

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G166	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 11/21/2014
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NAME OF PROVIDER OR SUPPLIER GIBSON COUNTY ARC PRINCE	STREET ADDRESS, CITY, STATE, ZIP CODE 1512 S JEFFERSON 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
W000000	<p>This visit was for the investigation of complaint #IN00158552.</p> <p>Complaint #IN00158552 - Substantiated. Federal/State deficiency related to the allegation was cited at W154.</p> <p>Dates of Survey: November 19, 20, 21, 2014</p> <p>Provider Number: 15G166 Aims Number: 100234410 Facility Number: 000700</p> <p>Surveyor: Mark Ficklin, QIDP</p> <p>This deficiency also reflects state findings in accordance with 460 IAC 9. Quality Review completed 12/2/14 by Ruth Shackelford, QIDP.</p>	W000000		
W000154	<p>483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated.</p> <p>Based on record review and interview, the facility failed for 1 of 1 incident of injury (fractured humerus, client D) of unwitnessed origin reviewed to ensure all</p>	W000154	All staff have been trained on the use of the investigation template to be used with an accident or injury and where it is located on the computer. It has the nature of the event, the witnesses(staff and	12/03/2014

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>injuries of an unknown origin are thoroughly investigated.</p> <p>Findings include:</p> <p>Record review of the facility incident reports was done on 11/20/14 at 10:25a.m. The incident report review indicated the following: The reportable incident report dated 10/23/14 indicated client D had a fall at the facility operated day program that resulted with client D having a fractured left humerus bone. The 10/23/14 facility "Signs and Symptoms Checklist" indicated the cause of the accident as "[client D] said she tripped over feet." The report did not indicate if the fall was witnessed. There was no documentation of a thorough investigation including client and staff interviews to determine the possible cause of the injury.</p> <p>Professional staff #2 was interviewed on 11/20/14 at 12:48p.m. Staff #2 indicated the above identified incident of injury which resulted with client D's fractured humerus was not witnessed by any staff. Staff #2 indicated the incident had not been thoroughly investigated. Staff #2 indicated they did not have documented interviews of clients and staff to determine the cause of client D's 10/23/14 unknown injury.</p>		<p>consumers). It will be attached.12/26/2014 Corrective Action we will be using the sentinel events procedure when an unexpected occurrence involving death or serious physical or psychological injury or the risk thereof. Serious injury specifically includes loss of limb or loss of function including temporary loss of function. The corrective preventative action form will be completed to find the root cause and correction will be made in addition to filling out the investigation template. The corrective action will be monitored through quality assurance and through the department director. Date implemented 12/03/2014.</p>				

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

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OMB NO. 0938-0391

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	This federal tag relates to complaint #IN00158552. 9-3-2(a)				