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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G437 | X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____ | X3) DATE SURVEY COMPLETED 06/24/2015 |
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| NAME OF PROVIDER OR SUPPLIER GIBSON COUNTY ARC STOUT ST | STREET ADDRESS, CITY, STATE, ZIP CODE 1015 S STOUT ST PRINCETON, IN 47670 |
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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|------------------------|---|---------------|---|----------------------|
| W 0000 Bldg. 00 | <p>This visit was for a fundamental recertification and state licensure survey.</p> <p>Dates of survey: June 19, 22, 23 and 24, 2015.</p> <p>Provider Number: 15G437 AIMS Number: 100244590 Facility Number: 000951</p> <p>The following federal deficiency also reflects state findings in accordance with 460 IAC 9.</p> | W 0000 | | |
| W 0336 Bldg. 00 | <p>483.460(c)(3)(iii) NURSING SERVICES</p> <p>Nursing services must include, for those clients certified as not needing a medical care plan, a review of their health status which must be on a quarterly or more frequent basis depending on client need.</p> <p>Based on record review and interview for 1 of 3 sampled clients (#1), the facility failed to complete a head to toe nursing assessment of the client at least quarterly.</p> <p>Findings include:</p> | W 0336 | As of 06/05/2015 the residential nurse has completed a head to toe assessment on all clients in the home. Going forward the nurse has created a schedule and spreadsheet to follow to ensure all assessments are completed. Director will follow up monthly | 06/24/2015 |

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>Record review for client #1 was completed on 6/23/15 at 1:40 PM. Client #1's medical record indicated his annual physical, including a head to toe assessment, was completed on 3/11/15. Quarterly nursing assessments were completed on 1/6/15 and 9/29/14. There was no quarterly nursing assessment for April, May or June of 2014.</p> <p>Interview with the facility's Registered Nurse (RN) on 6/23/15 at 2:30 PM indicated there was no quarterly nursing assessment completed on client #1 during the months of April, May or June of 2014. The RN stated "a quarterly nursing assessment should have been completed on [client #1] during that time. Another nurse was employed here at that time and was in charge of completing his nursing assessments."</p> <p>9-3-6(a)</p> | | with the nurse to oversee that this is being done. | | |