

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G269	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/01/2012
NAME OF PROVIDER OR SUPPLIER RESIDENTIAL CRF INC			STREET ADDRESS, CITY, STATE, ZIP CODE 622 MAIN ST RUSHVILLE, IN 46173		
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W0000	<p>This visit was for the investigation of Complaint #IN00109878.</p> <p>Complaint #IN00109878: Substantiated, Federal and State deficiencies related to the allegations are cited at W104, W122, W149 and W157.</p> <p>Survey Dates: July 17, 18, 27 and August 1, 2012</p> <p>Facility Number: 000789 Provider Number: 15G269 Aim Number: 100234980</p> <p>Surveyor: Jo Anna Scott, Medical Surveyor III</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 8/8/12 by Ruth Shackelford, 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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W0104	<p>483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility. Based on observation, record review and interview for 1 of 3 sampled clients (client A), the facility's governing body failed to exercise operating direction over the facility to ensure the facility implemented its written policy and procedures to prevent neglect of client A in regard to the client's AWOL (Absent Without Leave) behavior and neglected to take corrective action to address the client's AWOL behavior.</p> <p>Findings include:</p> <ol style="list-style-type: none"> The governing body failed to exercise general policy and operating direction over the facility to ensure the facility implemented written policy and procedure to prevent neglect of client A in regard to the client's AWOL behavior. Please see W149. The governing body failed to take sufficient corrective action to address client A's elopement behavior by not ensuring the 1 on 1 staffing had been clearly defined as to what the staff were required to do. Please see W157. <p>This federal tag relates to complaint</p>	W0104	<p>W104 GOVERNING BODY Staff has been retrained on the duties and specifics of the BMP in regard to Client A.'s AWOL. The governing body will implement weekly reviews to assess 1). Progress of Client A weekly/status report; 2). Staff assessment of efficiency of the BMP; and 3). Any changes needed to further protect Client A. The governing body will oversee this process until Client A has transitioned from the agency. Responsible: Systems Manager, QDDP Date Completed: August 31, 2012 and ongoing What corrective action(s) will be accomplished for these residents found to have been affected by the deficient practice: Monitoring to assure staff are trained on client issues and updates, and follow along to assure staff follow through as stated in training. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken: At present, no other clients have been identified. If so, then monitoring will occur to assure training is provided, and followed. What measures will</p>	08/31/2012			

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	#IN00109878. 9-3-1(a)		be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur: Annual training of staff along with training of new hires on policy and procedures, along with any training needed for client changes in programming. How the corrective action(s) will be monitored to ensure the deficient practice will not recur: The governing body will implement weekly reviews to assess 1). Progress of Client weekly/status report; 2). Staff assessment of efficiency of the BMP; and 3) Any changes needed to further protect the Client..		

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W0122	<p>483.420 CLIENT PROTECTIONS The facility must ensure that specific client protections requirements are met. Based on observation, record review and interview for 1 of 3 sampled clients (client A), the facility failed to meet Condition of Participation: Client Protections. The facility failed to implement written policy and procedure to prevent neglect of client A in regards to AWOL (Absent Without Leave) behavior. The facility also neglected to take sufficient corrective action which clearly defined the 1 on 1 staffing duties while working with client A.</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. The facility neglected to implement written policy and procedure to prevent neglect of client A in regard to the client's AWOL behavior. Please see W149. 2. The facility neglected to take sufficient corrective action to address client A's elopement behavior by not ensuring the 1 on 1 staffing had been clearly defined as to what the staff were required to do. Please see W157. <p>This federal tag relates to complaint #IN00109878.</p> <p>9-3-2(a)</p>	W0122	<p>W 122 CLIENT PROTECTIONS Client A has stated that he "does not want to live in a group home". Taking into consideration that Client A does not want to live at the Main Street group home anymore, BDDS, and the guardian were notified of his decision to move out. A notice of termination of services has been sent to the guardian. In the interim, the Policy and Procedures are being followed by providing training of staff who works with Client A. Training clearly defines the duties of the One on One. New procedures are in place following the plan approved 7/18/2012 to assure client protection. One on one will continue as long as Client A remains in the group home. Individual counseling, and behavioral services provided by Meridian Services will continue. Weekly reviews will be forwarded to the governing body for review. Responsible: QDDP Completed: 8/31/2012 What corrective action(s) will be accomplished for these residents found to have been affected by the deficient practice: Monitoring to assure staff are trained on client issues and updates, and follow along to assure staff follow through as stated in training. How the</p>	08/31/2012			

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			<p>facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken: At present, no other clients have been identified. If so, then monitoring will occur to assure training is provided, and followed.</p> <p>What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur: Annual training of staff along with training of new hires on policy and procedures, along with any training needed for client changes in programming. How the corrective action(s) will be monitored to ensure the deficient practice will not recur: The governing body will implement weekly reviews to assess 1). Progress of Client weekly/status report; 2). Staff assessment of efficiency of the BMP; and 3) Any changes needed to further protect the Client..</p>		

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W0149	<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.</p> <p>Based on observation, record review and interview for 1 of 3 sampled clients (client A), the facility neglected to implement its policy and procedures in regard to the client's AWOL (Absent Without Leave) behavior.</p> <p>Findings includes:</p> <p>The facility's internal incident reports, reportable incident reports and/or investigations were reviewed on 7/17/12 at 2:30 PM. The facility's internal incident reports, reportable incident reports and/or investigations indicated the following:</p> <ul style="list-style-type: none"> - 11/2/11 - Client A jumped out of a parked van and took off running. - 4/21/12 - Client A was AWOL. - 6/21/12 - "[Client A] had been grocery shopping with peers and became upset when a peer bumped into him. The report indicated [client A] thought it had been done on purpose and began yelling and cursing at peer. The report indicated staff prompted [client A] to go to his 	W0149	<p>W 149 CLIENT PROTECTIONS Client A has stated that he "does not want to live in a group home". Taking into consideration that Client A does not want to live at the Main Street group home anymore, BDDS, and the guardian were notified of his decision to move out. A notice of termination of services has been sent to the guardian. In the interim, the Policy and Procedures are being followed by providing re-training of staff who works with Client A to prevent failure to provide appropriate supervision. Training clearly defines the duties of the One on One. New procedures are in place following the plan approved 7/18/2012. One on one will continue as long as consumer remains in the group home setting. Individual counseling, and behavioral services provided by Meridian Services will continue. Weekly reviews will be forwarded to the governing body for review.</p> <p>Responsible: QDDP Completed: 8/31/2012 What corrective action(s) will be accomplished for these residents found to have been affected by the deficient practice: Monitoring to assure staff are trained on client issues and updates, and follow along to</p>	08/31/2012			

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	<p>room to calm down. [Client A] did go to his room but continued to scream and curse. [Client A] came down stairs and started yelling again. He went out the front door at approximately 8:23 PM. Staff followed and were able to keep a visual until 8:32 PM. The police were notified and returned [client A] to the home at approximately 8:59 PM."</p> <p>- 7/1/12 - "[Client A] became angry and started screaming. He demanded to talk to his dad. Staff indicated he could call his father when he calmed down. [Client A] kicked a box fan across the room and broke it. [Client A] took off out the back door and started running with staff following. The staff lost contact with [client A] and police were called at approximately 9:52 PM. Police came to the house at 10:45 PM and had not seen [client A]. When police started to leave the home he was seen walking on the back deck."</p> <p>- 7/15/12 - "A severe storm with rain, wind and lightning was occurring while the clients were sitting on front porch. Staff prompted the clients to come into the home. [Client A] had a sweeper cleaning tool in the waistband of his pants and became angry when staff prompted him to put it away. [Client A] went outside with staff following him and</p>		<p>assure staff follow through as stated in training. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken: At present, no other clients have been identified. If so, then monitoring will occur to assure training is provided, and followed.</p> <p>What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur: Annual training of staff along with training of new hires on policy and procedures, along with any training needed for client changes in programming.</p> <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur: The governing body will implement weekly reviews to assess 1). Progress of Client weekly/status report; 2). Staff assessment of efficiency of the BMP; and 3) Any changes needed to further protect the Client..</p>		

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	<p>walked up and down the alley with staff inside, he bolted down the alley with the staff following. The other staff started a search by van. Staff would briefly lose sight of him as he ducked through yards and around bushes. The QDDP was contacted and instructed the staff to call the police. At 11:00 PM the police called the home indicating they had seen him by the city police station and when staff got there he was gone. The police were called again at 1:40 AM and were told [client A] was missing. At 3:20 AM, staff received a call that he was seen walking on State Road [name]. The police had detained him while the group home picked him up at 3:30 AM."</p> <p>During the observation period on 7/17/12 at 2:00 PM, client A was observed going upstairs to his room while his staff #4 was watching TV (television) in the living room. At 3:00 PM client A was observed going outside while staff #4 stayed in the home. At 5:50 PM client A was sitting on the back deck and staff #4 was in the house. Staff #4 could not see client A from the house.</p> <p>The Behavior Support Plan (BSP) dated 2/24/11 to 2/25/12 for client A was reviewed on 7/18/12 at 2:00 PM. The BSP included the following behaviors: "Disruptive - May yell and scream and</p>			

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	<p>stomp around. Engages in behavior which causes focus to be on him.</p> <p>Engages in activity which causes current activity to stop.</p> <p>Provoking Others - Antagonizing others to the point of a confrontation.</p> <p>Making sexually suggestive comments.</p> <p>Physical Aggression/Destruction of Property - May become easily agitated and combative. May destroy items in the area or kick at them or throw them.</p> <p>Engages other wrestling hold or grasp.</p> <p>Space violation - Engage others too closely. Press himself up against another person.</p> <p>Resistance - May refuse to follow requests. Sneaks around to get away when approval has not given.</p> <p>Entering area without permission - May be engaging in inappropriate behaviors.</p> <p>Inappropriate Comments - (Sexual in nature).</p> <p>Other Behaviors: AWOL (Leaving the group home unsupervised and without permission."</p> <p>The BSP indicated the AWOL had been reinstated on 8/1/2010. The BSP indicated "Staff should be aware that [client A] has left the group home without permission on more than one occasion. He was upset about some personal matters and walked away from the home</p>			

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	<p>despite staff's attempts to stop him. The IDT (Interdisciplinary Team) has implemented strategy that involves close supervision during times when [client A] is obviously upset. Staff will intervene as needed to prevent him from leaving the group home without supervision. If [client A] should leave the home staff should notify their Supervisor immediately. This plan will be reviewed in 3 months, and deferred after a six month period from the last incident involving AWOL." The BSP did not provide clear instructions on what close supervision included.</p> <p>The BSP dated 2/23/12 to 2/23/13 was reviewed on 7/17/12 at 2:10 PM and included the same target behaviors indicating AWOL as follows: "As a result of the most recent incident of leaving the home without supervision the IDT decided that an alarm will be installed on [client A's] bedroom door in order to alert staff when he leaves his room at night. This is considered a temporary intervention and will be discontinued when it can be certain that he will no longer attempt to leave the house at night unsupervised..." The BSP still included the close supervision during times when client A was upset. The BSP did not include specific instructions on close supervision.</p>						

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	<p>The revision of the BSP dated 2/24/12 with a revised date of 7/16/12 was reviewed on 7/18/12 at 4:00 PM and indicated the following:</p> <ol style="list-style-type: none"> "Staff will maintain constant supervision, keeping [client A] in sight at all times except for bathroom visits. Staff should insure that there is not a second unsecured exit from the bathroom." "If [client A] attempts to leave the home staff will stop him and redirect him back to the home." "If [client A] does leave the home without supervision, staff should make an initial search for him and if not located staff should report the incident to the local authorities and follow (Residential CRF Inc.) reporting of incident policy as well." "[Client A] should be transferred to a home with male staff persons and less vulnerable roommates to lessen the chances of him harming others." "[Client A] should participate in an effective program of psychotherapy conducted by a trained professional with experience in dealing with antisocial personality disorders and effective medications for the treatment of this disorder." <p>The above revision to the 2/24/12 BSP had not been started.</p>			
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	<p>Interview with staff #1, Qualified Developmental Disabilities Professional (QDDP) on 7/18/12 at 3:30 PM indicated the IDT had agreed the BSP should be revised and the Behavior Clinician (BC) had done the changes, but they had not put the plan in place because of waiting on Human Rights approval. Phone interview with staff #1 on July 27, 2012 indicated the plan was still waiting on approval before the changes could be put into effect.</p> <p>Interview with client A on 7/17/12 at 2:00 PM indicated he did not want to live in a group home. Client A indicated he wanted to be on his own and didn't like the rules he has to follow in the home.</p> <p>Interview with staff #1, QDDP, on 7/17/12 at 3:30 PM indicated client A had been on 1 on 1 staffing since an incident at the workshop on 1/23/12. Staff #1, QDDP, indicated client A had been suspended at that time and had not been attending any day program. Staff #1, QDDP indicated currently the 1 on 1 staff just had to know where client A was and did not have to keep him in sight at all times. Staff #1, QDDP, stated client A was aware the police would not arrest him and admits that client A "does not want to be in the group home." Staff #1 further indicated client A had been receiving</p>						

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	<p>counseling since he was suspended from work in January and they were considering placing him in another home where there were male staff and other opportunities for day program.</p> <p>Review of the facility policy and procedures on Consumer Abuse, undated, was conducted on 7/18/12 at 2:30 PM. The policy defines Neglect as "...failure to provide appropriate care, food, medical care or supervision." The policy indicated "Abuse neglect, exploitation and mistreatment of a consumer are unacceptable and will not be tolerated..."</p> <p>This federal tag relates to complaint #IN00109878.</p> <p>9-3-2(a)</p>						

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W0157	<p>483.420(d)(4) STAFF TREATMENT OF CLIENTS If the alleged violation is verified, appropriate corrective action must be taken. Based on record review and interview for 1 of 3 sampled clients (client A), the facility failed to take sufficient corrective action to address client A's elopement behavior by not ensuring the 1 on 1 staffing had been clearly defined as to what the staff were required to do.</p> <p>Findings include:</p> <p>The facility's internal incident reports, reportable incident reports and/or investigations were reviewed on 7/17/12 at 2:30 PM. The facility's internal incident reports, reportable incident reports and/or investigations indicated the following:</p> <ul style="list-style-type: none"> - 11/2/11 - Client A jumped out of a parked van and took off running. - 4/21/12 - Client A went AWOL. - 6/21/12 - "[Client A] had been grocery shopping with peers and became upset when a peer bumped into him. The report indicated [client A] thought it had been done on purpose and began yelling and cursing at peer. The report indicated staff prompted [client A] to go to his room to calm down. [Client A] did go to 	W0157	<p>W 157 STAFF TREATMENT OF CLIENT: Staff have received re-training on the guidelines of the BMP. approved 7/18/2012, which continues in effect after the exit date on August 1, 2012. . This BMP details the guidelines for dealing with Client A's behaviors, specifically AWOL. There has been a pattern of reduction of Client A's AWOL behavior since the survey exit on 8/1/2012. The governing body will continue to review weekly to determine Client A's status, if staff are following guidelines. In addition any correction or changes needed to assure Client A's safety will be directed to the governing body for review. Responsible: QDDP, Systems Manager Date: 8/31/2012</p> <p>What corrective action(s) will be accomplished for these residents found to have been affected by the deficient practice: Monitoring to assure staff are trained on client issues and updates, and follow along to assure staff follow through as stated in training. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken: At present, no other clients have been identified. If so, then</p>	08/31/2012			

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	<p>his room but continued to scream and curse. [Client A] came down stairs and started yelling again. He went out the front door at approximately 8:23 PM. Staff followed and were able to keep a visual until 8:32 PM. The police were notified and returned [client A] to the home at approximately 8:59 PM."</p> <p>- 7/1/12 - "[Client A] became angry and started screaming. He demanded to talk to his dad. Staff indicated he could call his father when he calmed down. [Client A] kicked a box fan across the room and broke it. [Client A] took off out the back door and started running with staff following. The staff lost contact with [client A] and police were called at approximately 9:52 PM. Police came to the house at 10:45 PM and had not seen [client A]. When police started to leave the home he was seen walking on the back deck."</p> <p>- 7/15/12 - "A severe storm with rain, wind and lightning was occurring while the clients were sitting on front porch. Staff prompted the clients to come into the home. [Client A] had a sweeper cleaning tool in the waistband of his pants and became angry when staff prompted him to put it away. [Client A] went outside with staff following him and walked up and down the alley with staff</p>		<p>monitoring will occur to assure training is provided, and followed.</p> <p>What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur: Annual training of staff along with training of new hires on policy and procedures, along with any training needed for client changes in programming. How the corrective action(s) will be monitored to ensure the deficient practice will not recur: The governing body will implement weekly reviews to assess 1). Progress of Client weekly/status report; 2). Staff assessment of efficiency of the BMP; and 3) Any changes needed to further protect the Client..</p>				

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	<p>inside, he bolted down the alley with the staff following. The other staff started a search by van. Staff would briefly lose sight of him as he ducked through yards and around bushes. The QDDP was contacted and instructed the staff to call the police. At 11:00 PM the police called the home indicating they had seen him by the city police station and when staff got there he was gone. The police were called again at 1:40 AM and were told [client A] was missing. At 3:20 AM, staff received a call that he was seen walking on State Road [name]. The police had detained him while the group home picked him up at 3:30 AM."</p> <p>During the observation period on 7/17/12 at 2:00 PM, client A was observed going upstairs to his room while his staff #4 was watching TV (television) in the living room. At 3:00 PM client A was observed going outside while staff #4 stayed in the home. At 5:50 PM client A was sitting on the back deck and staff #4 was in the house. Staff #4 could not see client A from the house.</p> <p>The Behavior Support Plan (BSP) dated 2/24/11 to 2/25/12 for client A was reviewed on 7/18/12 at 2:00 PM. The plan indicated the definition and procedure to be used as follows: "AWOL (Leaving the group home</p>			

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	<p>unsupervised and without permission." The BSP indicated the AWOL had been reinstated on 8/1/2010. The BSP indicated "Staff should be aware that [client A] has left the group home without permission on more than one occasion. He was upset about some personal matters and walked away from the home despite staff's attempts to stop him. The IDT (Interdisciplinary Team) has implemented strategy that involves close supervision during times when [client A] is obviously upset. Staff will intervene as needed to prevent him from leaving the group home without supervision. If [client A] should leave the home staff should notify their Supervisor immediately. This plan will be reviewed in 3 months, and deferred after a six month period from the last incident involving AWOL." The BSP did not provide clear instructions on what close supervision included.</p> <p>The BSP dated 2/23/12 to 2/23/13 for client A was reviewed on 7/17/12 at 2:30 PM. The BSP indicated the following: "As a result of the most recent incident of leaving his home without supervision the IDT decided that an alarm will be installed on [Client A's] bedroom door in order to alert staff when he leaves his room at night. This is considered a temporary intervention and will be</p>						

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	<p>discontinued when it can be certain that he will no longer attempt to leave the house at night unsupervised...." The BSP still included the close supervision during times when client A was upset. The BSP did not include specific instructions on close supervision.</p> <p>Interview with staff #1, QDDP, on 7/17/12 at 3:30 PM indicated client A had been on 1 on 1 staffing since an incident at the workshop on 1/23/12. Staff #1, QDDP, indicated client A had been suspended at that time and had not been attending any day program. Staff #1, QDDP indicated currently the 1 on 1 staff just had to know where client A was and did not have to keep him in sight at all times. Staff #1, QDDP, indicated there were no specific instructions on the close supervision.</p> <p>This federal tag relates to complaint #IN00109878.</p> <p>9-3-2(a)</p>						

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