

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G270	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  11/23/2015
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NAME OF PROVIDER OR SUPPLIER  RESIDENTIAL CRF INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1725 W COUNTRY CLUB RD CONNERSVILLE, IN 47331
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W 0000  Bldg. 00	<p>This visit was for a fundamental annual recertification and state licensure survey.</p> <p>Dates of Survey: November 18, 19, 20 and 23, 2015.</p> <p>Facility Number: 000790 Provider Number: 15G270 AIM Number: 100243550</p> <p>These federal deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review of this report completed by #15068 on 12/3/15.</p>	W 0000		
W 0186  Bldg. 00	<p>483.430(d)(1-2) DIRECT CARE STAFF</p> <p>The facility must provide sufficient direct care staff to manage and supervise clients in accordance with their individual program plans.</p> <p>Direct care staff are defined as the present on-duty staff calculated over all shifts in a 24-hour period for each defined residential living unit.</p> <p>Based on observation and interview for 3 of 3 sample clients (#1, #2 and #3) and 3 additional clients (#4, #5 and #6), the facility failed to ensure sufficient direct</p>	W 0186	Residential CRF will ensure that direct care staff are present during their working hours Staff will be in-serviced on the appropriate protocol to follow	12/23/2015

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	<p>care staff to supervise the clients during transport and while at the group home.</p> <p>Findings include:</p> <p>Observations were conducted at the group home on 11/18/15 between 3:20 PM and 5:30 PM.</p> <p>__At 3:20 PM upon arriving at the home, client #2 opened the front door for this surveyor. When asked where was staff, client #2 gestured and pointed toward client #3's bedroom. Within a few minutes staff #1 appeared and stated, "I'm sorry, [client #3] was having a behavior." Staff #1 indicated the clients arrived home from the day program at 3:15 PM.</p> <p>__One staff was in the home with six clients from 3:15 PM until 3:54 PM.</p> <p>__The second staff arrived at the home at 3:54 PM.</p> <p>During interview with staff #1 on 11/18/15 at 3:25 PM, staff #1:</p> <p>__Stated the second staff "had to run out for something," and then stated "It's something between the staff and the office. I guess I need to call someone." Staff #1 called someone and stated a second staff "should be here soon."</p> <p>__Indicated he transported clients #1, #2, #3, #4, #5 and #6 by himself from the day program to the group home.</p>		<p>when they are either running late or will be missing work for any reason Staff will notify their supervisor when they are going to be absent from a work shift so other staff may be notified to fulfill our staff to client ratio Residential supervisor will monitor homes at least weekly to ensure staff are following protocol</p> <p>Staff Responsible: Residential Supervisor, QIDP</p>		

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W 0331	<p>During interview with staff #2 on 11/18/15 at 3:54 PM, staff #2:            ___ Indicated the class he was taking was running late and that was why he was not in the home to assist with the clients.            ___ Indicated he had not called to inform anyone that he was running late.</p> <p>During interview with the Qualified Intellectual Disabilities Professional (QIDP) on 11/18/15 at 5:15 PM, the QIDP:            ___ Indicated there were to be two direct care staff in the home at all times to provide supervision and assistance when all clients were home (clients #1, #2, #3, #4, #5 and #6).            ___ Indicated there were to be two direct care staff at all times when transporting clients in the van.            ___ Indicated staff #1 should have called his supervisor and reported the second staff had not arrived in the home so that a substitute staff could have been provided for transport and to assist with supervision of the clients until the second staff could arrive.</p> <p>9-3-3(a)</p> <p>483.460(c) NURSING SERVICES</p>			

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Bldg. 00	<p>The facility must provide clients with nursing services in accordance with their needs. Based on observation, record review and interview for 2 of 4 sample clients (#1 and #2), the facility nursing services failed to ensure:</p> <p>__Staff assessed client #1 for pain and notified nursing services of client #1's complaint of being dizzy, having a headache and not feeling well.</p> <p>__Staff followed medication protocol when giving medication to client #3.</p> <p>Findings include:</p> <p>1. Observations were conducted at the group home on 11/18/15 between 3:20 PM and 5:30 PM.</p> <p>__At 3:20 PM client #1 was sitting in a recliner in the living room with his feet up watching television with a throw over his lap. Client #1 indicated he had recently had surgery and had just gotten his staples removed and lifted his shirt and exposed his abdomen and stated, "See, I just got my staples out." Client #1 had a long pink surgical scar on his abdomen.</p> <p>__At 4 PM client #1 was asked by staff #2 to come to the medication room for his PM medications. Client #1 stood up and ambulated slowly to the medication room. Client #1 was pale in color and was unsteady on his feet. Client #1</p>	W 0331	<p>Residential CRF will continue to ensure that all clients are provided with nursing service in accordance with their needs. Residential staff will be in-serviced on following the appropriate nursing protocol for when a client is not feeling well Staff will also be in-serviced on correct medication administration, and the steps to follow if a client drops their pill House staff will be monitored on a weekly basis on administrerring medication Staff Responsible: Nurse, Supervisor, QIDP</p>	12/23/2015

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	<p>grasped items nearby to steady himself while ambulating and stumbled slightly while walking. Staff #2 asked client #1 how he was feeling and client #1 stated, "I feel miserable, [staff #2]. My head hurts and I'm dizzy." Staff #2 gave client #1 his PM Depakote 250 milligrams and client #1 returned to the living room to sit down. Staff #2 did not assess client #1 for pain and/or address client #1's complaint of being dizzy, not feeling well and having a headache. Staff #2 did not offer client #1 anything for pain.</p> <p>__At 4:10 PM staff #2 prompted client #1 to assist with the evening meal preparation. Client #1 got up from the chair in the living room and slowly walked to the kitchen where he was prompted to set the table for the evening meal.</p> <p>__At 4:20 PM client #1 had finished setting the table and was standing in the kitchen beside staff #2. Client #1 was asked how he was feeling now. Client #1 stated, "I feel miserable [name of surveyor]. I feel dizzy and my head hurts." Staff #2 heard client #1 and again did not assess and/or address client #1's complaint of not feeling well.</p> <p>__At 4:38 PM client #1 and his housemates sat down at the dining room table for their evening meal.</p> <p>During this observation period staff #2</p>			

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	<p>did not assess client #1 for pain, take client #1's vital signs and/or call the nurse in regard to client #1's complaints of feeling miserable, dizzy and/or having a headache.</p> <p>Client #1's record was reviewed on 11/19/15 at 1 PM. Client #1's November 2015 physician's orders indicated client #1 had an order for Acetaminophen 325 milligrams two tablets every four hours for pain if needed.</p> <p>During interview with staff #2 and the Qualified Intellectual Disabilities Professional (QIDP) on 11/18/15 at 5 PM, the QIDP indicated the staff should have assessed and addressed client #1's complaints of not feeling well. The QIDP indicated nursing services should be notified of client #1's physical condition and complaints. Staff #2 stated, "I will call the nurse now."</p> <p>During interview with the facility's LPN on 11/20/15 at 3 PM, the LPN:            ___ Indicated the staff should have assessed client #1 when the client made complaints of not feeling well and being dizzy and the staff should have notified nursing services.            ___ Indicated the staff did call nursing services later on the evening of 11/18/15 after being prompted by the QIDP and</p>			

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	<p>the LPN went to the home and assessed the client.</p> <p>2. Observations were conducted at the group home on 11/19/15 between 6:30 AM and 7:30 AM. At 7:28 AM staff #2 placed a Dilantin 100 milligram tablet into client #3's hand. Client #3 dropped the tablet onto the floor, picked up the tablet and proceeded to take it. Staff #2 did not prompt client #3 to not take the tablet that fell on the floor.</p> <p>During interview with staff #2 on 11/19/15 at 7:30 AM, staff #2:            ___ Stated, "If they (the clients) drop a pill on the floor, it's ok for them (the clients) to pick it up and take it."            ___ Stated, "If we (the staff) drop a pill on the floor, we have to discard it and get another one."</p> <p>During interview with the facility's LPN on 11/20/15 at 3 PM, the LPN:            ___ Indicated all medications that were dropped on the floor were to be placed in an envelope and sent back to the pharmacy and the staff should provide the client a new pill.            ___ Indicated the staff should have prompted client #3 not to take a medication that fell on the floor.</p> <p>9-3-6(a)</p>			

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W 0369 Bldg. 00	<p>483.460(k)(2) DRUG ADMINISTRATION</p> <p>The system for drug administration must assure that all drugs, including those that are self-administered, are administered without error.</p> <p>Based on observation, record review and interview for 2 of 20 medications observed being administered, the facility failed to ensure all medications were administered without error to clients #1 and #4.</p> <p>Findings include:</p> <p>Observations were conducted at the group home on 11/19/15 between 6:30 AM and 7:30 AM.</p> <p>__At 6:50 AM client #1 ate his morning meal of scrambled eggs, toast, juice and milk.</p> <p>__At 7:15 AM staff #2 gave client #4 his AM medications of Adderall 20 mg (milligrams), Seroquel 200 mg, Fluoxetine 20 mg and Abilify 5 mg for behavior modification. Staff #2 did not give client #4 Depakote 500 mg with his AM medications during this observation period.</p> <p>__At 7:23 AM staff #2 gave client #1 his</p>	W 0369	<p>Residential CRF will in-service staff on the correct medication administration protocol All medications will be given as ordered by the physician and as indicated on the MAR. Residential home staff will be in-serviced on medication administration. Residential supervisor/and or nursing staff will monitor medication passes on a weekly basis.</p> <p>Staff that made the medication were trained and in-serviced by our facility nurse. They were monitored and observed while administering the next med pass. Staff will be monitored on a weekly basis to ensure they complete the med pass accurately. Staff Responsible: Nurse, Supervisor, QIDP</p>	12/23/2015

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	<p>AM medications that included Omeprazole 20 mg for GERD (Gastroesophageal Reflux Disease). Review of the pharmacy label/directions on the medication card of Omeprazole indicated client #1 was to take the Omeprazole "before a meal for stomach." Staff #2 indicated he was not aware the Omeprazole was to be given prior to client #1 eating his breakfast and stated, "I'll have to talk to the nurse about it." Staff #2 indicated comparing the medication labels and directives from the pharmacy on the medication bubble packs to the clients' MARs (Medication Administration Records) was to be done at each medication pass. Staff #2 stated, "I guess I overlooked that."</p> <p>Review of client #1's and #4's November 2015 MAR on 11/19/15 at 7:45 AM indicated:            ___ Client #1 was to receive Omeprazole prior to eating a meal.            ___ Client #4 was to receive Depakote 500 mg every morning with AM medications for IED (Intermittent Explosive Disorder).</p> <p>During interview with staff #1 and staff #2 on 11/19/15 at 6:30 AM, both staff indicated no early AM medications had been given and all clients would receive their AM (7 AM and 8 AM) medications</p>			

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	<p>after eating their breakfast.</p> <p>During interview with the facility's LPN on 11/20/15 at 3 PM, the LPN:            ___ Indicated the staff were to follow the directions provided on the medication labels.            ___ Indicated at the beginning of every month the facility RN was to check the MARs against the physician's orders to ensure the accuracy of the MARs.            ___ All medications were to be given as ordered by the physician and as indicated on the clients' MARs.</p> <p>9-3-6(a)</p>			