

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G546	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/07/2014
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NAME OF PROVIDER OR SUPPLIER RESIDENTIAL CRF INC	STREET ADDRESS, CITY, STATE, ZIP CODE 2846 W SR 44 CONNERSVILLE, IN 47331
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W000000	This visit was for a fundamental recertification and state licensure survey. Dates of Survey: February 3, 4 and 7, 2014. Surveyor: Vickie Kolb, RN Facility Number: 001060 Provider Number: 15G546 AIM Number: 100245400 These federal deficiencies also reflect state findings in accordance with 460 IAC 9. Quality review completed February 14, 2014 by Dotty Walton, QIDP.	W000000		
W000316	483.450(e)(4)(ii) DRUG USAGE Drugs used for control of inappropriate behavior must be gradually withdrawn at least annually. Based on record review and interview for 1 of 3 sample clients receiving medications to control maladaptive behaviors (#1), the facility failed to provide evidence an annual medication reduction had been attempted or specific contraindications as to why an attempt was not made. Findings include:	W000316	Client #1 had an appointment with his physician on 2-20-14 to assess his medication needs. Residential CRF will ensure that anual reductions are completed or specific contraindications as to why attempt was not made will be made available. Residential nursing staff and behavior clinician will review the client's charts on a monthly basis to assess if a client is appropriate for a reduction. Residential QIDP	03/09/2014

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>Client #1's record was reviewed on 2/4/14 at 11:30 AM. Client #1's physician's orders for 2013/2014 indicated client #1 took Depakote ER (Extended Release) 250 milligrams once a day for Impulse control. Client #1's BSP (Behavior Support Plan) of 7/10/13 indicated client #1 had targeted behaviors of hugging, disruption and resistance. Client #1's annual behavior progress note of 7/10/13 indicated "No significant change in target behaviors noted this past year. [Client #1] is fairly stable at this time."</p> <p>Review of client #1's monthly behavior records of 2013 indicated no documented behaviors from 6/2013 through 10/2013, one incident of resistance in November and two incidents of refusal to take his medications in December, 2013.</p> <p>Client #1's quarterly medication reviews for 2013/2014 indicated no changes in client #1's Depakote dosage.</p> <p>Client #1's record indicated the last reduction of behavior modification medication was conducted in 2011. Client #1's record indicated no attempt of medication reduction and/or</p>		will review charts on a monthly basis to ensure that clients receiving medications to control maladaptive behaviors receive an annual reduction assessment. Staff Responsible: QIDP, Nurse, Behavior Clinician				

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W000369	<p>contraindications as to why an attempt was not made since the reduction of 2011.</p> <p>Interview with the QIDP (Qualified Intellectual Disabilities Professional) and the facility nurse on 2/4/14 at 3 PM indicated the last attempt of medication reduction for client #1 was 2011. The QIDP indicated no other attempts at a medication reduction had been made since 2011. The nurse and the QIDP indicated no documentation of contraindication as to why an attempt of reduction in client #1's behavior modification medication should not be attempted.</p> <p>9-3-5(a)</p> <p>483.460(k)(2) DRUG ADMINISTRATION The system for drug administration must assure that all drugs, including those that are self-administered, are administered without error. Based on observation, record review and interview for 3 of 18 medications observed being administered, the facility failed to ensure all medications were administered without error to client #6.</p> <p>Findings include:</p>	W000369	Residential CRF will retrain staff in regards to administering medication without error. Staff will be retrained on Core A&B standards and procedures. Residential nurse will retrain and observe identified staff during medication administration. Staff will be monitored until they can perform the medication without	03/09/2014

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	<p>Observations were conducted of the medication pass at the group home on 2/4/14 between 8 AM and 8:30 AM. At 8:05 AM staff #2 gave client #6 Flomax 0.4 mg (milligrams) for incontinence and Clonazepam 1 mg for movement disorder. Staff #2 did not give client #6 Sertraline for anxiety or Proscar for prostrate health.</p> <p>Review of client #6's MAR (Medication Administration Record) for 2/2014 on 2/4/14 at 8:30 AM indicated client #6 was to have Sertraline 100 mg, Proscar 5 mg and Clonazepam 1 mg at 8 AM and Flomax 0.4 mg at bedtime.</p> <p>Review of client #6's physician's orders for 2/2013 on 2/4/14 at 10 AM indicated client #6 was to have Sertraline 100 mg, Proscar 5 mg and Clonazepam 1 mg at 8 AM and Flomax 0.4 mg at bedtime.</p> <p>During interview with staff #2 on 2/4/14 at 8:35 AM staff #2 stated "Someone must have put the PM med (medication) in with the AM meds." Staff #2 indicated he had not given client #6 Sertraline or Proscar and the Flomax was to be given at bedtime.</p> <p>Interview with LPN #2 on 2/4/14 at 10 AM indicated all medications were to be given as per the physician's orders and</p>		<p>error. Initially, staff will be (were) monitored ,by the RN for three consecutive days to ensure the morning med pass and evening med pass are(were) being completed correctly. Residential staff will be monitored at least weekly by the house supervisor and/ or nursing staff on performing medication administrations. Staff Responsible: Nurse, Supervisor, QIDP</p>				

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	<p>the client's MARs. LPN #2 stated, "I do the training and there is no room for error. He (staff #2) will be retrained and pulled from giving medications until he has received and passed the retraining." LPN #2 stated staff #2 "couldn't have done the triple check the way he was supposed to or else he wouldn't have made a mistake."</p> <p>9-3-6(a)</p>			