

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G114	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/20/2013
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NAME OF PROVIDER OR SUPPLIER RESIDENTIAL CRF INC	STREET ADDRESS, CITY, STATE, ZIP CODE 324 W 3RD ST CONNERSVILLE, IN 47331
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W000000	<p>This visit was for an annual fundamental recertification and state licensure survey.</p> <p>Dates of Survey: March 6, 7 and 20, 2013.</p> <p>Facility Number: 000651 Provider Number: 15G114 AIMS Number: 100234250</p> <p>Surveyor: Vickie Kolb, RN, BSN, Public Health Nurse Surveyor III</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9.</p> <p>Quality review completed March 26, 2013 by Dotty Walton, Medical Surveyor III.</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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W000210	<p>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.</p> <p>Based on record review and interview for 1 of 4 sampled clients (#2), the facility failed to ensure the IDT (Interdisciplinary Team) assessed and/or re-assessed client #2 to determine causing factors of elevated blood glucose levels.</p> <p>Findings include:</p> <p>Client #2's record was reviewed on 3/7/13 at 12 PM. The client's record indicated a diagnosis of, but not limited to, Type II Diabetes. Client #2's physician's orders of 1/29/13 indicated every AM client #2 was to take 8 units of Lantus Insulin, Metformin HCL 500 mg (milligrams) and Glipizide 5 mg for blood sugar control. Client #2 was last seen by her physician on 1/3/13. The physician indicated the client was doing well and for the staff to monitor client #2's BG (Blood Glucose) levels 3 times a day. The physician's orders did not indicate for client #2's BG levels to be forwarded to the physician's office and/or a recommendation client #2 see a specialist for an evaluation.</p> <p>Client #2's GCR (Glucometer Checks</p>	W000210	Residential CRF will ensure that client's individual needs are being met through their individualized programming. Residential will have Client#2 re assessed by her physican to help determine the causing factor of her elevated blood sugars. She also has an appointment with an endocrinologist for assessment. The nurse will review Client# 2's GCR to make certain the instructions are accurate and effective. Residential CRF will amend Client#2's BMP to address the issue of stealing food. Staff Responsible: Nurse, QMRP	04/19/2013

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	<p>Records) for 2013 indicated "If blood sugar is above 140 call office (group home facility office)." The GCRs for January indicated client #2's BG (blood glucose) was 140 or above 38 out of 97 checks. The GCRs for February indicated client #2's BG was 140 or above 44 out of 84 checks. The GCRs for March indicated client #2's BG was 140 or above 10 out of 19 checks.</p> <p>Client #2's BG results before breakfast indicated client #2's BG levels in the AM were within normal limits (80 - 120) most of the times taken. Client #2's BG results before lunch indicated frequently elevated BG levels prior to the noon meal. The GCRs indicated the following noon results:</p> <p>1/1/13 - 278 1/3/13 - 220 1/6/13 - 214 1/7/13 - 313 1/13/13 - 234 1/14/13 - 218 1/16/13 - 276 1/17/13 - 262 1/18/13 - 219 1/19/13 - 220 1/20/13 - 264 1/21/13 - 252 1/26/13 - 251 1/30/13 - 210</p>						

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	<p>2/3/13 - 245 2/4/13 - 265 2/13/13 - 268 2/15/13 - 322 2/16/13 - 225 2/17/13 - 350 2/18/13 - 222 2/20/13 - 235 2/21/13 - 231 2/22/13 - 290 2/23/13 - 301 2/24/13 - 213 2/27/13 - 308 2/28/13 - 253 3/1/13 - 281 3/3/13 - 325 3/4/13 - 325 3/6/13 - 260</p> <p>Client #2's record did not indicate any documented incidents of client #2 ingesting high calorie food and/or drink and/or eating non menu food items. Client #2's record indicated client #2 did not have a BSP (Behavior Support Plan) and/or specific targeted maladaptive behaviors.</p> <p>Interview with staff #1 on 3/7/13 at 8:15 AM, stated client #2 had a history of "sneaking food, but that was a long time ago." Staff #1 indicated client #2 followed her diet when at the group home and the staff were not aware of client #1</p>						

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	<p>taking food or eating food that was not on the menu. Staff #1 stated client #2 was not directly supervised for the behavior of ingesting non menu food items, but if caught, "we would have reported it."</p> <p>Interview with DP (Day Program) staff #1 and #2 on 3/7/13 at 9 AM indicated client #2's BG tests were "always" done prior to client #2 eating her lunch. DP staff #2 stated client #2 had a history of "sneaking" food, but staff was not aware of that behavior being an issue "for quite some time." DP staff #2 stated client #2 had a "sweet disposition" and could "easily" talk another client into giving her some extra food. DP staff #1 stated snack foods were locked in the filing cabinet in the office for diabetic clients that were low and needed something due to low blood glucose, "not specifically" for client #2. DP staff #1 indicated all the clients' lunch boxes were accessible to all the clients, including client #2. DP staff #1 stated if client #2 had gotten into any of the lunch boxes besides her own, "someone would have told on her." DP staff #1 indicated there were no pop and/or food machines at the day program. DP staff #1 stated "in the past" client #2 would go downstairs and drink the punch and/or Kool-aid that "might be sitting out for refreshments, but we haven't had drinks sitting out for a long time." DP</p>			

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	<p>staff #1 stated the staff stored their lunches in a small kitchen area, "but the clients never go back there and if they did, someone would see them." When asked if specific protocols were in place as to when to call the nurse, DP staff #1 indicated the DP staff let the facility nurse know if client #2's BG was "really high" and/or "really low" or if they had any problems with client #2 while she was at the day program.</p> <p>Interview with the facility nurse on 3/7/13 at 3:30 PM indicated she did not know the BGR indicated the office was to be called if client #2's BG was 140 and/or above. The facility nurse indicated the staff did not call the office each time client #2's BG was 140 or higher. The facility nurse stated client #2 had been hospitalized "several years ago" in regards to high blood sugar levels and "had almost died." The facility nurse stated client #2 had a history of "sneaking" food. When asked if the IDT had assessed client #2 for eating non menu food items and/or sneaking food, the facility nurse stated, "No." When asked if the IDT had assessed and/or reassessed client #2 in regard to her frequent elevated BG levels, the facility nurse stated, "No." When asked if client #2 had an in depth assessment by a (medical specialist) in regard to client #2's diabetic health, the facility nurse stated,</p>			

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	<p>"No." The facility nurse indicated client #2's PCP (Primary Care Physician) had been ordering client #2's diabetic medications</p> <p>Interview with the QMRP (Qualified Mental Retardation Professional) on 3/7/13 at 3:45 PM indicated the IDT had not assessed and/or reassessed client #2 to determine if additional food was a factor or if the client required further studies and/or an evaluation by a specialist. The QMRP indicated the IDT had not assessed and/or reassessed client #2 in regard to client #2's frequently elevated BG levels while at the day program.</p> <p>9-3-4(a)</p>			

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W000331	<p>483.460(c) NURSING SERVICES</p> <p>The facility must provide clients with nursing services in accordance with their needs. Based on record review and interview for 1 of 4 sampled clients (#2), the facility's nursing services failed to ensure nursing met client #2's medical needs in regard to client #2's diabetes and to ensure diabetic protocols and/or a health/risk plan were implemented to include parameters of low and high blood glucose levels, when the staff should notify the nurse and how the staff were to supervise the client due to a history of eating non menu items.</p> <p>Findings include:</p> <p>Client #2's record was reviewed on 3/7/13 at 12 PM. The client's record indicated a diagnosis of, but not limited to, Type II Diabetes. Client #2's physician's orders of 1/29/13 indicated every AM client #2 was to take 8 units of Lantus Insulin, Metformin HCL 500 mg (milligrams) and Glipizide 5 mg for blood sugar control. Client #2 was last seen by her physician on 1/3/13. The physician indicated the client was doing well and for the staff to monitor client #2's BG (Blood Glucose) levels 3 times a day.</p> <p>Client #2's 2013 GCRs (Glucometer Check Records) in client #2's MAR (Medication Administration Record)</p>	W000331	Residential CRF will ensure that all medical needs of the client's are met. Nursing services will review their plan for Client#2's diabetes and make necessary changes. Nursing services will review nursing plans to be sure that diabetic protocols and health risk plans are implemented and are being followed correctly on a monthly basis. Client#2 will be re assessed for her blood sugar levels by her physician and endocrinologist. Client #2's BMP will be reviewed and amended to reflect her history of stealing food. Staff Responsible: Nurse, Behavior Clinican, QMRP	04/19/2013			

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	<p>indicated "If blood sugar is above 140 call office (group home facility office)." The GCRs for January indicated client #2's BG (blood glucose) was 140 or above 38 out of 97 checks. The GCRs for February indicated client #2's BG was 140 or above 44 out of 84 checks. The GCRs for March indicated client #2's BG was 140 or above 10 out of 19 checks. Client #2's record did not indicate the facility nurse and/or the facility "office" were notified of BG results above 140.</p> <p>Client #2's BG results before breakfast indicated client #2's BG levels in the AM were within normal limits (80 - 120) most of the times taken. Client #2's BG results before lunch indicated frequently elevated BG levels prior to the noon meal. The GCRs indicated the following noon results:</p> <p>1/1/13 - 278 1/3/13 - 220 1/6/13 - 214 1/7/13 - 313 1/13/13 - 234 1/14/13 - 218 1/16/13 - 276 1/17/13 - 262 1/18/13 - 219 1/19/13 - 220 1/20/13 - 264 1/21/13 - 252</p>			

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	<p>1/26/13 - 251 1/30/13 - 210 2/3/13 - 245 2/4/13 - 265 2/13/13 - 268 2/15/13 - 322 2/16/13 - 225 2/17/13 - 350 2/18/13 - 222 2/20/13 - 235 2/21/13 - 231 2/22/13 - 290 2/23/13 - 301 2/24/13 - 213 2/27/13 - 308 2/28/13 - 253 3/1/13 - 281 3/3/13 - 325 3/4/13 - 325 3/6/13 - 260</p> <p>Client #2's record did not indicate the staff called the office and/or notified nursing of client #2's BG checks above 140. Client #2's record indicated an undated HRI "High Risk Issue" of Diabetes. The record indicated symptoms of diabetes are fatigue, thirst, weight loss, blurred vision and frequent urination. The HRI indicated "Staff will report any changes or additions in symptoms to [name of facility] Direct Care staff, Nurse, or QMRP [Qualified Mental Retardation Professional]." The HRI</p>			

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	<p>indicated "Should any changes occur, the following people should be notified," the LPN (Licensed Practical Nurse), the Area Supervisor and the Incident Reporting Management. The client's record failed to indicate an individualized health care plan and/or risk plan in regard to client #2's diabetes that indicated specifically when the nurse was to be notified, parameters for low and high blood sugar results and how the staff were to supervise client #2 in regards to client #2's history of eating food outside of her regularly scheduled menu items.</p> <p>Interview with staff #1 on 3/7/13 at 8:15 AM, stated client #2 had a history of "sneaking food, but that was a long time ago." Staff #1 indicated client #2 followed her diet when at the group home and the staff was not aware of client #1 taking food or eating food that was not on the menu.</p> <p>Interview with DP (Day Program) staff #1 and #2 on 3/7/13 at 9 AM stated client #2's BG tests were "always" done prior to client #2 eating her lunch. DP staff #2 stated client #2 had a history of "sneaking" food, but was not aware of that behavior being an issue "for quite some time." DP staff #2 stated client #2 had a "sweet disposition" and could "easily" talk another client into giving her</p>			

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	<p>some extra food. DP staff #1 stated snack foods were locked in the filing cabinet in the office for clients that were diabetic, "not specifically" for client #2 or due to client #2 stealing food. DP staff #1 indicated all the clients' lunch boxes were accessible to all the clients at the day program, including client #2. DP staff #1 stated if client #2 had gotten into any of the lunch boxes, "someone would have told on her." DP staff #1 stated "in the past" client #2 would go downstairs and drink the punch and/or Kool-aid that "might be sitting out for refreshments, but we haven't had drinks sitting out for a long time." DP staff #1 stated the staff stored their lunches in a small kitchen area, "but the clients never go back there and if they did, someone would see them." When asked if specific protocols were in place as to when to call the nurse, DP staff #1 stated the DP staff let the facility nurse know if client #2's BG was "really high" and/or "really low" or if they had any problems with client #2 while she was at the day program.</p> <p>Interview with the facility nurse on 3/7/13 at 3:30 PM indicated she did not know the BGR indicated the office was to be called if client #2's BG was 140 and/or above. The facility nurse stated, "That needs to be changed." The facility nurse indicated the staff did not notify the facility nurse</p>			

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	<p>each time client #2's BG was 140 or higher. The facility nurse stated client #2 had been hospitalized "several years ago" in regard to high blood sugar levels and "had almost died." The facility nurse stated client #2 had a history of "sneaking" food. The facility nurse indicated client #2's PCP (Primary Care Physician) had been ordering client #2's diabetic medications and tests. The facility nurse indicated she did not approach the client's PCP for any special studies and/or further medical evaluations. The facility nurse indicated she was faxing client #2's PCP the BG results weekly until 5/21/12 when client #2's PCP told the facility nurse not to fax any further BG results. The facility nurse indicated client #2 had just recently switched to another physician (general practitioner). The facility nurse indicated client #2 did not have a specific health/risk plan in place in regard to diabetic protocols for client #2 that included parameters of low and high results of BG tests, when the staff should notify the nurse, what the staff were to do in regard to high and low BG tests and how the staff were to supervise client #2 in regard to eating non menu food items and/or sneaking food.</p> <p>9-3-6(a)</p>			

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