

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G546		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  11/30/2012	
NAME OF PROVIDER OR SUPPLIER  RESIDENTIAL CRF INC				STREET ADDRESS, CITY, STATE, ZIP CODE 2846 W SR 44 CONNERSVILLE, IN 47331			
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W0000	<p>This visit was for a fundamental annual recertification and state licensure survey.</p> <p>Dates of Survey: November 19, 20, 21, 27, 28, 29, and 30, 2012.</p> <p>Surveyors: Susan Eakright, Medical Surveyor III/QMRP Vickie Kolb, Public Health Nurse Surveyor III</p> <p>Provider Number: 15G546 AIM Number: 100245400 Facility Number: 001060</p> <p>These federal deficiencies also reflect state findings in accordance with 460 IAC 9.</p> <p>Quality Review was completed on 12/6/12 by Tim Shebel, Medical Surveyor III.</p>			W0000			

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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W0249	<p>483.440(d)(1) PROGRAM IMPLEMENTATION</p> <p>As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan.</p> <p>Based on observation, record review, and interview, for 1 of 3 sampled clients (client #1) with a BSP (Behavior Support Plan), the facility failed to implement client #1's BSP when opportunities existed.</p> <p>Findings include:</p> <p>On 11/19/12 from 3:15pm until 5:15pm, client #1 was observed at the group home. At 3:15pm, client #1 and Facility Staff (FS) #1 were in the front yard of the group home. Client #1 independently filled his lawn mower with gasoline as FS #1 watched. From 3:15pm until 4:45pm, client #1 mowed leaves with his personal mower in the front, side, and back yard of the group home. From 3:15pm until 4:45pm, the FS #1 went outside to check on client #1 four times (or every 15 minutes) and client #1 was not within eyesight supervision of the facility staff.</p> <p>A review of client #1's record was completed on 11/20/12 at 9:40am. Client</p>	W0249	Residential CRF will ensure that each client's IPP's and BSP's are implemented and followed as written whenever opportunities present themselves. Residential staff will be re-inserviced on the importance of following and implementing the BSP's as written. The house supervisor will check the home on a weekly basis to ensure that the BSP's are being implemented as written. The behavior clinician will review all BSP's on a monthly basis to ensure that they are effective for each client, Staff Responsible: QMRP, Supervisor, Behavior Clinician	12/30/2012

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	<p>#1's 7/11/12 Individual Support Plan (ISP) and 7/11/12 Behavior Support Plan (BSP) both indicated a goal/objective to decrease incidents of maladaptive behaviors by 15% over the next 12 months. Client #1's 7/11/12 BSP indicated "Other Behaviors: Verbal Abuse may threaten others, Leave Area may say he is leaving the group home and tells everyone that he is leaving and will go out into yard. Tinkering with Machinery/Adaptive Devices: [Client #1] will take lawn mowers apart. He does not wait for supervision or permission to do it. He often destroys the equipment in the process...Staff should block him from leaving it is OK (okay) for him to be in the yard or on the premises without staff directly present as long as you (the facility staff) are able to keep him in sight and he is in no immediate danger."</p> <p>An interview with the Qualified Mental Retardation Professional (QMRP) was conducted on 11/21/12 at 9:15am. The QMRP indicated client #1 should have been within eye sight of the facility staff when he operated the lawn mower in the yard of the group home. The QMRP indicated client #1 does not recognize danger and client #1's BSP was not implemented by facility staff when opportunities existed.</p>			

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	9-3-4(a)			

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W0331	<p>483.460(c) NURSING SERVICES The facility must provide clients with nursing services in accordance with their needs.</p> <p>Based on observation, record review and interview for 1 of 3 sampled clients (client #1), the facility failed to ensure nursing services met the client #1's medical needs in regards to an injury to the client's right hand.</p> <p>Findings include:</p> <p>On 11/19/12 from 3:15pm until 5:15pm, client #1 was observed at the group home. At 3:15pm, client #1 and Facility Staff (FS) #1 were in the front yard of the group home. Client #1 independently filled his lawn mower with gasoline without gloves. Client #1 was observed to have a burned skin area on his right pinky finger. From 3:15pm until 4:45pm, client #1 mowed leaves with his lawn mower in the front yard.</p>	W0331	Residential CRF will ensure that each client's nursing services are in accordance with their individual needs. The nursing staff will review any incident reports that are submitted to the office. Any noted injury will be addressed by the nurse and any following along treatment will be noted and documented by the nursing staff. Nursing staff will be re- inserviced on these steps and procedures. Staff responsible: QMRP, Nurse	12/30/2012			

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	<p>During the 11/20/12 observation period between 11:30 AM and 12:30 PM, at the facility day program, client #1 was observed to have a 3 - 3 1/2cm (centimeters) by 1 - 1 1/2cm injury to the anterior right fifth (pinky) finger.</p> <p>Client #1 was interviewed on 11/20/12 at 11:40 A.M.. Client #1 was asked how he had injured his hand and the client stated, "I burned it." The client indicated he had burned his hand on the muffler of his lawn mower while trying to remove leaves that were blocking the muffler.</p> <p>Review of the facility's undated incident report on 11/21/12 at 11 AM of an incident that happened on 11/14/12 indicated client #1 had injured his right 5th finger while working in the yard. The report indicated the facility staff applied an antibiotic ointment and a band aid.</p> <p>Client #1's record was reviewed on 11/21/12 at 11:30 AM. Client #1's nursing notes did not indicate the facility nurse had assessed client #1's injury, provided staff instruction on how to care for the client #1's injury or provided follow up care. Client #1's immunization record indicated the client #1's last Tetanus vaccine was provided in 2001.</p>			

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	<p>Interview with day program (dp) staff #1 on 11/20/12 at 12:10 PM indicated earlier that morning one of the staff at the day program had placed a bandage over the client #1's injury on his right hand. Dp staff #1 indicated the facility nurse had not provided direct instructions on how to care for the client #1's injury. Dp staff #1 stated "We try to keep it covered but [Client #1] takes it off."</p> <p>Interview with the facility nurse on 11/21/12 at 12:30 PM indicated she had seen client #1 at the day program after his injury but was unsure of the date and/or time. When asked which hand the client injured, the facility nurse stated "I think the left." The facility nurse indicated she had failed to document an assessment, follow up care, and staff training in regards to client #1's injury. When asked if the facility had provided client #1 with a Tetanus vaccine, the facility nurse stated "No because we couldn't get it (the vaccine)." The facility nurse indicated the facility was unable to obtain the Tetanus vaccine. The facility nurse indicated client #1 could have gotten the Tetanus vaccine at a local clinic. The facility nurse indicated client #1's last Tetanus vaccine was given in 2001.</p> <p>9-3-6(a)</p>						

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W0369	<p>483.460(k)(2) DRUG ADMINISTRATION The system for drug administration must assure that all drugs, including those that are self-administered, are administered without error.</p> <p>Based on observation, record review, and interview, the facility failed to ensure medications were administered without error for 1 of 1 medication doses administered on 11/19/12 during the evening medication pass (client #1) and for 1 of 15 doses observed administered on 11/20/12 during the morning medication pass (client #1).</p> <p>Findings include:</p> <p>On 11/19/12 at 4:45pm, medication observation and interview were completed with Facility Staff (FS) #1 and client #1. At 4:45pm, FS #1 selected client #1's "Voltaren 75mg (milligrams) 1 tab twice a day after meals for Arthritis." At 4:50pm, FS #1 administered the medication to client #1 and client #1 left the medication room. At 4:50pm, client #1 walked directly from the medication administration area and went to sit at the dining room table for supper. At 4:50pm, client #1 filled his plate and consumed his first bite of food of the supper meal.</p> <p>On 11/20/12 at 7:42am, medication observation and interview were</p>	W0369	Residential CRF will ensure that all drugs will be administered without error. Residential staff will be re-inserviced on the correct medication administration procedure. The nursing staff will review these procedures with staff. The house supervisor will monitor on a weekly basis to ensure that staff are administering medications correctly. Staff responsible: QMRP, Nurse	12/30/2012			

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	<p>completed with Facility Staff (FS) #1 and client #1. At 7:42am, FS #1 selected client #1's "Voltaren 75mg 1 tab twice a day after meals for Arthritis." At 7:50am, FS #1 administered the medication to client #1 and client #1 left the medication room. At 8:06am, client #1 sat down at the dining room table for breakfast and consumed his first bite of food at the breakfast meal.</p> <p>On 11/20/12 at 7:50am, client #1's 11/2012 MAR (Medication Administration Record) and client #1's 7/25/12 "Physician's Order" both indicated "Voltaren 75mg (milligrams) 1 tab twice a day after meals for Arthritis."</p> <p>On 11/21/12 at 9:15am, an interview with the Agency Nurse and the QDP (Qualified Developmental Professional) was conducted. The Agency Nurse and the QDP both indicated staff should follow the physician's order and the label on each medication administered. The LPN (Licensed Practical Nurse) indicated the facility followed Core A/Core B Medication Administration training and stated staff should have followed client #1's physician's order to give his medication after the meal "not before" the meal.</p> <p>On 11/21/12 at 10am, a record review of</p>						

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	<p>the facility's undated "Medication Administration" policy and procedure was completed. The policy indicated staff were to administer medications according to physician's order and pharmacy cautionary labels.</p> <p>On 11/21/12 at 10am, a record review of the facility's undated "Living in the Community" Core A/Core B training for medication administration indicated staff were to administer medications according to physician's order and pharmacy labels.</p> <p>9-3-6(a)</p>			