

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G478	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/01/2014
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NAME OF PROVIDER OR SUPPLIER RESIDENTIAL CRF INC	STREET ADDRESS, CITY, STATE, ZIP CODE 2534 W SR 44 LIBERTY, IN 47353
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(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 a fundamental annual recertification and state licensure survey.</p> <p>Dates of Survey: September 29 and October 1, 2014.</p> <p>Surveyor: Vickie Kolb, RN</p> <p>Facility Number: 000992 Provider Number: 15G478 AIM Number: 100244940</p> <p>This federal deficiency also reflects state findings in accordance with 460 IAC 9. Quality Review completed 10/9/14 by Ruth Shackelford, QIDP.</p>	W000000		
W000323	<p>483.460(a)(3)(i) PHYSICIAN SERVICES</p> <p>The facility must provide or obtain annual physical examinations of each client that at a minimum includes an evaluation of vision and hearing.</p> <p>Based on record review and interview for 1 of 2 sampled clients (#2), the facility failed to ensure the client's vision was evaluated annually.</p> <p>Findings include:</p> <p>Client #2's record was reviewed on</p>	W000323	<p>The facility will assure that an annual screening of vision will be completed in a timely manner.</p> <p>The facility will also assure that the information documented annually will address their ability to see and include information which will assist the team to determine active treatment needs of the individual. The team will</p>	10/31/2014

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>10/1/14 at 1 PM. Client #2's annual physical evaluation of 7/31/14 did not indicate a vision evaluation. The evaluation indicated client #2 had a "droopy right eyelid."</p> <p>Client #2's record indicated client #2's most recent vision evaluation by the client's Optometrist was conducted on 12/5/12. The evaluation indicated</p> <p>__1) "Optic atrophy (deterioration of the optic nerve) OU (right eye)</p> <p>__2) Macular degen (degeneration) (a chronic eye disease that causes vision loss in the center of the field of vision) OU</p> <p>__3) UC ptosis (a drooping of the upper eyelid) OD."</p> <p>Interview with the facility's LPN on 10/1/14 at 2 PM indicated client #2's annual physical evaluation did not include a vision evaluation. The LPN indicated client #2's most current vision evaluation was on 12/5/12.</p> <p>9-3-6(a)</p>		<p>also address issues which can only be assessed through a specialized comprehensive evaluation to determine if changes have occurred to warrant further evaluation/referral. Nursing will assure that the proper documentation of this information is included on the physical annually, or as necessary to fulfill the requirements of this standard. Periodic audit, on at least a semi-annual basis will assure that this information is charted in the individual records. Responsible: Nursing, QIDP, Administrative staff</p>		