

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G186		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/25/2013	
NAME OF PROVIDER OR SUPPLIER RESIDENTIAL CRF INC				STREET ADDRESS, CITY, STATE, ZIP CODE 637 E MAIN ST DANVILLE, IN 46122			
(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 an annual fundamental recertification and state licensure survey.</p> <p>Dates of Survey: 10/22/13, 10/23/13, 10/24/13 and 10/25/13.</p> <p>Facility Number: 000719 Provider Number: 15G186 AIMS Number: 100234670</p> <p>Surveyor: Keith Briner, QIDP</p> <p>This deficiency also reflects a state finding in accordance with 460 IAC 9. Quality Review completed 10/30/13 by Ruth Shackelford, QIDP.</p>			W000000			

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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W000436	<p>483.470(g)(2) SPACE AND EQUIPMENT</p> <p>The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client.</p> <p>Based on observation, record review and interview for 1 of 8 clients with adaptive equipment, the facility failed to teach client #1 to use her prescription eyeglasses.</p> <p>Findings include:</p> <p>Observations were conducted at the group home on 10/23/13 from 6:20 AM through 8:30 AM. Client #1 was observed throughout the observation period. Client #1 did not wear eyeglasses.</p> <p>Observations were conducted at the group home on 10/23/13 from 4:22 PM through 5:30 PM. Client #1 was observed throughout the observation period. Client #1 did not wear eyeglasses.</p> <p>Client #1's record was reviewed on 10/23/13 at 1:30 PM. Client #1's Vision examination form dated 9/19/13 indicated, "Wear eyeglasses as tolerated." Client #1's ISP (Individual Support Plan) dated 9/12/13 did not indicate a formal training objective to support client #1 increase her tolerance for the use of her prescription eyeglasses.</p> <p>QIDPD (Qualified Intellectual Disabilities</p>	W000436	Residential CRF will write and implement a goal for Client # 1 for using her prescription eyeglasses. The QIDP will review each client's programming on a monthly basis to ensure that those clients needing programming on wearing/using adaptive devices will have programs in place for that need. Staff Responsible: QIDP, Nursing	11/24/2013			

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	<p>Professional Designee) #1 was interviewed on 10/24/13 at 4:40 PM. QIDPD #1 indicated client #1 had a pair of prescription eyeglasses. QIDPD #1 indicated client #1 refused to wear her eyeglasses. QIDPD #1 indicated client #1's ISP dated 9/12/13 did not include supports to increase client #1's tolerance for the use of her prescription eyeglasses.</p> <p>9-3-7(a)</p>				