STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G024	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 04/09/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ADEC INC	807 MOTTVILLE RD BRISTOL, IN 46507

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W0000	This visit was for a full annual recertification and state licensure survey. Dates of Survey: March 2, 3, 4 and 9, 2012. Surveyor: Kathy Wanner, Medical Surveyor III. Facility number: 000590 Provider number: 15G024 AIM number: 100248560 These federal deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 4/16/12 by Ruth Shackelford, Medical Surveyor III.	W0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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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W0122	483.420 CLIENT PROTECTIONS The facility must ensure that specific client protections requirements are met. Based on record review and interview, the Condition of Participation: Client Protections, was not met as the facility neglected to protect 1 of 4 sampled clients (client #1) who had a known high risk of falling to protect client #1 from continuing to fall and injuring herself. Findings include: 1. Please see W149: The facility neglected to implement their policy to protect 1 of 4 sampled clients (client #1) who had a known high risk of falls from falling and suffering subsequent head trauma. 2. Please see W157: The facility failed to take sufficient corrective action to protect 1 of 4 sampled clients (client #1) who had a known high risk of falls from repeatedly falling and suffering subsequent head trauma. 9-3-2(a)	W0122	Please note corrections for W149 and W157 for corrective action.	04/25/2012

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W0149	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 record review and interview, the facility neglected to implement their policy to protect 1 of 4 sampled clients (client #1) who had a known high risk of falls from falling and suffering subsequent head trauma. Findings include: The facility records were reviewed on 4/3/12 at 3:25 P.M. including the Bureau of Developmental Disabilities Services (BDDS) reports and the Accident/Illness (A & I) Reports. The reports indicated the following: An A & I report dated 7/11/11 indicated while at the day program client #1 "went to sit and missed chair." The report indicated client #1 had a 1/2" (one-half inch) abrasion on her right elbow and a bruise under her right arm (size of bruise illegible). An A & I report dated 7/13/11 at 6:00 P.M. indicated client #1 "tripped with her walker and fell on her left leg." The report indicated "No bruises on her leg yet." An A & I report dated 8/11/11 at 5:45 P.M. indicated client #1 "fell with her walker in kitchen; [client #1] fell on her buttocks." The report indicated there were no injuries. An A & I report dated 8/21/11 at 5:15 P.M. indicated client #1 was "sitting down and the chair	W0149	The following interventions along with several psychiatric reviews had been implemented to help client #1.: Physical Therapy evaluation – 1/19/2010 Physical Therapy and Occupational Therapy Evaluation – 6/15/2010 Per PT evaluation recommendation, walker wheels were tried in a "fixed" position. Had a numebr of falls, wheels went back to "swivel" position – 6/28/2010 Stand By Assist for fire drills – 7/6/2010 Gait Belt as needed – 7/18/2011 PT ordered by PCP – 9/7/2011 Traumatic brain injury - 9/14/2011 CT scan – 9/14/2011 Side rails on bed – 9/19/2011 Chair alarm – 9/19/2011 Neurological appointment with Dr. Wu – 9/27/2011 Physical Therapy Evaluation – 9/29/2011 CT scan – 9/29/2011 Physical therapy at EGH (uncooperative) Discharged with home exercises – 9/29/2011 Discontinue use of walker – use wheelchair – 9/29/2011 EEG – 10/4/2011 Physical Therapy at EGH – 10/4/2011 Physical Therapy at EGH	04/25/2012

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	slid out from under her, she fell on her butt (buttocks) but there were no marks as of now. Bruising may develop." An A & I report dated 8/28/11 at 11:30 A.M. indicated client #1 "tripped over chair and fell on her buttocks." The report indicated there were no injuries at the time. A BDDS report dated 9/15/11 for an incident on 9/14/11 at 12:30 A.M. (SIC) indicated "[Client #1] fell at day program yesterday afternoon. She was taken to the [name] Emergency Room (ER) to be checked out. She underwent a CT scan and lab work while in the ER. The CT scan showed a spot of concern. She was admitted for overnight observations. Her lab work came back normal." A follow-up BDDS report dated 9/22/11 for the incident on 9/14/11 indicated "...A CT scan and MRI showed an area of bleeding on her brain. The tests were administered a day later and showed the area had stopped bleeding. She was discharged (from hospital) on 9/17/11 with a new diagnosis of Traumatic Brain Injury (TBI). [Client #1] does have a fall risk plan, that was being followed correctly at the time. She was standing up using her walker when she lost her balance and fell. [Client #1] is now in a wheelchair with a wheel chair alarm so staff can help her if she tries to get out of the wheelchair. She also has bed rails on her bed to prevent further falls." A follow-up BDDS report dated 9/29/11 for the incident on 9/14/11 indicated "...a follow-up CT scan to be completed today, and results sent to her physician. ...did go to Physical Therapy (PT) and her walker was discontinued due to her unstabliness (sic). She will continue to do home exercises for strength and will attend physical therapy ...for the next four weeks. Her alarm and		(uncooperative and aggressive) Discharged with home exercises – 10/13/2011 Bed alarm – 11/8/2011 Alarm chart put into place - 11/29/2011 CT scan completed due to fall (ER visit), with no findings – 12/6/2011 Pelvic Positioner – 12/13/2011 Anti Tippers for front and back – 12/30/2011 In addition, items have been either removed from her room or bolted to her wall so that they cannot fall on her when she oulls on them. She has had no further injuries. Staff have been trained to stay with the resident when she chooses to be out of her chair and on the floor. Resident has a recent dx of dimentia. Client #1 has a safety plan in place and all staff have been trained failure to comply will result in disciplinary action PERSON RESPONSIBLE QDDP	

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	bed rails have been added to her fall risk plan." A BDDS report dated 12/6/11 for an incident on 12/6/11 at 10:00 A.M. indicated client #1 was in her bedroom attempting to get out of her wheelchair. Staff heard the alarm. Client #1 did not wait for staff and tried to catch herself by reaching for her TV. The TV fell on top of her as she fell. She received a cut to her forehead. She was transported to the ER by ambulance. Hospital Discharge instructions for client #1 dated 12/06/2011 were reviewed on 4/4/12 at 1:32 P.M. and indicated " Arrange for a follow-up appointment with your Primary Care Provider (PCP) in 7 (seven) days for suture removal...You have had a head injury which does not appear serious at this time. A concussion is a state of changed mental ability, usually from a blow to the head...After injuries such as yours, most problems occur within the first 24 hours....A bruise on the brain (concussion) requires a few days for recovery." An A & I report dated 1/15/12 at 8:50 P.M. indicated "Staff were assisting [client #1] with getting into bed. [Client #1] rocked her self to get situated and when she did she bumped the right side of her forehead onto the side railing of her bed. 3 cm (three centimeter) bump on the right side of her forehead and broise (sic) on cheek." Client #1's record was reviewed on 4/4/12 at 1:32 P.M.. Client #1's record indicated her diagnoses included but were not limited to Moderate Mental Retardation, Encephalopathy (inflammation of the brain), Ataxia (muscle incoordination), TBI, Bi-Polar Depression, Osteopenia (decreased calcification or density of bone), Impulse Control Disorder (ICD), HX of Pituitary Tumor, resolved, and Borderline Personality Disorder. Client #1's			

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	Fall Risk Plan dated 9/2011, 12/1/2011, and 3/2012 indicated client #1 was to use a wheelchair at all times. Staff are to be with her anytime she is out of the wheelchair. Client #1 was to not use her walker. Client #1 had a pelvic positioner, bed alarm and wheelchair alarm, and bed rails to help prevent falls. Staff are to provide assistance with transfers. Staff are to prompt to "not hurry take her time" when client #1 ambulates in her wheelchair. Client #1 was to use a shower chair and staff are to remain with her when she is in the restroom. Client #1's record indicated a fall risk assessment was completed each quarter, and client #1 was a "high risk" for falls. The fall Risk Plan did not indicate the date the handwritten interventions to the typed plan were added. Client #1's Health Care Support Plan dated 6/2011, 9/2011, 12/2011 and 3/2012 indicated client #1 was " 2. At risk for falls due to history of falls, a. Ensure client is using walker properly" was crossed out and "Wheelchair full time with alarm side rails on bed" was hand written in. b. "keep environment clear of clutter. c. Wheelchair to be used during periods of unsteady gait" was crossed out. d. "PT evaluation completed." The word completed was crossed out and "being done" was hand written in and crossed out and the word "completed" was handwritten in. "Bed alarm for safety. Pelvic positioner for safety" were hand written in. The hand written entries were undated. A PT/Neurological Evaluation dated 9/14/2011 indicated "Pt. (patient) had a fall on 9/14/11 hitting her head and suffered a cerebral bleed...prior to this fall patient was using a w.w. (walker) for ambulation but were given reports pt. was falling frequently. Now in w/c (wheelchair) only...frequent loss of balance and falling when walking." Recommendations "transfer toward w/c with supervision...recommend pt. not attempt walking with her walker due to her history of frequent falls and recent head injury." A psychiatric progress note dated 12/7/11 indicated			

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	"Pt. had a fall recently and head injury and since then has been experiencing visual hallucinations. She is extremely difficult to deal with to begin with...but with head injury it is getting even more difficult." A PT evaluation dated 4/2010 indicated "using walker, use wheelchair for long distances." Client #1's record indicated she had a PRN (as needed) order for staff to use a gait belt to assist her with ambulating. Documentation regarding the frequency of client #1's falls prior to 7/11/11 was not available for review. The facility's records were reviewed on 4/3/12 at 2:35 PM. A review of the facility's, "Incident Reporting Policy," dated 08/29/07, indicated, "It is the policy of ADEC to: Ensure the health and safety of all its clients. Regard a reportable incident as any event or occurrence characterized by risk or uncertainty, resulting in or having the potential to result in significant harm or injury to an individual or death of an individual. Not tolerate abuse, neglect or exploitation of clients by staff members, clients or persons in the community. Maintain, train its staff, and implement all current state agency/authority incident reporting requirements. Protect the confidentiality of all persons involved in an investigation...." The Director of Residential Operations (DRO) was interviewed on 4/5/12 at 11:45 A.M.. When asked about client #1's falls and what had been done to help protect her, the DRO stated client #1 has "always been a high fall risk, and is very independent." The staff were following the recommendations of her physicians and her PT. The DRO indicated client #1 had continued to fall and injure herself. The DRO stated the entries in client #1's risk plan and health care plan "should have been dated."			

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	9-3-2(a)			

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W0157	483.420(d)(4) STAFF TREATMENT OF CLIENTS If the alleged violation is verified, appropriate corrective action must be taken. Based on record review and interview, the facility failed to take sufficient corrective action to protect 1 of 4 sampled clients (client #1) who had a known high risk of falls from repeatedly falling and suffering subsequent head trauma. Findings include: The facility records were reviewed on 4/3/12 at 3:25 P.M. including the Bureau of Developmental Disabilities Services (BDDS) reports and the Accident/Illness (A & I) Reports. The reports indicated the following: An A & I report dated 7/11/11 indicated while at the day program client #1 "went to sit and missed chair." The report indicated client #1 had a 1/2" (one-half inch) abrasion on her right elbow and a bruise under her right arm (size of bruise illegible). An A & I report dated 7/13/11 at 6:00 P.M. indicated client #1 "tripped with her walker and fell on her left leg." The report indicated "No bruises on her leg yet." An A & I report dated 8/11/11 at 5:45	W0157	The following interventions along with several psychiatric reviews had been implemented to help client #1.:Physical Therapy evaluation – 1/19/2010Physical Therapy and Occupational Therapy Evaluation – 6/15/2010Per PT evaluation recommendation, walker wheels were tried in a “fixed” position. Had a numebr of falls, wheels went back to “swivel” position – 6/28/2010Stand By Assist for fire drills – 7/6/2010Gait Belt as needed – 7/18/2011PT ordered by PCP – 9/7/2011Traumatic brain injury - 9/14/2011CT scan – 9/14/2011Side rails on bed – 9/19/2011Chair alarm – 9/19/2011Neurological appointment with Dr. Wu – 9/27/2011Physical Therapy Evaluation – 9/29/2011CT scan – 9/29/2011Physical therapy at EGH (uncooperative) Discharged with home exercises – 9/29/2011Discontinue use of walker – use wheelchair – 9/29/2011EEG – 10/4/2011Physical Therapy at EGH – 10/4/2011Physical Therapy at EGH (uncooperative and aggressive) Discharged with home exercises – 10/13/2011Bed alarm – 11/8/2011Alarm chart put into place - 11/29/2011CT scan completed due to fall (ER visit), with no findings – 12/6/2011Pelvic	04/25/2012

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	P.M. indicated client #1 "fell with her walker in kitchen; [client #1] fell on her buttocks." The report indicated there were no injuries. An A & I report dated 8/21/11 at 5:15 P.M. indicated client #1 was "sitting down and the chair slid out from under her, she fell on her butt (buttocks) but there were no marks as of now. Bruising may develop." An A & I report dated 8/28/11 at 11:30 A.M. indicated client #1 "tripped over chair and fell on her buttocks." The report indicated there were no injuries at the time. A BDDS report dated 9/15/11 for an incident on 9/14/11 at 12:30 A.M. (SIC) indicated "[Client #1] fell at day program yesterday afternoon. She was taken to the [name] Emergency Room (ER) to be checked out. She underwent a CT scan and lab work while in the ER. The CT scan showed a spot of concern. She was admitted for overnight observations. Her lab work came back normal." A follow-up BDDS report dated 9/22/11 for the incident on 9/14/11 indicated "...A CT scan and MRI showed an area of bleeding on her brain. The tests were administered a day later and showed the		Positioner – 12/13/2011Anti Tippers for front and back – 12/30/2011In addition, items have been either removed from her room or bolted to her wall so that they cannot fall on her when she oulls on them. She has had no further injuries. Staff have been trained to stay with the resident when she chooses to be out of her chair and on the floor. Resident has a recent dx of dimentia.Client #1 has a safety plan in place and all staff have been trainedfailure to comply will result in disciplinary action. Nursing staff have been trained on initialing and dating changes to fall plans.PERSON RESPONSIBLE QDDP LPN	

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	area had stopped bleeding. She was discharged (from hospital) on 9/17/11 with a new diagnosis of Traumatic Brain Injury (TBI). [Client #1] does have a fall risk plan, that was being followed correctly at the time. She was standing up using her walker when she lost her balance and fell. [Client #1] is now in a wheelchair with a wheel chair alarm so staff can help her if she tries to get out of the wheelchair. She also has bed rails on her bed to prevent further falls." A follow-up BDDS report dated 9/29/11 for the incident on 9/14/11 indicated "...a follow-up CT scan to be completed today, and results sent to her physician. ...did go to Physical Therapy (PT) and her walker was discontinued due to her unstabliness (sic). She will continue to do home exercises for strength and will attend physical therapy ...for the next four weeks. Her alarm and bed rails have been added to her fall risk plan." A BDDS report dated 12/6/11 for an incident on 12/6/11 at 10:00 A.M. indicated client #1 was in her bedroom attempting to get out of her wheelchair. Staff heard the alarm. Client #1 did not wait for staff and tried to catch herself by reaching for her TV. The TV fell on top of her as she fell. She received a cut to her forehead. She was transported to the ER			

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	by ambulance. Hospital Discharge instructions for client #1 dated 12/06/2011 were reviewed on 4/4/12 at 1:32 P.M. and indicated " Arrange for a follow-up appointment with your Primary Care Provider (PCP) in 7 (seven) days for suture removal...You have had a head injury which does not appear serious at this time. A concussion is a state of changed mental ability, usually from a blow to the head...After injuries such as yours, most problems occur within the first 24 hours....A bruise on the brain (concussion) requires a few days for recovery." An A & I report dated 1/15/12 at 8:50 P.M. indicated "Staff were assisting [client #1] with getting into bed. [Client #1] rocked her self to get situated and when she did she bumped the right side of her forehead onto the side railing of her bed. 3 cm (three centimeter) bump on the right side of her forehead and broise (sic) on cheek." Client #1's record was reviewed on 4/4/12 at 1:32 P.M.. Client #1's record indicated her diagnoses included but were not limited to Moderate Mental Retardation, Encephalopathy (inflammation of the brain), Ataxia (muscle incoordination), TBI, Bi-Polar Depression, Osteopenia			

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	(decreased calcification or density of bone), Impulse Control Disorder (ICD), HX of Pituitary Tumor, resolved, and Borderline Personality Disorder. Client #1's Fall Risk Plan dated 9/2011, 12/1/2011, and 3/2012 indicated client #1 was to use a wheelchair at all times. Staff are to be with her anytime she is out of the wheelchair. Client #1 was to not use her walker. Client #1 had a pelvic positioner, bed alarm and wheelchair alarm, and bed rails to help prevent falls. Staff are to provide assistance with transfers. Staff are to prompt to "not hurry take her time" when client #1 ambulates in her wheelchair. Client #1 was to use a shower chair and staff are to remain with her when she is in the restroom. Client #1's record indicated a fall risk assessment was completed each quarter, and client #1 was a "high risk" for falls. The fall Risk Plan did not indicate the date the handwritten interventions to the typed plan were added. Client #1's Health Care Support Plan dated 6/2011, 9/2011, 12/2011 and 3/2012 indicated client #1 was " 2. At risk for falls due to history of falls, a. Ensure client is using walker properly" was crossed out and "Wheelchair full time with alarm side rails on bed" was hand written in. b. "keep environment clear of clutter. c. Wheelchair to be used during periods of unsteady gait" was crossed out. d. "PT			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G024	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 04/09/2012
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	evaluation completed." The word completed was crossed out and "being done" was hand written in and crossed out and the word "completed" was handwritten in. "Bed alarm for safety. Pelvic positioner for safety" were hand written in. The hand written entries were undated. A PT/Neurological Evaluation dated 9/14/2011 indicated "Pt. (patient) had a fall on 9/14/11 hitting her head and suffered a cerebral bleed...prior to this fall patient was using a w.w. (walker) for ambulation but were given reports pt. was falling frequently. Now in w/c (wheelchair) only...frequent loss of balance and falling when walking." Recommendations "transfer toward w/c with supervision...recommend pt. not attempt walking with her walker due to her history of frequent falls and recent head injury." A psychiatric progress note dated 12/7/11 indicated "Pt. had a fall recently and head injury and since then has been experiencing visual hallucinations. She is extremely difficult to deal with to begin with...but with head injury it is getting even more difficult." A PT evaluation dated 4/2010 indicated "using walker, use wheelchair for long distances." Client #1's record indicated she had a PRN (as needed) order for staff to use a gait belt to assist her with ambulating. Documentation regarding the frequency of client #1's falls prior to			

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	7/11/11 was not available for review. A confidential interview (CI) was conducted between 4/3/12 and 4/5/12. The CI stated "I am very concerned about the care [client #1] is getting. I have seen bruises and injuries and no one seems to have noticed them or how she got them. It seems like she was falling more frequently and they didn't check into why. She can be very difficult, and I think she doesn't always get the care she needs because of how she acts." The Qualified Mental Retardation Professional (QMRP) was interviewed on 4/5/12 at 11:25 A.M.. The QMRP indicated client #1 was often non-compliant with allowing staff to assist her with ambulating which also included staff using the gait belt. The QMRP indicated client #1 was going to PT until she was discharged on 9/29/11 due to being uncooperative, and being asked to leave the office due to her behaviors. The QMRP indicated client #1 had been referred for a new PT evaluation in 9/2011, but had fallen before the evaluation could be completed. The QMRP indicated the most recent PT evaluation completed was completed on 6/15/2010 and client #1 was recommended to " continue to use reverse walker." The QMRP indicated client #1			

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	had continued to fall and injure herself. The Director of Residential Operations (DRO) was interviewed on 4/5/12 at 11:45 A.M.. When asked about client #1's falls and what had been done to help protect her, the DRO stated client #1 has "always been a high fall risk, and is very independent." The staff were following the recommendations of her physicians and her PT. The DRO indicated client #1 had continued to fall and injure herself. The DRO stated the entries in client #1's risk plan and health care plan "should have been dated." 9-3-2(a)			

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W0210	483.440(c)(3) INDIVIDUAL PROGRAM PLAN Within 30 days after admission, the interdisciplinary team must perform accurate assessments or reassessments as needed to supplement the preliminary evaluation conducted prior to admission. Based on record review and interview, the facility failed to have 1 of 4 sampled clients (client #1) with a known history of falls to be reassessed when her frequency and severity of injuries from her falls increased. Findings include: The facility records were reviewed on 4/3/12 at 3:25 P.M. including the Bureau of Developmental Disabilities Services (BDDS) reports and the Accident/Illness (A & I) Reports. The reports indicated the following: An A & I report dated 7/11/11 indicated while at the day program client #1 "went to sit and missed chair." The report indicated client #1 had a 1/2" (one-half inch) abrasion on her right elbow and a bruise under her right arm (size of bruise illegible). An A & I report dated 7/13/11 at 6:00 P.M. indicated client #1 "tripped with her walker and fell on her left leg." The report indicated "No bruises on her leg yet."	W0210	The following interventions along with several psychiatric reviews had been implemented to help client #1.:Physical Therapy evaluation – 1/19/2010Physical Therapy and Occupational Therapy Evaluation – 6/15/2010Per PT evaluation recommendation, walker wheels were tried in a “fixed” position. Had a numebr of falls, wheels went back to “swivel” position – 6/28/2010Stand By Assist for fire drills – 7/6/2010Gait Belt as needed – 7/18/2011PT ordered by PCP – 9/7/2011Traumatic brain injury - 9/14/2011CT scan – 9/14/2011Side rails on bed – 9/19/2011Chair alarm – 9/19/2011Neurological appointment with Dr. Wu – 9/27/2011Physical Therapy Evaluation – 9/29/2011CT scan – 9/29/2011Physical therapy at EGH (uncooperative) Discharged with home exercises – 9/29/2011Discontinue use of walker – use wheelchair – 9/29/2011EEG – 10/4/2011Physical Therapy at EGH – 10/4/2011Physical Therapy at EGH (uncooperative and aggressive) Discharged with home exercises – 10/13/2011Bed alarm – 11/8/2011Alarm chart put	04/24/2012

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	An A & I report dated 8/11/11 at 5:45 P.M. indicated client #1 "fell with her walker in kitchen; [client #1] fell on her buttocks." The report indicated there were no injuries. An A & I report dated 8/21/11 at 5:15 P.M. indicated client #1 was "sitting down and the chair slid out from under her, she fell on her butt (buttocks) but there were no marks as of now. Bruising may develop." An A & I report dated 8/28/11 at 11:30 A.M. indicated client #1 "tripped over chair and fell on her buttocks." The report indicated there were no injuries at the time. A BDDS report dated 9/15/11 for an incident on 9/14/11 at 12:30 A.M. (SIC) indicated "[Client #1] fell at day program yesterday afternoon. She was taken to the [name] Emergency Room (ER) to be checked out. She underwent a CT scan and lab work while in the ER. The CT scan showed a spot of concern. She was admitted for overnight observations. Her lab work came back normal." A follow-up BDDS report dated 9/22/11 for the incident on 9/14/11 indicated "...A CT scan and MRI showed an area of		into place - 11/29/2011CT scan completed due to fall (ER visit), with no findings – 12/6/2011Pelvic Positioner – 12/13/2011Anti Tippers for front and back – 12/30/2011In addition, items have been either removed from her room or bolted to her wall so that they cannot fall on her when she oulls on them. She has had no further injuries. Staff have been trained to stay with the resident when she chooses to be out of her chair and on the floor. Resident has a recent dx of dimentia.Client #1 has a safety plan in place and all staff have been trainedfailure to comply will result in disciplinary actionPERSON RESPONSIBLE QDDP	

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	bleeding on her brain. The tests were administered a day later and showed the area had stopped bleeding. She was discharged (from hospital) on 9/17/11 with a new diagnosis of Traumatic Brain Injury (TBI). [Client #1] does have a fall risk plan, that was being followed correctly at the time. She was standing up using her walker when she lost her balance and fell. [Client #1] is now in a wheelchair with a wheel chair alarm so staff can help her if she tries to get out of the wheelchair. She also has bed rails on her bed to prevent further falls." A follow-up BDDS report dated 9/29/11 for the incident on 9/14/11 indicated "...a follow-up CT scan to be completed today, and results sent to her physician. ...did go to Physical Therapy (PT) and her walker was discontinued due to her unstabliness (sic). She will continue to do home exercises for strength and will attend physical therapy ...for the next four weeks. Her alarm and bed rails have been added to her fall risk plan." A BDDS report dated 12/6/11 for an incident on 12/6/11 at 10:00 A.M. indicated client #1 was in her bedroom attempting to get out of her wheelchair. Staff heard the alarm. Client #1 did not wait for staff and tried to catch herself by reaching for her TV. The TV fell on top			

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	of her as she fell. She received a cut to her forehead. She was transported to the ER by ambulance. Hospital Discharge instructions for client #1 dated 12/06/2011 were reviewed on 4/4/12 at 1:32 P.M. and indicated " Arrange for a follow-up appointment with your Primary Care Provider (PCP) in 7 (seven) days for suture removal...You have had a head injury which does not appear serious at this time. A concussion is a state of changed mental ability, usually from a blow to the head...After injuries such as yours, most problems occur within the first 24 hours....A bruise on the brain (concussion) requires a few days for recovery." An A & I report dated 1/15/12 at 8:50 P.M. indicated "Staff were assisting [client #1] with getting into bed. [Client #1] rocked her self to get situated and when she did she bumped the right side of her forehead onto the side railing of her bed. 3 cm (three centimeter) bump on the right side of her forehead and broise (sic) on cheek." Client #1's record was reviewed on 4/4/12 at 1:32 P.M.. Client #1's record indicated her diagnoses included but were not limited to Moderate Mental Retardation, Encephalopathy (inflammation of the			

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	brain), Ataxia (muscle incoordination), TBI, Bi-Polar Depression, Osteopenia (decreased calcification or density of bone), Impulse Control Disorder (ICD), HX of Pituitary Tumor, resolved, and Borderline Personality Disorder. Client #1's Fall Risk Plan dated 9/2011, 12/1/2011, and 3/2012 indicated client #1 was to use a wheelchair at all times. Staff are to be with her anytime she is out of the wheelchair. Client #1 was to not use her walker. Client #1 had a pelvic positioner, bed alarm and wheelchair alarm, and bed rails to help prevent falls. Staff are to provide assistance with transfers. Staff are to prompt to "not hurry take her time" when client #1 ambulates in her wheelchair. Client #1 was to use a shower chair and staff are to remain with her when she is in the restroom. Client #1's record indicated a fall risk assessment was completed each quarter, and client #1 was a "high risk" for falls. The fall Risk Plan did not indicate the date the handwritten interventions to the typed plan were added. Client #1's Health Care Support Plan dated 6/2011, 9/2011, 12/2011 and 3/2012 indicated client #1 was " 2. At risk for falls due to history of falls, a. Ensure client is using walker properly" was crossed out and "Wheelchair full time with alarm side rails on bed" was hand written in. b. "keep environment clear of clutter. c.			

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	Wheelchair to be used during periods of unsteady gait" was crossed out. d. "PT evaluation completed." The word completed was crossed out and "being done" was hand written in and crossed out and the word "completed" was handwritten in. "Bed alarm for safety. Pelvic positioner for safety" were hand written in. The hand written entries were undated. A PT/Neurological Evaluation dated 9/14/2011 indicated "Pt. (patient) had a fall on 9/14/11 hitting her head and suffered a cerebral bleed...prior to this fall patient was using a w.w. (walker) for ambulation but were given reports pt. was falling frequently. Now in w/c (wheelchair) only...frequent loss of balance and falling when walking." Recommendations "transfer toward w/c with supervision...recommend pt. not attempt walking with her walker due to her history of frequent falls and recent head injury." A psychiatric progress note dated 12/7/11 indicated "Pt. had a fall recently and head injury and since then has been experiencing visual hallucinations. She is extremely difficult to deal with to begin with...but with head injury it is getting even more difficult." A PT evaluation dated 4/2010 indicated "using walker, use wheelchair for long distances." Client #1's record indicated she had a PRN (as needed) order for staff to use a gait belt to assist her with			

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	ambulating. Documentation regarding the frequency of client #1's falls prior to 7/11/11 was not available for review. The Qualified Mental Retardation Professional (QMRP) was interviewed on 4/5/12 at 11:25 A.M.. The QMRP indicated client #1 was often non-compliant with allowing staff to assist her with ambulating which also included staff using the gait belt. The QMRP indicated client #1 was going to PT until she was discharged on 9/29/11 due to being uncooperative, and being asked to leave the office due to her behaviors. The QMRP indicated client #1 had been referred for a new PT evaluation in 9/2011, but had fallen before the evaluation could be completed. The QMRP indicated the most recent PT evaluation completed was completed on 6/15/2010 and client #1 was recommended to " continue to use reverse walker." The QMRP indicated client #1 had continued to fall and injure herself. The Director of Residential Operations (DRO) was interviewed on 4/5/12 at 11:45 A.M.. When asked about client #1's falls and what had been done to help protect her, the DRO stated client #1 has "always been a high fall risk, and is very independent." The staff were following the recommendations of her physicians			

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	and her PT. The DRO indicated client #1 had continued to fall and injure herself. The DRO stated the entries in client #1's risk plan and health care plan "should have been dated." 9-3-4(a)			

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W0336	483.460(c)(3)(iii) NURSING SERVICES Nursing services must include, for those clients certified as not needing a medical care plan, a review of their health status which must be on a quarterly or more frequent basis depending on client need. Based on record review and interview, the facility failed to provide a quarterly nursing assessment for 2 of 4 sampled clients (clients #1 and #4). Findings include: Client #1's record was reviewed on 4/4/12 at 1:32 P.M.. There was no evidence in client #1's record to indicate the need for a medical care plan. Client #1's record did not include a quarterly nursing assessment between the dates of 1/19/11 and 7/15/11. Client #4's record was reviewed on 4/4/12 at 3:30 P.M.. There was no evidence in client #4's record to indicate the need for a medical care plan. Client #4's record did not include a quarterly nursing assessment between the dates of 1/19/11 and 7/11. The Director of Residential Operations (DRO) was interviewed on 4/5/12 at 11:25 A.M.. When asked about the missing nursing quarterly assessments for client #1 and client #4, the DRO indicated there were no additional nursing assessments available for review. 9-3-6(a)	W0336	All facility nurses have been trained on the timely completion of quarterly nursing assessments. A tracking system has been implemented so that the heath service coordinator is aware of when the assessments are due and when they are completed. Failure to comply with this correction will result in disciplinary action.PERSON RESPONSIBLE: Health Service Coordinator	04/18/2012

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W0346	483.460(d)(4) NURSING STAFF If the facility utilizes only licensed practical or vocational nurses to provide health services, it must have a formal arrangement with a registered nurse to be available for verbal or onsite consultation to the licensed practical or vocational nurse. Based on record review and interview, for 8 of 8 clients who lived in the home (Clients #1, #2, #3, #4, #5, #6, #7 and #8), the facility failed to have a Registered Nurse (RN) on staff or to have a formal arrangement with an RN to be available for verbal or onsite consultations to the LPNs. Findings include: Facility records were reviewed on 4/3/12 at 3:25 P.M. including Bureau of Developmental Disabilities Services (BDDS) reports and Incident/Accident reports. There was no indication the facility had a formal arrangement with a RN or a RN on staff to provide verbal and/or onsite consultation for the facility LPNs as needed for clients #1, #2, #3, #4, #5, #6, #7, and #8. The facility Director of Residential Operations (DRO) was interviewed on 4/5/12 at 11:48 A.M.. When asked if the facility had an RN on staff or as a consultant, the DRO stated "No, we have	W0346	On 4/26/12 an interview is set up for a possible contractual agreement with a NP who will provide consultation to the nursing staff and make on cite visits as needed. If this meeting is not successful, the facility will continue to seek services of an RN.Person Responsible: DRO	04/26/2012

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	a Doctor as our Medical Director. There are nurses at his office we can contact." The DRO indicated the facility did not have a formal arrangement with a RN. 9-3-6(a)			