

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G186	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  05/01/2013
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NAME OF PROVIDER OR SUPPLIER  RESIDENTIAL CRF INC	STREET ADDRESS, CITY, STATE, ZIP CODE 637 E MAIN ST DANVILLE, IN 46122
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W000000	<p>This visit was for the investigation of complaint #IN00126082 and the investigation of complaint #IN00128214.</p> <p>Complaint #IN00126082: Substantiated, federal and state deficiencies related to the allegation(s) are cited at W104, W153, W154 and W381.</p> <p>Complaint #IN00128214: Substantiated, no deficiencies related to the allegation(s) are cited.</p> <p>Dates of Survey: 4/29/13, 4/30/13 and 5/1/13.</p> <p>Facility Number: 000719 Provider Number: 15G186 AIMS Number: 100234670</p> <p>Surveyor: Keith Briner, QIDP</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 5/8/13 by Ruth Shackelford, QIDP.</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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W000104	<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 interview and record review for 4 of 4 sampled clients (A, B, C and D) plus 4 additional clients (E, F, G and H), the governing body failed to exercise general policy, budget and operating direction over the facility to ensure an allegation of exploitation regarding clients A, B, C, D, E, F, G and H was reported and investigated.</p> <p>Findings include:</p> <p>Confidential interview (CI) #1 indicated administrative staff (AS) #1, AS #2 and AS #3 had discussed allegations of QIDP-D (Qualified Intellectual Disabilities Professional- Designee) #1 stealing clients A, B, C, D, E, F, G and H's food from the group home. CI #1 indicated AS #1, AS #2, and AS #3 had discussed allegations regarding QIDP-D #1 stealing the group home's lawn furniture.</p> <p>Interview with QIDP-D #1 was conducted on 4/30/13 at 5:15 PM. When asked if she was aware of any allegations of facility staff stealing clients' food or lawn furniture from the group home, QIDP-D #1 stated, "It was me. The investigation</p>	W000104	Residential CRF will continue to develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client's. Any allegations of abuse will be reported and investigated. Supervisors, QMRP's, Regional Directors and Incident Reporting Managers will be re trained on the procedures to be followed in dealing with any issues regarding mistreatment, neglect or abuse. Residential CRF abuse policy and incident reporting will be reviewed. The training will be more detailed in terms of defining reportable incidents and the action/actions that need to be taken to correctly investigate the allegation. The system "broke down" when the supervisor was not aware that an incident report was required for such an allegation. The supervisor has been retrained on all areas of resident rights and reportable incidents. Staff Responsible: Regional Director, QMRP	05/31/2013	

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	<p>was with me. [AS #2] and [AS #3] came out here and asked me about food. It was. I am so embarrassed. It was a misunderstanding." QIDP-D #1 stated, "[AS #1] knew about the investigation. [AS #1] wasn't with [AS #2] and [AS #3] when they came, but we talked about it later on the phone."</p> <p>AS #1 was interviewed on 4/30/13 at 12:39 PM. When asked if she was aware of any allegations of facility staff stealing clients' food or lawn furniture from the group home, AS #1 stated, "No, not that I know of."</p> <p>The facility's BDDS (Bureau of Developmental Disabilities Services) reports and investigations were reviewed on 4/30/13 at 4:40 PM. The review did not indicate a BDDS report or investigation regarding QIDP-D #1 and allegations of theft of clients' food/lawn furniture.</p> <p>This federal tag relates to complaint #IN00126082.</p> <p>9-3-1(a)</p>				

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W000153	<p>483.420(d)(2) STAFF TREATMENT OF CLIENTS The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures. Based on interview and record review for 1 of 14 allegations of abuse, neglect, mistreatment and exploitation, the facility failed to report an allegation of exploitation for 4 of 4 sampled clients (A, B, C and D) plus 4 additional clients (E, F, G and H) immediately in accordance with state law to BDDS (Bureau of Developmental Disabilities Services).</p> <p>Findings include:</p> <p>Confidential interview (CI) #1 indicated administrative staff (AS) #1, AS #2 and AS #3 had discussed allegations of QIDP-D (Qualified Intellectual Disabilities Professional- Designee) #1 stealing clients A, B, C, D, E, F, G and H's food from the group home. CI #1 indicated AS #1, AS #2, and AS #3 had discussed allegations regarding QIDP-D #1 stealing the group home's lawn furniture.</p> <p>Interview with QIDP-D #1 was conducted on 4/30/13 at 5:15 PM. When asked if she was aware of any allegations of facility</p>	W000153	Residential CRF will continue to develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client's. Any allegations of abuse, neglect mistreatment and exploitation will be reported and investigated. Supervisors, QMRP's, Regional Director's, and Incident Reporting Managers will be retrained on the correct steps and procedures to be followed with any allegation of abuse or neglect. Residential CRF Abuse Policy and Incident Reporting procedures will be reviewed. The training will be more detailed in outlining the importance of investigating all allegations and the definitions of reportable incidents. The system "broke down" when the supervisor was unaware that such allegations were to be reported. The supervisor has been retrained on the importance of reporting all allegations of abuse and neglect. Staff Responsible: Regional Director, QMRP	05/31/2013	

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	<p>staff stealing clients' food or lawn furniture from the group home, QIDP-D #1 stated, "It was me. The investigation was with me. [AS #2] and [AS #3] came out here and asked me about food. It was. I am so embarrassed. It was a misunderstanding." QIDP -D #1 stated, "[AS #1] knew about the investigation. [AS #1] wasn't with [AS #2] and [AS #3] when they came, but we talked about it later on the phone."</p> <p>AS #1 was interviewed on 4/30/13 at 12:39 PM. When asked if she was aware of any allegations of facility staff stealing clients' food or lawn furniture from the group home, AS #1 stated, "No, not that I know of."</p> <p>The facility's BDDS (Bureau of Developmental Disabilities Services) reports and investigations were reviewed on 4/30/13 at 4:40 PM. The review did not indicate a BDDS report regarding QIDP-D #1 and allegations of theft of clients' food/lawn furniture.</p> <p>This federal tag relates to complaint #IN00126082.</p> <p>9-3-1(b)(5) 9-3-2(a)</p>			

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W000154	<p>483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated.</p> <p>Based on interview and record review for 1 of 14 allegations of abuse, neglect, mistreatment and exploitation, the facility failed to conduct an investigation of an allegation of exploitation for 4 of 4 sampled clients (A, B, C and D) plus 4 additional clients (E, F, G and H).</p> <p>Findings include:</p> <p>Confidential interview (CI) #1 indicated administrative staff (AS) #1, AS #2 and AS #3 had discussed allegations of QIDP-D (Qualified Intellectual Disabilities Professional- Designee) #1 stealing clients A, B, C, D, E, F, G and H's food from the group home. CI #1 indicated AS #1, AS #2, and AS #3 had discussed allegations regarding QIDP-D #1 stealing the group home's lawn furniture.</p> <p>Interview with QIDP-D #1 was conducted on 4/30/13 at 5:15 PM. When asked if she was aware of any allegations of facility staff stealing clients' food or lawn furniture from the group home, QIDP-D #1 stated, "It was me. The investigation was with me. [AS #2] and [AS #3] came out here and asked me about food. It was.</p>	W000154	Residential CRF will ensure to have evidence that all alleged violations are thoroughly investigated. All allegations of abuse, neglect, mistreatment and exploitation will be thoroughly investigated and reported. Supervisors, QMRP's, Regional Directors and Incident Reporting Managers will be re trained on the correct steps and procedures for reporting ant allegations of abuse /neglect. Residential CRF consumer abuse policy and incident reporting will be reviewed. The training will be more detailed in the form of defining reportable incidents and the actions to be taken. The system "broke down" with the supervisor being unaware that that an incident report was required for such allegations. The supervisor has been retrained on all areas of resident rights and reportable incidents and the procedures to be followed in dealing with any issues regarding suspected mistreatment, neglect, abuse or exploitation. Staff Responsible: Regional Director, QMRP	05/31/2013			

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	<p>I am so embarrassed. It was a misunderstanding." QIDP -D #1 stated, "[AS #1] knew about the investigation. [AS #1] wasn't with [AS #2] and [AS #3] when they came, but we talked about it later on the phone."</p> <p>AS #1 was interviewed on 4/30/13 at 12:39 PM. When asked if she was aware of any allegations of facility staff stealing clients' food or lawn furniture from the group home, AS #1 stated, "No, not that I know of."</p> <p>The facility's BDDS (Bureau of Developmental Disabilities Services) reports and investigations were reviewed on 4/30/13 at 4:40 PM. The review did not indicate an investigation regarding QIDP-D #1 and allegations of theft of clients' food/lawn furniture.</p> <p>This federal tag relates to complaint #IN00126082.</p> <p>9-3-2(a)</p>				

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W000381	<p>483.460(l)(1) DRUG STORAGE AND RECORDKEEPING The facility must store drugs under proper conditions of security. Based on observation and interview for 4 of 4 sampled clients (A, B, C and D) plus 4 additional clients (E, F, G and H), the facility failed to ensure the security of clients' medications.</p> <p>Findings include:</p> <p>Observations were conducted at the group home's hotel room on 4/29/13 from 5:30 PM to 7:08 PM. Clients A, B, C, D, E, F, G and H's medications were stored in a duffle bag underneath a table located within the hotel room. Clients A, B, C, D, E, F, G and H's medications were locked in the unsecured duffle bag.</p> <p>Observations were conducted at the group home's hotel room on 4/30/13 from 3:45 PM through 5:45 PM. Clients A, B, C, D, E, F, G and H's medications were stored in a duffle bag on top of a bed located within the hotel room. Clients A, B, C, D, E, F, G and H's medications were locked in the unsecured duffle bag.</p> <p>Interview with QIDP-D (Qualified Intellectual Disabilities Professional-Designee) #1 on 4/30/13 at 5:40 PM indicated the clients' medications should be stored in a secure location.</p>	W000381	Residential CRF will ensure that all client's medications are kept in a secure location. Medications were moved to a secured, locked filing cabinet following the survey. Staff REsponsible: QMRP, House Manager	05/31/2013			

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