

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 09/23/2011
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NAME OF PROVIDER OR SUPPLIER RESIDENTIAL CRF INC	STREET ADDRESS, CITY, STATE, ZIP CODE 2375 W US HWY 36 DANVILLE, IN46122
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W0000	<p>This visit was for a fundamental recertification and state licensure survey.</p> <p>Survey dates: September 20, 21, 22 and 23, 2011</p> <p>Facility Number: 001027 Provider Number: 15G513 AIM Number: 100245180</p> <p>Surveyor: Steven Schwing, Medical Surveyor III</p> <p>These deficiencies also reflect state findings in accordance with 431 IAC 1.1. Quality Review completed 9/27/11 by Ruth Shackelford, Medical Surveyor III.</p>	W0000		
W0104	<p>The governing body must exercise general policy, budget, and operating direction over the facility.</p> <p>Based on observation, record review and interview for 8 of 8 clients living in the group home (#1, #2, #3, #4, #5, #6, #7 and #8), the governing body failed to ensure holes in walls were repaired timely.</p> <p>Findings include:</p> <p>Observations were conducted at the group home on 9/20/11 from 3:35 PM to 5:52 PM and 9/21/11 from 5:54 AM to 8:23 AM. During the observations, there was a 3 inch by 3 inch hole in the half wall between the living room and the kitchen. On 9/21/11 at 8:12 AM, a hole was noted on the bathroom wall behind the door where the lock hit the wall. The hole was 1 inch by inch in diameter. This affected clients #1, #2, #3, #4, #5, #6, #7 and #8.</p> <p>A review of the facility's maintenance repair forms was attempted on 9/21/11 and 9/22/11. The facility was unable to provide the maintenance repair requests forms for review.</p> <p>An interview with the Qualified Mental Retardation Professional - Designee (QMRP-D) was conducted on</p>	W0104	Residential CRF will continue to ensure that all maintenance needs of the group home are met in a timely manner. The holes noted in the walls have been repaired. Staff have been in serviced on reporting any damages to the home in a timely manner to the maintenance department. Residential supervisor will check the home on a weekly basis to ensure maintenance needs are being addressed. Staff Responsible: QMRP, Maintenance	10/23/2011

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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W0125	<p>9/21/11 at 10:28 AM. The QMRP-D indicated the hole in the wall near the kitchen sink was recently repaired. She indicated she was unable to locate the maintenance request documentation. On 9/22/11 at 11:39 AM, the QMRP-D indicated the hole in the wall behind the bathroom door had not been reported to her and she was unaware of the hole.</p> <p>1.1-3-1(a)</p> <p>The facility must ensure the rights of all clients. Therefore, the facility must allow and encourage individual clients to exercise their rights as clients of the facility, and as citizens of the United States, including the right to file complaints, and the right to due process. Based on observation, record review and interview for 8 of 8 clients living in the group home (#1, #2, #3, #4, #5, #6, #7 and #8), the facility failed to ensure the clients' rights by having a locked cover on the thermostat and a second latch on the outside gate latches.</p> <p>Findings include:</p> <p>Observations were conducted at the group home on 9/20/11 from 3:35 PM to 5:52 PM and 9/21/11 from 5:54 AM to 8:23 AM. During the observations, the thermostat was locked with a plastic cover. The front outside gate had a second latch on the gate latch lock. The second latch had to be removed in order for the gate latch to be opened. The thermostat cover and second latch on the gate latch affected clients #1, #2, #3, #4,</p>	W0125	Residential CRF will continue to ensure the rights of all clients. Residential CRF will remove the locked box from around the thermostat. Residential IDT will review each client's BMP and will determine if the latch is necessary for any of the client's BMP. Informed consent will be completed by those client's not requiring the latch as part of their individualized program. The behavior clinician will monitor such programs on a monthly basis to determine if such measures continue to be necessary. Staff Responsible: QMRP, Behavior Clinician	10/23/2011	

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	<p>#5, #6, #7 and #8.</p> <p>A review of client #1's record was conducted on 9/22/11 at 10:41 AM. There was no documentation in his record indicating the thermostat needed to be locked or the gate needed to have a second latch in the lock of the gate latch.</p> <p>A review of client #2's record was conducted on 9/22/11 at 11:22 AM. There was no documentation in his record indicating the thermostat needed to be locked or the gate needed to have a second latch in the lock of the gate latch.</p> <p>A review of client #3's record was conducted on 9/22/11 at 11:44 AM. There was no documentation in his record indicating the thermostat needed to be locked or the gate needed to have a second latch in the lock of the gate latch.</p> <p>A review of client #4's record was conducted on 9/22/11 at 12:17 PM. There was no documentation in his record indicating the thermostat needed to be locked or the gate needed to have a second latch in the lock of the gate latch.</p> <p>A review of client #5's record was conducted on 9/22/11 at 12:47 PM. There was no documentation in his record indicating the thermostat needed to be</p>				

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	<p>locked or the gate needed to have a second latch in the lock of the gate latch.</p> <p>A review of client #6's record was conducted on 9/22/11 at 12:51 PM. There was no documentation in his record indicating the thermostat needed to be locked or the gate needed to have a second latch in the lock of the gate latch.</p> <p>A review of client #7's record was conducted on 9/22/11 at 12:55 PM. There was no documentation in his record indicating the thermostat needed to be locked or the gate needed to have a second latch in the lock of the gate latch.</p> <p>A review of client #8's record was conducted on 9/22/11 at 1:03 PM. There was no documentation in his record indicating the thermostat needed to be locked or the gate needed to have a second latch in the lock of the gate latch.</p> <p>An interview with direct care staff (DCS) #4 was conducted on 9/20/11 at 3:41 PM. DCS #4 indicated the thermostat was accessible with a key by staff; she indicated the clients did not have access to the thermostat. She indicated the thermostat had been locked during her 13 months of employment. She indicated the locked cover was in place to keep the clients from using the thermostat.</p>			

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W0153	<p>An interview with the QMRP-D (Qualified Mental Retardation Professional - Designee) was conducted on 9/20/11 at 5:35 PM. The QMRP-D indicated there was no plan in any of the clients' program plans addressing the use of the locked plastic cover on the thermostat. The QMRP-D indicated the cover was in place to keep the clients from turning the temperature up and down and to protect the thermostat.</p> <p>An interview with the QMRP was conducted on 9/22/11 at 1:18 PM. The QMRP indicated the use of a locked thermostat cover and second latch on the gate latch was not part of the clients' plans.</p> <p>1.1-3-2(a)</p> <p>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.</p> <p>Based on record review and interview for 2 of 2 incident reports reviewed involving client to client abuse affecting clients #2 and #6, the facility failed to ensure the administrator was immediately notified and a report was submitted to the Bureau of Developmental Disabilities Services</p>	W0153	Residential CRF will continue to ensure that all allegations of mistreatment, neglect or abuse, as wellas, injuries of unknown source are reported immediately to the administrator or to otherofficials in acordance with the State law through established	10/23/2011

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	<p>(BDDS) of client to client abuse, in accordance with state law.</p> <p>Findings include:</p> <p>A review of the facility's incidents reports was conducted on 9/21/11 at 10:24 AM. For the following reports of client to client abuse, there was no documentation the administrator was notified of the incidents:</p> <p>-On 8/3/11 at 11:40 AM, client #6 was pinched by a peer (report did not indicate who) while at the workshop. Client #6 had a "red area" close to his left elbow.</p> <p>-On 3/23/11 at 2:50 PM, a peer (report did not indicate who) struck client #2 on his left shoulder while at the workshop.</p> <p>An interview with the Qualified Mental Retardation Professional - Designee (QMRP-D) was conducted on 9/22/11 at 1:09 PM. The QMRP-D indicated she did not have documentation the administrator was notified of the two incidents of client to client abuse. The QMRP-D indicated there was no documentation the incidents were reported to BDDS. The QMRP-D indicated client to client abuse should be reported to BDDS.</p> <p>An interview with the QMRP was conducted on 9/22/11 at 1:18 PM. The QMRP indicated she did not have</p>		<p>procedures. Residential CRF will ensure that all incidents of client to client abuse will be reported within 24 hours to BDDS. All investigations will be reported to the administrator within 5 working days of the incident. Residential CRF will train staff on the policy of notifying BDDS of incidents. Staff will also be trained on notifying the administrator within 5 working days of the incident with the results and summation of the incident in writing. Staff Responsible: QMRP</p>		

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W0156	<p>documentation the administrator was notified of the client to client abuse.</p> <p>1.1-3-1(b)(5) 1.1-3-2(a)</p> <p>The results of all investigations must be reported to the administrator or designated representative or to other officials in accordance with State law within five working days of the incident.</p> <p>Based on record review and interview for 4 of 4 investigations conducted affecting clients #2, #4, #6 and #7, the facility failed to ensure the results of investigations were reported to the administrator within 5 working days of the incident.</p> <p>Findings include:</p> <p>A review of the facility's incident/investigative reports was conducted on 9/21/11 at 10:24 AM. The following investigations did not contain documentation of the date and time the administrator was notified of the results of the investigation:</p> <ul style="list-style-type: none"> -On 2/7/11 at 6:00 PM, client #4 was found to have a bruise (report did not indicate size or color) on his left thigh during his shower. -On 3/23/11 at 2:50 PM, client #2 was struck by a peer (did not indicate who) while at the workshop. -On 5/16/11 at 2:50 PM, client #7 told workshop staff he got a peer pregnant. -On 8/3/11 at 11:40 AM, client #6 was pinched by a peer (report did not indicate who) while at the workshop. Client #6 had a "red area" close to his left elbow. <p>An interview with the Qualified Mental Retardation Professional - Designee (QMRP-D) was conducted on 9/22/11 at 1:09 PM. The QMRP-D indicated she did not have documentation of when the results of the investigations were submitted to the administrator.</p> <p>An interview with the QMRP was conducted on 9/22/11 at 1:18 PM. The QMRP indicated she did not have</p>	W0156	Residential CRF will ensure that all investigations will be reported to the administrator within 5 working days of the incident. Residential staff will be trained on the policy of reporting incidents within 24 hours to BDDS. Residential staff will be trained on investigating such incidents and reporting the results and summation within 5 working days to the administrator in writing. Staff Responsible: QMRP	10/23/2011

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W0436	<p>documentation of when the results of the investigations were submitted to the administrator.</p> <p>1.1-3-2(a)</p> <p>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.</p> <p>Based on observation, interview and record review for 1 of 8 clients who wore glasses (#2), the facility failed to ensure his glasses were repaired timely.</p> <p>Findings include:</p> <p>Observations were conducted at the group home on 9/20/11 from 3:35 PM to 5:52 PM and 9/21/11 from 5:54 AM to 8:23 AM. On 9/20/11 at 4:31 PM, client #2's left side of his glasses was extended out from his left ear. The ear piece of his glasses was bent in a way the ear piece was not behind his ear. On 9/20/11 at 5:01 PM, staff #3 attempted to fix client #2's glasses. On 9/21/11 at 6:49 AM, client #2's glasses, left side, was not behind his ear. The ear piece was hanging on the outside of his ear. Staff #1 put the left side of his glasses behind his ear.</p> <p>A review of client #2's record was conducted on 9/22/11 at 11:22 AM.</p>	W0436	Residential CRF will ensure that all clients' adaptive equipment will be maintained and kept in good repair. Residential staff will check client's adaptive equipment on a daily basis to ensure that it is in working order. If any client's glasses need to be repaired they will be taken to the optometrist for adjustment. Client #2's glasses will be repaired. Staff Responsibl: QMRP	10/23/2011

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W0460	<p>Client #2 received new glasses on 6/28/11. There was no documentation in his record indicating client #2 went to have his glasses repaired.</p> <p>An interview with the Qualified Mental Retardation Professional - Designee (QMRP-D) was conducted on 9/22/11 at 1:09 PM. The QMRP-D indicated the facility had not recently taken client #2 to get his glasses repaired.</p> <p>1.1-3-7(a)</p> <p>Each client must receive a nourishing, well-balanced diet including modified and specially-prescribed diets. Based on observation, record review and interview for 8 of 8 clients living in the group home (#1, #2, #3, #4, #5, #6, #7 and #8), the facility failed to ensure the food on the menu was served or a nutritionally equivalent substitution was offered.</p> <p>Findings include:</p> <p>An observation was conducted at the group home on 9/21/11 from 5:54 AM to 8:23 AM. At 6:33 AM, clients #1, #2, #3, #4, #5, #6, #7 and #8 started eating breakfast. The food served included cereal, toast, orange juice, milk, margarine, and jelly. The clients did not</p>	W0460	Residential CRF will continue to ensure that all clients receive a well balanced and nourishing diet. Staff will be re trained on providing nutritional and nourishing meals. Staff will be re trained on offering food substitutions that are nutritionally equivalent to items posted on the menu. Staf Responsible: QMRP, Dietician	10/23/2011	

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W0488	<p>eat sausage. The clients were not offered a nutritionally equivalent substitution for sausage.</p> <p>A review of the menu was conducted on 9/21/11 at 6:30 AM. The menu, dated 9/19/11 - 9/26/11, indicated the following was to be served: 1/2 cup orange juice, 2 waffles or french toast, 2 tablespoons syrup, 1 teaspoon margarine, 1-2 sausage patties and 1 cup milk.</p> <p>An interview with the Qualified Mental Retardation Professional - Designee (QMRP-D) was conducted on 9/22/11 at 1:09 PM. The QMRP-D indicated the staff had looked at the wrong date for the food to be served. The QMRP-D indicated the staff should have offered sausage patties or a nutritionally equivalent substitution during breakfast.</p> <p>1.1-3-8(a)</p> <p>The facility must assure that each client eats in a manner consistent with his or her developmental level.</p> <p>Based on observation and interview for 7 of 8 clients living in the group home (#2, #3, #4, #5, #6, #7 and #8), the facility failed to ensure the clients served themselves during breakfast.</p> <p>Findings include:</p>	W0488	Residential CRF will assure that each client eats in a manner consistent with his or her developmental level. Residential CRF will continue to develop program plans that meet the individual needs of the client's. Each client is encouraged to achieve all daily activities as	10/23/2011	

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	<p>Observations were conducted at the group home on 9/20/11 from 3:35 PM to 5:52 PM and 9/21/11 from 5:54 AM to 8:23 AM. On 9/20/11 at 4:02 PM, client #1 had 8 Tupperware containers lined up on the kitchen counter. Client #1 was putting mixed vegetables into each container. Staff #3 indicated the mixed vegetables were for lunch on 9/21/11. On 9/21/11 at 5:58 AM, client #1 was setting the table with bowls, glasses and silverware. At 6:05 AM, client #1 put cereal into each of the 8 bowls on the table. At 6:10 AM, client #1 poured milk into 2 cups with chocolate and stirred the contents. Client #1 served orange juice to 2 cups. At 6:12 AM, client #1 poured milk into 5 cups. At 6:15 AM, client #1 poured milk into the 8 bowls of cereal. Staff #1, #3 and #4 did not redirect client #1 to allow each client to serve themselves. Clients #2, #3, #4, #5, #6, #7 and #8 were in the same area and available to serve themselves; staff did not prompt the clients to serve themselves.</p> <p>An interview with the Qualified Mental Retardation Professional - Designee (QMRP-D) was conducted on 9/22/11 at 1:09 PM. The QMRP-D indicated each client was able and should be serving their own drinks and cereal, with staff assistance.</p>		<p>independently as possible. Residential CRF will re train staff in the mportance of allowing each client this independence. Staff will be re trained on meal time protocol and allowing each client to serve themselves at their optimal skill level. Staff Responsible: QMRP</p>	

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W9999	<p>1.1-3-8(a)</p> <p>State Findings</p> <p>The following Community Residential Facilities for Persons with Developmental Disabilities rule was not met:</p> <p>1) 431 IAC 1.1-3-1 Governing Body</p> <p>(b) The residential provider shall report the following circumstances to the division by telephone no later than the first business day followed by written summaries as requested by the division.</p> <p>This state rule was not met as evidenced by:</p> <p>Based on record review and interview for 3 of 8 clients living in the group home (#4, #6 and #7), the facility failed to ensure BDDS (Bureau of Developmental Disabilities Services) was notified of reportable incidents (falls with injury) within 24 hours, in accordance with state law.</p> <p>Findings include:</p> <p>A review of the facility's incident reports was conducted on 9/21/11 at 10:24 AM. The following falls with injury were not reported to BDDS.</p> <p>-On 7/27/11 at 10:45 AM, client #6 fell on his face with exiting the dentist's office. Nurse was notified and staff were instructed to watch for signs of confusion every two hours through the evening and night. Taken to physician on 7/28/11 "as a precaution." First aid was given.</p> <p>-On 7/11/11 at 11:30 AM, client #7 fell at the workshop. He complained of pain on his left</p>	W9999	Residential CRF will continue to ensure that all allegations of mistreatment, neglect or abuse, as well as, injuries of unknown source are reported immediately to the administrator or other officials in accordance with the State law through established procedures. Residential CRF will ensure that all incidents of client to client abuse will be reported within 24 hours to BDDS. All investigations will be reported to the administrator within 5 working days of the incident. Residential CRF will train staff on the policy of notifying BDDS within 24 hours of an incident. Staff will also be trained on notifying the administrator within 5 working days of the incident with the results and summation of the incident in writing. Residential CRF will continue to ensure that all personnel who administer medication to clients will have successfully completed training using materials approved by the council. All staff in the home had successfully completed training. The scores for the test were on the back of the certification document and were in the	10/23/2011

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 09/23/2011
NAME OF PROVIDER OR SUPPLIER RESIDENTIAL CRF INC			STREET ADDRESS, CITY, STATE, ZIP CODE 2375 W US HWY 36 DANVILLE, IN46122		
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	<p>buttocks.</p> <p>-On 7/9/11 at 1:00 PM, while walking into the house, client #6 fell down on the porch. First aid was given. The report did not indicate the body part injured.</p> <p>-On 5/27/11 at 2:05 PM, client #4 fell causing redness and a scrape below his left knee while at the workshop.</p> <p>-On 3/15/11 at 5:30 PM, client #6 fell and scraped his arm on the corner of the island. First aid was given.</p> <p>-On 3/2/11 at 3:30 PM, client #6 fell and scraped his right knee and forehead. First aid was given.</p> <p>An interview with the Qualified Mental Retardation Professional - Designee (QMRP-D) was conducted on 9/21/11 at 10:35 AM. The QMRP-D indicated she was not reporting falls with injury unless the injury was serious. The QMRP-D stated, "I guess I didn't interpret it that literally."</p> <p>1.1-3-1(b)</p> <p>2) The following Community Residential Facilities for Persons with Developmental Disabilities Rule was not met.:</p> <p>431 IAC 1.1-3-6 Health Care Services</p> <p>(b) All personnel who administer medication to residents or observe residents self-administering medication shall have received and successfully completed training using materials approved by the council.</p> <p>THIS STATE RULE WAS NOT MET AS EVIDENCED BY:</p> <p>Based on interview and record review for 1 of 3 employee files reviewed (staff #3), the facility failed to ensure staff successfully completed training prior to administering medications.</p>		employee's file. Staff Responsible: QMRP, Nurse		

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	<p>Findings include:</p> <p>A review of the facility's employee files was conducted on 9/22/11 at 10:29 AM. Staff #3's file did not indicate the test scores staff #3 received for Core A and B (medication administration training).</p> <p>An interview with the Qualified Mental Retardation Professional - Designee (QMRP-D) was conducted on 9/22/11 at 1:09 PM. The QMRP-D indicated she was unable to locate documentation of staff #3's tests scores for Core A and B in his employee file. She indicated staff #3 did administer medications to the clients in the home.</p> <p>1.1-3-6(b)</p>				