

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G513	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  08/27/2012
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NAME OF PROVIDER OR SUPPLIER  RESIDENTIAL CRF INC	STREET ADDRESS, CITY, STATE, ZIP CODE 2375 W US HWY 36 DANVILLE, IN 46122
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W0000	<p>This visit was for a fundamental recertification and state licensure survey.</p> <p>Dates of Survey: August 20, 21, 22, 23, 24, and 27, 2012</p> <p>Facility Number: 001027 Provider Number: 15G513 AIMS Number: 100245180</p> <p>Surveyor: Brenda Nunan, RN, Public Health Nurse Surveyor III</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 9/4/12 by Ruth Shackelford, Medical Surveyor III.</p>	W0000		
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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</p> <p>The governing body must exercise general policy, budget, and operating direction over the facility.</p> <p>Based on observation, record review and interview, the Governing Body failed to exercise general policy and operating direction to include/implement policies and procedures to address the Elder Justice Act; which required specific individuals in applicable long term care facilities to report any reasonable suspicion of crimes committed against a resident of that facility; (pursuant to 6703(B)(3) of The Patient Protection and Affordable Care Act of 2010 according to section 1150B of the Social Security Act.) for 4 of 4 sampled clients (#1, #2, #3, and #4), and 4 additional clients (#5, #6, #7, and #8).</p> <p>Findings include:</p> <p>During observations at the facility on 08/22/2012 from 3:15 p.m. until 5:30 p.m. and on 08/23/2012 from 6:30 a.m. until 8:15 a.m. clients #1, #2, #3, #4, #5, #6, #7 and #8 were observed to be living in the facility.</p> <p>An undated Operational Policy and Procedure Manual was reviewed on 08/21/2012 at 6:15 a.m. The Governing Body failed to approve and include the</p>	W0104	<p>Residential CRF will ensure to include the Elder Justice Act into our Operational Policy and Procedure Manuel. Residential CRF will develop and implement written policy and procedures which address the Elder Justice Act. The supervisor will check on a weekily basis to ensure the Elder Justice Act is posted in our facilities.</p> <p>Staff Responsible: QMRP, Supervisor</p>	09/26/2012	

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	<p>Elder Justice Act (as defined above) in their agency's written policies and procedures.</p> <p>During an interview on 08/21/2012 at 11:00 a.m., the Qualified Developmental Disabilities Professional Designee stated, "I have not heard of the Elder Justice Act."</p> <p>During an interview on 08/22/2012 at 10:00 a.m., Group Home Supervisor #2 indicated he was unaware of the required implementation of the Elder Justice Act.</p> <p>During an interview on 08/22/2012 at 12:10 p.m. Human Resource Director #1 indicated the agency was aware of the Elder Justice Act, but the facility policies had not specifically addressed the Act and the facility had not commenced procedural changes for training.</p> <p>9-3-1(a)</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. Based on record review and interview, the facility failed to include/implement policies and procedures which included/addressed the Elder Justice Act; which requires specific individuals in applicable long term care facilities to report any reasonable suspicion of crimes committed against a resident of that facility; (pursuant to 6703(B)(3) of The Patient Protection and Affordable Care Act of 2010 according to section 1150B of the Social Security Act.) for 4 of 4 sampled clients (#1, #2, #3, and #4), and 4 additional clients (#5, #6, #7, and #8).</p> <p>Findings include:</p> <p>During observations at the facility on 08/22/2012 from 3:15 p.m. until 5:30 p.m. and on 08/23/2012 from 6:30 a.m. until 8:15 a.m. clients #1, #2, #3, #4, #5, #6, #7 and #8 were observed to be living in the facility.</p> <p>An undated Operational Policy and Procedure Manual was reviewed on 08/21/2012 at 6:15 a.m. The facility failed to approve and include the Elder Justice Act (as defined above) in their agency's written policies and procedures.</p>	W0149	Residential CRF will ensure that the Elder Justice Act is added to our Operational Policy and Procedure Manuel. Residential CRF staff will be inserviced on the Elder Justice Act and its requirements. The supervisor will check on a weekly basis to ensure that the Elder Justice Act is posted in our facilities. Staff Responsible: QMRP, Supervisor	09/26/2012	

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	<p>During an interview on 08/21/2012 at 11:00 a.m., the Qualified Developmental Disabilities Professional Designee stated, "I have not heard of the Elder Justice Act."</p> <p>During an interview on 08/22/2012 at 10:00 a.m., Group Home Supervisor #1 indicated he was unaware of the required implementation of the Elder Justice Act.</p> <p>During an interview on 08/22/2012 at 12:10 p.m. Human Resource Director #1 indicated the agency was aware of the Elder Justice Act, but the facility policies had not specifically addressed the Act and the facility had not commenced procedural changes for training.</p> <p>9-3-2(a)</p>						

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W0189	<p>483.430(e)(1) STAFF TRAINING PROGRAM The facility must provide each employee with initial and continuing training that enables the employee to perform his or her duties effectively, efficiently, and competently.</p> <p>Based on record review, observation and interview, the facility failed to train staff in safe procedures for entering/exiting the van for 1 of 4 sampled clients (client #3).</p> <p>Findings include:</p> <p>The facility's reportable incidents were reviewed on 08/21/2012 at 10:45 a.m. An Indiana Division of Disability and Rehabilitative Services Incident Report, dated, 05/12/2012 at 5:00 p.m., indicated client #3 fell while boarding the van. The corrective action plan indicated client #3 would be encouraged to utilize a step stool for entering/exiting the van.</p> <p>An Indiana Division of Disability and Rehabilitative Services Incident Report, dated, 08/20/2012 at 8:25 a.m. indicated client #3 fell while getting on the van.</p> <p>During observations on 08/22/2012 at 3:15 p.m., client #3 exited the van without a step stool. Direct Support Professional (DSP) #1 did not offer or encourage use of the step stool.</p>	W0189	Residential CRF staff will be trained on safe procedures for clients to enter and exit the van. A stool will be provided for those clients needing assistance. Staff will be trained in the correct manner to use the stool for entering and exiting the van. The supervisor will check on a weekly basis to ensure that a stool is available for clients to use and that staff are practicing safe exiting and entering procedures for the van. Staff Responsible: QMRP, Supervisor	09/26/2012			

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	<p>During observations on 08/23/2012 at 8:10 a.m., client #3 entered the van without a step stool. DSP #1 and House Manager (HM) #2 did not offer or encourage use of the step stool.</p> <p>During an interview on 08/22/2012 at 3:15 p.m., DSP #1 indicated a step stool was kept in the van. He stated the stool had not been utilized by any clients "for a long time."</p> <p>During an interview on 08/23/2012 at 1:40 p.m., Qualified Developmental Disabilities Professional Designee (QDDP-D) stated, "I know staff were trained," in regard to client #3 using the step stool for entering/exiting the van. She indicated there was no documentation to verify staff training after it was included in a plan of correction for an incident report.</p> <p>9-3-3(a)</p>				

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W0210	<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 observation, record review and interview, the facility failed to assess maladaptive behaviors related to wearing shoes at Day Services for 1 of 4 sampled clients (client #4).</p> <p>Findings include:</p> <p>During observations at Day Services on 08/23/2012 at 9:30 a.m., client #4 wore socks without skid resistant soles and did not wear shoes to protect his feet from injury. Trays of metal parts (screws) were being sorted on tables in the work area. The work shop floor had a smooth, hard surface. Some co-workers utilized wheelchairs for mobility.</p> <p>Client #4's record was reviewed on 08/23/2012 at 12:50 p.m. The Behavioral Support Plan (BSP) dated, 09/22/2011, indicated target behaviors of anxiety during medical/dental appointments and inappropriate sexual behaviors.</p> <p>The Individual Support Plan (ISP), dated 09/22/2011, indicated target behaviors of irritability, physical aggression,</p>	W0210	Residential CRF will assess maladaptive behaviors as they present themselves. Residential CRF will reassess Client # 4's BMP and will address the issue of not wearing his shoes at the workshop. Residential CRF will implement a goal for Client #4 to wear his shoes at the workshop. The supervisor will check on a weekly basis to ensure that staff are encouraging Client #4 to wear his shoes at the workshop. Staff Responsible: QMRP, Supervisor	09/26/2012			

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	<p>self-injury, hair pulling and PICA (eating non-food items). The BSP did not address refusals to wear shoes.</p> <p>During an interview on 08/23/2012 at 9:50 a.m. Day Service Staff (DSS) #1 indicated client #4 removed his shoes after arriving at Day Services. DSS #1 indicated client #4 ambulated to the rest room and dining area in his socks. She stated, "He has behaviors if we try to make him wear shoes."</p> <p>During an interview on 08/23/2012 at 10:00 a.m., Day Service Director (DSD) #1 indicated closed toe shoes were required by all persons entering the work areas to prevent foot injury from dropped objects and to prevent foot injury from accidental stepping on toes or accidental rolling across the foot with a wheelchair. He indicated client #4 should have worn shoes. DSD #1 stated, "[Client #4] has major behaviors when we try to get him to wear shoes."</p> <p>During an interview on 08/23/2012 at 1:20 p.m., Qualified Developmental Disabilities Professional Designee (QDDP-D) #1 indicated the facility had not assessed the maladaptive behaviors associated with wearing shoes.</p> <p>9-3-4(a)</p>						

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W0227	<p>483.440(c)(4) INDIVIDUAL PROGRAM PLAN The individual program plan states the specific objectives necessary to meet the client's needs, as identified by the comprehensive assessment required by paragraph (c)(3) of this section. Based on observation, interview and record review for 1 of 4 sampled clients (client #4), the facility failed to ensure the client's Individual Support Plan (ISP) addressed the client's behavioral needs.</p> <p>Findings include:</p> <p>During observations on 08/23/2012 at 9:30 a.m. at the day service program, client #4 wore socks without skid resistant soles and did not wear shoes to protect his feet from injury. Trays of metal parts (screws) were being sorted on tables in the work area. The work shop floor had a smooth, hard surface. Some co-workers utilized wheelchairs for mobility.</p> <p>During an interview on 08/23/2012 at 9:50 a.m. Day Service Staff (DSS) #1 indicated client #4 removed his shoes after arriving at Day Services. DSS #1 indicated client #4 ambulated to the rest room and dining area in his socks. She stated, "He has behaviors if we try to make him wear shoes."</p>	W0227	Residential CRF will assess the individualized needs of each of our clients. Residential staff will reassess the ISP for Client # 4 to ensure that it addresses all of Client # 4's behavioral concerns and needs. Client # 4's behavioral plan will reflect the need to assist named Client in keeping his shoes on at the workshop. A goal has been implemented to assist Client # 4 in keeping on his shoes. The supervisor will check on a weekly basis to ensure that staff are encouraging Client #4 in keeping his shoes on at the workshop. Staff Responsible: QMRP, Supervisor	09/26/2012	

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	<p>During an interview on 08/23/2012 at 10:00 a.m., Day Service Director (DSD) #1 indicated closed toe shoes were required by all persons entering the work areas to prevent foot injury from dropped objects and to prevent foot injury from accidental stepping on toes or accidental rolling across the foot with a wheelchair. He indicated client #4 should have worn shoes. DSD #1 stated, "[Client #4] has major behaviors when we try to get him to wear shoes."</p> <p>An undated, "Sycamore Work Center Code of Conduct" was reviewed on 08/23/2012 at 10:40 a.m. The policy indicated, "...Footwear (no sandals, flip flops, open toed shoes, Crocs or croc like shoes)...."</p> <p>Client #4's record was reviewed on 08/23/2012 at 12:50 p.m. The Behavioral Support Plan (BSP) dated, 09/22/2011, indicated target behaviors of anxiety during medical/dental appointments and inappropriate sexual behaviors.</p> <p>The Individual Support Plan (ISP), dated 09/22/2011, indicated target behaviors of irritability, physical aggression, self-injury, hair pulling and PICA (eating non-food items). The BSP did not address refusals to wear shoes.</p>						

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	<p>During an interview on 08/23/2012 at 1:20 p.m., Qualified Developmental Disabilities Professional Designee (QDDP-D) #1 indicated the facility had not implemented the Day Service dress code policy.</p> <p>9-3-4(a)</p>			

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W0278	<p>483.450(b)(1)(iii) MGMT OF INAPPROPRIATE CLIENT BEHAVIOR</p> <p>Procedures that govern the management of inappropriate client behavior must insure, prior to the use of more restrictive techniques, that the client's record documents that programs incorporating the use of less intrusive or more positive techniques have been tried systematically and demonstrated to be ineffective. Based on record review and interview, the facility failed to ensure the least restrictive interventions were tried prior to introducing behavioral medication for 1 of 4 sampled clients (client #2).</p> <p>Findings include:</p> <p>Client #2's record was reviewed on 08/23/2012 at 11:30 a.m. A Behavioral Support Plan (BSP), dated 09/22/2011, indicated client #2 had a target behavior of irritability which included agitation.</p> <p>A Behavioral Progress Report, dated January 2012 indicated, "...Significant increase in target behaviors noted this past quarter...." The note did not indicate additional behavioral interventions were developed.</p> <p>A physician's order, dated 04/13/2012, indicated, "... (symbol for increase) Thorazine (used for treatment of psychotic disorders) to 150 mg</p>	W0278	Residential CRF insure, prior to the use of more restrictive techniques, that the client's record documents that programs incorporating the use of less intrusive or more positive techniques have been tried and proven to be ineffective. The behavioral clinician will review client's behaviors on a monthly basis. If behaviors have increased dramatically ,new techniques/procedures will be tried before suggesting medication changes. Staff Responsible: Behavior Clinician, QMRP	09/26/2012	

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	<p>(milligrams) tid (three times daily) for agitation...." The record did not indicate revisions to the BSP with behavioral interventions prior to increasing the Thorazine dose from 100 mg three times daily to 150 mg three times daily.</p> <p>During an interview on 08/23/2012 at 1:40 p.m., Qualified Developmental Professional Designee (QDDP-D) indicated the facility had not revised the behavioral support plan and had not attempted less restrictive interventions prior to increasing the Thorazine dose.</p> <p>9-3-5(a)</p>				