

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  04/17/2014
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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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W000000	This visit was for a recertification and state licensure survey.  Dates of Survey: April 14, 15, 16, 17, 2014  Provider Number: 15G623 Aims Number: 100249470 Facility Number: 001182  Surveyor: Mark Ficklin, QIDP	W000000		
W000249	These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 4/23/14 by Ruth Shackelford, QIDP. 483.440(d)(1) PROGRAM IMPLEMENTATION 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.  Based on observation, record review and interview, the facility failed for 1 of 4 sampled clients (#2) and one non-sample client (#6) to ensure client #2's identified behavior support plan (BSP) and client #6's mobility training program, were implemented when opportunities were present.  Findings include:  An observation was done on 4/14/14 from	W000249	<u>W249</u>  Plan of Correction: Staff will be retrained on implementing training objectives when the opportunity presents itself. Staff will also be retrained on following all interventions in an individual's BSP.  Preventive Action: : Staff will be retrained on implementing training	05/17/2014

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>4:12p.m. to 5:51p.m. at the group home. At 4:50p.m., client #6 walked from the living room to the medication room without the use of a cane. At 4:56p.m., client #6 walked to the dining room table without the use of a cane. At 5:19p.m., client #6 took her plate to the kitchen sink without the use of her cane. Client #6 received verbal directional prompts to help to avoid walking into the counter. Client #6 then went to the bathroom, walking without her cane. Client #6 walked into a chair in the living room on her way to the bathroom and was prompted by staff to put her hands out while walking in the hallway.</p> <p>An observation was done on 4/15/14 from 5:11a.m. to 6:55a.m. at the group home. At 6:04 a.m., client #2 hugged staff #5 without any redirection. At 6:30a.m., client #2 hugged client #3 without redirection from staff #5 who was standing next to them.</p> <p>Record review for client #2 was done on 4/16/14 at 2:12p.m. Client #2's current BSP (9/24/13) indicated client #2 had a training program to address personal space. The BSP indicated client #2 was to be redirected by staff when he hugged others.</p> <p>Record review for client #6 was done on 4/16/14 at 2:41p.m. Client #6 had individual program plan (IPP) dated 11/1/13. The IPP indicated client #6 had a "walking stick" for blindness. The IPP indicated client #6 had a training program to use her cane for safety.</p> <p>Professional staff #1 was interviewed on 4/16/14 at 3:14p.m. Staff #1 indicated client #2 had the identified behavior of personal space included in his BSP. Staff #1 indicated client #2 was to be redirected to be aware of personal space whenever he hugged others.</p>		<p>objectives when the opportunity presents itself. Staff will also be retrained on following all interventions in an individual's BSP.</p> <p>Monitoring: Manager will be in the home at least 3Xs a week to ensure IPP and BSPs are being implemented.</p> <p>Responsible Party: Managers</p> <p>Date to be completed: 5/17/2014</p>	

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W000257	<p>Staff #1 indicated client #6 should use her cane whenever she was up.</p> <p>9-3-4(a) 483.440(f)(1)(iii) PROGRAM MONITORING &amp; CHANGE The individual program plan must be reviewed at least by the qualified mental retardation professional and revised as necessary, including, but not limited to situations in which the client is failing to progress toward identified objectives after reasonable efforts have been made.</p> <p>Based on record review and interview, the facility failed for 1 of 4 sampled clients (#4) to ensure client #4's training program in which client #4 was failing to progress (wear eyeglasses daily), was reviewed and revised as necessary by the facility's qualified intellectual disabilities professional (QIDP).</p> <p>Findings include:</p> <p>Record review for client #4 was done on 4/16/14 at 1:08p.m. Client #4's 5/23/13 individual program plan (IPP) indicated client #4 had a training program to wear his eyeglasses daily. The QIDP monthly data reviews for 11/13 through 2/14 were reviewed on 4/16/14 at 1:08p.m. The QIDP monthly program reviews indicated client #4 had achieved 0% ("refused") for every month from 11/13 through 2/14. There was no documentation the QIDP had addressed/revised the eyeglass program since the 5/23/13 IPP.</p> <p>Professional staff #1 was interviewed on 4/16/14 at 3:14p.m.. Staff #1 indicated client #4's eyeglass training program data, from</p>	W000257	<p><u>W257</u></p> <p>Plan of Correction: New IPP-training objective will be put in place for the individual and eye glasses. Manager will be retrained on when it is appropriate to revise an IPP, and implementation of new training objectives. Staff will be retrained on the importance of reporting to manager when training objectives are not effective.</p> <p>Preventive Action: New IPP- training objective will be put in place for the individual and eye glasses. Manager will be retrained on when it is appropriate to revise an IPP, and implementation of new training objectives. Staff will be retrained on the importance of reporting to manager when training objectives are not effective.</p> <p>Monitoring: Manager will be in the home at least 3Xs a week to ensure</p>	05/17/2014

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W000263	<p>11/13 through 2/14, indicated client #4 had achieved 0% for every month. Staff #1 indicated client #4 had continued to refuse to wear his eyeglasses from 3/14 through the the present date, 4/16/14. Staff #1 indicated there was no documentation the QIDP had addressed and revised client #4's eyeglass wear training program. Staff #1 indicated client #4 was in need of a program revision for his eyeglass wear training.</p> <p>9-3-4(a) 483.440(f)(3)(ii) PROGRAM MONITORING &amp; CHANGE The committee should insure that these programs are conducted only with the written informed consent of the client, parents (if the client is a minor) or legal guardian.</p> <p>Based on record review and interview, the facility's human rights committee (HRC) failed for 1 of 4 sampled clients (#1) with a guardian, to ensure the facility had received written informed consent from the guardian, in regards to client #1's restrictive program which included physical restraint and behavior medication use, prior to HRC approval.</p> <p>Findings include:</p> <p>Record review for client #1 was done on 4/16/14 at 2:37p.m. Client #1's 7/1/13 individual program plan (IPP) indicated client #1 had a restrictive behavior plan that included the use of physical restraint for physical aggression behavior and behavior medication for oppositional defiance. The IPP indicated client #1 had a guardian. The facility's human rights committee (HRC) had</p>	W000263	<p>IPP and BSPs are being implemented.</p> <p>Responsible Party: Manger, Assistant Residential Coordinator</p> <p>Date to be completed: 5/17/2014</p> <p><u>W263</u></p> <p>Plan of Correction: Managers and Nurses will be retrained on the HRC process. They will ensure that all required signatures are obtained before presenting any plans to the HRC.</p> <p>Preventive Action: Managers and Nurses will be retrained on the HRC process. They will ensure that all required signatures are obtained before presenting any plans to the HRC.</p> <p>Monitoring: Assistant Residential Coordinator will check the documentation before HRC meetings and ensure all signatures are present.</p>	05/17/2014

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W000331	<p>approved the IPP on 9/24/13. There was no documentation of written consent by client #1's legal guardian.</p> <p>Professional staff #1 was interviewed on 4/16/14 at 3:14p.m. Staff #1 indicated the facility did not have written informed consent from client #1's guardian in regards to client #1's restrictive behavior program. Staff #1 indicated the facility's HRC had approved client #1's restrictive behavior program without written informed consent from client #1's guardian.</p> <p>9-3-4(a) 483.460(c) NURSING SERVICES The facility must provide clients with nursing services in accordance with their needs.</p> <p>Based on observation, interview and record review, the facility failed to ensure nursing services monitored current medical needs for 1 of 4 sampled clients (#4). The facility failed to ensure client #4 received nursing services and documented care for an open area on his nose.</p> <p>Findings include:</p> <p>An observation was done on 4/14/14 at the group home between 4:12p.m. and 5:51p.m. At 4:12p.m., client #4 was observed to have a red, partially scabbed area, approximately 1 inch long on the bridge of his nose. At 4:38p.m., staff #4 indicated client #4's red area on his nose was from an incident when client #4 rubbed a hoodie over it and then the scab comes off during showers.</p> <p>Client #4 was interviewed on 4/15/14 at 6:38a.m. Client #4 indicated the scab on the</p>	W000331	<p>Responsible Party: Managers, Assistant Residential Coordinator</p> <p>Date to be completed: 5/17/2014</p> <p><b><u>W331</u></b></p> <p>Plan of Correction: Nurses will be retrained on putting notes in the individuals file about nursing measures and treatment plans. Staff will be retrained on the importance of reporting any issues to the nurses immediately and following up when the issues is not resolving itself.</p> <p>Preventive Action: Nurses will be retrained on putting notes in the individuals file about nursing measures and treatment plans. Staff will be retrained on the importance of reporting any issues to the nurses immediately and following up when the issues is not resolving itself.</p> <p>Monitoring: Health Care Coordinator will monitor nurses</p>	05/17/2014			

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	<p>area on his nose comes off during his showers.</p> <p>Client #4's record was reviewed on 4/16/14 at 1:08p.m. There was no documentation in regards to the area on client #4's nose. There were no nursing measures or treatment plan in place.</p> <p>Professional staff #2 (nurse) was interviewed on 4/16/14 at 3:14p.m. Staff #2 indicated they thought the area on client #4's nose had occurred about 10 days ago. Staff #2 indicated they were aware of the area on client #4's nose. Staff #2 indicated there was nothing documented about the care and treatment for the area on client #4's nose.</p> <p>9-3-6(a)</p>		<p>notes periodically over the month</p> <p>Responsible Party: Nurse, Health Care Coordinator Date to be completed: 5/17/2014</p>	