

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G350	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 07/02/2014
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NAME OF PROVIDER OR SUPPLIER RESIDENTIAL CRF INC	STREET ADDRESS, CITY, STATE, ZIP CODE 311 N DORSETT DR CONNERSVILLE, IN 47331
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W000000	<p>This visit was for an annual recertification and state licensure survey.</p> <p>Dates of Survey: June 30, July 1 and 2, 2014.</p> <p>Facility Number: 000866 Provider Number: 15G350 AIMS Number: 100244200</p> <p>Surveyor: Vickie Kolb, RN</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 7/9/14 by Ruth Shackelford, QIDP.</p>	W000000		
W000323	<p>483.460(a)(3)(i) PHYSICIAN SERVICES</p> <p>The facility must provide or obtain annual physical examinations of each client that at a minimum includes an evaluation of vision and hearing.</p> <p>Based on record review and interview for 1 of 3 sampled clients (#3), the facility failed to ensure the client's hearing was evaluated annually.</p> <p>Findings include:</p>	W000323	Residential nursing staff has made an appointment for client # 3 to receive an updated hearing evaluation. Residential nursing staff will monitor each clients overall care plan on a monthly basis to ensure that all appointments and treatments are	08/01/2014

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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W000331	<p>Client #3's record was reviewed on 7/1/14 at 2 PM. Client #3's annual physical evaluation of 2/24/14 indicated no hearing evaluation. Client #3's record indicated client #3's most current hearing evaluation was conducted on 3/26/10.</p> <p>Interview with the facility LPN on 7/1/14 at 3 PM indicated client #3's physician did not address client #3's hearing when the annual physical was conducted on 2/24/14. The LPN indicated client #3's most current hearing evaluation was 3/26/10.</p> <p>9-3-6(a)</p> <p>483.460(c) NURSING SERVICES The facility must provide clients with nursing services in accordance with their needs. Based on observation, record review and interview for 1 of 3 sampled clients (#3) and 1 additional client (#4), the facility nursing services failed to develop and implement a plan of care in regard to client #3's insomnia and to ensure the staff documented client #3's sleep patterns. The facility nursing services failed to ensure the staff monitored and documented client #4's injuries from SIB</p>	W000331	<p>up to date. Administrative staff will randomly check medical status to assure medical needs are addressed in a timely manner. Staff Responsible: Nursing, QIDP, Supervisor</p> <p>Residential nursing staff will provide nursing care plans to address the individual needs of our client's. The plan will include guidelines to address how the staff are to supervise, monitor and assist those client's in need. A nursing care plan has been implemented for client# 3 for taking Ambien for insomnia. Client#3's sleep patterns will monitored and documented. A nursing care plan for Client#4 had</p>	08/01/2014

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	<p>(Self Injurious Behaviors) of skin picking.</p> <p>Findings include:</p> <p>1. Client #3's record was reviewed on 7/1/14 at 2 PM. Client #3's monthly physician's orders from June 2013 through June 2014 indicated client #3 was taking Ambien every night at bedtime for insomnia. Client #3's record indicated no plan of care in regard to client #3's insomnia. Client #3's record indicated no monitoring and/or documentation of client #3's sleep patterns.</p> <p>Interview with the facility LPN on 7/2/14 at 3 PM indicated there was no plan of care in regard to client #3's insomnia. The LPN indicated there was no documentation of client #3's sleep patterns.</p> <p>2. Observations were conducted at the group home on 6/30/14 between 4 PM and 6 PM. Client #4 had several small scabbed areas on her right lower leg.</p> <p>Client #4's record was reviewed on 7/1/14 at 2:30 PM. __ Client #4's BSP (Behavior Support Plan) of 4/9/14 indicated client #4 had a targeted behavior of SIB and "May pick</p>		<p>been developed and implemented for Skin Integrity due to client#4's skin picking. The IDT will review other consumers who may have SIB or insomnia issues and the ISP/BMP will be updated to reflect their status. Staff Responsible: Nursing, QIDP, Behavioral Services, Direct Care Staff</p>	

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	<p>at sores till they bleed...." Client #4's behavior records for 2014 indicated no incidents of SIB.</p> <p>__ Client #4's "Impaired Skin Integrity (sic) Due to (SIB)" Health Risk Plan dated 4/14/14 indicated, not all inclusive, "If there is a sign of picking injury, staff will specify type, size and degree of injury. Staff will treat any injured area with the appropriate first aid. If any injury has been noted, staff will document on status of injury until healed. Any new injuries during this time will be noted as such, and followed until healed...."</p> <p>__ Client #4's nursing notes of 6/28/14 indicated "Rec'd (received) call that [client #4] had picked a couple places on her Rt (right) shin. Was treated with ATB (antibiotic) oint (ointment) and band aid. Instructed to monitor."</p> <p>Client #4's record indicated no documentation of the size, shape and/or degree of injury from skin picking by the LPN and/or the staff. The client's record did not indicate the staff were monitoring and/or documenting client #4's injuries due to skin picking.</p> <p>During interview with staff #2 and the QIDP (Qualified Intellectual Disabilities Professional) on 6/30/14 at 6 PM, staff #2 indicated client #4 had a history of</p>			

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	picking her skin to the point of causing injury and scabbing. Staff #2 indicated she worked seven days on and seven days off and she had just started her seven days on today, 6/30/14. Staff #2 indicated client #4 had scabs on her right lower leg when she last worked (the week of 6/16/14 through 6/22/14). Staff #2 stated client #4's right lower leg was "worse than when I last worked." After reviewing client #4's BSP with staff #2, staff #2 stated, "I didn't think of her skin picking as SIB, but I guess I was wrong." Staff #2 indicated the staff had not documented client #4's skin picking and/or injuries from picking. The QIDP asked staff #2 if the staff had filled out an I/A (Incident/Accident) report to document when first found and the staff stated, "Not that I know of. I didn't." The QIDP stated the staff "should have filled out an Incident Report." The QIDP asked staff #2 if the staff had filled out a Pick Sheet. Staff #2 indicated she did not know what a Pick Sheet was. The QIDP informed the staff the Pick Sheet was something new the facility had initiated on all clients that had issues with SIB of skin picking to be able to track and monitor the clients' injuries. The QIDP stated the staff "should have" reported the injury to nursing, filled out an incident report and started a Pick Sheet when the staff first noticed client #4's injury due to			

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	<p>picking. The QIDP indicated the staff then were to monitor the injury daily and document on the Pick Sheet until the injury was healed</p> <p>Interview with the facility LPN on 7/2/14 at 3 PM indicated the staff had notified her on 6/28/14 of client #4's picking. The LPN stated she provided the Skin Picking Tracking Sheet to the home "last night" and the current staff in the home "have been retrained" on monitoring and documenting client #4's injuries due to SIB.</p> <p>9-3-6(a)</p>						