

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 04/15/2013
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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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W000000	<p>This visit was for a recertification and state licensure survey. This visit included the investigation of complaint #IN00124656.</p> <p>Complaint #IN00124656: Substantiated, federal and state deficiencies related to the allegation are cited at W186.</p> <p>Dates of Survey: April 1, 2, 4, 11, 12, and 15, 2013</p> <p>Provider Number: 15G613 Aims Number: 100245650 Facility Number: 001177</p> <p>Surveyor: Mark Ficklin, Medical Surveyor III</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9.</p> <p>Quality review completed April 19, 2013 by Dotty Walton, Medical Surveyor III.</p>	W000000		
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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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W000149	<p>483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. Based on interview and record review, the facility failed for 1 of 2 allegations of client abuse/neglect reviewed (clients A, F), to implement policy and procedures to ensure allegations of abuse/neglect were immediately reported to the administrator and to ensure all corrective action was identified and completed.</p> <p>Findings include:</p> <p>Review of the facility's incident/investigations was done on 4/1/13 at 12:50p.m. The following 11/5/12 abuse investigation indicated: On 11/2/12, direct care staff (DCS) #6 reported to the facility an allegation of abuse by DCS staff #7 to clients A and F (disrespectful tone of voice). The report indicated the incident had occurred on 10/25/12. The investigation/incident report indicated the facility administrator was not made aware of the 10/25/12 allegation of abuse until 11/2/12. The investigation indicated the abuse was substantiated and the staff was terminated. The investigation had no further identified corrective action needs in regards to staff reporting alleged abuse late.</p>	W000149	<p>Upon investigation of allegation of suspected abuse/neglect, staff over clients A and F was terminated on 11/8/12. The facility has retrained all staff on policy 995, Incident Reporting. This was completed on 4/3/13. All staff also completed online Syberworks tested which was completed by 4/7/13. The facility also retrained all staff on policy 885, suspected abuse and neglect of consumers which was completed on 4/7/13. The BDDS coordinators will be retrained to file a BDDS report to the state within 24 hours of occurrence or knowledge. This will be completed by 5/15/13. The agency will provide monthly retraining over company policy 995. The agency will also provide annual retraining via Syberworks for Incident Reporting. While an investigation is being completed in regards to the incident reported, the consumer(s) will not be allowed to be in contact with any staff who is still being investigated. Upon completion of the investigation, a determination in employment will be made.</p>	05/15/2013			

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	<p>The facility's policy and procedures were reviewed on 4/12/13 at 8:44a.m.</p> <p>1. The policy dated 2/7/09 "Incident Reporting" documented: "It is the policy of GCARC to report all reportable incidents or unusual occurrences using the BDDS Incident report web site within 24 hours of occurrence. All staff are trained on incident reporting and understand that even if they may not be the designated reporting person, they are responsible to ensure follow up on incidents."</p> <p>2. The policy dated 11/18/11 "Suspected Abuse and Neglect of Consumers" documented: "Verbal abuse includes, but is not limited to, using verbal or written ridiculing, profane, or abusive language with or towards a consumer, and/or using gestures with disparaging or derogatory implications. If alleged abuse occurs per the above definitions, staff will notify the departmental director and/or after business hours the administration staff. The written reports must be completed within 24 hours. A designated individual, such as a QMRP, will train staff on this policy and procedure."</p> <p>Professional staff #1 was interviewed on 4/12/13 at 10:30a.m. Professional staff #1 indicated facility staff had not followed</p>						

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	<p>facility policy and procedures by failing to immediately report an allegation of staff to client abuse, occurred on 10/25/12 and staff reported 11/2/12. Professional staff #1 indicated the facility's corrective action for the 11/2/12 allegation of abuse, had not identified the need to retrain staff on policy and procedures regarding immediately reporting allegations of abuse/neglect.</p> <p>9-3-2(a)</p>			

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W000153	<p>483.420(d)(2) STAFF TREATMENT OF CLIENTS The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures. Based on record review and interview, the facility failed for 1 of 2 alleged abuse incidents (clients A, F) reviewed, to immediately report allegations to the administrator in accordance with state law.</p> <p>Findings include:</p> <p>Review of the facility's incident/investigations was done on 4/1/13 at 12:50p.m. The following 11/5/12 abuse investigation indicated: On 11/2/12, direct care staff (DCS) #6 reported to the facility an allegation of abuse by DCS staff #7 to clients A and F (disrespectful tone of voice). The report indicated the incident had occurred on 10/25/12. The investigation/incident report indicated the facility administrator was not made aware of the 10/25/12 allegation of abuse until 11/2/12.</p> <p>Staff #1 was interviewed on 4/12/13 at 10:30a.m. Professional staff #2 indicated facility staff had not followed facility policy and procedures by failing to</p>	W000153	<p>Upon investigation of allegation of suspected abuse/neglect, staff over clients A and F was terminated on 11/8/12. The facility has retrained all staff on policy 995, Incident Reporting. This was completed on 4/3/13. All staff also completed online Syberworks tested which was completed by 4/7/13. The facility also retrained all staff on policy 885, suspected abuse and neglect of consumers which was completed on 4/7/13. The BDDS coordinators will be retrained to file a BDDS report to the state within 24 hours of occurrence or knowledge. This will be completed by 5/15/13. The agency will provide monthly retraining over company policy 995. The agency will also provide annual retraining via Syberworks for Incident Reporting. While an investigation is being completed in regards to the incident reported, the consumer(s) will not be allowed to be in contact with any staff who is still being investigated. Upon completion of the investigation, a determination in employment will be made.</p>	05/15/2013	

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	<p>immediately report an allegation of staff to client abuse on 10/25/12. Professional staff #2 indicated the DCS staff were aware of the allegation on 10/25/12 and reported it to the facility administrator on 11/2/12.</p> <p>9-3-2(a)</p>				

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W000157	<p>483.420(d)(4) STAFF TREATMENT OF CLIENTS If the alleged violation is verified, appropriate corrective action must be taken. Based on record review and interview, the facility failed for 1 of 2 investigations of alleged abuse (staff to client verbal) reviewed (clients A, F), to ensure appropriate corrective action was taken.</p> <p>Findings include:</p> <p>Review of the facility's incident/investigations was done on 4/1/13 at 12:50p.m. The following 11/5/12 abuse investigation indicated: On 11/2/12, direct care staff (DCS) #6 reported to the facility an allegation of abuse by DCS staff #7 to clients A and F (disrespectful tone of voice). The report indicated the incident had occurred on 10/25/12. The investigation/incident report indicated other DCS were aware of allegations of abuse by DCS #7 to clients A and F prior to the allegation reported on 11/2/12. The investigation indicated the abuse was substantiated and staff #7 was terminated. The investigation had no further identified corrective action in regards to staff reporting alleged abuse late.</p> <p>Interview of staff #1 on 4/12/13 at 10:30a.m. indicated the corrective action for the above incident was not</p>	W000157	The facility has retrained all staff on policy 995, Incident Reporting. This was completed on 4/3/13. All staff also completed online Syberworks tested which was completed by 4/7/13. The facility also retrained all staff on policy 885, suspected abuse and neglect of consumers which was completed on 4/7/13. The BDDS coordinators will be retrained to file a BDDS report to the state within 24 hours of occurrence or knowledge. This will be completed by 5/15/13. While an investigation is being completed in regards to the incident reported, the consumer will not be allowed to be in contact with any staff who still being investigated. Upon completion of the investigation, a determination in employment will be made.	05/15/2013			

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	documented. Staff #1 indicated the DCS should have been retrained regarding timely reporting of abuse/neglect. 9-3-2(a)			

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W000159	<p>483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional. Based on record review and interview, the facility failed for 1 of 3 sampled clients (A) to ensure each client's active treatment program was coordinated and monitored by the facility's qualified intellectual disabilities professional (QIDP), by the QIDP not completing quarterly program reviews.</p> <p>Findings include:</p> <p>Record review for client A was done on 4/11/13 at 11:40a.m. Client A's QIDP program reviews indicated client A had an individual program plan (IPP) dated 9/8/12. There were no documented QIDP program reviews during the time period of 9/8/12 through 4/11/13.</p> <p>Staff #2 (QIDP) was interviewed on 4/12/13 at 10:30a.m. Staff #2 indicated the QIDP should be reviewing the clients' programs at least quarterly. Staff #2 indicated quarterly QIDP program reviews had not been done for client A since 9/12.</p> <p>9-3-3(a)</p>	W000159	Due to the former QMRP neglecting his program duties before his departure from the company. The current QDDP has been in-serviced to have monthly and quarterly program reviews completed by the 15th of each month.	05/15/2013			

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W000186	<p>483.430(d)(1-2) DIRECT CARE STAFF</p> <p>The facility must provide sufficient direct care staff to manage and supervise clients in accordance with their individual program plans.</p> <p>Direct care staff are defined as the present on-duty staff calculated over all shifts in a 24-hour period for each defined residential living unit.</p> <p>Based on observation, record review and interview, the facility failed for 3 of 3 sampled clients (A, B, C) and three non-sample clients (D, E, F) to ensure a sufficient number of direct care staff worked in the home to supervise and manage the clients to meet their needs.</p> <p>Findings include:</p> <p>An observation was done at the group home on 4/4/13 from 3:50p.m. to 4:22p.m. During the observation there were 6 clients (A, B, C, D, E, F) and 2 direct care staff. At 3:50p.m. staff #8 was in the medication room doing the medication pass with client A. Staff #5 was supervising clients B, C, D, E and F. At 4:53p.m., staff #5 went with client D to his bedroom. This left clients B, C, E and F with no direct staff supervision. Client A returned to the living room at 3:54p.m. with no staff in the area. Staff #5 also assisted client E in his bedroom before returning to the living room at</p>	W000186	<p>The facility has signed a contract with Bella Staffing which is a temp service in Princeton IN. As of today 5/2/13 we currently have triple staff at 116 North 8 th Street, Princeton, IN 47670 during the busy time in the mornings and the busy times in the evenings. Staff will also be retrained on Client A behavior management plan addressing "cannot enter kitchen without supervision due to the opportunity to mismanage snacks or horde food he is driven to. This will be completed by 5/15/13. The agency will continue to monitor this by providing yearly re-training on all behavior plans. Also, on April 23, 2013, we participated in a job fair at Gibson County Fairgrounds where we had 16 people apply. Since that time, we have been able to interview and hire at least 10 to 12 employees.</p>	05/15/2013	

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	<p>3:59p.m. Interview of staff #5 at 4:00p.m. on 4/4/13, indicated client E was a 2 person assist with transfers, client A was line of sight supervision due to falls and behaviors and client F was line of sight supervision due to history of going outside.</p> <p>Record review on 4/15/13 at 8:30a.m. of the facility's "Consumer Work Reported" time reports from 3/24/13 through 4/6/13, indicated only 2 staff worked on the following evening shifts between 3p.m. to 11p.m: 3/24/13, 3/25/13, 3/26/13, 3/27/13, 3/28/13, 3/30/13, 3/31/13, 4/2/13, 4/4/13, 4/5/13.</p> <p>Record review for client A was done on 4/11/13 at 11:40a.m. Client A had a 9/8/12 behavior management plan that included/addressed: "cannot enter kitchen without supervision due to opportunity to mismanage snacks or horde food, he is food driven." Client A had a 9/8/12 individual program plan (IPP). Client A's IPP identified line of sight supervision due to ambulation issues with history of falls, behaviors usually in the kitchen and diabetes.</p> <p>Confidential staff interview indicated there were usually 2 staff scheduled for the evening shift at the group home. The</p>						

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	<p>interview indicated 3 staff were needed to meet the programming and hygiene needs of the clients.</p> <p>Administrative staff #1 was interviewed on 4/12/13 at 10:30a.m. Staff #1 indicated there should be 3 staff on duty during the afternoon/evening to assist with medication pass, bathing/toileting, dining and programming. Staff #1 indicated client A was to be kept in line of sight due to falls and behaviors. Staff #1 indicated the facility was continuing to actively seek new employees for the group home and to fill shift openings with administrative staff if needed.</p> <p>This federal tag relates to the investigation of complaint #IN00124656.</p> <p>9-3-3(a)</p>				

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W000210	<p>483.440(c)(3) INDIVIDUAL PROGRAM PLAN Within 30 days after admission, the interdisciplinary team must perform accurate assessments or reassessments as needed to supplement the preliminary evaluation conducted prior to admission.</p> <p>Based on observation, record review and interview, the facility failed for 2 of 3 sampled clients (A, C) to ensure clients A and C had been reassessed in regards to their dining needs.</p> <p>Findings include:</p> <p>An observation was done on 4/1/13 from 3:25p.m. to 5:24p.m. at the group home. At 5:10p.m. clients A and C ate supper. Clients A and C had green beans and spaghetti on regular style plates. Clients A and C were unable to scoop the food on their plates. Clients A and C had pushed their food off their plates and were eating off of the dining room table. Staff #5 was interviewed on 4/1/13 at 5:12p.m. Staff #5 indicated clients A and C had some spillage from their plates in the past while scooping food. Staff #3 indicated client C used to use a divided plate but doesn't use one now because there was no order for one. Staff #3 indicated clients A and C may benefit from a different style plate.</p> <p>The record of client A was reviewed on 4/11/13 at 11:40a.m. Client A had an</p>	W000210	Speech evaluations completed on consumer A and consumer C to address dining issues. This will be completed by 5/15/13. The facility will get in contact with the physician to have lift plates for client A and client C. this will be resolved by 5/15/13. The team will also ensure this is included in both client dining and IPP plans by 5/15/13. The agency will continue to monitor this by providing yearly re-training on all dining plans as well a retrain al staff regarding when to fill out a signs and symptom form. Additional retraining will be completed in regards to signs and symptom forms as deemed essential.	05/15/2013			

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	<p>individual program plan (IPP) dated 9/8/12. The IPP did not address client A's identified difficulty with eating some items on a regular style plate.</p> <p>The record of client C was reviewed on 4/11/13 at 2:12p.m. Client C had an IPP dated 12/7/12. The IPP did not address client C's identified difficulty with eating some items on a regular style plate.</p> <p>Staff #2 (qualified intellectual disabilities professional, QIDP) was interviewed on 4/12/13 at 10:30a.m. QIDP #1 indicated clients A and C had not been reassessed for dining skills and may be in need of another style plate or adaptive equipment to assist with their independent dining skills.</p> <p>9-3-4(a)</p>			

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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			
(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			
W000336	<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. Based on record review and interview, the facility failed for 3 of 3 sampled clients (A, B, C) to provide the clients with a quarterly health status review between 11/12 through 4/11/12.</p> <p>Findings include:</p> <ol style="list-style-type: none"> The record of client A was reviewed on 4/11/13 at 11:40a.m. Client A's documented quarterly nursing reviews indicated quarterly reviews were completed during 5/12, 8/12 and 11/12. Client A's 3/28/13 Physician's Orders indicated client A was not on a medical care plan. The record of client B was reviewed on 4/11/13 at 2:45p.m. Client B's documented quarterly nursing reviews indicated quarterly reviews were completed during 5/12, 8/12, and 11/12. Client B's 3/28/13 Physician's Orders indicated client B was not on a medical care plan. The record of client C was reviewed on 4/11/13 at 2:12p.m. Client C's 	W000336	Client A, B, and C nursing quarterly reports will be completed no later than 5/15/13. The nurses will be trained that nursing reports must be completed by the 15 th of each month/quarter and should send a email to the QDDP/Director making them aware that the reports have completed.	05/15/2013			

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	<p>documented quarterly nursing reviews indicated quarterly reviews were completed during 5/12, 8/12 and 11/12. Client C's 3/28/13 Physician's Orders indicated client C was not on a medical care plan.</p> <p>Interview of staff #3 (nurse) on 4/12/13 at 10:30a.m., indicated clients A, B and C were not on a medical care plan. Staff #3 indicated there was no documentation the quarterly nursing reviews for clients A, B and C had been completed since 11/12.</p> <p>9-3-6(a)</p>				