the results of the investigation. Results of the 7/14/11 investigation indicated staff #1 and staff #2 were terminated. The 7/14/11 investigation indicated staff #1 was to be within arms reach of client A and not in another room. Staff #2 should not have placed food within client A's reach, due to it not being in a puree form.</p>		<p>meal prep and dining. When staff are noted to be deficient with practice they receive inservice training from the administrative staff that includes the QMRP and designees as well as nursing staff. Termination of employment can result when employees fail to provide supervision for the residents. 2. In order to identify other residents having the potential to be affected by the same deficient practice, all group home residents will have supervision during meal prep and eating, this also includes snack time, and their individual dining plans will be implemented with staff supervision and assistance as needed. Staff are required to be seated seated at the dining table during meals to enhance monitoring as well as observation and assistance when needed. 3. To ensure the deficient practice does not recur again, all staff have been trained on an updated dining plan for the client affected. The client now has a personal dining (card table) area where he can not reach for foods from the tables or from peers. The client affected is in close proximity to staff and peers during meal time so he is not isolated from his peers, and staff are readily available to observe the client and provide adequate supervision for him during meal time. 4. In order to ensure the deficient practice will not recur all staff are trained on the</p>		

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	<p>Client A's record was reviewed on 11/23/11 at 2 PM. Client A's 5/10/11 Health/Risk Plan indicated client A was a potential for choking/aspiration, currently received a pureed diet, 1500 calorie, receive one portion, avoid red beverages, small spoon and sipper cup. Staff should supervise all meals and snacks. Client A's 2/9/11 Nutritional assessment indicated client A was to have staff supervise meals and snacks. Client A's 7/11 Medication Administration Record indicated staff were to monitor all oral intake.</p> <p>Interview with the Home Manager (HM) on 11/28/11 at 4 PM indicated staff #1 should have been within arms reach of client A at all times in the home due to his food stealing and elopement. The HM also indicated staff #2 should have not placed food within client A's reach due to his food stealing and the food was not as client A's diet was prescribed. The HM stated "Both [staff #1] and [staff #2] did not follow [client A's] plan for dining, his plan to be within arms reach or his high risk plan."</p> <p>This federal tag relates to complaint #IN00099912.</p> <p>9-3-8(a)</p>		<p>consumers individual diet plans and health risk plans. For quality assurance purposes the home manager and QMRP conduct periodic checks and monthly audits to ensure the consumers have adequate supervision and training. 5. All of the above is to be implemented no later than 12/30/2011.</p>		