

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G551	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 07/15/2014
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NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES-ADEPT	STREET ADDRESS, CITY, STATE, ZIP CODE 8211 CHRISTIANA LN INDIANAPOLIS, IN 46256
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W000000	<p>This visit was for the investigation of Complaint #IN00151337.</p> <p>Complaint #IN00151337: Substantiated, Federal and state deficiencies related to the allegations are cited at W102, W104, W122, W149 and W157.</p> <p>Dates of Survey: 6/30, 7/1, 7/2 and 7/15/14.</p> <p>Facility number: 001065 Provider number: 15G551 AIM number: 100239840</p> <p>Surveyor: Paula Eastmond, QIDP-TC</p> <p>These federal deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 7/22/14 by Ruth Shackelford, QIDP.</p>	W000000		
W000102	<p>483.410 GOVERNING BODY AND MANAGEMENT The facility must ensure that specific governing body and management requirements are met. Based on interview and record review, the facility failed to meet the Condition of Participation: Governing Body for 1</p>	W000102	<p>CORRECTION: <i>The facility must ensure that specific governing body and management requirements are</i></p>	08/10/2014

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

TITLE

(X6) DATE

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

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	<p>additional client (E). The governing body failed to ensure the facility implemented its written policy and procedures to prevent neglect of client E. The governing body failed to ensure the facility took corrective measures in regard to retraining all staff on assisting clients with adaptive equipment to prevent injuries while loading/unloading the van.</p> <p>Findings include:</p> <ol style="list-style-type: none"> The governing body failed to ensure the facility met the Condition of Participation: Client Protections for 1 additional client E. The governing body failed to ensure the facility implemented its written policy and procedures to prevent neglect of the client in regard to a fall which resulted in both of client E's legs being fractured. The governing body failed to ensure the facility retrained staff in loading/unloading the van to prevent injuries to clients. Please see W122. The governing body failed to ensure the facility implemented its written policy and procedures to prevent neglect of client E as the facility failed to ensure facility staff did not cause significant injuries to a client who had a history of fractures. The governing body failed to ensure the facility took appropriate 		<p><i>met.</i> Specifically, the governing body has provided direction and oversight to assure that:</p> <p>Administrative staff have retrained all facility employees on safe loading and unloading techniques including but not limited to safe boarding procedures, appropriate use of wheelchair tie downs, securing with lap and shoulder harnesses and use of wheelchair seatbelts.</p> <p>PREVENTION: Supervisory staff will be expected to observe loading and unloading of the facility van no less than twice weekly, at the facility and day service providers, providing hands on training and coaching as needed. Members of the Operations Team will monitor documentation to assure front line supervision occurs as directed. Additionally members of the Operations Team will observe facility staff preparing for transport and unloading the facility van no less than weekly for 60 days and as needed but no less than monthly thereafter. Formal classroom-style and competency-based transport training will occur as needed but no less than annually.</p> <p>RESPONSIBLE PARTIES: QIDP, Residential Manager, Direct Support Staff, Operations Team</p>	

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W000104	<p>corrective actions in regard to retraining staff to assist client E to safely load and/or unload a van. Please see W104.</p> <p>This federal tag relates to complaint #IN00151337.</p> <p>9-3-1(a)</p> <p>483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility. Based on interview and record review for 1 additional client (E), the governing body failed to exercise general policy and operating direction over the facility to ensure the facility did not neglect the client in regard to a fall which resulted in significant injury of the client. The governing body failed to exercise general policy and operating direction over the facility to ensure the facility took corrective measures to retrain staff on assisting clients with adaptive equipment to prevent injuries while loading/unloading the van.</p> <p>Findings include:</p> <p>1. The governing body failed to exercise general policy and operating direction over the facility to ensure the facility</p>	W000104	<p>CORRECTION: <i>The Governing body must exercise general policy, budget and operating direction over the facility. Specifically, the governing body has provided direction and oversight to assure that:</i></p> <p>Administrative staff have retrained all facility employees on safe loading and unloading techniques including but not limited to safe boarding procedures, appropriate use of wheelchair tie downs, securing with lap and shoulder harnesses and use of wheelchair seatbelts.</p> <p>PREVENTION: Supervisory staff will be expected to observe loading and unloading of the facility van no less than twice weekly, at the facility and day service providers, providing hands on training and coaching</p>	08/10/2014

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W000122	<p>implemented its written policy and procedures to prevent neglect of client E as the facility failed to ensure facility staff did not cause significant injuries to a client who had a history of fractures. Please see W149.</p> <p>2. The governing body failed to exercise general policy and operating direction over the facility to ensure the facility took appropriate corrective action in regard to retraining staff to assist client E to safely load and/or unload a van. Please see W157.</p> <p>This federal tag relates to complaint #IN00151337.</p> <p>9-3-1(a)</p> <p>483.420 CLIENT PROTECTIONS The facility must ensure that specific client protections requirements are met. Based on interview and record review, the facility failed to meet the Condition of Participation: Client Protections for 1 additional client (E). The facility failed to implement its policy and procedures to prevent neglect of client E in regard to the client falling out of his wheelchair which resulted in a significant injury. The facility failed to take corrective action in regard to retraining all staff on</p>	W000122	<p>as needed. Members of the Operations Team will monitor documentation to assure front line supervision occurs as directed. Additionally members of the Operations Team will observe facility staff preparing for transport and unloading the facility van no less than weekly for 60 days and as needed but no less than monthly thereafter. Formal classroom-style and competency-based transport training will occur as needed but no less than annually.</p> <p>RESPONSIBLE PARTIES: QIDP, Residential Manager, Direct Support Staff, Operations Team</p> <p>CORRECTION: <i>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client.</i> Specifically, Administrative staff have retrained all facility employees on safe loading and unloading techniques including but not limited to safe boarding procedures, appropriate use of wheelchair tie downs, securing with lap and shoulder harnesses and use</p>	08/10/2014

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W000149	<p>assisting clients with adaptive equipment to prevent injuries while loading/unloading the van.</p> <p>Findings include:</p> <ol style="list-style-type: none"> The facility failed to implement its written policy and procedures to prevent neglect of client E as the facility failed to ensure facility staff did not cause significant injuries to a client who had a history of fractures. Please see W149. The facility failed to take appropriate corrective action in regard to retraining staff to assist client E to safely load and/or unload a van. Please see W157. <p>This federal tag relates to complaint #IN00151337.</p> <p>9-3-2(a)</p> <p>483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. Based on interview and record review for 1 additional client (E), the facility neglected to implement its written policy and procedures to prevent neglect of the client. The facility neglected to ensure facility staff did not cause significant</p>	W000149	<p>of wheelchair seatbelts.</p> <p>PREVENTION: Supervisory staff will be expected to observe loading and unloading of the facility van no less than twice weekly, at the facility and day service providers, providing hands on training and coaching as needed. Members of the Operations Team will monitor documentation to assure front line supervision occurs as directed. Additionally members of the Operations Team will observe facility staff preparing for transport and unloading the facility van no less than weekly for 60 days and as needed but no less than monthly thereafter. Formal classroom-style and competency-based transport training will occur as needed but no less than annually.</p> <p>RESPONSIBLE PARTIES: QIDP, Residential Manager, Direct Support Staff, Operations Team</p> <p>CORRECTION: <i>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. Specifically, Administrative staff have retrained all</i></p>	08/10/2014

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	<p>injuries to a client who had a history of fractures.</p> <p>Findings include:</p> <p>The facility's reportable incident reports and/or investigations were reviewed on 7/1/14 at 1:00 PM. The facility's 5/5/14 reportable incident report indicated "Staff [staff #2] was assisting [client E] (individual supported by ResCare) with leaving Day Service, pushing his wheelchair forward off the sidewalk over the curb. [Client E] fell forward and landed on his knees. Staff transported [client E] to the [name of medical clinic] for evaluation. The [name of clinic] physician referred the client to [name of hospital] Emergency Department for additional evaluation and treatment. X-rays revealed a closed cordyle (sic) fracture of the left femur (lower end of thigh bone close to the knee) and [client E] was admitted to the hospital for orthopedic treatment. [Client E] is diagnosed with osteoporosis and has a history of fractures. He has high risk plans in place for fractures, falls and limited mobility. The incident is under investigation and staff [staff #2] has been suspended pending the results. ResCare nursing staff will remain in communication with hospital personnel to assure continuity of care."</p>		<p>facility employees on safe loading and unloading techniques including but not limited to safe boarding procedures, appropriate use of wheelchair tie downs, securing with lap and shoulder harnesses and use of wheelchair seatbelts.</p> <p>PREVENTION: Supervisory staff will be expected to observe loading and unloading of the facility van no less than twice weekly, at the facility and day service providers, providing hands on training and coaching as needed. Members of the Operations Team will monitor documentation to assure front line supervision occurs as directed. Additionally members of the Operations Team will observe facility staff preparing for transport and unloading the facility van no less than weekly for 60 days and as needed but no less than monthly thereafter. Formal classroom-style and competency-based transport training will occur as needed but no less than annually.</p> <p>RESPONSIBLE PARTIES: QIDP, Residential Manager, Direct Support Staff, Operations Team</p>	

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	<p>The facility's attached 5/5/14 Fall Assessment indicated client E had a broken knee from the 5/5/14 incident. The fall assessment indicated the client fell to both knees when staff was wheeling the client to load the van. The fall assessment indicated a section entitled "HOW COULD THIS BE PREVENTED IN THE FUTURE?" The fall assessment section indicated "teach people how to bring down consumers from curves."</p> <p>The facility's 5/5/14 through 5/9/14 Investigative Summary indicated staff #2 refused to allow the facility to interview her. The facility's investigation indicated staff #2 documented in the facility's internal incident report "[Client E] was leaving the day program. When I (staff #2) was taking [client E] to the van, he fell on his knee from the curb, on the street. On the right knee is scraped up but the left knee he says hurts the most. I was told to take him to [name of clinic], to [name of hospital] to the ER (emergency room) for 2 X-Rays on his knees." The facility's 5/5/14 through 5/9/14 investigation indicated "...Summary of Interviews:</p> <p>[Direct Support Staff #1] (DSS) Christiana staff arrived to pick them up</p>			

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	<p>and I (DSS #1) walked [client E] (in his wheelchair) to the bottom of the ramp and Christiana staff took over. Christiana staff pushed [client E] forward off the sidewalk and he fell out of the wheelchair forward into the street.</p> <p>[Qualified Intellectual Disabilities Professional (QIDP) #2] Staff from a lot of houses pick people up in wheelchairs in front of the main door where there is a curb instead of the accessible sidewalk. We tell them not to all the time but they don't listen to us. I know I have told [staff #2] not to park there. I didn't document the training.</p> <p>[Clinical Supervisor #3] Staff pick people up in wheelchairs in front of the main door where there is a curb instead of the accessible sidewalk every day. I'm not certain if I have told [staff #2] specifically not to park there but we tell them not to almost every day...."</p> <p>The facility's 5/5/14 through 5/9/14 investigation indicated "...Conclusion: 1. The evidence substantiates that the actions of [staff #2] (DSS/alleged perpetrator) resulted in [client E] (individual supported by ResCare/alleged victim) sustaining a closed cordyle (sic) fracture of the left femur. Specifically,</p>			

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	<p>by her own admission, [staff #2] pushed [client E] over a curb instead of using the available wheelchair ramp. 2. The evidence substantiates that the actions of [staff #2] (DSS/alleged perpetrator) constitute neglect. 3. The evidence does not substantiate that ResCare-Indianapolis ICF (Intermediate Care Facility) supervisory staff fail (sic) to provide [staff #2] (DSS/alleged perpetrator) with Consumer Specific Training for [client E]. Specifically [staff #2's] CST (Client Specific Training) for [client E] is on file at the ResCare-Indianapolis ICF Core Office."</p> <p>The facility's 5/9/14 Indianapolis ICF Investigation Peer Review form indicated the following recommendations:</p> <p>"1. Term (terminate) DSS [staff #2] for Neglect Resulting in Serious Injury 7.1 A1. 2. Facility environmental adaptation-accessible curb, or other change to prevent future falls. 3. Review adaptive equipment at all service sites to assure equipment is specific to individuals & (and) fits appropriately & is in good working order." The facility's 5/9/14 peer review of the incident neglected to indicate any corrective action in regard to staff training/re-training of group home staff and/or day service staff in regard to</p>			

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	<p>loading and/or unloading clients safely to prevent falls/injuries.</p> <p>Client E's hospital records were reviewed on 7/2/14 at 10:11 AM. Client E's 5/5/14 ED (Emergency Department) notes indicated "[Client E] is a 67 y.o. (year old) male who presents to the ED with BLE (bilateral lower extremity) pain s/p (status post) fall today. The pt's (patient's) caregiver stst (states) that the pt fell from his wheelchair while getting into the van today. The pt is non-ambulatory. Hx (history) of bilateral fx (fracture) of legs. Pt sent from [name of medical clinic]. Denies SOB (shortness of breath), activity change, weakness, LOC (level of Consciousness), HPI (History of Present Illness) limited d/t (due to) the condition of the pt...." The ED note indicated client E had "...Edema on both knees anteriorly..."</p> <p>Client E's X-ray of the right knee indicated "...Within the left femur, there is no evidence of acute fracture or dislocation. Within the left knee, there is a large knee joint effusion (presence of increased fluid). There is diffuse osteopenia. No definite acute fractures identified. Remote medial femoral condyle (round prominence end of a bone) irregularity is present. Tibia rod is present with screw. IMPRESSION: 1.</p>			

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	<p>Diffuse osteopenia with a large left knee joint effusion. No definite acute fractures identified however if there is continued concern, CT (cat scan) can be performed...."</p> <p>Client E's 5/5/14 X-ray report of the client's right knee indicated "...There is diffuse osteopenia...Within the right knee, there is a fat fluid present. Osseous (bone) structures identified anterior to the distal right femur which may relate to a displaced fracture fragment, potentially from the lateral femoral condyle." The X-ray indicated "...Further evaluation with CT is suggested...."</p> <p>Client E's 5/5/14 CT of his right knee indicated a CT scan was performed due to "Possible fracture." The CT scan indicated "...Impression: 1. fracture fragment of the posterior aspect of the lateral femoral condyle. This appears to be subacute or chronic with bony bridging along a portion of the fracture site. 2. Inferiorly displaced patella (knee cap). This would suggest a ruptured distal quadriceps tendon. There is a 1.7 cm (centimeter) bone fragment adjacent to the retracted tendon. This is not definitely acute. 3. Lipohearthrosis (fat and blood in the joint cavity following trauma). This is usually indicative of an acute fracture. I cannot</p>			

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	<p>definitely identify an acute fracture line. MRI may be of further benefit if warranted to assess for bone marrow edema. I suppose there could be an acute component to the healing fracture along the lateral femoral condyle posteriorly."</p> <p>Client E's 5/5/14 CT of his left knee indicated client E had a "...Transverse impacted fracture of the distal femoral shaft. There is inward impaction by 1.5 cm posteriorly." The report indicated "...There is a cortical step-off seen medially measuring about 3 mm (millimeters). The step-off laterally measures 5 mm. The fractures are more apparent posteriorly where there is step-off and impaction. The step-off measures 4 mm. The femoral shaft is impacted inward by 1.5 cm." The left cat scan report indicated a rod could be seen within client E's Tibia and "...An old healed fracture is noted throughout the tibial shaft. No patellar fracture is identified...."</p> <p>Client E's 5/5/14 Consultation note indicated the ED doctor spoke with an orthopedic doctor. The consultation note indicated "...Reevaluated pt and discussed results of the CT scans. The pt's caregiver was informed that the pt has bilateral femur fractures and will be admitted to the hospital. She expresses</p>			

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	<p>understanding. Clinical Impression: 1. Femoral condyle fracture, unspecified laterality, closed, initial encounter (right leg). 2. Fracture closed, femur, shaft, left, initial encounter. 3. Effusion of both knee joints...."</p> <p>Client E's 5/7/14 Discharge Summary indicated client E was transferred to a nursing home for continued treatment, rehabilitation and care.</p> <p>Client E's record was reviewed on 7/1/14 at 1:45 PM. Client E's 5/14 physician's orders indicated client E's diagnoses included, but were not limited to, Right Femoral Shaft Fracture, Left Lower leg Fractures, Osteoporosis, Demineralization of leg bones and History of Right Clavicle Fracture.</p> <p>Client E's 10/10/13 Individual Support Plan (ISP) indicated client E's diagnosis included, but was not limited to, "Orthopedic impairment." The 10/10/13 ISP indicated "...3). Due to fracture of his right leg several years ago, the doctor has reported that [client E] will always be confined to a wheelchair...." Client E's ISP indicated "...[Client E] has also resided in various nursing homes while recuperating from fractured bones. [Client E] was formally discharged from his current group home early in 1998</p>			

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	<p>after breaking his leg. He required extended rehabilitation in a nursing home...."</p> <p>Client E's High Risk Health Plans indicated client E had risk plans for history of fractures and decreased mobility. Client E's 5/12/14 risk plan for fractures indicated "...5. Staff to provide hands-on assistance when entering and exiting the van lift...."</p> <p>Client E's 6/6/14 Nurse Medical Note indicated "6/6/14 on 6/5/14 I (nurse staff #1) went to visit and receive training on transferring [client E] at [name of nursing home]; he still has not fully healed (sic) he has casts on both legs and at this time the staff at the home through ResCare does not have adequate training to care for [client E]; it would be a safety risk for transferring him to and from his wheelchair. -the (sic) house is not accessible for a hoyer lift. -the (sic) sliding board would not be as level d/t the PT room. (Set up for falls/injuries). - [Client E] has hx (history) of fx due to lifting under arms, brittle bones, -weak (sic) bones -bilateral (sic) fx still healing. -[Client E] is limited to help transfer."</p>			

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	<p>Interview with Clinical Supervisor (CS) #1, #2 and the QIDP on 7/1/14 at 3:00 PM indicated client E fell out of his wheelchair at the day program. CS #1 indicated client E fell out of his wheelchair while being transported to the group home's van. CS #1 stated facility staff was "pushing (client E) forward in wheelchair" off a curb. CS #1 indicated client E did not have a seat belt on for safety. CS #1 stated "He was not supposed to have one over old fracture (injury)." CS #1 indicated client E was sent out to the hospital after the client fell out of his wheelchair. The QIDP, CS #1 and #2 indicated client E was admitted to the hospital and did not return to the group home. The QIDP, CS #1 and #2 indicated client E was admitted to a nursing home for treatment. The QIDP, CS #1 and #2 indicated client E was to return to the group home once he was discharged from the nursing home. CS #1 stated "He (client E) was not ready when nursing home wanted to discharge." When asked if facility staff were retrained in regard to loading and exiting clients from the van, CS #1 stated "No training. No other clients in wheelchair at group home." CS #1 indicated the curb at the day program had been redone.</p> <p>Interview the QIDP on 7/2/14 at 11:15 AM indicated she was at the hospital</p>			

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	<p>with client E. The QIDP indicated she was aware client E had both legs fractured.</p> <p>Interview with CS #2 on 7/2/14 at 3:15 PM indicated the facility conducted an investigation in regard to the incident. CS #2 indicated the facility's investigation found staff #2 caused the client to fall out of the wheelchair and be injured. CS #2 stated the staff was "pushing [client E's] wheelchair over a curb and the client fell forward into the street." CS #2 indicated he learned through the investigation ResCare staff was aware facility staff was assisting the clients over the curb versus using the wheelchair ramp. CS #1 stated the facility determined client E's injuries were a result of "Neglect."</p> <p>The facility's policy and procedures were reviewed on 7/1/14 at 1:25 PM. The facility's 9/14/07 Abuse, Neglect, Exploitation policy indicated "ResCare staff actively advocate for the rights and safety of all individuals..." The policy defined physical neglect as "failure to provide goods and/or services necessary for the individual to avoid physical harm...Failure to meet the basic need requirements such as food, shelter, clothing and to provide a safe environment..."</p>			

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W000157	<p>This federal tag relates to complaint #IN00151337.</p> <p>9-3-2(a)</p> <p>483.420(d)(4) STAFF TREATMENT OF CLIENTS If the alleged violation is verified, appropriate corrective action must be taken. Based on interview and record review of 1 of 2 allegations of neglect and/or injuries of unknown origin reviewed, the facility failed to take appropriate corrective action in regard to retraining staff to assist client E to safely load and/or unload a van.</p> <p>Findings include:</p> <p>The facility's reportable incident reports and/or investigations were reviewed on 7/1/14 at 1:00 PM. The facility's 5/5/14 reportable incident report indicated "Staff [staff #2] was assisting [client E] (individual supported by ResCare) with leaving Day Service, pushing his wheelchair forward off the sidewalk over the curb. [Client E] fell forward and landed on his knees. Staff transported [client E] to the [name of medical clinic] for evaluation. The [name of clinic] physician referred the client to [name of</p>	W000157	<p>CORRECTION: <i>If the alleged violation is verified, appropriate corrective action must be taken. Specifically, Administrative staff have retrained all facility employees on safe loading and unloading techniques including but not limited to safe boarding procedures, appropriate use of wheelchair tie downs, securing with lap and shoulder harnesses and use of wheelchair seatbelts.</i></p> <p>PREVENTION: Supervisory staff will be expected to observe loading and unloading of the facility van no less than twice weekly, at the facility and day service providers, providing hands on training and coaching as needed. Members of the Operations Team will monitor documentation to assure front line supervision occurs as directed. Additionally members of the Operations Team will observe facility staff preparing for transport and unloading the facility van no less than weekly for 60 days and as needed but no</p>	08/10/2014

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	<p>hospital] Emergency Department for additional evaluation and treatment. X-rays revealed a closed cordyle (sic) fracture of the left femur (lower end of thigh bone close to the knee) and [client E] was admitted to the hospital for orthopedic treatment. [Client E] is diagnosed with osteoporosis and has a history of fractures. He has high risk plans in place for fractures, falls and limited mobility. The incident is under investigation and staff [staff #2] has been suspended pending the results...."</p> <p>The facility's attached 5/5/14 Fall Assessment indicated client E had a broken knee from the 5/5/14 incident. The fall assessment indicated the client fell to both knees when staff was wheeling the client to load the van. The fall assessment indicated a section entitled "HOW COULD THIS BE PREVENTED IN THE FUTURE?" The fall assessment section indicated "teach people how to bring down consumers from curves."</p> <p>The facility's 5/5/14 through 5/9/14 Investigative Summary indicated staff #2 refused to allow the facility to interview her. The facility's investigation indicated staff #2 documented in the facility's internal incident report "[Client E] was leaving the day program. When I (staff</p>		<p>less than monthly thereafter. Formal classroom-style and competency-based transport training will occur as needed but no less than annually.</p> <p>RESPONSIBLE PARTIES: QIDP, Residential Manager, Direct Support Staff, Operations Team</p>	

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	<p>#2) was taking [client E] to the van, he fell on his knee from the curb, on the street. On the right knee is scraped up but the left knee he says hurts the most. I was told to take him to [name of clinic], to [name of hospital] to the ER (emergency room) for 2 X-Rays on his knees." The facility's 5/5/14 through 5/9/14 investigation indicated "...Summary of Interviews:</p> <p>[Direct Support Staff #1] (DSS) Christiana staff arrived to pick them up and I (DSS #1) walked [client E] (in his wheelchair) to the bottom of the ramp and Christiana staff took over. Christiana staff pushed [client E] forward off the sidewalk and he fell out of the wheelchair forward into the street.</p> <p>[Qualified Intellectual Disabilities Professional (QIDP) #2] Staff from a lot of houses pick people up in wheelchairs in front of the main door where there is a curb instead of the accessible sidewalk. We tell them not to all the time but they don't listen to us. I know I have told [staff #2] not to park there. I didn't document the training.</p> <p>[Clinical Supervisor #3] Staff pick people up in wheelchairs in front of the main door where there is a curb instead of the accessible sidewalk</p>			

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	<p>every day. I'm not certain if I have told [staff #2] specifically not to park there but we tell them not to almost every day...."</p> <p>The facility's 5/5/14 through 5/9/14 investigation indicated "...Conclusion: 1. The evidence substantiates that the actions of [staff #2] (DSS/alleged perpetrator) resulted in [client E] (individual supported by ResCare/alleged victim) sustaining a closed cordyle (sic) fracture of the left femur. Specifically, by her won admission, [staff #2] pushed [client E] over a curb instead of using the available wheelchair ramp. 2. The evidence substantiates that the actions of [staff #2] (DSS/alleged perpetrator) constitute neglect. 3. The evidence does not substantiate that ResCare-Indianapolis ICF (Intermediate Care Facility) supervisory staff fail (sic) to provide [staff #2] (DSS/alleged perpetrator) with Consumer Specific Training for [client E]. Specifically [staff #2's] CST (Client Specific Training) for [client E] is on file at the ResCare-Indianapolis ICF Core Office."</p> <p>The facility's 5/9/14 Indianapolis ICF Investigation Peer Review form indicated the following recommendations:</p> <p>"1. Term (terminate) DSS [staff #2] for</p>			

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	<p>Neglect Resulting in Serious Injury 7.1 A1. 2. Facility environmental adaptation-accessible curb, or other change to prevent future falls. 3. Review adaptive equipment at all service sites to assure equipment is specific to individuals & (and) fits appropriately & is in good working order." The facility's 5/9/14 peer review of the incident failed to indicate any corrective action in regard to staff training/re-training of group home staff and/or day service staff in regard to loading and/or unloading client E safely to prevent falls/injuries.</p> <p>Interview with Clinical Supervisor (CS) #1, #2 and the QIDP on 7/1/14 at 3:00 PM indicated client E fell out of his wheelchair at the day program. CS #1 indicated client E fell out of his wheelchair while being transported to the group home's van. CS #1 stated facility staff was "pushing (client E) forward in wheelchair" off a curb. When asked if facility staff were retrained in regard to loading and exiting clients from the van, CS #1 stated "No training. No other clients in wheelchair at group home." CS #1 indicated the curb at the day program had been redone.</p> <p>Interview with CS #2 on 7/2/14 at 3:15 PM indicated the facility conducted an investigation in regard to the incident.</p>			

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	<p>CS #2 indicated the facility's investigation found staff #2 caused the client to fall out of the wheelchair and be injured. CS #2 stated the staff was "pushing [client E's] wheelchair over a curb and the client fell forward into the street." CS #2 indicated he learned through the investigation ResCare staff was aware facility staff was assisting the client's over the curb versus using the wheelchair ramp.</p> <p>This federal tag relates to complaint #IN00151337.</p> <p>9-3-2(a)</p>						