

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G349	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 12/22/2011
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NAME OF PROVIDER OR SUPPLIER PATHFINDER SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1135 E TIPTON ST HUNTINGTON, IN46750
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W0000	<p>This visit was for a fundamental recertification and state licensure survey.</p> <p>Date of Survey: December 20, 21, 22, 2011.</p> <p>Facility number: 000865 Provider number: 15G349 AIM number: 100244090</p> <p>Surveyor: Susan Reichert, Medical Surveyor III</p> <p>The following federal deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 12-30-11 by C. Neary, Program Coordinator.</p>	W0000		
W0114	<p>Any individual who makes an entry in a client's record must make it legibly, date it, and sign it.</p> <p>Based on record review and interview, the facility failed to provide dated documentation of the written informed consent of the client, parent/health care representative (HCR) or guardian and failed to provide dated documentation of the Human Rights Committee (HRC) review and approval of a Behavior Management Plan (BMP) for 3 of 3 sampled clients who had BMPs (clients #2, #3 and #5).</p>	W0114	<p>W114 An email reminder will be sent out by 1-14-12 to all QDDP's that prior to submitting their Behavior Management Plans to the Human Rights Committee, they will assure that the plan has already been approved by the client as well as their legal guardian or health care representative. When it is signed by the client and their representative, it will be dated. Once they have given approval to the plan as written, then the QDDPs will present the plan at</p>	01/12/2012

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>Findings include:</p> <p>Client #2's record was reviewed on 12/21/11 at 12:15 PM. Client #2's Individual Support Plan (ISP) dated 3/10/11 indicated client #2 had a HCR to assist her with decisions. Client #2's record indicated she had a BMP dated 12/6/11, which included psychotropic medication to address agitation and physical interventions including CPI (Crisis Prevention Interventions). Client #2's BMP was signed by client #2, her staff, team, and the HRC without indication of the date. Her HCR signed on a separate page dated 12/18/11. There were no dates indicating when the plan was approved.</p> <p>Client #3's record was reviewed on 12/21/11 at 11:30 AM. Client #3's Individual Support Plan (ISP) dated 1/7/11 indicated client #3 had a guardian to assist her with decisions. Client #3's record indicated she had a BMP dated 1/7/11, which included psychotropic medication to address signs of mental illness. Client #3's BMP was signed by client #3, her staff, team, her guardian, her mother and the HRC without indication of the date. There were no dates indicating when the plan was approved.</p> <p>Client #5's record was reviewed on</p>		<p>the next scheduled Human Rights Committee meeting. When it is presented at the Human Rights Committee meeting and signatures are collected, there will be a notation made at the bottom of the signature page as to when the meeting was held. The QDDPs will monitor this. As they are writing new plans, updating or revising current plans, prior to a plan being presented to Human Rights they will make sure they have the dated signatures of the client the plan is written for as well as their representative.</p>		

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W0149	<p>12/21/11 at 9:45 AM. Client #5's record indicated he had a health care representative to assist him in making decisions. A 12/6/11 BMP indicated client #5 received medication to treat symptoms of depression and dementia. Client #5's health care representative, client #5, client #5's team and the agency's HRC signed the plan without indicating the approval date.</p> <p>The Qualified Developmental Disabilities Service Professional was interviewed 12/21/11 and indicated the plans had been approved prior to her knowledge that the approval dates should be documented and client #2 and #5's plans would be reviewed at the next HRC meeting. She indicated client #2's plan had been reviewed and approved by the HRC prior to client #2's HCR's approval as the HCR had been unavailable to review the plan.</p> <p>9-3-1(a)</p> <p>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client.</p> <p>Based on observation, record review and interview, the facility neglected to develop and implement policy and procedures to implement immediate and effective corrective action to protect 1 of</p>	W0149	W149 The agency's Handling Client Abuse, Neglect, Injuries of Unknown Origin & BDDS Incident Reporting Policy/Procedure will be updated to now include a section on Corrective Action Procedures. This will be done by 1-14-12. The update will include	01/12/2012	

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	<p>3 sampled clients (client #5) from falls resulting in injury.</p> <p>Findings include:</p> <p>The facility's reportable incidents to the Bureau of Developmental Disabilities Services (BDDS) and internal incident reports were reviewed on 12/20/11 at 3:00 PM and included the following reports involving client #5:</p> <p>-A BDDS report dated 5/19/11 indicated client #5 fell at the kitchen counter causing a 1 inch cut to his elbow requiring first aid, despite staff attempts to prevent his fall. The report indicated staff had implemented client #5's fall risk plan which included the use of a helmet, walker and gait belt. Corrective action indicated staff would be asked to review client #5's fall risk plan and to continue to be observant when he was standing in case he might fall again. A follow up report dated 5/25/11 indicated as a response to the question "What is [client #5's] level of supervision and proximity of staff to intervene or prevent falls?" that there were 3 to 4 staff in the home and "Staff work to make sure that they are with [client #5] when he is up and moving." The report indicated client #5's plan had been reviewed and updated "less than a month ago" by the agency nurse.</p>		<p>the following information: "A possible case of neglect can be information contained in our Behavior Reports and/or Accident/Incident reports. A repetitive behavior or injury that occurs for a client should be examined by the IDT for possible ways to change the environment, ways to change how the client is interacted with during a behavior, adaptive equipment changes/updates, changes to High Risk Plans or writing a new plan, etc. When a trend is found by the QDDP or Residential Nurse, the IDT should meet to discuss the situation and changes or updates made as needed." As stated in the policy update the need for corrective action will be monitored by the QDDP, or Residential Nurse. This policy will be reviewed on an annual basis to ensure that procedures are in place for the protection of all individuals served.</p>		

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	-BDDS report dated 5/24/11 indicated client #5 had fallen earlier in the day at day services and at 5:00 PM had fallen "on his butt" in the group home when he lost his balance. The report indicated client #5's fall risk plan had been implemented and he was wearing his adaptive equipment to prevent falls and staff had implemented his plan as they were trained. Staff later observed a 5 inch by 1 inch bruise on client #5's right hip during a shower that evening. The report indicated client #5's plan would continue to be followed. A follow up question regarding the incident "Please include whether the team will review the current fall risk plan and whether any changes are being made to prevent future falls, noting that staff did follow the plan appropriately but that he fell with sizeable bruise occurring" indicated a response of "[Client # 5's] team reviewed his fall risk plan and found to be thorough and reflective of his needs. No changes are being made to it at this time." A follow up report dated 5/24/11 indicated staff would be retrained on client #5's Fall Prevention Protocol and would be asked to direct any specific questions they still had about the plan to the Q (Qualified Developmental Disabilities Professional) in writing.				

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	<p>-An internal incident report dated 7/16/11 indicated client #5 fell in the shower while removing his pants after removing his gait belt and helmet, sustaining a bump to his head unspecified in size. The report indicated staff were with client #5, but client #5 failed to respond to prompts to replace his adaptive equipment prior to being seated and they were unable to prevent his fall.</p> <p>-A BDDS report dated 7/25/11 indicated client #5 failed to wait for staff assistance despite staff request to do before exiting the van and fell on his left side, causing a 1 inch scratch to his left elbow requiring first aid. The report indicated client #5 "was very independent and often will indicate to staff that he is going to wait, but then will start anyhow." The report indicated client #5's fall prevention protocol had been updated and was current to his needs, and a goal to wait until staff are beside him to get out of the van. "[Client #5] values his independence, but it is difficult to get him to stay seated or notify staff of getting up to move due to his dementia (he doesn't remember the prompts and still desires to be independent). Staff do their best to keep him from falling by continuing to prompt and monitor him for movement..." A follow up report dated 7/29/11 answering the question "What is</p>				

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	<p>[client #5's] level of supervision and proximity that staff should be to prevent or intervene in falls" indicated "Staff assist him with ambulation with his gait belt when he is up and moving. Staff have been instructed to be in the same room or at least line of site when [client #5] is sitting, in case he starts to get up to walk."</p> <p>-A BDDS report dated 8/6/11 indicated client #5 fell while attempting to move around the open dishwasher door, causing him to stumble. Staff was able to prevent his fall, but he sustained a small scrape on his right middle finger as a result of the incident. Staff were to continue to monitor client #5 to prevent falls and client #5 "likes to be independent and will not always follow staff directives."</p> <p>-An internal incident report dated 8/6/11 indicated client #5 was doing dishes and tripped over the open dishwasher door and suggestions to avoid reoccurrence indicated "Staff remain as near [client #5] as much as possible."</p> <p>-A BDDS report dated 9/4/11 indicated client #5 fell while drying off in the shower despite being assisted by staff. Later a 3 inch bruise appeared on his left side above his hip. The report indicated client #5's plan was implemented as</p>			

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	<p>written. No other corrective action was indicated.</p> <p>-A BDDS report dated 9/12/11 indicated client #5 was sitting at a table working a puzzle and did not indicate to staff he was going to get up. When he got up, he lost his balance, fell and received a 2 inch bruise on the underside of his right arm. "Staff present were counseled regarding proximity they need to be to prevent such incidents."</p> <p>-An internal incident report dated 9/12/11 indicated staff had heard a banging noise and went to see what had happened and found client #5 on the floor. A suggestion to prevent reoccurrence indicated "watch for signs that [client #5] needs help up or moving around."</p> <p>-A BDDS report dated 11/4/11 indicated client #5 fell at day services while brushing his teeth and losing his balance, sustaining a scrape to his left forearm 4.5 by .5 inches long and within the scrape a cut .5 by .5 inches requiring first aid. The report indicated client #5's fall risk protocol was implemented as written and staff were retrained on the plan. An undated follow up to the incident indicated "Staff do their best to anticipate [client #5's] movements and position themselves accordingly as much as they</p>				

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	<p>can. It's difficult to stop the momentum of [client #5's] unexpected falls, so sometimes injuries do occur." No additional corrective action was indicated in the report.</p> <p>Observation in the group home was completed on 12/20/11 from 3:46 PM until 5:40 PM. During the observation, client #5 sat alone in the living room of the home working a puzzle at a table, walked through the living room and kitchen without staff assistance and went to the laundry room. Upon client #5's arrival in the laundry room, the house manager held client #5's gait belt and then assisted client #5 to push a laundry basket to the living room. Client #5 then sat and folded laundry alone in the living room. After folding the laundry, client #5 got up from his chair without staff assistance and carried the folded linens to the closet in the adjacent hall way and returned to pick up the empty laundry basket in the living room. Staff #1, #8 and the house manager were in other rooms of the group home and were not within eyesight of client #5 while he folded and put away the laundry. At 4:26 PM, the house manager walked with client #5 while holding his gait belt while he returned the plastic laundry basket without the use of the rolling laundry basket to the laundry room.</p>				

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	<p>Observations were completed in the group home again on 12/21/11 from 6:45 AM until 7:50 AM. During the observation, client #5 got up from the table at which he was working a puzzle in the living room and walked unaided by staff around the table to pick an item up from the floor and continued to work a puzzle while staff were in other areas of the house and not within eyesight of client #5.</p> <p>Client #5's Fall Prevention Plan revised 4/26/11 was reviewed on 12/20/11 at 4:58 PM and indicated client #5 "has many falls each month,...balance and gait lead him to have many falls, [client #5] values independence and will not always ask for assistance as needed or wait for help...staff walk next to [client #5] to provide assistance when needed when walking on uneven ground...[client #5] is educated on the importance of asking for staff assistance when walking without his walker or while in the bathroom." The plan indicated client #5 was to be assisted while getting in and out of the van and use the handle of a grocery cart. Adaptive equipment to be used for client #5 included the use of a helmet, rolling walker while ambulating, rolling clothes basket/clothes hanger for laundry duties. There was no additional information regarding staff supervision or other staff techniques to use to protect client #5 from</p>			

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	<p>falls.</p> <p>Staff #4 was interviewed on 12/21/11 at 7:41 AM and indicated client #5's plan included the use of staff assistance to walk with him if there were enough staff available, and indicated he was to use a gait belt, shower chair and helmet. She indicated client #5 was able to walk around without staff assistance, but stated, "In the morning we try to stay one to one (supervision level)" and indicated client #5 fell more often in the morning hours.</p> <p>Client #5's full record was reviewed on 12/21/11 at 9:45 AM. His Individual Support Plan dated 3/31/11 included an objective to wait to get out of the van and the Fall Prevention Protocol dated 4/26/11. There was no evidence of a revision to client #5's Fall Prevention Protocol since 4/26/11.</p> <p>The Qualified Developmental Disabilities Professional (QDDP) was interviewed on 12/21/11 at 9:58 PM. She indicated client #5's plan to prevent falls had not been revised since 4/26/11. When asked about his level of supervision to prevent falls, she stated, "Line of sight is best-that way they can catch him when he is up and moving." She indicated client #5's plan had not been updated to indicate the supervision level for client #5, but staff</p>				

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	<p>had been asked to provide line of sight supervision as much as possible. She indicated there were times staff would not be able to implement line of sight supervision due to the assistance requirements of other clients living in the group home. She indicated client #5's falls had decreased since the implementation of his current plan but stated, "It's a pattern."</p> <p>Notes to the group home staff provided by the QDDP were reviewed on 12/21/11 at 10:51 AM and included the following:</p> <p>-A note dated 3/3/11 indicated "Please make sure you are with him as much as possible when he is up and walking and make sure to use his gait belt. Remember that he tends to fall more...when carrying things, etc. Please watch for these moments so you can be assisting him as needed."</p> <p>-A note dated 5/20/11 indicated a request for staff to review client #5's fall risk plan. "He was injured during his last fall, and I would like for you to do your best to assist him when he's up walking. I know that [client #5] is a very independent person, and will not let you know that he is getting up. Please just do your best to monitor his whereabouts!"</p> <p>-A note dated 7/29/11 indicated "Please make sure that you are with [client #5]</p>			

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W0157	<p>when he is up and walking. If he is sitting, please keep him in your line of sight, but preferably be in the same room with him...."</p> <p>The facility's policy Handling Client Abuse, Neglect, Injuries of Unknown Origin and BDDS Incident Reporting dated 10/5/11 was reviewed on 12/20/11 at 3:15 PM and included "Any alleged, suspected, or actual abuse (physical, sexual, emotional or domestic improper treatment), neglect (failure to provide appropriate care, environment, food, medical care or supervision), exploitation or any other mistreatment must be immediately reported." The policy failed to indicate the agency's policy regarding protecting clients from abuse, neglect or exploitation, and failed to address corrective action to protect clients.</p> <p>9-3-2(a)</p> <p>If the alleged violation is verified, appropriate corrective action must be taken.</p> <p>Based on observation, record review and interview, the facility neglected to implement immediate and effective</p>	W0157	W157 The following plan will be put into place to address the falls of client #5 which could result in potential injury. Client #5's high	01/20/2012

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	<p>corrective action to protect 1 of 3 sampled clients (client #5) from falls resulting in injury.</p> <p>Findings include:</p> <p>The facility's reportable incidents to the Bureau of Developmental Disabilities Services (BDDS) and internal incident reports were reviewed on 12/20/11 at 3:00 PM and included the following reports involving client #5:</p> <p>-A BDDS report dated 5/19/11 indicated client #5 fell at the kitchen counter causing a 1 inch cut to his elbow requiring first aid, despite staff attempts to prevent his fall. The report indicated indicated staff had implemented client #5's fall risk plan which included the use of a helmet, walker and gait belt. Corrective action indicated staff would be asked to review client #5's fall risk plan and to continue to be observant when he is standing in case he might fall again. A follow up report dated 5/25/11 indicated as a response to the question "What is [client #5's] level of supervision and proximity of staff to intervene or prevent falls?" that there were 3 to 4 staff in the home and "Staff work to make sure that they are with [client #] when he is up and moving." The report indicated client #5's plan had been reviewed and updated "less than a</p>		<p>risk plan for falls will be updated by 1-14-12. It will include staff supervision level of client #5 and a showering safety procedure for staff to follow when assisting client #5 with showers. A retraining of direct care staff on the updated plan will be done. This will be done by the Residential Nurse by 1-20-12. The IDT will review any falls client #5 has to see if immediate action or changes need made to the high risk plan to ensure client #5's continued safety. Client #5's primary physician will be contacted by 1-14-12 to see if he will write a script recommending an OT home evaluation assessment for client #5. Once a script is secured an OT home assessment will be scheduled and any recommendations made will be addressed by the IDT. This will be done by the QDDP by 1-14-12. Client #5 will switch bedrooms once renovations are done to make a bedroom more accessible to all areas of the home. Currently client #5's bedroom is located at the far end of the home away from kitchen; laundry room and medication pass area in the office. By moving him to more centrally located bedroom staff will be able to monitor his whereabouts more readily to come to his assistance and client #5 will have less distance to travel, hopefully reducing the potential to fall. Maintenance requests to get the</p>		

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	<p>month ago" by the agency nurse.</p> <p>-BDDS report dated 5/24/11 indicated client #5 had fallen earlier in the day at day services and at 5:00 PM had fallen "on his butt" in the group home when he lost his balance. The report indicated client #5's fall risk plan had been implemented and he was wearing his adaptive equipment to prevent falls and staff had implemented his plan as they were trained. Staff later observed a 5 inch by 1 inch bruise on client #5's right hip during a shower that evening. The report indicated client #5's plan would continue to be followed. A follow up question regarding the incident "Please include whether the team will review the current fall risk plan and whether any changes are being made to prevent future falls, noting that staff did follow the plan appropriately but that he fell with sizeable bruise occurring" indicated a response of "[Client # 5's] team reviewed his fall risk plan and found to be thorough and reflective of his needs. No changes are being made to it at this time." A follow up report dated 5/24/11 indicated staff would be retrained on client #5's Fall Prevention Protocol and would be asked to direct any specific questions that still have about the plan to the Q (Qualified Developmental Disabilities Professional) in writing.</p>		<p>work started will be put in by 1-14-12. Community Supports Coordinator will monitor the progress of the work and the anticipated time frames of completion. Client #5's Health Care Representative will be contacted to see if she will give consent for a bed alarm, if approved it will be presented for Human Rights approval and implemented. The alarm would alert staff if client #5 is up and moving around at night so they can assist him and hopefully prevent a potential fall. The QDDP will contact the HCR by 1-14-12 to get consent, and then contact Human Rights members. The Residential nurse will order the bed alarm. The IDT will meet to review any falls client #5 has to see if any immediate action or changes need implemented to ensure his continued safety. Client #5's health and safety status will also be reviewed at his quarterly progress meetings to see if any actions need taken. <input type="checkbox"/></p>		

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	<p>-An internal incident report dated 7/16/11 indicated client #5 fell in the shower while removing his pants after removing his gait belt and helmet sustaining a bump to his head unspecified in size. The report indicated staff were with client #5, but client #5 failed to respond to prompts to replace his adaptive equipment prior to being seated and they were unable to prevent his fall.</p> <p>-A BDDS report dated 7/25/11 indicated client #5 failed to wait for staff assistance despite staff request to do before exiting the van and fell on his left side, causing a 1 inch scratch to his left elbow requiring first aid. The report indicated client #5 "was very independent and often will indicate to staff that he is going to wait, but then will start anyhow." The report indicated client #5's fall prevention protocol had been updated and was current to his needs, and a goal to wait until staff are beside him to get out of the van. "[Client #5] values his independence, but it is difficult to get him to stay seated or notify staff of getting up to move due to his dementia (he doesn't remember the prompts and still desires to be independent). Staff do their best to keep him from falling by continuing to prompt and monitor him for movement..." A follow up report dated</p>			

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	<p>7/29/11 answering the question "What is [client #5's] level of supervision and proximity that staff should be to prevent or intervene in falls" indicated "Staff assist him with ambulation with his gait belt when he is up and moving. Staff have been instructed to be in the same room or at least line of site when [client #5] is sitting, in case he starts to get up to walk."</p> <p>-A BDDS report dated 8/6/11 indicated client #5 fell while attempting to move around the open dishwasher door, causing him to stumble. Staff was able to prevent his fall, but he sustained a small scrape on his right middle finger as a result of the incident. Staff were to continue to monitor client #5 to prevent falls and client #5 "likes to be independent and will not always follow staff directives." An internal incident report dated 8/6/11 indicated client #5 was doing dishes and tripped over the open dishwasher door and suggestions to avoid reoccurrence indicated "Staff remain as near [client #5] as much as possible."</p> <p>-A BDDS report dated 9/4/11 indicated client #5 fell while drying off in the shower despite being assisted by staff. Later a 3 inch bruise appeared on his left side above his hip. The report indicated client #5's plan was implemented as</p>			

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	<p>written. No other corrective action was indicated.</p> <p>-A BDDS dated 9/12/11 indicated client #5 was sitting at a table working a puzzle and did not indicate to staff he was going to get up. When he got up, he lost his balance, fell and received a 2 inch bruise on the underside of his right arm. "Staff present were counseled regarding proximity they need to be to prevent such incidents." An internal incident report dated 9/12/11 indicated staff had heard a banging noise and went to see what had happened and found client #5 on the floor. A suggestion to prevent reoccurrence indicated "watch for signs that [client #5] needs help up or moving around."</p> <p>-A BDDS report dated 11/4/11 indicated client #5 fell at day services while brushing his teeth and losing his balance, sustaining a scrape to his left forearm 4.5 by .5 inches long and within the scrape a cut .5 by .5 inches requiring first aid. The report indicated client #5's fall risk protocol was implemented as written and staff were retrained on the plan. An undated follow up to the incident indicated "Staff do their best to anticipate [client #5's] movements and position themselves accordingly as much as they can. It's difficult to stop the momentum of [client #5's] unexpected falls, so</p>			

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	<p>sometimes injuries do occur." No additional corrective action was indicated in the report.</p> <p>Observation in the group home was completed on 12/20/11 from 3:46 PM until 5:40 PM. During the observation, client #5 sat alone in the living room of the home working a puzzle at a table, walked through the living room and kitchen without staff assistance and went to the laundry room. Upon client #5's arrival in the laundry room the house manager held client #5's gait belt and then assisted client #5 to push a laundry basket to the living room. Client #5 then sat and folded laundry alone in the living room. After folding the laundry, client #5 got up from his chair without staff assistance and carried the folded linens to the closet in the adjacent hall way and returned to pick up the empty laundry basket in the living room. Staff #1, #8 and the house manager were in other rooms of the group home and were not within eyesight of client #5 while he folded and put away the laundry. At 4:26 PM, the house manager walked with client #5 while holding his gait belt while he returned the plastic laundry basket without the use of the rolling laundry basket to the laundry room.</p> <p>Client #5's Fall Prevention Plan revised 4/26/11 was reviewed on 6/20/11 at 4:58</p>				

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	<p>PM and indicated client #5 "has many falls each month,...balance and gait lead him to have many falls, [client #5] values independence and will not always ask for assistance as needed or wait for help...staff walk next to [client #5] to provide assistance when needed when walking on uneven ground...[client #5 is educated on the importance of asking for staff assistance when walking without his walker or while in the bathroom." The plan indicated client #5 was to be assisted while getting in and out of the van and use the handle of a grocery cart. Adaptive equipment to be used for client #5 included the use of a helmet, rolling walker while ambulating, rolling clothes basket/clothes hanger for laundry duties. There was no additional information regarding staff supervision or other staff techniques to use to protect client #5 from falls.</p> <p>Observations were completed in the group home again on 12/21/11 from 6:45 AM until 7:50 AM. During the observation, client #5 got up from the table at which he was working a puzzle in the living room and walked unaided by staff around the table to pick an item up from the floor and continued to work a puzzle while staff were in other areas of the house and not within eyesight of client #5.</p>				

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	<p>Staff #4 was interviewed on 12/21/11 at 7:41 AM and indicated client #5's plan included the use of staff assistance to walk with him if there were enough staff available, and indicated he was to use a gait belt, shower chair and helmet. She indicated client #5 was able to walk around without staff assistance, but stated, "In the morning we try to stay one to one (supervision level)" and indicated client #5 fell more often in the morning hours.</p> <p>Client #5's full record was reviewed on 12/21/11 at 9:45 AM. His Individual Support Plan dated 3/31/11 included an objective to wait to get out of the van and the Fall Prevention Protocol dated 4/26/11. There was no evidence of a revision to client #5's Fall Prevention Protocol since 4/26/11.</p> <p>The Qualified Developmental Disabilities Professional (QDDP) was interviewed on 6/21/11 at 9:58 PM. She indicated client #5's plan to prevent falls had not been revised since 4/26/11. When asked about his level of supervision to prevent falls, she stated, "Line of sight is best-that way they can catch him when he is up and moving." She indicated client #5's plan had not been updated to indicate the supervision level for client #5, but staff had been asked to provide line of sight supervision as much as possible. She</p>				

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	<p>indicated there were times staff would not be able to implement line of sight supervision due to the assistance requirements of other clients living in the group home. She indicated client #5's falls had decreased since the implementation of his current plan but stated, "It's a pattern."</p> <p>The facility's reportable incidents to the Bureau of Developmental Disabilities Services (BDDS) and internal incident reports were reviewed on 12/20/11 at 3:00 PM and included the following reports involving client #5:</p> <p>-A BDDS report dated 5/19/11 indicated client #5 fell at the kitchen counter causing a 1 inch cut to his elbow requiring first aid, despite staff attempts to prevent his fall. The report indicated staff had implemented client #5's fall risk plan which included the use of a helmet, walker and gait belt. Corrective action indicated staff would be asked to review client #5's fall risk plan and to continue to be observant when he was standing in case he might fall again. A follow up report dated 5/25/11 indicated as a response to the question "What is [client #5's] level of supervision and proximity of staff to intervene or prevent falls?" that there were 3 to 4 staff in the home and "Staff work to make sure that they are</p>				

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	<p>with [client #5] when he is up and moving." The report indicated client #5's plan had been reviewed and updated "less than a month ago" by the agency nurse.</p> <p>-BDDS report dated 5/24/11 indicated client #5 had fallen earlier in the day at day services and at 5:00 PM had fallen "on his butt" in the group home when he lost his balance. The report indicated client #5's fall risk plan had been implemented and he was wearing his adaptive equipment to prevent falls and staff had implemented his plan as they were trained. Staff later observed a 5 inch by 1 inch bruise on client #5's right hip during a shower that evening. The report indicated client #5's plan would continue to be followed. A follow up question regarding the incident "Please include whether the team will review the current fall risk plan and whether any changes are being made to prevent future falls, noting that staff did follow the plan appropriately but that he fell with sizeable bruise occurring" indicated a response of "[Client # 5's] team reviewed his fall risk plan and found to be thorough and reflective of his needs. No changes are being made to it at this time." A follow up report dated 5/24/11 indicated staff would be retrained on client #5's Fall Prevention Protocol and would be asked to direct any specific questions they still</p>				

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	<p>had about the plan to the Q (Qualified Developmental Disabilities Professional) in writing.</p> <p>-An internal incident report dated 7/16/11 indicated client #5 fell in the shower while removing his pants after removing his gait belt and helmet, sustaining a bump to his head unspecified in size. The report indicated staff were with client #5, but client #5 failed to respond to prompts to replace his adaptive equipment prior to being seated and they were unable to prevent his fall.</p> <p>-A BDDS report dated 7/25/11 indicated client #5 failed to wait for staff assistance despite staff request to do before exiting the van and fell on his left side, causing a 1 inch scratch to his left elbow requiring first aid. The report indicated client #5 "was very independent and often will indicate to staff that he is going to wait, but then will start anyhow." The report indicated client #5's fall prevention protocol had been updated and was current to his needs, and a goal to wait until staff are beside him to get out of the van. "[Client #5] values his independence, but it is difficult to get him to stay seated or notify staff of getting up to move due to his dementia (he doesn't remember the prompts and still desires to be independent). Staff do their best to</p>				

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	<p>keep him from falling by continuing to prompt and monitor him for movement..." A follow up report dated 7/29/11 answering the question "What is [client #5's] level of supervision and proximity that staff should be to prevent or intervene in falls" indicated "Staff assist him with ambulation with his gait belt when he is up and moving. Staff have been instructed to be in the same room or at least line of site when [client #5] is sitting, in case he starts to get up to walk."</p> <p>-A BDDS report dated 8/6/11 indicated client #5 fell while attempting to move around the open dishwasher door, causing him to stumble. Staff was able to prevent his fall, but he sustained a small scrape on his right middle finger as a result of the incident. Staff were to continue to monitor client #5 to prevent falls and client #5 "likes to be independent and will not always follow staff directives."</p> <p>-An internal incident report dated 8/6/11 indicated client #5 was doing dishes and tripped over the open dishwasher door and suggestions to avoid reoccurrence indicated "Staff remain as near [client #5] as much as possible."</p> <p>-A BDDS report dated 9/4/11 indicated client #5 fell while drying off in the</p>				

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	<p>shower despite being assisted by staff. Later a 3 inch bruise appeared on his left side above his hip. The report indicated client #5's plan was implemented as written. No other corrective action was indicated.</p> <p>-A BDDS report dated 9/12/11 indicated client #5 was sitting at a table working a puzzle and did not indicate to staff he was going to get up. When he got up, he lost his balance, fell and received a 2 inch bruise on the underside of his right arm. "Staff present were counseled regarding proximity they need to be to prevent such incidents."</p> <p>-An internal incident report dated 9/12/11 indicated staff had heard a banging noise and went to see what had happened and found client #5 on the floor. A suggestion to prevent reoccurrence indicated "watch for signs that [client #5] needs help up or moving around."</p> <p>-A BDDS report dated 11/4/11 indicated client #5 fell at day services while brushing his teeth and losing his balance, sustaining a scrape to his left forearm 4.5 by .5 inches long and within the scrape a cut .5 by .5 inches requiring first aid. The report indicated client #5's fall risk protocol was implemented as written and staff were retrained on the plan. An</p>				

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	<p>undated follow up to the incident indicated "Staff do their best to anticipate [client #5's] movements and position themselves accordingly as much as they can. It's difficult to stop the momentum of [client #5's] unexpected falls, so sometimes injuries do occur." No additional corrective action was indicated in the report.</p> <p>Observation in the group home was completed on 12/20/11 from 3:46 PM until 5:40 PM. During the observation, client #5 sat alone in the living room of the home working a puzzle at a table, walked through the living room and kitchen without staff assistance and went to the laundry room. Upon client #5's arrival in the laundry room, the house manager held client #5's gait belt and then assisted client #5 to push a laundry basket to the living room. Client #5 then sat and folded laundry alone in the living room. After folding the laundry, client #5 got up from his chair without staff assistance and carried the folded linens to the closet in the adjacent hall way and returned to pick up the empty laundry basket in the living room. Staff #1, #8 and the house manager were in other rooms of the group home and were not within eyesight of client #5 while he folded and put away the laundry. At 4:26 PM, the house manager walked with client #5 while holding his gait belt</p>			

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	<p>while he returned the plastic laundry basket without the use of the rolling laundry basket to the laundry room.</p> <p>Observations were completed in the group home again on 12/21/11 from 6:45 AM until 7:50 AM. During the observation, client #5 got up from the table at which he was working a puzzle in the living room and walked unaided by staff around the table to pick an item up from the floor and continued to work a puzzle while staff were in other areas of the house and not within eyesight of client #5.</p> <p>Client #5's Fall Prevention Plan revised 4/26/11 was reviewed on 12/20/11 at 4:58 PM and indicated client #5 "has many falls each month,...balance and gait lead him to have many falls, [client #5] values independence and will not always ask for assistance as needed or wait for help...staff walk next to [client #5] to provide assistance when needed when walking on uneven ground...[client #5] is educated on the importance of asking for staff assistance when walking without his walker or while in the bathroom." The plan indicated client #5 was to be assisted while getting in and out of the van and use the handle of a grocery cart. Adaptive equipment to be used for client #5 included the use of a helmet, rolling walker while ambulating, rolling clothes</p>			

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NAME OF PROVIDER OR SUPPLIER PATHFINDER SERVICES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 1135 E TIPTON ST HUNTINGTON, IN46750		
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	<p>basket/clothes hanger for laundry duties. There was no additional information regarding staff supervision or other staff techniques to use to protect client #5 from falls.</p> <p>Staff #4 was interviewed on 12/21/11 at 7:41 AM and indicated client #5's plan included the use of staff assistance to walk with him if there were enough staff available, and indicated he was to use a gait belt, shower chair and helmet. She indicated client #5 was able to walk around without staff assistance, but stated, "In the morning we try to stay one to one (supervision level)" and indicated client #5 fell more often in the morning hours.</p> <p>Client #5's full record was reviewed on 12/21/11 at 9:45 AM. His Individual Support Plan dated 3/31/11 included an objective to wait to get out of the van and the Fall Prevention Protocol dated 4/26/11. There was no evidence of a revision to client #5's Fall Prevention Protocol since 4/26/11.</p> <p>The Qualified Developmental Disabilities Professional (QDDP) was interviewed on 12/21/11 at 9:58 PM. She indicated client #5's plan to prevent falls had not been revised since 4/26/11. When asked about his level of supervision to prevent falls, she stated, "Line of sight is best-that way</p>				

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	<p>they can catch him when he is up and moving." She indicated client #5's plan had not been updated to indicate the supervision level for client #5, but staff had been asked to provide line of sight supervision as much as possible. She indicated there were times staff would not be able to implement line of sight supervision due to the assistance requirements of other clients living in the group home. She indicated client #5's falls had decreased since the implementation of his current plan but stated, "It's a pattern."</p> <p>Notes to the group home staff provided by the QDDP were reviewed on 12/21/11 at 10:51 AM and included the following:</p> <p>-A note dated 3/3/11 indicated "Please make sure you are with him as much as possible when he is up and walking and make sure to use his gait belt. Remember that he tends to fall more...when carrying things, etc. Please watch for these moments so you can be assisting him as needed."</p> <p>-A note dated 5/20/11 indicated a request for staff to review client #5's fall risk plan. "He was injured during his last fall, and I would like for you to do your best to assist him when he's up walking. I know that [client #5] is a very independent person, and will not let you know that he</p>			

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	<p>is getting up. Please just do your best to monitor his whereabouts!"</p> <p>-A note dated 7/29/11 indicated "Please make sure that you are with [client #5] when he is up and walking. If he is sitting, please keep him in your line of sight, but preferably be in the same room with him...."There was no evidence the supervision needs of client #5 had been incorporated into his written plan.</p> <p>9-3-2(a)</p>				