

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G183	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/27/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER RESIDENTIAL CRF INC	STREET ADDRESS, CITY, STATE, ZIP CODE 8500 W US HWY 36 MODOC, IN 47358
---	--

(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 an annual fundamental recertification and state licensure survey.</p> <p>Survey Dates: February 24, 25 and 27, 2014.</p> <p>Facility Number: 000716 Provider Number: 15G183 AIM Number: 100234690</p> <p>Surveyor: Vickie Kolb, RN</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 3/6/14 by Ruth Shackelford, QIDP.</p>	W000000		
W000149	<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 for 2 of 3 sample clients (#2 and #3) and 1 additional client (#8), the facility failed to implement written policy and procedures to ensure: __ All allegations of client to client abuse were reported to the administrator, the Bureau of Developmental</p>	W000149	<p>The facility policy which states that allegations of abuse, neglect, exploitation and mistreatment will be reported and thoroughly investigated was not followed by this QIDP. The QIDP was made aware of the stated incident between Client# 3 and Client #8 the day it happened, and talked to both clients shortly after the incident occurred. An agency</p>	03/28/2014

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G183	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/27/2014
NAME OF PROVIDER OR SUPPLIER RESIDENTIAL CRF INC			STREET ADDRESS, CITY, STATE, ZIP CODE 8500 W US HWY 36 MODOC, IN 47358		
(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	
	<p>Disabilities Services (BDDS) and to Adult Protective Services (APS) in accordance with state law for clients #3 and #8.</p> <p>__All injuries of unknown origin and allegations of abuse were thoroughly investigated for clients #2, #3 and #8.</p> <p>Findings include:</p> <p>The facility's policies and procedures were reviewed on 2/24/14 at 1:30 PM. The undated "Consumer Abuse Policy and Incident Reporting" indicated "Abuse, neglect, exploitation and mistreatment of a consumer are unacceptable and will not be tolerated at Residential CRF, Inc..... Residential CRF, Inc. will ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source... reported immediately to the supervisor and to other officials in accordance with State Law. Residential CRF, Inc. will have evidence that all alleged violations are thoroughly investigated...." The policy indicated all injuries of unknown origin were to be thoroughly investigated "no matter how minor."</p> <p>Please see W153: For 1 of 2 allegations of client to client abuse for clients #3 and #8, the facility failed to immediately report the allegations of abuse to the</p>		<p>incident report had been filed, but did not report, following the BDDS guidelines due to no significant injury. Also the policy as related to incidents of unknown origin being investigated (11/20/13 abrasion on client #2 from her rubbing her arm, 11/22/13 bruise on client #2 upper arm bumped on her drawer, and 2/12/14 abrasions on client#2 arm from hitting hand on her drawers) was not followed, even though consumer told staff what caused the injuries. Staff were retrained on 3/5/2014 on Investigation Training given by Steve Corya. This staff failed to follow federal guidelines on these incidents, following BDDS guidelines instead on reporting procedures. The QIDP and supervisor have been retrained on reporting and investigation procedures. QIDP will assure that incidents will be reported per company and federal guidelines. QIDP will notify staff of differences of BDDS and federal guidelines and assure that all necessary individuals are notified in the event of a reportable or unknown incident. Responsible: QIDP, Supervisor, Administrator</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G183	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/27/2014
NAME OF PROVIDER OR SUPPLIER RESIDENTIAL CRF INC			STREET ADDRESS, CITY, STATE, ZIP CODE 8500 W US HWY 36 MODOC, IN 47358		
(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	
W000153	<p>administrator, to BDDS and APS in accordance with state law.</p> <p>Please see W154: For 1 of 1 incident of client to client abuse for clients #3 and #8 and 3 of 3 injuries of unknown origin for client #2, the facility failed to ensure all injuries of unknown origin and all client to client abuse were investigated.</p> <p>9-3-2(a)</p> <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 record review and interview for 1 of 2 allegations of client to client abuse for clients #3 and #8, the facility failed to immediately report the allegations of abuse to the administrator, to the Bureau of Developmental Disabilities Services (BDDS) and to Adult Protective Services (APS) in accordance with state law.</p> <p>Findings include:</p> <p>The facility's reportable and investigative records were reviewed on 2/24/14 at 1:30 PM.</p>	W000153	The QIDP and Supervisor have been retrained on incident reporting guidelines for Reporting Mistreatment, Neglect and Abuse and Incidents of Unknown Source on March 5, 2014 by Steve Corya. This QIDP was following BDDS guidelines and since there was no injury in the incident between client #8 and #3, no formal report was generated. The staff was on the van and witnessed the incident, and an internal report was filed. QIDP spoke with both individuals after the incident. The injuries sustained by client #2 were not observed, but reported to staff by	03/28/2014	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G183		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/27/2014	
NAME OF PROVIDER OR SUPPLIER RESIDENTIAL CRF INC				STREET ADDRESS, CITY, STATE, ZIP CODE 8500 W US HWY 36 MODOC, IN 47358			
(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			
W000154	<p>An I/A (Incident/Accident) report of 11/11/13 at 3 PM indicated client #8 was upset with client #3 for touching the vent in the facility van. The report indicated client #8 was "screaming and yelling" and hit client #3 two times on the shoulder with his fist. The facility records indicated the administrator, BDDS and APS were not notified of the client to client abuse.</p> <p>Interview with the QIDP (Qualified Intellectual Disabilities Professional) on 2/27/14 at 2 PM indicated the administrator, BDDS and APS were not notified of the client to client abuse. The QIDP indicated the facility followed the guidelines sent out from BDDS. The QIDP stated, "We understood it to mean we only had to report it (client to client abuse) if there was a significant injury."</p> <p>9-3-2(a)</p> <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 record review and interview for 1 of 1 incident of client to client abuse for clients #3 and #8 and 3 of 3 injuries of unknown origin for client #2,</p>	W000154	<p>client #2. The QIDP and Supervisor will assure that such incidents will be reported and thoroughly investigated per federal guidelines and company policy. Incidents will be reported immediately to the administrator or other officials through established procedures. QIDP will notify staff of differences of BDDS and federal guidelines and assure that all necessary individuals are notified in the event of a reportable or unknown incident. Responsible: QIDP, Supervisor, Administrator.</p> <p>The QIDP and Supervisor received re-training on thorough investigation procedures of unknown incidents and incidents involving client to client abuse,</p>	03/28/2014			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G183		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/27/2014	
NAME OF PROVIDER OR SUPPLIER RESIDENTIAL CRF INC				STREET ADDRESS, CITY, STATE, ZIP CODE 8500 W US HWY 36 MODOC, IN 47358			
(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			
	<p>the facility failed to ensure all injuries of unknown origin and all client to client abuse were investigated.</p> <p>Findings include:</p> <p>The facility's reportable and investigative records were reviewed on 2/24/14 at 1:30 PM.</p> <p>An I/A (Incident/Accident) report of 11/11/13 at 3 PM indicated client #8 was upset with client #3 for touching the vent in the facility van. The report indicated client #8 was "screaming and yelling" and hit client #3 two times on the shoulder with his fist. The facility records indicated no investigation in regard to the client to client abuse.</p> <p>__An I/A report of 11/20/13 at 5 PM indicated the staff noted an abrasion on client #2's left inner arm. The report indicated client #2 stated she rubbed it.</p> <p>__An I/A report of 11/22/13 at 6:30 PM indicated staff noted a bruise on client #2's left upper arm. The report indicated client #2 reported she bumped it on her drawer.</p> <p>__An I/A report of 2/12/14 at 7:30 AM indicated the staff noted three abrasions on client #2's right hand. The report indicated client #2 reported she hit her hand on her drawer.</p>		<p>neglect or mistreatment on March 5, 2014 by Steve Corya. The QIDP will be responsible for assuring that any incidents of client to client abuse are investigated thoroughly and reported to the administrator as directed by Federal guidelines and company policy. In addition QIDP will assure that incidents which are classified as "Unknown" in origin will be investigated formally. QIDP will notify staff of differences of BDDS and Federal guidelines and assure that documentation of interviews with consumers is included with the investigation process. Responsible: QIDP, Supervisor, Administrator</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G183	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/27/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER RESIDENTIAL CRF INC	STREET ADDRESS, CITY, STATE, ZIP CODE 8500 W US HWY 36 MODOC, IN 47358
---	--

(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
W000240	<p>The facility records indicated no investigations in regard to client #2's unknown injuries.</p> <p>Interview with the QIDP (Qualified Intellectual Disabilities Professional) on 2/27/14 at 2 PM indicated client #2 was not a reliable source in regard to her injuries. The QIDP indicated client #2 had dementia. The QIDP indicated client #2's injuries reported on 11/20/13, 11/22/13 and 2/12/13 had not been observed by staff and had not been investigated. The QIDP indicated the incidents of client to client abuse had not been investigated. The QIDP indicated she had talked to the clients involved but had not conducted a thorough investigation. The QIDP indicated all allegations of abuse/neglect and injuries of unknown origin were to be investigated.</p> <p>9-3-2(a)</p> <p>483.440(c)(6)(i) INDIVIDUAL PROGRAM PLAN The individual program plan must describe relevant interventions to support the individual toward independence. Based on record review and interview for 1 of 4 sampled clients (#2), the client's ISP/BSP (Individualized Support Plan/Behavior Support Plan) failed to</p>	W000240	The ISP for client #2 has been updated to address client's dementia and SIB (picking). The care plans for client #2 have been updated to reflect her current	03/28/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G183		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/27/2014	
NAME OF PROVIDER OR SUPPLIER RESIDENTIAL CRF INC				STREET ADDRESS, CITY, STATE, ZIP CODE 8500 W US HWY 36 MODOC, IN 47358			
(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			
	<p>address how the staff were to supervise, monitor and assist client #2 in regard to the client's dementia and self injurious behavior of picking.</p> <p>Findings include:</p> <p>Observations were conducted at the group home on 2/24/14 between 4 PM and 6 PM. Client #2 had a small scabbed area on her nose.</p> <p>The facility's reportable records were reviewed on 2/24/14 at 1:30 PM.</p> <p>__The 10/22/13 I/A (Incident/Accident) report indicated client #2 had been picking at her forehead and had a small open area of 1/4 inch. The report indicated the area was rinsed with peroxide and an antibiotic ointment was applied and the staff trimmed client #2's fingernails.</p> <p>__The 11/13/13 I/A report indicated client #2 had a "puss area" with a round red area on her 4th knuckle. The report indicated the nurse assessed client #2 and documented small areas on client #2's left hand/wrist/knuckles that client #2 had picked at.</p> <p>__The 11/20/13 I/A report indicated the staff noted an "abrasion" on client #2's left middle arm "1 inch long and 1/4 inch wide." The report indicated client #2 "states she rubbed it."</p>		<p>status. Care plans will include to staff were to supervise, monitor and assist client #2. The IDT will review the other consumers who have SIB or dementia issues and the ISP/BSP will be updated to reflect their status. The IDT met 3/12/2014 to discuss SIB behaviors for client #2. The BSP has been updated to formalize an intervention to include picking. This behavior had been tracked as part of her BSP. Consents have been obtained to reflect plan changes. The IDT will review data for other clients who have SIB, and update any interventions which need revision. In order to insure that the ISP includes relevant interventions to support all individuals, but more specifically those individuals diagnosed with memory loss or Dementia to support the individual toward independence. Residential CRF will provide a care plan that will address how the staff are to supervise, monitor and assist those clinets in need. Client #2 was assessed on 2/25/2014 using the Folstein Mini-Mental Status Exam in order to establish a baseline of mental performance. Direct Care Staff were trained in regard to recording incidents of observed memory loss and how to intervene. The mental status of client #2 is being monitored on a daily basis. A report will be generated on a quarterly basis (4 months) and recommendations</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G183	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/27/2014
NAME OF PROVIDER OR SUPPLIER RESIDENTIAL CRF INC			STREET ADDRESS, CITY, STATE, ZIP CODE 8500 W US HWY 36 MODOC, IN 47358		
(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	
	<p>__The 1/16/14 I/A report indicated client #2 called for staff to look at sores on her arm and leg. The report indicated client #2 had three sores on left leg and one on her left arm. The report indicated client #2 stated it was a rash, her skin was dry and "they itched, so she scratched them until they were open."</p> <p>__The 1/27/14 I/A report indicated client #2 was sitting on her bed picking at the bridge of her nose. The report indicated the staff applied an antibiotic ointment and a Band-Aid to her nose.</p> <p>__The 2/10/14 I/A report indicated the staff noted two open areas on client #2's nose resulting from client #2 picking. The report indicated the staff applied an antibiotic cream, peroxide and a Band-Aid.</p> <p>__The 2/12/14 I/A report indicated the staff noted three abrasions on client #2's right hand. The report indicated client #2 reported she had bumped her hand on her dresser.</p> <p>Client #2's record was reviewed on 2/25/14 at 4 PM.</p> <p>Client #2's record indicated diagnoses of, but not limited to, Downs Syndrome and Dementia. Client #2's quarterly physician's orders of 1/29/14 indicated client #2 was taking Aricept 10 mg (milligrams) and Namenda 20 mg a day</p>		<p>made to physician for medication adjustment as needed. The intent of this plan is not to withdraw medication, but to try to determine the effectiveness of the medication being administered as it relates to mental status. All individuals currently receiving treatment for Dementia will be assessed in this way and a care plan developed following the above method. As the general population ages, so does the ID population. It is anticipated that more and more people with intellectual challenges will begin to show signs of memory loss/dementia. Therefore, the direct care staff will serve as the "front line" for the observing and reporting of any individuals who may be showing signs of memory loss. The IDT will be responsible for insuring that the development and implementation of care plans for those in need is completed. Responsible: QIDP, Nursing, Behavioral Services, Direct Care Staff</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G183	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/27/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER RESIDENTIAL CRF INC	STREET ADDRESS, CITY, STATE, ZIP CODE 8500 W US HWY 36 MODOC, IN 47358
---	--

(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
	<p>for memory/dementia. Client #2's ISP/BSP of 3/25/13 failed to include how and what the staff were to monitor and how the staff were to assist client #2 in regard to the client's dementia.</p> <p>Client #2's BSP of 3/25/13 indicated client #2 had a history of picking and "sometimes reopening sores." The BSP indicated "It is important to continue reinforcing [client #2] for doing the right thing such as... not picking at sores." The BSP did not indicate how the staff were to reinforce client #2's not picking or not reopening sores. Client #2's BSP did not indicate specific interventions or alternate activities to provide client #2 when picking. Client #2's ISP/BSP did not indicate how the staff were to monitor client #2 in regard to her picking her skin.</p> <p>During interview with the QIDP (Qualified Intellectual Disabilities Professional) and the LPN on 2/27/14 at 2 PM, the LPN indicated client #2's ISP currently did not include a plan that specified what symptoms/behaviors the staff were to monitor and/or document or how the staff were to supervise and assist client #2 with her ADLs (Adult Daily Living Skills) in regard to dementia. The QIDP indicated client #2's ISP would be revised to include</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G183	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/27/2014
NAME OF PROVIDER OR SUPPLIER RESIDENTIAL CRF INC			STREET ADDRESS, CITY, STATE, ZIP CODE 8500 W US HWY 36 MODOC, IN 47358		
(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	
W000323	<p>client #2's needs in regard to dementia and memory loss. The QIDP stated the staff were to "redirect" when client #2 was picking. The QIDP indicated the BSP did not include picking in part 2 of the BSP "Hierarchy of Interventions."</p> <p>9-3-4(a)</p> <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 4 sampled clients (#2), the facility failed to ensure the client's hearing was evaluated annually.</p> <p>Findings include:</p> <p>Client #2's record was reviewed on 2/25/14 at 4 PM. Client #2's hearing evaluation of 5/9/07 indicated client #2 had mild to severe mixed hearing loss. Client #2's record indicated on 7/31/07 client #2 was fitted for bilateral hearing aids. Client #2's record indicated the most current hearing evaluation was conducted in 2007.</p> <p>Interview with the facility LPN on 2/25/14 at 4:30 PM indicated client #2's</p>	W000323	<p>A hearing evaluation for client #2 has been scheduled for completion. The evaluation recommendations will be entered into the client record and recommendations will be followed for client #2. The client files will be subject to audit at least annually to assure that evaluations for client #2 and all other clients will be completed in a timely manner per facility practice. Responsible: Nursing, QIDP, Direct Care Staff</p>	03/28/2014	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G183		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/27/2014	
NAME OF PROVIDER OR SUPPLIER RESIDENTIAL CRF INC				STREET ADDRESS, CITY, STATE, ZIP CODE 8500 W US HWY 36 MODOC, IN 47358			
(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			
W000331	<p>physician examined client #2's ears when client #2 had her annual physical on 12/6/13. The LPN indicated client #2's physician did not do a hearing/audiometric evaluation in regard to client #2's hearing. The LPN indicated it was facility practice to have clients' hearing tested every 5 years and more often if they had problems. The LPN indicated she was in the process of getting all the clients' hearing tested again.</p> <p>9-3-6(a)</p> <p>483.460(c) NURSING SERVICES The facility must provide clients with nursing services in accordance with their needs. Based on observation, interview and record review for 1 of 4 sampled clients (#2), nursing services failed to develop and implement a plan of care in regard to client #2's behavior of picking her skin and to address the recommendation for artificial tears with client #2's physician.</p> <p>Findings include:</p> <p>1. Observations were conducted at the group home on 2/24/14 between 4 PM and 6 PM. Client #2 had a small scabbed area on her nose. Interview with staff #1</p>	W000331	<p>1. A nursing care plan has been developed for client #2 to address picking and skin integrity. A system has been developed to assess/track the status of new and previously opened areas on client #2 to address skin integrity, wound care, infection control and notification of nursing services. Responsible: Nursing, QIDP, Direct Care Staff 2. The facility nurse addressed the order for OTC artificial tears for client #2 with physician. Medication was ordered and staff will use eye drops as instructed. The nurse will assure that all medication orders are verified and filled in a</p>	03/28/2014			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G183		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/27/2014	
NAME OF PROVIDER OR SUPPLIER RESIDENTIAL CRF INC				STREET ADDRESS, CITY, STATE, ZIP CODE 8500 W US HWY 36 MODOC, IN 47358			
(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			
	<p>and #2 on 2/25/14 at 7:45 AM indicated the scabbed area on client #2's nose was from client #2 picking at her skin.</p> <p>The facility's reportable records were reviewed on 2/24/14 at 1:30 PM.</p> <p>__The 10/22/13 I/A (Incident/Accident) report indicated client #2 had been picking at her forehead and had a small open area of 1/4 inch. The report indicated the area was rinsed with peroxide and an antibiotic ointment was applied and the staff trimmed client #2's fingernails.</p> <p>__The 11/13/13 I/A report indicated client #2 had a "puss area" with a round red area on her 4th knuckle. The report indicated the nurse assessed client #2 and documented small areas on client #2's left hand/wrist/knuckles that client #2 had picked.</p> <p>__The 11/20/13 I/A report indicated the staff noted an "abrasion" on client #2's left middle arm "1 inch long and 1/4 inch wide." The report indicated client #2 "states she rubbed it."</p> <p>__The 1/16/14 I/A report indicated client #2 called for staff to look at sores on her arm and leg. The report indicated client #2 had three sores on left leg and one on her left arm. The report indicated client #2 stated it was a rash, her skin was dry and "they itched, so she scratched them until they were open."</p>		<p>timely manner. Residential CRF policy states that all medications, including OTC, must have a pharmacy label prior to administration. Administrative staff will randomly check medical status to assure medical needs are addressed in a timely manner. Responsible: Nursing, QIDP, Supervisor</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G183	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/27/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER RESIDENTIAL CRF INC	STREET ADDRESS, CITY, STATE, ZIP CODE 8500 W US HWY 36 MODOC, IN 47358
---	--

(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
	<p>__ The 1/27/14 I/A report indicated client #2 was sitting on her bed picking at the bridge of her nose. The report indicated the staff applied an antibiotic ointment and a Band-Aid to her nose.</p> <p>__ The 2/10/14 I/A report indicated the staff noted two open areas on client #2's nose resulting from client #2 picking. The report indicated the staff applied an antibiotic cream, peroxide and a Band-Aid.</p> <p>__ The 2/12/14 I/A report indicated the staff noted three abrasions on client #2's right hand. The report indicated client #2 reported she had bumped her hand on her dresser.</p> <p>Client #2's record was reviewed on 2/25/14 at 4 PM. Client #2's Behavior Support Plan of 3/25/13 indicated client #2 had self injurious behaviors of picking at sores until causing injury or bleeding.</p> <p>Client #2's nursing notes indicated, not all inclusive: __ 11/14/13 "Staff stopped by and stated [client #2] had an infected place on her Rt (right) hand.... Noted a raised infected area on her right hand between 3rd and 4th knuckle. No redness or temp noted. Was noted to have a scab in the center of the infected area. Stated she had picked at it. No drainage noted.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G183		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/27/2014	
NAME OF PROVIDER OR SUPPLIER RESIDENTIAL CRF INC				STREET ADDRESS, CITY, STATE, ZIP CODE 8500 W US HWY 36 MODOC, IN 47358			
(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			
	<p>Notified the [name of residential manager] to make appt (appointment) to have [client #2's] hand checked." __11/15/13 "Was seen by [name of doctor] today for infected area on Rt. hand. The area was opened and drained...." __11/16/13 "Area on hand looks much better.... Encouraged [client #2] to not pick at her skin." __11/22/13 "Hand is healed...." __1/9/14 "Continues to be encouraged not to pick her skin."</p> <p>Client #2's monthly behavior records for August 2013 through January 2014 indicated client #2 had 25 incidents of picking her skin. Client #2's record indicated the staff were conducting daily skin checks for new areas but were not assessing/documenting/tracking previous open areas client #2 had picked.</p> <p>Client #2's record indicated no health care/risk plan in regard to client #2's skin integrity and behavior of picking that indicated how the staff were to monitor/document client #2's open wounds to ensure client #2 did not get skin infections and when the staff were to notify nursing.</p> <p>Interview with the LPN on 2/27/14 at 2</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G183	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/27/2014
NAME OF PROVIDER OR SUPPLIER RESIDENTIAL CRF INC			STREET ADDRESS, CITY, STATE, ZIP CODE 8500 W US HWY 36 MODOC, IN 47358		
(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	
	<p>PM indicated no specific health care/risk plan in regard to client #2's behavior of picking her skin. When asked who was to assess/monitor client #2's on going open wounds, the LPN indicated the staff were to check client #2 daily and document new areas on the client's medication record with a plus sign. The LPN indicated no documentation of assessments and/or tracking system in place to monitor client #2's wounds until healed.</p> <p>2. Client #2's record was reviewed on 2/25/14 at 4 PM. Client #2's 11/15/13 Physician's notes from client #2's Optometrist recommended client #2 use over the counter artificial tears whenever her eyes felt itchy. Review of client #2's quarterly physician's orders for 1/29/14 indicated no order for artificial tears.</p> <p>Interview with the LPN on 2/25/14 at 4:30 PM indicated the facility pharmacy would not place a label on an over the counter medication without a physician's order. The LPN indicated she had not addressed the recommendation for the use of artificial tears with client #2's physician.</p> <p>9-3-6(a)</p>				