

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G513	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 02/26/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER RESIDENTIAL CRF INC	STREET ADDRESS, CITY, STATE, ZIP CODE 2375 W US HWY 36 DANVILLE, IN 46122
---	---

(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
W 0000 Bldg. 00	<p>This visit was for a fundamental annual recertification and state licensure survey.</p> <p>Dates of Survey: February 17, 18, 19 and 26, 2016.</p> <p>Facility Number: 001027 Provider Number: 15G513 AIMS Number: 100245180</p> <p>These federal deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review of this report completed by #15068 on 3/4/16.</p>	W 0000		
W 0104 Bldg. 00	<p>483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility.</p> <p>Based on observation, record review and interview for 4 of 4 sampled clients (#1, #2, #3 and #4) and 4 additional clients (#5, #6, #7 and #8), the governing body failed to exercise general policy, budget, and operating direction over the facility to ensure the home was maintained and</p>	W 0104	Residential CRF will make the necessary repairs to the home Residential supervisor, QIDP and administrator will assess the home on a monthly basis to ensure that is maintained and good repair at all times Work orders will be completed on an as needed basis and will be	03/27/2016

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: 15G513		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/26/2016	
NAME OF PROVIDER OR SUPPLIER RESIDENTIAL CRF INC				STREET ADDRESS, CITY, STATE, ZIP CODE 2375 W US HWY 36 DANVILLE, IN 46122			
(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>in good repair at all times.</p> <p>Findings include:</p> <p>Observations were conducted at the group home of clients #1, #2, #3, #4, #5, #6, #7 and #8 on 2/17/16 between 3:25 PM and 7 PM and on 2/18/16 between 5:45 AM and 8:30 AM. During the observation periods the following was observed:</p> <p>__ There were eight wooden straight chairs in the dining room/kitchen area. Four of the eight chairs were wobbly and moved side to side when sat on.</p> <p>__ Client #3's and #6's dresser drawers were missing some of the drawer handles and/or the drawer handles needed repaired and were hanging loosely from the dresser drawers.</p> <p>__ Two of the four bulbs in the ceiling fan in the living room were not working.</p> <p>__ The arms of the leather recliner in client #2's room were cracked, peeling and torn with padding exposed.</p> <p>__ The carpet outside of the shower/bath had a large run in the carpet where the fibers had been pulled out.</p> <p>__ There was a large dark stained area on the carpet in front of the shower bathroom.</p> <p>__ The faucet in the bathroom sink was corroded with lime, rust and other unidentifiable substances.</p>		<p>monitored by the administrator to ensure that they are completed in a timely manner</p> <p>Staff Responsible: Administrator, QIDP, Supervisor</p>				

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 02/26/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER RESIDENTIAL CRF INC	STREET ADDRESS, CITY, STATE, ZIP CODE 2375 W US HWY 36 DANVILLE, IN 46122
---	---

(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 light strip above the sink in the bathroom had three large bulbs. Two of the three bulbs did not work.</p> <p>__ Several of the windows throughout the home had air conditioners in the windows. Some of the windows with air conditioners were covered in plastic and some were not. Some of the windows with plastic on them, the plastic had pulled loose and a cold draft could be felt around the window/air conditioner. A cold draft could also be felt around some of the air conditioners/windows with no plastic covering them. Several of the windows had a black substance in and around the air conditioners and window sills.</p> <p>__ The top of the chest freezer was rusted, corroded and spotted with a dark mold type of substance. Food items were filled to the top of the chest freezer and a thick layer of ice covered the inside walls of the freezer.</p> <p>__ The freezer of the standup refrigerator was full of thirty plus rolls of sausage and packages of sausage links. A thick layer of ice covered several packages of food.</p> <p>During interview with staff #1 on 2/18/16 at 7 AM, staff #1:</p> <p>__ Indicated the cleaner used to clean the floor in the kitchen/dining room area left the floor with a film and the kitchen chairs did not slide on the floors. Staff #1</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G513	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 02/26/2016
NAME OF PROVIDER OR SUPPLIER RESIDENTIAL CRF INC			STREET ADDRESS, CITY, STATE, ZIP CODE 2375 W US HWY 36 DANVILLE, IN 46122		
(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	
W 0240 Bldg. 00	<p>stated, "That's probably why the chairs are wobbly." ___ Stated the facility bought their food in bulk and there was enough sausage in the freezer for the clients in the home "for about three months." ___ Indicated the staff were to defrost the freezer when needed and stated, "They (the freezers) needed to be defrosted and cleaned out." During interview with the Qualified Intellectual Disabilities Professional (QIDP) on 2/19/16 at 2 PM, the QIDP indicated the home was to be maintained and in good repair at all times. 9-3-1(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 (#1), the client's Individualized Support Plan (ISP) failed to include how the staff were to assist client #1 throughout the day due to symptoms of dementia and what the staff were to monitor and document in regard</p>	W 0240	A plan will be implemented to address Client's #1 dementia Any client taking a medication for dementia will have a plan implemented to monitor and document how the staff are to assist the client in regard to their memory loss Residential CRF nursing services and behavior	03/27/2016	

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 02/26/2016	
NAME OF PROVIDER OR SUPPLIER RESIDENTIAL CRF INC				STREET ADDRESS, CITY, STATE, ZIP CODE 2375 W US HWY 36 DANVILLE, IN 46122			
(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>to client #1's dementia.</p> <p>Findings include:</p> <p>Client #1's record was reviewed on 2/18/16 at 11:30 AM.</p> <p>__ Client #1's record indicated client #1 had diagnoses of severe mental intellectual ability and Downs Syndrome.</p> <p>__ Client #1's 2015 quarterly physician's orders dated 11/30/15 indicated client #1 received Namenda 10 milligrams twice a day for symptoms of Dementia.</p> <p>__ Client #1's record indicated no Behavior Support Plan (BSP).</p> <p>__ Client #1's ISP dated 9/15/15 indicated no plan to include what the staff were to monitor and to document in regard to client #1's confusion and/or memory loss related to Dementia and how the staff were to assist client #1 throughout the day in regard to the client's confusion and/or memory loss.</p> <p>During interview with the Qualified Intellectual Disabilities Professional (QIDP) on 2/19/16 at 2 PM, the QIDP:</p> <p>__ Indicated client #1 was taking Namenda due to increased memory loss and confusion related to Dementia.</p> <p>__ Indicated client #1 did not have a BSP.</p> <p>__ Indicated the staff did not document any data in regard to memory loss, confusion and or signs of Dementia for</p>		<p>clinician will review the clients programming to determine which client's need programming to address dementia ResCRF nursing services and QIDP will review the programming monthly to ensure clients with dementia are receiving programming to address this need</p> <p>Staff Responsible: QIDP, Nurse, Behavior Clinician</p>				

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 02/26/2016
NAME OF PROVIDER OR SUPPLIER RESIDENTIAL CRF INC			STREET ADDRESS, CITY, STATE, ZIP CODE 2375 W US HWY 36 DANVILLE, IN 46122		
(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	
W 0253 Bldg. 00	<p>client #1. __ Indicated client #1's ISP did not address client #1's use of Namenda or how the staff were to monitor and assist client #1 in regard to Dementia.</p> <p>9-3-4(a)</p> <p>483.440(e)(2) PROGRAM DOCUMENTATION The facility must document significant events that are related to the client's individual program plan and assessments. Based on record review and interview, the facility failed to ensure the staff provided a descriptive documentation of the clients' targeted behaviors when displayed for 3 of 3 sampled clients (#2, #3 and #4) with BSPs (Behavior Support Plans).</p> <p>Findings include:</p> <p>1. Client #2's record was reviewed on 2/18/16 at 12:30 PM. Client #2's BSP of 9/19/15 indicated targeted behaviors of attention seeking, inappropriate sexual behaviors, hoarding and aggression.</p> <p>Client #2's monthly behavior records from October 2015 through January 2016</p>	W 0253	Residential CRF will continue to document significant events that are related to the clients individualized program plan Behaviors are documented monthly for the clients BMP Staff failed to give a narrative of specific behaviors Staff will be inserviced on giving a narrative of the specific behavior All clients on BMPs will have a descriptive note for each specific behavior Residential behavior clinician will review the monthly behavior sheets to ensure they include a descriptive note for behavior Staff Responsible: QIDP, Behavior Clinician	03/27/2016	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G513	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 02/26/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER RESIDENTIAL CRF INC	STREET ADDRESS, CITY, STATE, ZIP CODE 2375 W US HWY 36 DANVILLE, IN 46122
---	---

(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>indicated: 198 incidents of attention seeking. 100 incidents of inappropriate sexual behaviors. 65 incidents of hoarding. 101 incidents of aggression.</p> <p>Client #2's 9/15/15 Definition(s) of Target Behavior(s) indicated aggression to be "Slapping with an open hand, throwing things, breaking things intentionally. Hitting, kicking, cussing people out, making threatening gestures."</p> <p>Client #2's monthly behavior records indicated a tally mark for each incident. Client #2's record indicated no descriptive and/or narrative documentation of client #2's targeted behaviors.</p> <p>2. Client #3's record was reviewed on 2/18/16 at 1:30 PM. Client #3's BSP of 9/19/15 indicated targeted behaviors of obsessive behaviors, lying and disruption.</p> <p>Client #3's monthly behavior records from October 2015 through January 2016 indicated: 241 incidents of obsessive behaviors. 166 incidents of lying. 166 incidents of disruption.</p> <p>Client #3's monthly behavior records</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G513	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 02/26/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER RESIDENTIAL CRF INC	STREET ADDRESS, CITY, STATE, ZIP CODE 2375 W US HWY 36 DANVILLE, IN 46122
---	---

(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>indicated a tally mark for each incident. Client #3's record indicated no descriptive and/or narrative documentation of client #3's targeted behaviors.</p> <p>3. Client #4's record was reviewed on 2/18/16 at 2:30 PM. Client #4's BSP of 9/19/15 indicated targeted behaviors of refusals, inappropriate sexual behaviors, self-injurious behaviors and physical aggression.</p> <p>Client #4's monthly behavior records from October 2015 through January 2016 indicated: 135 incidents of refusals. 88 incidents of inappropriate sexual behaviors. 93 incidents of self-injurious behaviors. 27 incidents of physical aggression.</p> <p>Client #4's Definition(s) of Target Behavior(s) indicated physical aggression to be "Hitting, pushing or kicking others, hard and fast hand flapping, walking into your space while hand flapping, trying to break windows."</p> <p>Client #4's monthly behavior records indicated a tally mark for each incident. Client #4's record indicated no descriptive and/or narrative documentation of client #4's targeted</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G513	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 02/26/2016
NAME OF PROVIDER OR SUPPLIER RESIDENTIAL CRF INC			STREET ADDRESS, CITY, STATE, ZIP CODE 2375 W US HWY 36 DANVILLE, IN 46122		
(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	
W 0323 Bldg. 00	<p>behaviors.</p> <p>During interview with the Qualified Intellectual Disabilities Professional (QIDP) on 2/19/16 at 2 PM, the QIDP: ___ Indicated the staff were to document a descriptive note on the behavior tracking record to describe the targeted behavior displayed by the client. ___ Indicated the staff failed to document a descriptive note of client #2's, #3's and #4's targeted behaviors.</p> <p>9-3-4(a)</p> <p>483.460(a)(3)(i) PHYSICIAN SERVICES The facility must provide or obtain annual physical examinations of each client that at a minimum includes an evaluation of vision and hearing. Based on record review and interview for 3 of 4 sampled clients (#1, #2 and #3), the facility failed to ensure an annual evaluation of the clients' vision and/or hearing. Findings include: Client #1's record was reviewed on 2/18/16 at 11:30 AM.</p>	W 0323	Residential CRF will continue to obtain physical examinations of each client which include an annual evaluation of their vision and hearing which includes a screening as a minimum Identified client did receive an examination by a specialist on 8-17-14 No follow up was expressed by the specialist. Client #2's hearing was assessed by his physician at his annual physical on 11-23-15 The most	03/27/2016	

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 02/26/2016	
NAME OF PROVIDER OR SUPPLIER RESIDENTIAL CRF INC				STREET ADDRESS, CITY, STATE, ZIP CODE 2375 W US HWY 36 DANVILLE, IN 46122			
(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>__ Client #1's 9/15/15 Individualized Support Plan (ISP) indicated client #1 wore a hearing aid in his right ear. Client #1's record indicated client #1's most current hearing evaluation was conducted 9/22/14. Client #1's record indicated no further hearing evaluations since 2014.</p> <p>Client #2's record was reviewed on 2/18/16 at 12:30 PM.</p> <p>__ Client #2's 9/15/15 ISP indicated client #2 had "Bi-lateral hearing loss with hearing aids. Last hearing test 8/7/14." Client #2's record indicated no further hearing evaluations since 2014.</p> <p>__ Client #2's ISP indicated client #2 wore eyeglasses "as tolerated." The ISP indicated client #2's last vision evaluation was conducted on 7/22/14. Client #2's record indicated no further vision evaluations since 2014.</p> <p>Client #3's record was reviewed on 2/18/16 at 1:30 PM.</p> <p>__ Client #3's record indicated a hearing evaluation on 3/7/14 with recommendations for a hearing aid. On 6/3/14 client #3 received a hearing aid for his left ear. Client #3's record indicated no further hearing evaluations since receiving his hearing aid in 2014.</p> <p>__ Client #3's record indicated client #3 had a vision evaluation on 1/29/14 with recommendations for eyeglasses. Client</p>		<p>recent hearing/vision exams for all identified clients were in 2014, they all received annual assessments from their physician in 2015 Residential nursing staff will continue to monitor evaluations by specialist and physicians and will follow the specialist's and physician's expressed recommendations Staff Responsible: Supervisor, QIDP, Nurse</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G513	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 02/26/2016
NAME OF PROVIDER OR SUPPLIER RESIDENTIAL CRF INC			STREET ADDRESS, CITY, STATE, ZIP CODE 2375 W US HWY 36 DANVILLE, IN 46122		
(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	
W 0331 Bldg. 00	<p>#3's 9/15/15 ISP indicated client #3 "wears eyeglasses as tolerated." Client #3's record indicated no further vision evaluations since 2014.</p> <p>During interview with the Qualified Intellectual Disabilities Professional (QIDP) on 2/19/16 at 2 PM, the QIDP: ___ Indicated client #1's, #2's and #3's most current vision and hearing evaluations were conducted in 2014. ___ Indicated no further vision and/or hearing evaluations for review for clients #1, #2 and #3.</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 record review and interview for 2 of 4 sampled clients (#1 and #2), the facility's nursing services failed to assess and to monitor the clients in regard to upper respiratory infections and to assess and to monitor client #1 in regard to a urinary tract infection and a rash to his buttocks.</p> <p>Findings include:</p>	W 0331	Residential CRF will continue to provide clients with nursing services in accordance with their needs Nursing notes were completed for identified clients Clients with identified illnesses that require more timely assessments and interventions will receive individualized assessments, as needed Residential nurse will assess each client monthly. Residential supervisor will contact nurse on a daily basis to update	03/27/2016	

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 02/26/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER RESIDENTIAL CRF INC	STREET ADDRESS, CITY, STATE, ZIP CODE 2375 W US HWY 36 DANVILLE, IN 46122
---	---

(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>Client #1's record was reviewed on 2/18/16 at 11:30 AM. Client #1's physician's notes/orders indicated:</p> <p>__9/25/15 "Malodorous urine and frequency once a week - rash on buttocks right and left for few days. Not acting right, incontinence episode and not eating as well." The note indicated client #1 was given an antibiotic for a urinary tract infection.</p> <p>__10/5/15 "Red rash on buttocks, better per caregiver, finished antibx (antibiotic)... only sl (slight) redness on buttocks, not inflamed, poor appetite, incontinence... UTI (Urinary Tract Infection), yeast infection...." The note indicated a change in the client's cream to his buttocks.</p> <p>__11/13/15 "Green mucous, no fever... lungs clear... Sinusitis, Pharyngitis..." The note indicated client #1 was placed on Levaquin (an antibiotic) 500 mg (milligrams) daily for seven days.</p> <p>__12/31/15 "Still congested.... Bronchitis resolved...."</p> <p>__1/29/16 "Audible wheezing, no complaints, chest sounds congested x (times) 2 days.... Early Bronchitis.... red throat, wheezing." The notes indicated client #1 was placed on an antibiotic and was to receive Mucinex for chest congestion.</p> <p>Client #1's nursing notes indicated:</p>		nursing services of any status change of clients Any services or assessments that need to be addressed, will be addressed and monitored at that time Staff Responsible: Supervisor, Nurse	

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 02/26/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER RESIDENTIAL CRF INC	STREET ADDRESS, CITY, STATE, ZIP CODE 2375 W US HWY 36 DANVILLE, IN 46122
---	---

(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>_9/29/15 "Client seen (sic) MD with c/o (complaint of) incontinence - s/s (signs and symptoms) UTI - NO (no orders) noted."</p> <p>_10/5/15 "F/U (Follow Up) with [name of doctor]. No c/o UTI..."</p> <p>_11/30/15 Has no need of medical attention presently. Laughing with other (illegible)..."</p> <p>_12/23/15 "has URI (Upper Respiratory Symptoms) Has appt (appointment) with MD tomorrow."</p> <p>_12/24/15 "Meds ordered. To take as prescribed."</p> <p>_12/26/15 "Not making improvement. Change meds..."</p> <p>_12/31/15 "Has... and symptoms." (Unable to read nursing note.)</p> <p>_1/3/16 "Continues to improve - no new symptoms."</p> <p>_1/29/16 "URI symptoms returned. MD notified - orders obtained."</p> <p>_2/1/16 "Symptoms are improved. Continues with med - if (illegible)... will call MD and change med."</p> <p>Client #1's nursing notes indicated no assessment of client #1's rash of his buttocks.</p> <p>Client #1's nursing notes indicated no lung and/or upper respiratory assessments by nursing. Client #1's nursing notes failed to indicate nursing services assessed and monitored client #1's health</p>			

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 02/26/2016
NAME OF PROVIDER OR SUPPLIER RESIDENTIAL CRF INC			STREET ADDRESS, CITY, STATE, ZIP CODE 2375 W US HWY 36 DANVILLE, IN 46122		
(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>care in regard to client #1's skin integrity and recurring URI.</p> <p>Client #2's record was reviewed on 2/18/16 at 12:30 PM.</p> <p>Client #2's physician's notes/orders indicated: __ 12/21/15 "Increased fatigue, sounds croupy and green mucus draining from nose. All started this weekend. Increased irritability, vomited one day last week after intense coughing spell, eating and drinking ok. Napping much more than nml (normal). Pharyngitis, Sinusitis, mild wheezing." Client #2 was ordered an antibiotic of Levaquin 500 mg. for seven days. __ 1/29/16 "Wheezing, up all night, cough, exhaustion times one week....Ear wax... red throat with white drainage, lungs clear.... Wheezing, fatigue...." Antibiotic ordered.</p> <p>Client #2's nursing notes indicated: __ 12/21/15 "To MD for URI symptoms. Meds ordered." __ 12/24/15 "Not much change or... MD to rev (review) on 29th." __ 1/4/16 " Mostly cleared up...." __ 1/29/16 "Increased wheezing and URI symptoms again - Meds." __ 2/2/16 "Improving - continuing all meds."</p>				

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 02/26/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER RESIDENTIAL CRF INC	STREET ADDRESS, CITY, STATE, ZIP CODE 2375 W US HWY 36 DANVILLE, IN 46122
---	---

(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
--------------------	--	---------------	---	----------------------

W 0421 Bldg. 00	<p>Client #2's nursing notes indicated no lung and/or upper respiratory assessments by nursing. Client #2's nursing notes failed to indicate nursing services assessed and monitored client #2's health care needs in regard to a recurring URI.</p> <p>During interview with the Qualified Intellectual Disabilities Professional (QIDP) on 2/19/16 at 4 PM, the QIDP: ___ Indicated the facility's RN provided nursing services for clients #1 and #2. ___ Indicated when the clients needed medical services the Residential Manager would call the RN and/or instruct the staff to take the clients to their PCP (Primary Care Physician). ___ Indicated all nursing notes and assessments were provided for review.</p> <p>9-3-6(a)</p> <p>483.470(b)(4)(iv) CLIENT BEDROOMS The facility must provide each client with individual closet space in the client's bedroom with clothes racks and shelves accessible to the client. Based on observation and interview for 1 of 4 sample clients (#3), the facility failed to ensure the client was provided</p>	W 0421	A wardrobe will be purchased and put into Client#3's room All client rooms will be furnished with a wardrobe, if a closet is not	03/27/2016
--------------------	---	--------	--	------------

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 02/26/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER RESIDENTIAL CRF INC	STREET ADDRESS, CITY, STATE, ZIP CODE 2375 W US HWY 36 DANVILLE, IN 46122
---	---

(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>individual closet space with a clothes rack and shelves for client #3 to hang his clothing and store his possessions.</p> <p>Findings include:</p> <p>Observations were conducted at the group home on 2/17/16 between 3:25 PM and 7 PM and on 2/18/16 between 5:45 AM and 8:30 AM.</p> <p>__ Client #1 and client #3 shared a bedroom with one small closet.</p> <p>__ The closet was small and contained client #1's clothing and belongings</p> <p>__ Client #3 did not have a closet or a wardrobe with a place to hang his clothing and/or shelving for his personal possessions/clothing.</p> <p>During interview with client #3 on 2/18/16 at 6 AM, client #3:</p> <p>__ Indicated he did not have a closet to hang his clothing.</p> <p>__ Indicated he would like to have a place to hang his clothing.</p> <p>During interview with the Residential Manager (RM) on 2/17/16 at 1:30 PM, the RM:</p> <p>__ Indicated the bedroom shared by client #1 and client #3 had one closet.</p> <p>__ Indicated the closet was used by client #1.</p> <p>__ Indicated client #3 did not have a</p>		<p>available Residential supervisor and QIDP will check on a monthly basis to ensure that all clients have closet space</p> <p>Staff Responsible: Supervisor, QIDP</p>	

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 02/26/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER RESIDENTIAL CRF INC	STREET ADDRESS, CITY, STATE, ZIP CODE 2375 W US HWY 36 DANVILLE, IN 46122
---	---

(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
W 0436 Bldg. 00	<p>closet and/or wardrobe to hang his clothing.</p> <p>9-3-7(a)</p> <p>483.470(g)(2) SPACE AND EQUIPMENT The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client. Based on observation, interview and record review for 1 of 4 sampled clients (#1), with adaptive equipment, the facility failed to teach and/or provide training for client #1 to wear and care for his hearing aid.</p> <p>Findings include:</p> <p>Observations were conducted at the group home on 2/17/16 between 3:25 PM and 7 PM and on 2/18/16 between 5:45 AM and 8:30 AM. During both observation periods client #1 wore a hearing aid in his right ear.</p> <p>Client #1's record was reviewed on 2/18/16 at 11:30 AM. Client #1's 9/15/15 Individualized Support Plan (ISP)</p>	W 0436	Residential CRF will teach and inform clients to use and make informed choices about the use of devices identified as needed by the client Client #1 will have a program implemented to address hearing aid care. Staff will be in serviced on training clients in hearing aid care. Client programs will be reviewed and if any client is requiring assistance with an adaptive device a program will be written to address their individual needs Client programs will be reviewed on a monthly basis by the QIDP and Social Worker to ensure that all the client's individualized needs are being met Staff Responsible: QIDP, Social Worker, Supervisor	03/27/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G513	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 02/26/2016
NAME OF PROVIDER OR SUPPLIER RESIDENTIAL CRF INC			STREET ADDRESS, CITY, STATE, ZIP CODE 2375 W US HWY 36 DANVILLE, IN 46122		
(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	
W 0488 Bldg. 00	<p>indicated:</p> <p>__ Client #1 had a hearing aid for his right ear.</p> <p>__ Client #1 did not like to wear his hearing aid and the staff had to remind client #1 to wear it.</p> <p>__ No training objectives to assist client #1 with wearing and taking care of his hearing aid.</p> <p>During interview with staff #1 on 2/18/16 at 6:10 AM, staff #1:</p> <p>__ Indicated the staff kept client #1's hearing aid in the office at night and returned it to client #1 in the mornings.</p> <p>__ Indicated client #1's hearing aid was kept in the staff office at night and stated, "If not, he (client #1) would lose it."</p> <p>During interview with the Qualified Intellectual Disabilities Professional (QIDP) on 2/19/16 at 2 PM, the QIDP indicated no training objectives in place for client #1 in regard to wearing and/or caring for his hearing aid.</p> <p>9-3-7(a)</p> <p>483.480(d)(4) DINING AREAS AND SERVICE The facility must assure that each client eats</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G513	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 02/26/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER RESIDENTIAL CRF INC	STREET ADDRESS, CITY, STATE, ZIP CODE 2375 W US HWY 36 DANVILLE, IN 46122
---	---

(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>in a manner consistent with his or her developmental level.</p> <p>Based on observation and interview for 4 of 4 sampled clients (#1, #2, #3 and #4) and 4 additional clients (#5, #6, #7 and #8), the facility failed to ensure the staff provided training in family style dining when formal and informal training opportunities existed.</p> <p>Findings include:</p> <p>Observations were conducted at the group home on 2/17/16 between 3:25 PM and 7 PM.</p> <p>__ During this observation period clients #1, #2, #3, #4, #5, #6, #7 and #8 were observed eating their evening meal of pasta, salad, garlic bread and canned fruit.</p> <p>__ Staff #1, #2, and #3 stood beside and/or behind the clients in assisting them with serving and passing the food.</p> <p>__ The staff did not sit with the clients at the table.</p> <p>__ Staff #1, #2, and #3 and the Residential Manager stood around the table and behind the clients while they ate their evening meal.</p> <p>During interview with staff #1 and staff #2 on 2/18/16 at 7 AM:</p> <p>__ Staff #2 indicated the dining room was small which made it difficult for the staff</p>	W 0488	<p>Residential CRF will ensure that each client eats in a manner consistent with his or her developmental level Staff will be re in-serviced on family style dining and providing training opportunities when opportunities presented themselves Residential supervisor will monitor the group home on a weekly basis to ensure that staff is practicing family style dining for all clients Residential QIDP will monitor the home on a monthly basis to ensure all programs are being implemented</p> <p>Staff Responsible: Supervisor, QIDP</p>	03/27/2016

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 02/26/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER RESIDENTIAL CRF INC	STREET ADDRESS, CITY, STATE, ZIP CODE 2375 W US HWY 36 DANVILLE, IN 46122
---	---

(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>to sit with the clients while eating.</p> <p>__Staff #2 stated, "Usually one of us (the staff) sit with them (clients #1, #2, #3, #4, #5, #6, #7 and #8) while they eat. I don't know why we didn't last night."</p> <p>__Staff #1 stated, "I usually sit over there (a small table within a few feet of the dining room table) while they (the clients) eat because there's not much room."</p> <p>During interview with the Qualified Intellectual Disabilities Professional (QIDP) on 2/19/16 at 2 PM, the QIDP:</p> <p>__ Indicated the staff were to provide the clients with training in family style dining at every available opportunity.</p> <p>__ Stated the staff should be sitting at the table with the clients while they eat their meals at the group home and should "preferably" eat with the clients.</p> <p>9-3-8(a)</p>			
--	---	--	--	--