

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G256	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 06/14/2016
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NAME OF PROVIDER OR SUPPLIER RESIDENTIAL CRF INC	STREET ADDRESS, CITY, STATE, ZIP CODE 6155 W 800 N FOUNTAIN TOWN, IN 46130
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W 0000 Bldg. 00	<p>This visit was for a fundamental recertification and state licensure survey.</p> <p>Dates of Survey: June 9, 10, and 14, 2016.</p> <p>Facility Number: 000776 Provider Number: 15G256 AIMS Number: 100243510</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review of this report completed by #15068 on 6/21/16.</p>	W 0000		
W 0149 Bldg. 00	<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 for 3 of 3 sampled clients (#1, #2 and #3) and 3 additional clients (#4, #5 and #6), the facility failed to implement its policy and procedures to ensure all allegations of neglect, abuse and mistreatment were reported immediately to the administrator and to the BDDS (Bureau of Developmental Disabilities Services) per</p>	W 0149	The facility has in place a policy for reporting and thorough investigation of allegations of Abuse neglect or exploitation. The facility QIDP failed to report an incident where a consumer had stated she heard staff uttering a curse word. By report, the consumer had stated that the utterance she had heard was not directed at any other	07/14/2016

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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	<p>IAC 9-3-1(b)(5) and to APS (Adult Protective Services) per IC 12-10-3 according to state law and to ensure all allegations of abuse, neglect and mistreatment were thoroughly investigated.</p> <p>Findings include:</p> <p>The facility's policies and procedures were reviewed on 6/9/16 at 2 PM. The undated "Consumer Abuse Policy and Incident Reporting" indicated "Abuse, neglect, exploitation and mistreatment of a consumer are unacceptable and will not be tolerated at Residential CRF, Inc..... Residential CRF, Inc. will have evidence that all alleged violations are thoroughly investigated and must prevent further potential abuse while the investigation is in process."</p> <p>1. The facility failed to implement its policy and procedures to ensure all allegations of neglect, abuse and mistreatment were reported immediately to the administrator and to the BDDS and APS according to state law for clients #1, #2, #3, #4, #5 and #6. Please see W153.</p> <p>2. The facility failed to implement its policy and procedures to ensure all allegations of abuse and neglect were thoroughly investigated for clients #1, #2,</p>		<p>consumers. As per this, the incident was not reported as ANE. The facility did interview consumers which found no incident of ANE. This incident was reported to the surveyor at time of survey. An incident report was filed at the time the surveyor reported incident to the QIDP and supervisor. The incident was thoroughly investigated and completed on 6/16/2016. The facility QIDP failed to report initial incident to BDDS, APS and the administrator as per state law. The QIDP received inservice training on reporting policy for incidents The QIDP will report all incident as per agency policy The QIDP will also assure that any reported incident is thoroughly investigated and results reported to the appropriate sources in a timely manner Responsible: QIDP, Administrative staff, Supervisor</p>		

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W 0153 Bldg. 00	<p>#3, #4, #5 and #6. Please see W154.</p> <p>9-3-2(a) 9-3-1(b)(5)</p> <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 interview and record review for 1 of 2 allegations of abuse, neglect and mistreatment, the facility failed to ensure all allegations of neglect, abuse and mistreatment were reported immediately to the administrator and to the BDDS (Bureau of Developmental Disabilities Services) per IAC 9-3-1(b)(5) and APS (Adult Protective Services) per IC 12-10-3 according to state law for clients #1, #2, #3, #4, #5 and #6.</p> <p>Findings include: The facility's reportable and investigative records were reviewed on 6/9/16 at 2 PM. The facility records indicated no allegations of abuse/neglect or mistreatment in regard to staff and clients #1, #2, #3, #4, #5 and #6.</p>	W 0153	<p>The facility had investigated claims that "a client heard a staff cussing", but there was no allegation that it was directed toward any other consumers There was no report of an incident made at that time. The consumer reported this incident to the surveyor at the time of the survey. An incident report was filed following report of the surveyor to the QIDP and the Supervisor The QIDP failed to report the alleged incident, but staff investigated the claims of a staff cussing. The QIDP will assure that all allegations of ANE are reported immediately to the supervisor, BDDS, and APS. The QIDP will be inserviced on the agency policy regarding reporting of ANE and injury. The supervisor will assure that the QIDP is following policy. Responsible: QIDP, Supervisor,</p>	07/14/2016

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	<p>During interview with client #3 on 6/10/16 at 9:15 AM, client #3:</p> <p>__ Indicated she was not happy with the staff that worked the alternate week (staff #3 and #4).</p> <p>__ Stated, "A couple of weeks ago they [staff #3 and staff #4] were cussing and were mad at us (clients #1, #2, #3, #4, #5 and #6) and told some of us to shut up and go sit down. We didn't do anything wrong."</p> <p>__ Stated, "[Staff #4] got mad and slammed her hand down on the kitchen counter."</p> <p>__ Indicated staff #3 and #4 used foul language and talked in a mean tone of voice at times and stated, "We (clients #1, #2, #3, #4, #5 and #6) don't like it. He (staff #3) says the F word and that makes me feel nervous."</p> <p>__ Indicated she had not said anything prior to anyone because she was concerned by saying something she would make things worse for all of the clients in the home (clients #1, #2, #3, #4, #5 and #6) on the week staff #3 and #4 worked.</p> <p>__ Stated, "I told [the Day Program Supervisor (DPS)] what happened. I think she told [the Qualified Intellectual Disabilities Professional (QIDP)] and [the GHS (Group Home Supervisor)]. [The GHS] talked to me and to [client #6]. He didn't talk to anybody else."</p>		Administrative staff		

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	<p>__ Stated, "I wish they (staff #3 and #4) would retire. It's just not the same when they work."</p> <p>During interview with client #6 on 6/10/16 at 9:30 AM, staff #6:</p> <p>__ Indicated staff #3 and #4 sometimes used foul language around the clients and she didn't like it.</p> <p>__ Stated, "It makes me nervous cause I don't know what to expect or will happen when he (staff #3) acts like that."</p> <p>__ When asked are you afraid of any of the staff working in the home, client #6 stated, "No, not really. Just [staff #3] makes me nervous when he gets mad."</p> <p>__ Stated, "A couple of weeks ago he (staff #3) was mad about something and was cussing and she (staff #4) was pounding on the kitchen counter for no reason. I just don't like it when they are like that. I just wish they would retire."</p> <p>__ Stated, "He (staff #4) tells [client #4] to shut up. I don't think that's very nice. He didn't have to tell her to shut up."</p> <p>__ Indicated when staff #4 has nothing to do she lays on the sofa.</p> <p>__ Stated, "Once when I was cooking I accidentally turned on the wrong burner and he (staff #3) yelled, why did you do that?"</p> <p>__ Stated, "He (staff #3) tells us we don't know how to do things and he makes us feel bad about ourselves."</p>			

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	<p>___ Indicated on the weekend staff #3 and #4 worked the clients did not get to go out as often and staff #3 would take only one of the clients to the grocery store when they went to buy groceries.</p> <p>On 6/10/16 at 1 PM the QIDP provided the following facility records for review: ___ A note from the QIDP dated 5/24/16. The note indicated "I (the QIDP) received a call from [the DPS] this morning that [client #3] had said that house staff was cussing. [The DPS] indicated that according to [client #3] it was on [staff #3's] week. She indicated that [client #3] said she had overheard cussing but was not cussed at. She indicated that [client #6] also overheard cussing. I told her that I would have [the GHS] talk to the ladies to determine what they heard. [The DPS] will talk to the girls at [name of day program] today."</p> <p>___ Interview notes from the GHS dated 5/24/16. The interview notes indicated "Out of frustration he (staff #3) said 'F---' and walked out of the room but it was because of a personal phone call he had just received of bad news and that he was sorry that he used that language in front of the individuals."</p> <p>The QIDP and the GHS were interviewed on 6/10/16 at 2 PM. ___ The QIDP indicated she received a</p>			

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W 0154 Bldg. 00	<p>phone call from the DPS in regard to client #3's saying the staff had cussed and stated, "My understanding was he (staff #3) had not cussed at the girls but they (clients #3 and #6) had overhead the staff cussing." ___ The GHS indicated he had talked to clients #3 and #6 and they had told him the staff did not cuss at them but they had heard them cussing from another room. ___ The GHS indicated he had not talked with all of the clients or with staff #1 and #2. ___ The QIDP indicated all allegations of abuse/neglect and mistreatment were to be immediately to the administrator and to BDDS and APS within 24 hours after knowledge of an allegation of abuse/neglect and/or mistreatment. ___ The QIDP indicated she did not report the allegations made by client #3 on 5/24/16 to BDDS or APS</p> <p>9-3-2(a)</p> <p>483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated.</p>			

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	<p>Based on record review and interview for 2 of 2 allegations of abuse, neglect and mistreatment reviewed, the facility failed to ensure all allegations of abuse and neglect were thoroughly investigated for clients #1, #2, #3, #4, #5 and #6.</p> <p>Findings include:</p> <p>1. The facility's reportable and investigative records were reviewed on 6/9/16 at 2 PM. The facility records indicated no allegations of abuse/neglect or mistreatment in regard to staff and clients #1, #2, #3, #4, #5 and #6.</p> <p>During interview with client #3 on 6/10/16 at 9:15 AM, client #3: ___ Indicated she was not happy with the staff that worked the alternate week (staff #3 and #4). ___ Stated, "A couple of weeks ago they [staff #3 and staff #4] were cussing and were mad at us (clients #1, #2, #3, #4, #5 and #6) and told some of us to shut up and go sit down. We didn't do anything wrong." ___ Stated, "[Staff #4] got mad and slammed her hand down on the kitchen counter." ___ Indicated staff #3 and #4 used foul language and talked in a mean tone of voice at times and stated, "We (clients #1, #2, #3, #4, #5 and #6) don't like it. He</p>	W 0154	<p>1 The facility had investigated a statement by a client that "she had heard a staff cussing" Based on this statement, the facility found that the language was not directed at any consumer and the staff was reprimanded for use of inappropriate language The consumer reported an the incident to the surveyor which was stated totally different from what had been reported weeks earlier. At that time, the QIDP filed an incident report on 6/10/2016 and the incident investigation was thoroughly completed on 6/16/2016. The report was forwarded to the administrator on that day. The QIDP will assure that all allegations of ANE are thoroughly investigated and reported to the appropriate entities in a timely manner. 2. An incident reported to the QIDP on 12/2/2015 involving a consumer being struck by another consumer was investigated by Residential CRF. Per report of consumer, the incident happened in her room shared with her roommate, with the door closed. No other consumers observed the incident. Staff were unaware that any incident had occurred, and client did not know when the incident happened Guardian reported incident to QIDP. The facility failed to thoroughly investigate the alleged incident. The QIDP and administrative staff will assure that a thorough</p>	07/14/2016			

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	<p>(staff #3) says the F word and that makes me feel nervous." __ Indicated she had not said anything prior to anyone because she was concerned by saying something she would make things worse for all of the clients in the home (clients #1, #2, #3, #4, #5 and #6) on the week staff #3 and #4 worked. __ Stated, "I told [the Day Program Supervisor (DPS)] what happened. I think she told [the Qualified Intellectual Disabilities Professional (QIDP)] and [the GHS (Group Home Supervisor)]. [The GHS] talked to me and to [client #6]. He didn't talk to anybody else." __ Stated, "I wish they (staff #3 and #4) would retire. It's just not the same when they work." During interview with client #6 on 6/10/16 at 9:30 AM, staff #6: __ Indicated staff #3 and #4 sometimes used foul language around the clients and she didn't like it. __ Stated, "It makes me nervous cause I don't know what to expect or will happen when he (staff #3) acts like that." __ When asked are you afraid of any of the staff working in the home, client #6 stated, "No, not really. Just [staff #3] makes me nervous when he gets mad." __ Stated, "A couple of weeks ago he (staff #3) was mad about something and</p>		<p>investigation will occur with any allegation of ANE made. The staff, QIDP and supervisor will receive inservice training on incident reporting and investigation procedures. Administrative staff will assure that any reported incident is thoroughly investigated. Responsible: QIDP, Supervisor, Administrative staff</p>		

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	<p>was cussing and she (staff #4) was pounding on the kitchen counter for no reason. I just don't like it when they are like that. I just wish they would retire." __ Stated, "He (staff #4) tells [client #4] to shut up. I don't think that's very nice. He didn't have to tell her to shut up." __ Indicated when staff #4 has nothing to do she lays on the sofa. __ Stated, "Once when I was cooking I accidentally turned on the wrong burner and he (staff #3) yelled, why did you do that?" __ Stated, "He (staff #3) tells us we don't know how to do things and he makes us feel bad about ourselves." __ Indicated on the weekend staff #3 and #4 worked the clients did not get to go out as often and staff #3 would take only one of the clients to the grocery store when they went to buy groceries.</p> <p>On 6/10/16 at 1 PM the QIDP provided the following facility records for review: __ A note from the QIDP dated 5/24/16. The note indicated "I (the QIDP) received a call from [the DPS] this morning that [client #3] had said that house staff was cussing. [The DPS] indicated that according to [client #3] it was on [staff #3's] week. She indicated that [client #3] said she had overheard cussing but was not cussed at. She indicated that [client #6] also overheard cussing. I told her that</p>			

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	<p>I would have [the GHS] talk to the ladies to determine what they heard. [The DPS] will talk to the girls at [name of day program] today."</p> <p>__ Interview notes from the GHS dated 5/24/16. The interview notes indicated "Out of frustration he (staff #3) said 'F---' and walked out of the room but it was because of a personal phone call he had just received of bad news and that he was sorry that he used that language in front of the individuals."</p> <p>The QIDP and the GHS were interviewed on 6/10/16 at 2 PM.</p> <p>__ The QIDP indicated she received a phone call from the DPS in regard to client #3's saying the staff had cussed and stated, "My understanding was he (staff #3) had not cussed at the girls but they (clients #3 and #6) had overhead the staff cussing."</p> <p>__ The GHS indicated he had talked to clients #3 and #6 and they had told him the staff did not cuss at them but they had heard them cussing from another room.</p> <p>__ The GHS indicated he had not talked with all of the clients or with staff #1 and #2.</p> <p>__ The QIDP and the GHS indicated a thorough investigation was not conducted in regard to allegations of possible abuse in the home.</p>			

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	<p>2. The facility's reportable and investigative records were reviewed on 6/9/16 at 2 PM. The 12/3/15 BDDS report indicated on 12/2/15 at 4:50 PM while client #6 was home with her mother during a home visit, client #6 informed her mother her roommate (client #3) had hit her (client #6) in the chest several times with the palm of her hand causing client #6 to fall. The facility records indicated interviews with clients #3 and #6 and two of the four staff that worked in the home. The facility records indicated all clients and all staff in the home were not interviewed. The facility records did not indicate a thorough investigation was conducted.</p> <p>During interview with the QIDP on 6/10/16 at 2 PM, the QIDP: ___ Indicated client #6 did not report the abuse at the time of the incident and she was unsure exactly when the incident happened. ___ Indicated interviews with clients #3 and #6 and two of the four staff that worked in the home. ___ Indicated interviews were not conducted with all staff and all clients in the home. ___ Indicated all allegations of abuse were to be thoroughly investigated.</p> <p>9-3-2(a)</p>			

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W 0331 Bldg. 00	<p>483.460(c) NURSING SERVICES</p> <p>The facility must provide clients with nursing services in accordance with their needs. Based on observation, interview and record review for 1 additional client (#6), the facility staff failed to notify nursing services of client #6's fall resulting in an injury to client #6's knees.</p> <p>Findings include:</p> <p>The facility's reportable and investigative records were reviewed on 6/9/16 at 2 PM. The facility records indicated no falls with injury for client #6 for June 2016.</p> <p>Observations were conducted at the group home on 6/9/16 between 4:30 PM and 6:10 PM. Client #6 was a middle aged woman who wore a brace on her left leg and ambulated with an unsteady gait. Client #6 was wearing shorts that exposed her knees. Client #6 had small reddened areas on both knees.</p> <p>During interview with client #6 on 6/9/16 at 6:03 PM, client #6: __ Indicated on the previous Sunday she had fallen while in the bathroom and she had injured her knees.</p>	W 0331	<p>The facility staff failed to report a fall with injury which was reported to them by a client. The facility nurse was not notified of the fall which resulted in Client #6 having reddened areas on both knees. Staff will receive inservice training on procedure for reporting falls and injuries as the result of a fall. The QIDP will assure that all staff are knowledgeable on incident reporting procedures. The QIDP will assure that all staff in all homes are aware of the procedure. The supervisor will assure that staff are following proper reporting procedures in a timely manner. The nurse will also inservice staff as to proper documentation procedures for a fall with or without injury. Administrative staff will assure that proper reporting procedures are being followed. Responsible: QIDP, Supervisor, Nursing</p>	07/14/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G256	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 06/14/2016
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NAME OF PROVIDER OR SUPPLIER RESIDENTIAL CRF INC	STREET ADDRESS, CITY, STATE, ZIP CODE 6155 W 800 N FOUNTAIN TOWN, IN 46130
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	<p>__ Indicated the staff had not asked her how she injured her knees.</p> <p>__ Indicated she reported her fall to staff #3 the following Monday morning after falling on Sunday.</p> <p>During interview with the Qualified Intellectual Disabilities Professional (QIDP) on 6/10/16 at 3 PM, the QIDP:</p> <p>__ Indicated she spoke to staff #3 and staff #3 indicated client #6 had reported she had fallen and staff #3 had failed to call the nurse and/or to notify the facility supervisor of the fall and/or injury.</p> <p>__ The QIDP indicated staff were to report all falls to the nurse and the home supervisor immediately.</p> <p>__ Indicated the staff failed to report client #6's fall with injury to the nurse and the home supervisor.</p> <p>9-3-6(a)</p>			