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

FORM APPROVED
OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	15G437	A. BUILDING 00 B. WING	12/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ARC SOUTHWEST INDIANA, THE	1015 S STOUT ST PRINCETON, IN 47670

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W 0000 Bldg. 00	This visit was for a predetermined full recertification and state licensure survey. This visit included the Covid-19 focused infection control survey. Survey Dates: 12/13/21, 12/14/21, 12/15/21 and 12/16/21. Facility Number: 000951 Provider Number: 15G437 AIM Number: 100244590 These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review of this report completed by #15068 on 12/22/21.	W 0000		
W 0159 Bldg. 00	483.430(a) QIDP Each client's active treatment program must be integrated, coordinated and monitored by a qualified intellectual disability professional who- Based on record review and interview for 2 of 3 clients in the sample (#1 and #2), the facility's Qualified Intellectual Disabilities Professional (QIDP) failed to integrate, coordinate and monitor the clients' program plans. The QIDP failed to ensure the CFAs (Comprehensive Functional Assessments) for clients #1 and #2 were completed within 30 days of admission. The QIDP failed to ensure staff documented the implementation of program plan training objectives for May 2021 for clients #1 and #2. Findings include:	W 0159	The QIDP was Inserviced on integrating, coordinating and monitoring the consumer's program plans. This Inservice included: QIDP observes individuals, reviews data and progress, and revision program plans based on individual needs and performance. CFA to be completed within 30 days of admission and the pre-admission CFA can update prior to the initial IPP. Annually or as necessary the CFA will be completed and	01/06/2022

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE　　TITLE　　(X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 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 disclo 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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	1) On 12/15/21 at 8:15 AM, client #1's record was reviewed. Client #1 moved into the group home on 4/9/21. Client #1 had a quarterly review of the following training objectives completed on 9/23/21. "#1: Participate in Cooking. -August 0% -July 0% -June 0% -Quarterly 0% (Refusals) #2: Participate in Laundry. -August 12% -July 0% -June 0% -Quarterly 4% #3: Complete Daily household chore. -August 60% -July 0% -June 100% -Quarterly 53% #4: Shower. -August 92% -July 100% -June 100% -Quarterly 97% #5 Brush Teeth. -August 100% -July 100% -June 100% -Quarterly 100% #6 Follow low fat, low cholesterol, low sodium diabetic diet. -August 100% -July 100%		updated. The IPP goals/objectives will be developed from the information from the CFA's. IPP objectives will be updated according to progression or regression of the individual. Monthly and Quarterly reviews will state whether the objective/strategies have been met and if changes are necessary. Data Sheets for the objectives are placed in the home upon completion and revision of the IPP. Changes in the training objective/strategies will be reflected on the Data Sheets as the IPP is revised or initiated. Residential Director will create a checklist for the QIDP to follow upon receiving a new admission. Residential Director will randomly audit QIDP files on a monthly basis. Residential Director will sign off on monthlies, quarterlies, and IPP's for 6 months then randomly to guarantee changes to the program plans and CFA's are being completed accurately, in a timely manner, and the QIDP follows and documents the progress of all individuals correctly. Also will ensure objectives and strategies are according to SMART Goal Writing.	

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-June 100%
-Quarterly 100%

#7: Exercise.
-August 100%
-July 100%
-June 94%
-Quarterly 98%

#8 Community Outing.
-August 100%
-July 100%
-June 100%
-Quarterly 100% "

The quarterly review did not indicate whether or not client #1 met or did not meet his training objectives.

The quarterly review did not indicate a revision was made to the ISP.

2) On 12/15/21 at 9:32 AM, client #2's record was reviewed. Client #2 moved into the group home on 4/9/21. Client #2 had a quarterly review of the following training objectives completed on 9/23/21.

"#1: Participate in Cooking.
-August 0%
-July 0%
-June 0%
-Quarterly 0% All Refusals

#2: Participate in Laundry.
-August 11%
-July 0%
-June 0%
-Quarterly 4%

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#3: Participate in Household chore.
-August 0%
-July 0%
-June 0%
-Quarterly 0% All Refusals

#4: Shower.
-August 71%
-July 14%
-June 33%
-Quarterly 39%

#5 Completely dry off after shower.
-August 67%
-July 100%
-June 33%
-Quarterly 67%

#6 Encouraged to toilet every hour/avoid accidents.
-August 11%
-July 82%
-June 43%
-Quarterly 45%

#7: Encouraged to put on clean brief after accident.
-August 100%
-July 18%
-June 74%
-Quarterly 64%

#8: Brush Teeth.
-August 0%
-July 17%
-June 71%
-Quarterly 29%

#9: Follow Menu/1800 cal (calorie) diet.
-August 100%

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-July 100%
-June 88%
-Quarterly 96%

#10: Discuss healthy food choices for diabetics.
-August 13%
-July 50%
-June 100%
-Quarterly 54%

#11: Exercise.
-August 0%
-July 25%
-June 67%
-Quarterly 56%

#12: Community Outing.
-August 100%
-July 0%
-June 67%
-Quarterly 56%"

The quarterly review did not indicate whether or not client #2 met or did not meet her training objectives.

The quarterly review did not indicate a revision was made to the ISP.

On 12/15/21 at 11:28 AM, the QIDP stated, "Yes" training objectives should be written in measurable terms "so we can track their (the clients') progress." The QIDP indicated it was the responsibility of the QIDP to review and revise the ISP when a client has progressed or regressed. The QIDP indicated monthly and quarterly reviews were completed. The QIDP stated, "I revise the ISP at each quarter."

2) Please refer to W210. For 2 of 3 clients in the

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	sample (#1 and #2), the QIDP (Qualified Intellectual Disabilities Professional) failed to ensure the CFAs for clients #1 and #2 were completed within 30 days of admission. 3) Please refer to W252. For 2 of 3 clients in the sample (#1 and #2), the QIDP failed to ensure staff documented the implementation of program plan training objectives for May 2021 for clients #1 and #2. 9-3-3(a)			
W 0210 Bldg. 00	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. Based on record review and interview for 2 of 3 clients in the sample (#1 and #2), the facility failed to ensure CFAs (Comprehensive Functional Assessments) for clients #1 and #2 were completed within 30 days of admission. Findings include: On 12/15/21 at 8:15 AM, a review of client #1's record was conducted. Client #1 was admitted to the group home on 4/9/21. Client #1's CFA was completed on 7/4/21. On 12/15/21 at 9:32 AM, a review of client #2's record was conducted. Client #2 was admitted to the group home on 4/9/21. Client #2's CFA was completed on 7/4/21. On 12/15/21 at 11:26 AM, the PD (Program Director) and QIDP were interviewed. The PD	W 0210	Assessment must be completed within 30 days of admission and this can be the reviewed and updated pre-admission assessments. Inservice completed by QIDP states she will complete the CFA within 30 days of admission and the pre-admission CFA can be utilized and updated prior to the development of the initial IPP which will replace the introductory IPP. Annually or as necessary the CFA will be completed and updated according to progress. The IPP goals/objectives will be developed from the information from the CFA's. If QIDP desires the input of the home staff, QIDP will utilize her calendar or "Outlook	01/06/2022

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	indicated the functional assessments were to be completed by the QIDP within one month (30 days). The PD stated, "Yes" the assessments were completed late. The QIDP stated, "I sent it (the assessments) out for completion and I guess I just didn't pay attention to the date of when I got it back." 9-3-4(a)		Task" to remind her when the CFA's is due for current progress and completion. Residential Director will create a checklist for the QIDP to follow upon receiving a new admissions and will review the checklist and monitor for accuracy and completion of all tasks on checklist.	
W 0252 Bldg. 00	483.440(e)(1) PROGRAM DOCUMENTATION Data relative to accomplishment of the criteria specified in client individual program plan objectives must be documented in measurable terms.			
	Based on record review and interview for 2 of 3 clients in the sample (#1 and #2), the facility failed to ensure staff documented the implementation of program plan training objectives for May 2021 for clients #1 and #2. Findings include: 1) On 12/15/21 at 8:15 AM, client #1's record was reviewed. Client #1 moved into the group home on 4/9/21. The ISP (Individual Support Plan) dated 5/1/21 had the following training objectives: -"I will participate in cooking at least weekly. -I will participate in completing my laundry at least weekly. -I will complete my daily household chore. -I will participate in a shower at least 4 times weekly. -I will brush my teeth every morning. -I will follow a low fat, low cholesterol, low sodium diabetic diet.	W 0252	Data related to the accomplishments of the individual must be documented in measurable terms. Training objectives should be implemented when the IPP is implemented and Monthlies and Quarterlies should reflect measurable outcomes and progress of the individual. Inservice was completed by QIDP stating Data Sheets were to be place in the home upon completion of the IPP. Data will reflected through qualitative or numerical objectives/strategies. QIDP will use SMART Goal Writing. Monthlies and Quarterlies will state if the objective/strategies have been met or not. Residential Director will sign off on monthlies, quarterlies, and IPP's	01/06/2022

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	-I will exercise at least 10 minutes daily 3 times weekly. -I will participate in community outing weekly when no COVID quarantine." A review of client #1's Monthly Data Sheets was completed. -There was no documentation of monthly data sheets for training objectives for May 2021. 2) On 12/15/21 at 9:32 AM, client #2's record was reviewed. Client #2 moved into the group home on 4/9/21. The ISP dated 5/1/21 had the following training objectives: -"I will participate in cooking at least weekly. -I will complete my laundry at least weekly. -I will complete my daily household chore. -I will participate in shower at least 4 times weekly or after a BM (bowel movement) accident. -I will dry completely after a shower. -I will be encouraged to toilet every hour. -I will put clean briefs on when I have an accident. -I will brush my teeth daily. -I will follow group home menu and my 1800 calorie diet. -I will discuss with staff healthy food choices for my diabetes. -I will participate in at least 10 minutes of exercise 3 times weekly. -I will participate in community outing when no COVID quarantine." A review of client #2's Monthly Data Sheets was completed. -There was no documentation of monthly data sheets for training objectives for May 2021.		for 6 months then randomly to guarantee changes to the program plans and CFA's are being completed accurately, in a timely manner, and the QIDP follows and documents the progress of all individuals correctly. Also will ensure objectives and strategies are according to SMART Goal Writing.	

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	On 12/15/21 at 11:28 AM, the QIDP (Qualified Intellectual Disabilities Professional) indicated training objectives were to be implemented as soon as the ISP was implemented. 9-3-4(a)			
W 0382 Bldg. 00	483.460(l)(2) DRUG STORAGE AND RECORDKEEPING The facility must keep all drugs and biologicals locked except when being prepared for administration. Based on observation and interview for 8 of 8 clients in the group home (#1, #2, #3, #4, #5, #6, #7 and #8), the facility failed to store the clients' medications securely at all times. Findings include: On 12/13/21 from 3:38 PM to 5:59 PM, an observation was conducted at the group home. At 4:59 PM, staff #2 stepped out of the office of the group home to get client #6 for her medication pass. Staff #2 left client #6's medications on the desk of the office and left the office door open. Staff #2 was out of the room for 30 seconds. At 5:08 PM, staff #2 stepped out of the office of the group home to get client #7 for his medication pass. Staff #2 left client #7's medications on the desk of the office and left the office door open. Staff #2 was out of the room for 30 seconds. At 5:09 PM, staff #2 again stepped out of the office and left the office door open with client #7's medications sitting on the desk. Staff #2 was out of the room with the door open for 2 minutes. At 5:11 PM, staff #2 once again stepped out of the office and left the office door open with client #7's medications sitting on the desk. Staff #2 was away from the office for 5 minutes. At 5:28 PM, the RM (Resident Manager) wheeled client #7	W 0382	Facility must keep all drugs and biologicals locked up and secure except when medications are being prepared for administering. An inservice was completed stating staff should make sure to medication is secure at all times. Staff should lock up medications when leaving the med room. During the staff meeting on 1/4/22, a thorough training was completed regarding proper storage of medication. Everything can be placed in the medication closet to keep it secure until returning to the office or the office door must be locked when leaving medication out on the desk. Staff also were made aware of the danger to the consumers if meds are left unattended or not secured. Managers, nurses, QIDP, and Residential Director will monitor with drop-in and will enforce proper storage of medications by giving a written warning for non-compliance with this health and safety issue.	01/04/2022

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from the office to his recliner in the living room. The RM left the medication cabinet in the medication room unlocked. The RM left the office door open. The medication closet and office were left unoccupied for 1 minute. At 5:36 PM, staff #2 stepped out of the office and left client #5's medications on the desk in the office. Staff #2 left the medications unattended in the unlocked room for 3 minutes. This affected clients #1, #2, #3, #4, #5, #6, #7 and #8.

On 12/14/21 from 5:39 AM to 8:15 AM, an observation was conducted at the group home. At 6:38 AM, the RM stepped out of the office and got a box of Kleenex from a closet. The RM left the medication cabinet inside the unlocked medication closet open for 30 seconds. Client #4 sat in the medication room unattended. This affected clients #1, #2, #3, #4, #5, #6, #7 and #8.

On 12/13/21 at 5:52 PM, staff #2 stated, "Medications were to be locked in the group home." Staff #2 stated, "The door should not be left open if I need to leave the medication room."

On 12/14/21 at 8:14 AM, staff #3 stated, "Staff should not leave the medication room during medication pass. If staff do have to leave, the medications should be locked when no one is in the medication room."

On 12/15/21 at 11:16 AM, the Nurse and PD (Program Director) were interviewed. The PD stated, "Medications were to be locked at all times." The nurse stated, "Controlled medications are to be double locked." The nurse indicated when staff leave the office the door should be closed and locked behind them.

9-3-6(a)

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W 0455 Bldg. 00	483.470(l)(1) INFECTION CONTROL There must be an active program for the prevention, control, and investigation of infection and communicable diseases.			
	Based on observation, record review and interview for 8 of 8 clients in the group home (#1, #2, #3, #4, #5, #6, #7 and #8), the facility failed to ensure staff working in the home implemented proactive/preventative COVID-19 infection control measures. Findings include: On 12/13/21 from 3:38 PM to 5:59 PM, an observation was conducted at the group home. At 4:26 PM, staff #2 prepared to administer medications to client #1. Staff #2's facemask only covered his mouth. At 4:29 PM, staff #2 administered medications to client #1. Staff #2 did not prompt client #1 to wash or sanitize his hands. At 4:40 PM, staff #2 prepared to administer medications to client #2. Staff #2's facemask only covered his mouth. At 4:45 PM, staff #2 administered medications to client #2. Staff #2 did not prompt client #2 to wash or sanitize her hands. At 4:59 PM, staff #2 prepared to administer medications to client #6. Staff #2's facemask only covered his mouth. At 5:00 PM, staff #2 administered medications to client #6. Staff #2 did not prompt client #6 to wash or sanitize her hands. This affected clients #1, #2, #3, #4, #5, #6, #7 and #8. On 12/14/21 from 5:39 AM to 8:15 AM, an observation was conducted at the group home. At 5:39 AM, client #4 came to the dining room table for breakfast. Client #4 was not prompted to wash or sanitize her hands prior to coming to the table for breakfast. At 5:42 AM, client #1 came to	W 0455	There must be an active program for prevention, control, and investigation of infection and communicable diseases. An inservice was completed at the 1/4/22 staff meeting reviewed the correct way to wear the face mask during the entire shift, over both the nose and mouth to control the spread of diseases, germs, and respiratory spray from talking, sneezing, coughing, etc… The inservice also covered individuals washing hands or using hand sanitizer before taking meds; before eating snack, meals or getting into the refrigerator; and after using the bathroom. Also discussed individuals and staff wearing face mask properly while in public places and using hand sanitizer upon returning to van and home. This will be monitored by home manager and administrative staff which includes nurses, QIDP, and Residential Director. Employee warnings will apply if not complying with this standard.	01/04/2022

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the dining room table for breakfast. Client #1 was not prompted to wash or sanitize his hands prior to coming to the table for breakfast. At 5:55 AM, client #3 came to the kitchen and poured her orange juice and milk for breakfast and sat at the dining room table for breakfast. Client #3 was not prompted to wash or sanitize her hands for breakfast. At 6:58 AM, client #8 came to the dining room for breakfast. Client #8 was not prompted to wash or sanitize her hands prior to coming to the table for breakfast. At 7:36 AM, client #5 came to the dining room for breakfast. Client #5 was not prompted to wash or sanitize his hands before breakfast. This affected clients #1, #2, #3, #4, #5, #6, #7 and #8.

On 12/15/21 at 11:28 AM, the CDC (Center for Disease Control) website https://www.cdc.gov/coronavirus/2019-ncov/hcp/assisted-living.html#source-control was reviewed. The CDC website indicated the following:

-"Have a plan for visitor and personnel restrictions.
-Designate one or more facility employees to actively screen all visitors and personnel, including essential consultant personnel, for the presence of fever and symptoms consistent with COVID-19 before starting each shift/when they enter the building. Send visitors and personnel home if they have a fever (temperature of 100.0 oF (degrees) or greater) or symptoms consistent with COVID-19.

-Educate residents, family members, and personnel about COVID-19:
·Describe actions residents and personnel can take to protect themselves in the facility, emphasizing the importance of social (physical) distancing, hand hygiene, respiratory hygiene and

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	15G437	A. BUILDING 00 B. WING	12/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ARC SOUTHWEST INDIANA, THE	1015 S STOUT ST PRINCETON, IN 47670

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	cough etiquette, and source control. -Encourage source control. ·Everyone in the facility should practice source control. ·Personnel should wear a facemask (or cloth face covering if facemasks are not available or only source control is required) at all times while they are in the facility. ·Visitors should wear a cloth face covering while in the facility. Source Control: Use of a cloth face covering or facemask to cover a person's mouth and nose to prevent spread of respiratory secretions when they are talking, sneezing, or coughing." On 12/14/21 at 8:14 AM, staff #3 indicated clients should be encouraged to wash or sanitize their hands before meals and medications for sanitary purposes. Staff #3 stated, "Facemasks are to be worn covering both the nose and mouth." On 12/15/21 at 11:23 AM, the PD (Program Director) stated masks were to be worn over the nose and mouth "because of COVID". The PD indicated clients should be encouraged to wash or sanitize their hands prior to eating or taking their medications for sanitation and to prevent the spread of infection. 9-3-7(a)			
W 9999 Bldg. 00	State Findings The following Community Residential Facilities for Persons with Developmental Disabilities rule was	W 9999	Medication errors will be reported to BDDS within 24 hours of occurrence. Inservice was completed by staff	01/04/2022

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	not met: 460 IAC 9-3-1 Governing Body (b) The residential provider shall report the following circumstances to the division by telephone no later than the first business day followed by written summaries as requested by the division: 16.) A medication error or medical treatment error as follows: b) wrong medication dosage given and c.) missed medication - not given. This state rule was not met as evidenced by: Based on record review and interview for 3 of 6 incident/investigative reports reviewed affecting clients #5 and #7, the facility failed to ensure client #5 did not receive an extra dose of medication and client #7's missed medications were reported to the Bureau of Developmental Disabilities Services (BDDS) within 24 hours in accordance with state law. Findings include: On 12/13/21 at 11:08 AM, a review of the facility's incident/investigative reports was conducted and indicated the following: On 10/2/21 at 4:30 PM (reported to BDDS on 10/4/21) for client #7, "We were notified on 10/4 that during buddy check on 10/3, that staff found that Potassium Chloride (supplement) 10 meq (milliequivalent per liter) was not give (sic) at 4:30 PM dose on 10/2. No adverse reactions from not receiving evening dose. (He gets in the morning, as well). Staff that did not administer the KCI-(Potassium chloride) on 10/2 will be given a verbal warning, have a supervised medication pass her		to ensure, review, and retrain on the correct process of completing a buddy check and what is expected of them. Employee warning will not be given only to the person who created the medication error, but also to the buddy checker who did not complete the buddy check process or check meds thoroughly. Buddy Check is to be done immediately after the Med Passer has finished passing meds unless there is only one staff available during the med pass, then the next person on shift, within 15 minutes will complete the Buddy Check. The person who created the med error will be required to come to the office within 3 business days, complete the Corrective/Preventative Action to find the root cause and prevention of another med error, receive an employee warning, supervised med passes (at nurse and administrative convenience) and possibly retake Core B. Managers will schedule supervised med passes, Nurses will complete the employee warning and Core B training, and Residential Director will complete the CA/PA form with person who created the med error.	

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	next day of work, and be given the medication administration policy to read, sign and date. The staff that did not do the buddy check on time will be given a verbal warning, as well, to reiterate the importance of doing the buddy check on time." On 8/7/21 at 5:30 AM (reported to BDDS on 8/9/21) for client #7, "Medication Entecavir (treat hepatitis B) 0.5 mg (milligram) tablet was not given. Written warning. Supervised medication pass. Timely buddy checks." On 2/13/21 at 8:00 PM (reported to BDDS on 2/17/21), "During medication pass at 8:00 PM additional medication was given by mistake. This happened on 2/13/21 and 2/14/21. [Client #5] was to get Luvox (obsessive-compulsive behavior) 150 mg at bedtime, he received 250 mg each night. There was a medication increase with this medication from 100 mg to 150 mg at bedtime. It appears that staff did not follow MAR (Medication Administration Record). Will receive Employee warning, will receive an in service on passing medications and have a supervised medication pass." On 12/15/21 at 12:00 PM, the PD (Program Director), QIDP (Qualified Intellectual Disabilities Professional) and Nurse were interviewed. The QIDP indicated medication errors were to be reported within 24 hours of knowledge. The QIDP indicated a buddy check system was in place to ensure medications were administered correctly. The QIDP indicated if a medication error occurred after hours, the nurse was to be notified using the pager phone. The PD indicated the medication errors were reported late. The nurse stated, "It is a documentation error on the buddy checker for not following the procedure" of the buddy check system.			

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	9-3-1(b)			