

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G545	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 11/29/2011
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NAME OF PROVIDER OR SUPPLIER ST VINCENT NEW HOPE INC	STREET ADDRESS, CITY, STATE, ZIP CODE 9001 N HOLLIDAY DR INDIANAPOLIS, IN46260
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W0000	<p>This visit was for an investigation of complaint #IN00099909.</p> <p>Complaint #IN00099909: Substantiated, federal and state deficiencies related to the allegation(s) are cited at W102, W104, W122, W149, W154, W186, W189, W227, W210, W252, W318, W331, W368 and W369.</p> <p>Unrelated deficiency cited.</p> <p>Dates of Survey: 11/16, 11/17, 11/21, 11/22, 11/28 and 11/29/11</p> <p>Facility Number: 001059 Provider Number: 15G545 Aim Number: 100245370</p> <p>Surveyor: Paula Chika, Medical Surveyor III-Team Leader</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 12-13-11 by C. Neary, Program Coordinator.</p>	W0000		
W0102	<p>The facility must ensure that specific governing body and management requirements are met.</p> <p>Based on observation, interview and record review for 4 of 4 sampled clients (A, B, C and D), the governing body</p>	W0102	Credible Allegation of Compliance The corrective action indicated in the corresponding condition and	12/29/2011

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

TITLE

(X6) DATE

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

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	<p>failed to ensure the facility implemented its policy and procedures to prevent neglect of clients in regard to falls and a client with significant medical needs. The governing body failed to ensure the facility conducted thorough investigations, completed investigations in a timely manner, and to provide sufficient staff to supervise/meet the needs of clients. The governing body failed to ensure the facility met the health care needs of clients, administered medications without error and/or ensured all medications were administered as ordered.</p> <p>Findings include:</p> <p>1. The governing body failed to ensure the facility meet the Condition of Participation: Client Protections for 3 of 4 sampled clients (clients A, B, and C). The governing body failed to implement its policy and procedures to prevent neglect of clients in regard to falls and in regard to a client's health status/needs. The governing body failed to ensure the facility conducted an investigation in regard to an allegation of neglect in regard to a medication error which may have resulted in a client going to a local emergency room, and in regard to completing/conducting an investigation within 5 business days. Please see W122.</p>		<p>standard level citations has been addressed as outlined. St. Vincent New Hope has revised procedures and increased oversight at this facility to effectively correct said deficiencies. The onsite supervisor (Team Leader) of the home was also attempting to complete a performance improvement plan to improve direction, follow up and oversight of the home. Her lack of supervision ability and house management skills have continued to be confirmed as ineffective and she has been replaced. St. Vincent New Hope is committed to correcting and satisfying the said deficiencies and submits this plan of correction as evidence of that action.</p> <p>For Governing Body deficiency please see specific steps taken to address procedure implementation for investigations and reporting, client protections and health care services.</p> <p>All individuals, including clients A, B, and C will be reassessed risk of falls using the attached Fall Risk Assessment form</p> <p>A Post Fall IDT review in the event of a fall to evaluate cause of fall, current interventions or changes needed to treatment plan will be implemented. The format for this report was drafted from the BQIS (formerly Outreach Services) resource material. The IDT will investigate each fall and designate</p>		

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	<p>2. The governing body failed to meet the Condition of Participation: Health Care Services for 3 of 4 sampled clients (A, B and C). The governing body failed to ensure the facility's health care services met the health care needs of clients in regard to addressing/developing health care plans for a client who had a history of cancer and was still undergoing procedures/treatments, to update fall prevention plans, to review and/or monitor a client's health status, to ensure test procedure results were obtained, to follow/address recommended orders, to monitor staff to ensure they completed health documentation and/or informed the nurse of health issues as needed. The governing body failed to ensure the facility's health care services ensured all ordered medications were administered as ordered, to ensure all medications were administered without error and to ensure significant medical appointments/procedures were kept when scheduled as the facility's health services failed to ensure all staff understood basic medical terminology and acronyms. Please see W318.</p> <p>3. The governing body failed to ensure the facility implemented its written policy and procedures to prevent neglect of clients B and C in regards to addressing</p>		<p>changes to treatment plan, if any on the IDT investigation form as well as timelines and responsible party for the implementation.</p> <p>St. Vincent New Hope High Risk Plan format was reviewed and changed using the BQIS (formerly Outreach Services) template to better organize, coordinate and identify support needs for individuals with Risk Plan interventions.</p> <p>All risk plans were reviewed and updated.</p> <p>St. Vincent New Hope will conduct investigations when an act or omission of duty is deemed the cause of harm or potential from harm to an individual.</p> <p>Investigation format was revised to be consistent with DDRS proposed template for investigations. This format will facilitate a more concise, yet thorough investigation. The timeframes for investigations will be reviewed as they are submitted to Group Home Director.</p> <p>Nurse consultant and QMRP will review that all other appointments, follow up and needed reports have been received. This audit will identify needed appointments. All needed appts to be scheduled by 12/29, actual appt based on physician availability.</p> <p>Group Home Director will track all falls to monitor recurrence, effectiveness of plans or needed changes.</p> <p>Human Rights Committee will review</p>		

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	<p>falls with injuries and in regard to client A's medical/health needs.</p> <p>The governing body failed to ensure the facility conducted an investigation in regard to an allegation of neglect concerning client B.</p> <p>The governing body failed to ensure the facility completed all investigations within 5 working days for client B.</p> <p>The governing body failed to ensure sufficient numbers of staff worked during the morning, evening and/or weekend shifts to ensure clients had adequate supervision/monitoring to prevent potential falls of clients, who had a history of falls, and/or to meet the needs of clients A, B, C and D.</p> <p>The governing body failed to ensure the facility's nursing services met the health needs of the clients. The governing body failed to ensure the facility's nursing services ensured recommended procedures were completed timely for a client who had cancer, failed to develop and/or update clients' fall assessments/health/risk plans, and failed to ensure results of a bone density test was present in a chart. The governing body failed to ensure the facility's nursing services followed up on a</p>		<p>all fall investigations and trends by individual to monitor effectiveness or recurring issues to address. Group Home Director will review nursing notes monthly for accuracy and thorough documentation of health care needs as well as compliance with appointment scheduling. Group Home Director will review High Risk Plan revisions for all individuals in the facility.</p>		

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W0104	<p>recommendation to obtain a cat scan in a timely manner, to ensure facility staff documented seizure events, and/or to ensure the facility's nursing services monitored/completed monthly health status summaries/reviews of a client with significant medical needs for clients A, B and C.</p> <p>The governing body failed to ensure staff administered medications as ordered for clients A and B.</p> <p>The governing body failed to ensure all medications were administered without error for client B. Please see W104.</p> <p>This federal tag is related to complaint #IN00099909.</p> <p>9-3-1(a)</p> <p>The governing body must exercise general policy, budget, and operating direction over the facility.</p> <p>Based on observation, interview and record review for 4 of 4 sampled clients (A, B, C and D), the governing body failed to exercise general policy, budget and operating direction over the facility to ensure the facility implemented its policy and procedures to prevent neglect of clients in regard to falls and a client with significant medical needs. The governing</p>	W0104	Please refer to W102 for procedural changes, direction and oversight established to correct deficient actions.	12/29/2011	

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	<p>body failed to exercise general policy, budget and operating direction over the facility to ensure the facility conducted thorough investigations, completed investigations in a timely manner, and to provide sufficient staff to supervise/meet the needs of clients. The governing body failed to exercise general policy, budget and operating direction over the facility to ensure the facility met the health care needs of clients, administered medications without error and/or ensured all medications were administered as ordered.</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. The governing body failed to exercise general policy and operating direction over the facility to ensure its written policy and procedures were implemented to prevent neglect of clients B and C in regards to addressing falls with injuries and in regard to client A's medical/health needs. Please see W149. 2. The governing body failed to exercise general policy and operating direction over the facility to conduct an investigation in regard to an allegation of neglect concerning client B. Please see W154. 3. The governing body failed to exercise 				

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	<p>general policy and operating direction over the facility to ensure all investigations were completed within 5 working days for client B. Please see W156.</p> <p>4. The governing body failed to exercise general policy and operating direction over the facility to ensure sufficient numbers of staff worked during the morning, evening and/or weekend shifts to ensure clients had adequate supervision/monitoring to prevent potential falls of clients, who had a history of falls, and/or to meet the needs of clients A, B, C and D. Please see W186.</p> <p>5. The governing body failed to exercise general policy and operating direction over the facility to ensure the facility's nursing services met the health needs of the clients. The governing body failed to exercise general policy and operating direction over the facility to ensure the facility's nursing services ensured recommended procedures were completed timely for a client who had cancer, failed to develop and/or update clients' fall assessments/health/risk plans, and failed to ensure results of a bone density test was present in a chart. The governing body failed to exercise general policy and operating direction over the facility to</p>				

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W0122	<p>ensure the facility's nursing services followed up on a recommendation to obtain a cat scan in a timely manner, to ensure facility staff documented seizure events, and/or to ensure the facility's nursing services monitored/completed monthly health status summaries/reviews of a client with significant medical needs for clients A, B and C. Please see W331.</p> <p>6. The governing body failed to exercise general policy and operating direction over the facility to ensure staff administered medications as ordered for clients A and B. Please see W368.</p> <p>7. The governing body failed to exercise general policy and operating direction over the facility to ensure all medications were administered without error for client B. Please see W369.</p> <p>This federal tag is related to complaint #IN00099909.</p> <p>9-3-1(a) 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 3 of 4 sampled clients (clients A, B, and C). The facility failed to implement its policy and procedures to prevent neglect of clients in</p>	W0122	Please see W149, W154, W156 for corrective actions and monitoring	12/29/2011	

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	<p>regard to falls and in regard to a client's health status/needs. The facility failed to conduct an investigation in regard to an allegation of neglect in regard to a medication error which may have resulted in a client going to a local emergency room, and in regard to completing/conducting an investigation within 5 business days.</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. The facility neglected to implement its written policy and procedures to prevent neglect of clients (B and C) in regards to addressing falls with injuries, and in regard to ensuring client A's medical/health needs were addressed and significant appointments were kept. Please see W149. 2. The facility failed to conduct an investigation in regard to an allegation of neglect concerning client B. Please see W154. 3. The facility failed to ensure all investigations were completed within 5 working days regarding an incident with client B. Please see W156. <p>This federal tag is related to complaint #IN00099909.</p>				

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W0149	<p>9-3-2(a)</p> <p>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. Based on observation, interview and record review for 3 of 4 sampled clients (A, B and C), the facility neglected to implement its written policy and procedures to prevent neglect of clients B and C in regards to addressing falls with injuries and in regard to client A's medical/health needs.</p> <p>Findings include:</p> <p>1. The facility's reportable incident reports and/or investigations were reviewed on 11/16/11 at 12:15 PM. The facility's reportable incident reports/investigations indicated the following:</p> <p>-9/8/11 staff heard a "loud noise" from client C's bedroom. Client C was found on the floor in front of his chair with blood on the client's head. Client C was taken to a local emergency room (ER) due to a laceration above his left eyebrow which was 1 1/2 inches long and due to an abrasion on the client's left cheek area. The 9/8/11 reportable incident report indicated client C received stitches and</p>			W0149	<p><i>What corrective action will be accomplished for these residents found to have been affected by the deficient practice? All individuals, including clients A, B, and C will be reassessed risk of falls using the attached Fall Risk Assessment form1. Individuals scored 0, 1, or 2 will be categorized as low risk2. Individuals scored as 3 or greater will be categorized as high riskRisk Interventions to be determined by IDT after assessment may include, but not limited to:1. Training to staff upon hire and annually on fall prevention plan, risk and specific risk plan protocols for individual.2. Bed rail needs assessed and identified if appropriate3. Furniture in room assessed for safety and to prevent obstacles or injury risks.4. Room free of obstacles.5. Night light to be on in room (evenings and night)6. Bed in low position unless care is being delivered, unless medically contraindicated.7. Wheelchair locked when in stationary position.8. Wheelchair belt, tray secured9. Utilize assistive devices as ordered (glasses, cane, walker)10. St. Vincent New</i></p>		12/29/2011

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	<p>his Tetanus was updated.</p> <p>The facility's 9/27/11 follow-up report indicated client C was sitting in a "temporary chair" in his bedroom and it "tipped over." The 9/27/11 follow-up report indicated the client's parents ordered client C a "special made chair."</p> <p>-9/17/11 "[Client C] was walking through the living room and bumped his foot against housemates wheelchair and fell. When he fell he hit the area where he just previously had stitches removed from. - Nurse ON Call instructed staff to take [client C] to the ER...-Stitches were put back in laceration...."</p> <p>The facility's 9/27/11 follow-up report indicated client C tripped over a bag of blocks that were dropped in the floor by a peer. The follow-up report indicated client C "...caught his foot in the wheel of the wheelchair. [Client C] landed directly on the floor on his face and began bleeding immediately. The laceration was in the same place as the previous laceration from 9/8/11...Walker goal put in place with consent from parents for [client C] to use a roller walker at all times while awake...[Client C] met with Neurologist (routine exam scheduled) on 9/20/11, recommended CAT scan. GH (Group home manager) implemented</p>		<p>Hope Fall Risk Plan completed and implemented. 11. Order for PT/OT evaluate and treat upon admission, annually and upon change in status.12. Pharmacy review of medications quarterly13. Toileting assistance or cues every 2 hours 14. Assess need for electronic monitoring (bed alarm, chair alarm)15. Non skid footwear16. Assess and identify ambulation support needs (1:1, gait belt, etc.)A Post Fall IDT review in the event of a fall to evaluate cause of fall, current interventions or changes needed to treatment plan will be implemented. The format for this report was drafted from the BQIS (formerly Outreach Services) resource material. The IDT will investigate each fall and designate changes to treatment plan, if any on the IDT investigation form as well as timelines and responsible party for the implementation.St. Vincent New Hope High Risk Plan format was reviewed and changed using the BQIS (formerly Outreach Services) template to better organize, coordinate and identify support needs for individuals with Risk Plan interventions. All risk plans were reviewed and updated. High Risk Plan for Cancer related illness or treatment needs will be developed with physician at appointment on 12/23/11. All staff will be trained on High Risk Plans<i>How the facility will identify</i></p>				

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	<p>safety checks for every 30 minutes on [client C] noting his whereabouts and any assistance staff gave him (9/22/11). Parents/guardians do not want [client C] to wear a helmet. This was discussed with parents on 9/17/11 by GH Manager and 9/18/11 by Team leader...."</p> <p>The facility's 9/27/11 Fall/Injury Investigation indicated client C had a history of falls with injuries.</p> <p>-10/20/11 "[Client C] arrived at Day Services and entered the restroom. Staff entered a few minutes later and found that [client C] had fallen on the ground in the restroom. He had been utilizing his walker, and he was wearing his leg braces. He was conscious, but had two head lacerations, and bleeding and bruising on his cheek and mouth. Nurse consultant assisted with first aid and an ambulance was called. [Client C] was transported to the Emergency Room via ambulance. Plan to Resolve: Residential team is coordinating with DME (Durable Medical Equipment) coordinator at St. Vincent New Hope and [client C's] family to determine if additional equipment is needed to assist him with safe mobility. Medical follow up will be completed by the residential team."</p> <p>The facility's 11/8/11 day program fall</p>		<p><i>other residents having the potential to be affected by the same deficient practice and what corrective action will be taken</i> All residents have the potential to be affected by this deficient practice. All residents will be reassessed for corrective action and revision of High Risk Plan as noted above. Client C has a specific training goal to utilize his walker safely without running into people or objects. <i>What measure will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur</i> High Risk Plans will be reviewed annually with IDT.Post Fall IDT investigation of any fall event within the year.Walker use will be monitored weekly with data review by QMRP. <i>How the corrective action will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place and the date the systemic changes will occur.</i> Group Home Director will track all falls to monitor recurrence, effectiveness of plans or needed changes.Human Rights Committee will review all fall investigations and trends by individual to monitor effectiveness or recurring issues to address. Group Home Director will review nursing notes monthly for accuracy and thorough documentation of health care needs. Group Home Director will review High Risk Plan revisions</p>		

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	<p>investigation summary indicated client C fell in the men's bathroom at the day program, and day program staff heard client C yelling for help. The day program investigation summary indicated "...I (day program staff #1) proceeded into the restroom where I saw [client C] on the floor, on his back, with his walker on top of him. He had cuts on his forehead and mouth was bleeding profusely...." The 11/8/11 summary indicated client C had also complained of leg pain and was refusing to bear weight.</p> <p>The facility's 11/8/11 follow-up report indicated client client C received steri strips to his laceration on his left forehead and Bacitracin (antibiotic ointment) was to be applied to the laceration to client C's left cheekbone which did not require stitches. The follow-up report indicated client C also had a laceration along the client's gum line which did not require any type of treatment as it would heal on its own. The 11/8/11 follow-up report indicated the client's parents were considering the use of a helmet and an order for physical therapy/occupational therapy would be obtained at the client's next doctor's appointment scheduled for 11/10/11.</p> <p>During the 11/16/11 observation period between 3:10 PM and 7:10 PM, at the</p>		<p>for all individuals in the facility. Group Home QMRP will be onsite to monitor improvements 2 times per week minimum for the next 2 months. Group Home Director will be onsite weekly over the next month to provide onsite monitoring, care and oversight of improvements.</p>		

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	<p>group home, there were 5 staff to 8 clients in the group home. Client C utilized a roller walker when ambulating as client C had an unsteady gait. Client C had injuries to the left side of his face. Client C's lip was swollen and scabbed over with small cuts/lacerations to his chin area which were red and scabbed over. Client C also had a laceration/bruise above his upper left eyebrow. At 5:15 PM, client C walked into the dining room area where client D was setting the dining room table. Client D was in a wheelchair and client C was utilizing his roller walker. Client C was walking to his bedroom and walked directly into the back of client D's wheelchair with his walker. Client D told client C to go around him. Client C did not walk around client D and continued to hit client D's wheelchair with his walker until client D moved out of client C's way. At 6:50 PM, client C was in his bedroom with the door open. Client C's walker was at the entrance of the client's bedroom door while client C was walking around his bedroom without the walker. When client C came out of his bedroom, client C grabbed his walker and moved at a fast pace, almost running over the surveyor. None of the 5 staff, who were working (staff #2, #3, #4, #5 and #6), were in the area to redirect client C to use his walker while ambulating in his bedroom and/or to encourage the client to slow down</p>				

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	<p>when using his walker. Client C did not wear and/or utilize a helmet during the observation period.</p> <p>Client C's record was reviewed on 11/17/11 at 4:08 PM. Client C's 9/9/11 Aftercare Instructions indicated client C had a laceration to his face, head injury unspecified and contusion to his face due to a fall from a chair or bed. Client C's 10/20/11 Aftercare Instructions indicated client C had facial lacerations of 3 cm (centimeters), 2 cm and 1 cm and a lip abrasion.</p> <p>Client C's Monthly Health Reviews indicated the following (not all inconclusive):</p> <p>-8/5/11 client C fell at camp on 8/4/11. Client C received facial swelling around his eye and cheek bone with lacerations.</p> <p>-8/23/11 fell to his knees while outside while at the day program.</p> <p>-9/8/11 fell on 9/7/11 and went to ER due to laceration above his left eye.</p> <p>-9/17/11 client C fell when he tripped over a peer's wheelchair. Client C reopened injury to right eye.</p> <p>-9/20/11 "...N.O. (new order) CT (cat</p>				

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	<p>scan) head d/t (due to head trauma...Family does not want client to undergo CT scan does not feel client will tolerate procedure. MD (medical doctor) notified. Will continue to monitor."</p> <p>-10/14/11 client C had "scaring above (L) (left) r/t (related to) injuries...."</p> <p>-10/20/11 "Client fell @ (at) group home & (and) was sent to the ER for facial lacerations. Dermabond used."</p> <p>-11/15/11 spoke to doctor in regard to CT scan as parents want to know if it can be done with sedation. The note indicated the doctor ordered the CAT scan with general anesthesia.</p> <p>-11/16/11 "[Client C] fell @ day program walking to the van. 0 (zero) injuries. [Client C] fell in his room trying to get up without staff & walker. [Client C] has cuts on his lip. Ice & Bacitracin applied. Assessed [client C] today. Lip swollen with 2 cuts on lip & 1 on chin."</p> <p>-11/17/11 "[Client C] fell @ Day Program leaning to the side of chair trying to get up. 0 injuries noted. Instructed staff to monitor [client C] for swelling, pain, dizziness, change in mental status...Instructed staff to complete 30 min (minute) checks & to allow [client C]</p>				

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	<p>to sit in chairs with arms on them."</p> <p>-11/18/11 "Correction to client's fall on 11/17 @ Day Services. Client fell getting to sit down on chair with no arms (sic). Client is to have stand by assist (with) transfers and should have walker (with) in reach."</p> <p>Client C's 9/17/11 Medical Appointment/New Order form indicated "Opened an old injury on forehead due to fall."</p> <p>Client C's 9/20/11 Medical Appointment/New Order form indicated "Continues frequent falls, worse past mo (month)...Will (check) CT head to r/o (rule out) SDH (subdural hematoma)." Client C's typed 9/20/11 neurological evaluation indicated "The patient had improved his gait significantly. He was using a walker regularly. However, he has gone downhill again in last month, and he has had 3 falls. Two were out of a chair when the chair broke, but he is a little bit less steady on his feet. Reauthorization of physical therapy has been requested...Recommendations: because of the recurrent head trauma, I am very concerned that he may be at risk for a subdural hematoma or intracranial pathology of other type. I think a noncontrast CAT scan should be</p>				

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	<p>performed. We will make an additional intervention decisions based on clinical course...."</p> <p>Client C's 9/19/11 to 9/19/12 Methodology sheet indicated client C had an objective to use his walker in all situations during awake hours with staff physical assistance and/or cues. The 9/19/11 methodology sheet indicated "1. Staff will monitor [client C] during awake hours and ensure he has his walker available at all times. This includes when he is in his room sitting in his chair. His walker is to be placed in front of him while watching TV (leisure goal). 2. Staff will cue [client C] to use his walker any time he needs to walk any distance within the Group Home, at Day program or in the community. 3. If [client C] is out walking around without his walker, he will need staff to provide stand by assistance for any walking until his walker can be retrieved for him. 4. If [client C] is walking without his walker, staff is to ask him where his walker is and remind him he needs to have his walker with him for assistance, and provide stand by assistance until walker is retrieved. 5. Staff is to cue [client C] to use his walker to and from any area in the home; bathroom, kitchen, dining room, living room; and he is to use his walker to and from the van, at day program and in the</p>				

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	<p>community. 6. When [client C] is sitting at the dining room table, his walker is to be next to him in case he needs it. When [client C] is sitting in the living room, his walker is to be placed directly in front of him for him to use to help get him up...."</p> <p>Client C's 10/25/11 Individual Support Plan (ISP) indicated client C's diagnoses included, but were not limited to, Cerebral Palsy and Glaucoma. Client C's record indicated a Fall Prevention Plan was developed/put in place on 11/15/11. The 11/15/11 Fall Prevention Plan indicated client C required a risk plan for falls due to falls with injury which occurred on 9/7/11, 9/17/11 and on 10/20/11. The 11/15/11 Fall Prevention Plan indicated 911 was to be called, CPR (Cardio Pulmonary Resuscitation) initiated and/or first aid was to be initiated if the client was "gravely ill" and/or unresponsive. The 11/15/11 fall plan indicated "...If a person is in the act of falling---</p> <ul style="list-style-type: none"> -Try to ease person to floor or seating if possible -Do not attempt to stop fall by grabbing person by arms or clothing. <p>Observe person after the fall for any injuries and treat accordingly If you are able to assist person up from floor, do so using proper body mechanics If you are unable to assist person up from</p>				

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	<p>floor, call Team Leader or On-Call for assistance...." The 11/15/11 fall plan indicated client C had a walker and staff were to complete fall documentation. The fall plan also indicated "...Other preventative measures: Staff can offer [client C] reminders to slow down. Due to sensory issues, [client C] is not tolerant of helmet or gait belt, nor does he want much staff assistance. Minimal touch assistance is all [client C] will tolerate." Client C's record and/or 10/25/11 ISP indicated client C's interdisciplinary team (IDT) last met on 6/7/11 in regard to a wound on client C's foot and diet recommendations. Client C's 10/25/11 ISP and/or record neglected to indicate client C's IDT met to review client C's 9/8, 9/17, 10/20 and 11/15/11 falls which resulted in injuries to ensure preventative measures were put in place to protect the client at the group home and at the day service program. Client C's record and/or 10/25/11 ISP neglected to indicate the client's IDT reviewed and/or addressed, in a timely manner, client C's doctor's recommendation to obtain a CAT scan due to the recent head injuries client C received due to the falls. Client C's 10/25/11 ISP also neglected to specifically address client C's identified need of walking into things/over things.</p> <p>Interview with staff #2 on 11/16/11 at</p>				

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	<p>5:38 PM indicated client C had a history of falls. Staff #2 stated client C was "not stable." Staff #2 indicated client C utilized a walker but still had falls.</p> <p>Interview with staff #6 on 11/16/11 at 6:10 PM indicated client C was at risk for falls. Staff #6 indicated client C had received injuries from a recent fall.</p> <p>Interview with staff #3 on 11/16/11 at 6:17 PM indicated client C fell two times on 11/15/11. Staff #3 indicated client C fell at the day program and in the group home. Staff #3 indicated she was not sure if client C was using his walker when he fell.</p> <p>Interview with staff #8 on 11/16/11 at 6:35 PM indicated client C had a history of falls and a walker was put in place to assist the client. Staff #8 indicated client C had also received physical therapy services in the past for 3 months to help increase the client's strength. Staff #8 indicated the facility received a helmet 2 days ago but it was not currently being used as the helmet was waiting to be evaluated.</p> <p>Interview with staff #5 on 11/16/11 at 7:02 PM indicated client C had a history of falls with injuries. Staff #5 indicated he was not sure how client C received the</p>				

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	<p>injuries to his face as client C did not have the injuries when staff #5 worked on 11/14/11. Staff #5 indicated staff were to monitor the client when he was walking around.</p> <p>Interview with staff #7 on 11/17/11 at 6:05 AM indicated she was told client C received the injuries from a fall on 11/15/11. Staff #7 stated there were several clients who had falls at the group home, but client C "fell much more." Staff #7 stated "[Client C] is unstable when walking. If anything in way, he will go down. He does not walk around." Staff #7 indicated client C fell in the living room, bedroom and in the bathroom in the past. Staff #7 indicated she would have to listen for him getting up at night to assist the client as he could fall trying to go to the bathroom. Staff #7 indicated client C required staff supervision when others were around and the client was ambulating with his walker.</p> <p>Confidential interview A stated client C had been "falling a lot lately." Confidential interview A indicated client C recently fell 3 different times and injured himself in the same areas and had to go to the hospital for treatment/stitches. When asked why client C was falling, confidential interview A stated "He does not look where he is going half the time."</p>				

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	<p>Confidential interview A indicated client C had a helmet which was brought by the client's parents. Confidential interview A indicated the helmet was waiting to be approved by PT (physical therapy) and OT (occupational therapy). When asked where client C would fall, confidential interview A stated "In bathroom, in kitchen. Falls everywhere." Confidential interview A stated "They need to help him more."</p> <p>Interview with administrative staff #1, the Qualified Mental Retardation Professional (QMRP) staff #1 and LPN #2 on 11/22/11 at 10:45 AM indicated client C had a history of falls with injuries. LPN #2 indicated client C fell 3 times last week (twice on 11/15/11 and on 11/17/11). LPN #2 indicated client C fell at the day program on 11/17/11 and the client had his walker beside him, but was not using it. LPN #2 and staff #1 indicated client C had not had the CAT scan completed as recommended by the neurologist. LPN #1 indicated the doctor was concerned about the client have a subdural hematoma due to the recent falls with head injuries. Staff #1 indicated the CAT scan which was recommended in 9/11 was scheduled to be completed on 12/2/11. Staff #1 stated the "family declined it." Administrative staff #1, the QMRP and staff #1 indicated the client's</p>				

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	<p>IDT had discussed the client's recent falls with injuries but there was no documentation of the meetings. Staff #1 and the QMRP indicated phone calls were made to the parents and conversations were held between the QMRP, staff #1, LPN #2 and administrative staff #1. Staff #1 and the QMRP indicated a roller walker was put in place after the 9/17/11 fall. The QMRP indicated the parent had said no to a helmet, but have since changed their minds. Staff #1 indicated a helmet had been purchased by the parents but was not being utilized until OT/PT assessed the client and reviewed the helmet on 11/23/11. LPN #2 indicated a fall prevention plan was put in place on 11/15/11 after the client had 3 falls with injuries which required a trip to the ER. LPN #2 indicated client C fell and hit the back of his head at the day program last week. When asked how facility staff were to monitor the client at the day program and group home, administrative staff #1 stated client C was placed on a "2 to 1 ratio" on Friday (11/18/11) at the day program. LPN #2 indicated she updated client C's 11/15/11 fall plan on 11/18/11 to include the use of a helmet, stand by assist and 30 minute safety checks. Staff #1, the QMRP and LPN #2 indicated client C did not have a fall plan prior to 11/15/11. Staff #1 and the QMRP indicated client C had an objective to use</p>			

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	<p>his walker when awake. Staff #1 and the QMRP indicated client C's 10/25/11 ISP did not address client C's identified need of walking into things/others. The QMRP, LPN #2 and staff #1 indicated client C's 11/18/11 fall prevention plan did not indicate how facility/workshop staff were to monitor the client to prevent any further falls/injuries. Administrative staff #1 indicated clients' IDTs would need to meet and start reviewing falls with injuries.</p> <p>2. The facility's reportable incident reports, facility's incident report and/or investigations were reviewed on 11/16/11 at 12:15 PM. The facility's reportable incident reports, facility incident reports and/or investigations indicated the following:</p> <p>-9/9/11 "[Client B] fell dining room while walking around the table (sic). His left foot caught in the wheel of another individuals wheelchair causing the fall. He fell down on his knees and hands and hit his forehead on the floor...He had a red mark on his forehead, right side just above the right eye...A previous injury w/ (with) scab on right knee had been re-opened and was bleeding...." The 9/9/11 reportable incident report indicated client B's mother wanted the staff to examine client B's feet for any injuries.</p>				

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	<p>The reportable incident report indicated the Team Leader checked client B's feet 3 different times on 9/9/11 and no swelling and/or bruising was noted to the client's feet. The 9/9/11 reportable incident report indicated "...Plan to arrange tables in dining room to allow more space between tables and wall (natural support) and matched up with small blue tape for accuracy each time at meal time. Seating of individuals to be monitored by staff..."</p> <p>The facility's 9/9/11 Fall/Injury Investigation indicated client B had a history of falls and had a fall on "...8/27/11...." (sic).</p> <p>-8/26/11 client B fell out of a chair and received a rug burn to both knees. The facility's 8/31/11 follow-up report indicated client B was walking around and tripped over the program books which were on the floor and the client's right shoe string was untied.</p> <p>-8/26/11 Occurrence Outside Practice Standards (OOPS) report indicated client B fell while he was walking around in the living room. The OOPS report indicated 2 staff were on duty at the time of the fall. One was in the kitchen and one was helping another client in the bathroom. The 8/26/11 OOPS report indicated the above mentioned fall was the second fall</p>						

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	<p>of the evening. The report indicated client B was not injured with the second fall. The follow-up report indicated staff were told to keep the floor free of clutter and to ensure the client's shoe strings were tied as client B would untie his shoes and then attempt to ambulate.</p> <p>-3/19/11 "While conducting a follow up body check on 03-19-2011, staff reported that [client B's] right ankle was swollen and bruising had appeared. STaff (sic) informed on call TL (Team Leader) and on call NC (Nurse Coordinator). Both parties agreed to have [client B] transported to the hospital ER for examinations (sic)...The follow up body check was being conducted due to falls that had happened on 03/18/2011...and the body check conducted 3/18/2011 revealed no injuries. X-rays were completed at the ER and revealed a fracture to his ankle...." The 6/2/11 follow up report indicated client B was kept in the hospital for 15 days and then discharged to a nursing home for rehabilitation.</p> <p>Client B's record was reviewed on 11/21/11 at 1:28 PM. Client B's 3/19/11 X-ray report indicated "There is evidence of a trimalleolar fracture. A spiral fracture is identified involving the distal fibular diaphysis. There is a mild degree of lateral and posterior displacement of</p>				

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	<p>the distal fracture fragment. A transverse fracture is identified in the base of the medial malleolus. There is a mild lateral displacement. There is a mildly displaced fracture through the dorsal aspect of the posterior malleolus...IMPRESSION: 1. Trimalleolar fracture."</p> <p>Client B's 3/19/11 medical consultation indicated client B had a "...history of multiple falls, especially with his recent seizure episodes. He basically fell at the group home and was found by staff to be on the floor unable to ambulate...." The 3/19/11 medical consult indicated surgery was going to be performed due to the fracture.</p> <p>Client B's 7/5/11 Occupational Therapy notes indicated client B was referred for services due to the client's "...R (right) ankle fx (fracture) approx (approximate) 5 days of intermittent falls in March 2011...." The 7/5/11 note indicated client B had been referred to the OT as the client was "...now afraid to shower. Per CG (care giver) pt (patient) has not had a shower since fall and R LE (right lower extremity) immobilized with cast...." Client B's 7/7/11 OT note indicated "...OT unable to determine from staff where pts (patient's) falls occurred. ? in bathroom and could this be the reason for fear of</p>						

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	<p>getting a shower at this time or has he been fearful/resistive in the past?...."</p> <p>Client B's 10/11 physician's order indicated client B's diagnoses included, but were not limited to, Cerebral Palsy and Seizure disorder.</p> <p>Client B's 11/10/11 Record of Seizure Observations indicated client B was walking and fell when the client had a seizure causing the client to hit his face. The seizure record indicated client B's magnet for his Vagal Nerve Stimulator (VNS) was used to stop the seizure.</p> <p>Client B's 10/7/11 seizure record indicated client B was walking and fell to the ground during a seizure. The seizure record did not indicate client B was injured when he fell.</p> <p>Client B's 10/13/11 Medical Appointment/New Order form indicated a Bone Density test/study was completed for bone disease on 10/13/11. Client B's 10/11 and/or 11/11 Health care Coordination Monthly Reviews indicated the facility neglected to obtain the results of the ordered/completed Bone Density test to determine if client B had any bone disease which would put the client at risk for fractures due to his falls.</p>				

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	<p>Client B's 1/3/11 Fall Prevention Plan indicated client B had 2 recent falls with injuries which required medical treatment in a 3 month period. The 1/3/11 plan indicated 911 was to be called, CPR initiated and/or first aid was to be initiated if the client was "gravely ill" and/or unresponsive. The 1/3/11 fall plan indicated "...If a person is in the act of falling---</p> <p>-Try to ease person to floor or seating if possible</p> <p>-Do not attempt to stop fall by grabbing person by arms or clothing.</p> <p>Observe person after the fall for any injuries and treat accordingly</p> <p>If you are able to assist person up from floor, do so using proper body mechanics</p> <p>If you are unable to assist person up from floor, call Team Leader or On-Call for assistance...." The 1/3/11 fall plan indicated client B's medication would be monitored and his falls documented. The fall plan also indicated "Other preventative measures: Wheelchair may be used when notably unsteady. [Client B] will not tolerate gait belt. Staff utilize stand by assistance while walking."</p> <p>Client B's record indicated the client's IDT last met on 9/8/11 in regard to dietary recommendations. Client B's 6/27/11 ISP indicated the facility/IDT neglected to</p>			

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	<p>meet, review and/or update client B's 1/3/11 fall prevention plan since the client fell and fractured his ankle in 3/11 and had falls (with and without seizures/injuries) on 8/26/11, 9/9/11, 10/7/11 and 11/10/11.</p> <p>Interview with staff #2 on 11/16/11 at 5:38 PM indicated client B was at risk for falls due to his seizures.</p> <p>Interview with staff #3 on 11/16/11 at 6:17 PM indicated client B would fall when having seizures.</p> <p>Interview with client B's parent/guardian on 11/22/11 at 9:51 AM indicated client B had a history of falls due to his seizures and gait. Client B's guardian indicated client B would not be able to tolerate wearing a helmet as the client did not like hats.</p> <p>Interview with staff #7 on 11/17/11 at 6:05 AM indicated client B was a fall risk.</p> <p>Interview with administrative staff #1, the Qualified Mental Retardation Professional (QMRP), staff #1 and LPN #2 on 11/22/11 at 10:45 AM indicated client B had a history of falls and had 2 falls since fracturing his ankle in 3/11. When asked if client B's IDT had addressed the client's falls and/or updated the client's fall plan</p>				

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	<p>since his fracture in 3/11, staff #1 and the QMRP indicated client B had a gait belt, wheelchair, alarm and stand by assist when he first returned to the group home. LPN #2 indicated client B's 1/11 fall plan needed to be updated. Staff #1 indicated client B was unsteady on his feet when he woke in the morning. LPN #2 indicated she did not have the result of client B's bone density study in the record. LPN #2 stated "We do not have a copy of the results. It went directly to his doctor."</p> <p>3. During the 11/16/11 observation period between 3:10 PM and 7:10 PM, client A arrived at the group home at 5:09 PM. Client A was in a wheelchair which was pushed by staff. Client A was pale in color in her face. While client A was eating her dinner at 6:05 PM, client A began making a gagging noise. Interview with staff #8 on 11/16/11 at 6:05 PM indicated client A's gagging was due to a procedure she had earlier in the day. Staff #8 then handed client A Ensure to drink.</p> <p>During the 11/17/11 observation period between 5:55 AM and 9:45 AM, at the group home, client A's bedroom door was closed at 5:55 AM. Client A stayed in her room in bed for most of the observation period. At 8:02 AM, staff #3 took client A's morning medications to the client's bedroom to administer. Client A was</p>				

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	<p>laying on her back covered up. Staff #3 woke the client, uncovered her to some extent and lifted the client up in the bed. Staff #3 also placed pillows behind the client's back to sit the client up for her medications. Client A told staff #3 she was not feeling well. Client A made a grimace facial expression as if client A was in pain when staff #3 lifted the client up in the bed. Client A started gagging when the pills were placed in her mouth. Staff #3 gave client A water to drink as the client was making a gagging sound/motion. At 9:35 AM, when client A was eating her breakfast, client started making a gagging sound/noise and motion.</p> <p>Client A's record was reviewed on 11/21/11 at 10:52 AM. Client A's Individual Progress Notes indicated the following (not all inclusive):</p> <p>-10/31/11 at 7:50 PM, "...Staff cut [client A's] food in small pieces to prevent 'gagging' that's been occurring. Staff cued her to take small bites & take sip as needed. [Client A] requested to go to bed after dinner and c/o (complained of) throat pain...."</p> <p>-11/1/11 at 6:30 AM, "[Client A] asleep when staff arrived, she slept ok but not feeling well. Asked for water several</p>			

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	<p>times throughout nite (sic)..." The 11/1/11 note indicated client A did not have a temperature at that time.</p> <p>-11/5/11 at 2:00 PM, "...[Client A] was gagging throughout meal. [Client A] was unable to eat breakfast & lunch. Staff gave her Ensure...."</p> <p>-11/7/11 late entry for 11/6/11 at 9:23 AM, "Upon giving [client A] her medications she was c/o pain in her chest. [Client A] also had signs and symptoms of increased temp of 99.7, increased heart rate of 100 and diaphoresis (excessive sweating). I (staff #9) called on call nurse (LPN #2) and she said give her acetaminophen (PRN) (as needed medication) for pain. [Client A] appeared to be felling better later in the day. [Client A] continues to gag throughout the day for the past week. [Client A] was unable to eat in the am. She ate no food for breakfast and small bits for lunch (sic)."</p> <p>-11/7/11 at 9:36 AM, client A asked staff to call her sister as client A wanted her sister to know "...she (client A) was sick. Her sister plans to call back @ (at) 1:00 pm to speak (with) [staff #1], so [client A] can be seen by a doctor. [Client A] is still c/o (complaining of) pain and refusing to eat meals. Today she had a temp of 100.1</p>				

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	<p>and was diaphoric. I (staff #9) called [LPN #2] and got voice mail, I (staff #9) left a message to see if [client A] could have something else for pain because the acetaminophen is not alleviation for pain (sic)."</p> <p>-11/8/11 at 2:30 PM, client A indicated she did not want lunch.</p> <p>-11/21/11 at 6:40 AM, "[Client A] awake lying in bed when staff arrived. [Client A] looks a little flushed & (and) when staff asked how she was feeling [client A] stated she wasn't feeling well and also asked for water. She was a little restless throughout the nite (sic). Staff checked her temp and it was 99.9 When staff awakened [client A] to give shower [client A] refused which is so very not like [client A]. [Client A] is still in bed sleeping."</p> <p>Client A's Medical Appointment/New Order Forms indicated the following (not all inclusive):</p> <p>-11/5/10 client A had a pelvic ultrasound completed and was diagnosed with Positional Urinary Incontinence.</p> <p>-11/16/10 ultrasound showed a "...mass in pelvis along post wall of bladder...."</p>				

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	<p>-12/13/10 will schedule cystoscopy of bladder due to mass</p> <p>-1/6/11 "Procedure Cystoscopy, transurethral Resection of Bladder Tumor Findings: 2-3 cm Papillary Bladder Tumor...."</p> <p>-4/2/11 pathology report indicated malignancy of tumor not identified. The note indicated "Need to schedule surveillance cysto (cystoscopy) in 3 months in OR (operating room)."</p> <p>-10/6/11 "F/U (follow-up) Bladder CA (cancer) Procedure-Cysto, Bladder Biopsy, RT (right) Ureteral Stent Findings- Papillary Lesion RT UO (urethral orifice) Rec (recommend) Await Path (pathology) Cysto 3 mos (months)."</p> <p>-10/18/11 unable to tolerate office cystoscopy stent removal procedure will do under general anesthesia.</p> <p>-11/10/11 "Dysphagia, Recent UTI (Urinary Tract Infection)."</p> <p>-11/15/11 seen doctor for physical examination. The form indicated client A was having a speech & swallowing problem since cystoscopy. The form also indicated client A was to have the stent removed on 11/16/11.</p>				

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W0154	<p>Client A's Health Care Coordination Monthly Health Reviews indicated the following (not all inclusive):</p> <p>-1/6/11 had a cystoscopy transurethral resection of a bladder tumor performed. The note indicated "The results revealed a 2-3 cm papillary bladder tumor...." The note indicated another procedure would be done to stage the carcinoma.</p> <p>-1/13/11 scheduled for surgery to stage the carcinoma on 1/28/11.</p> <p>-2/10/11 urinalysis ordered by doctor due to increase incontinence of urine and stool.</p> <p>-2/15/11 received call from doctor's nurse who indicated "...the histology came back on biopsy and [client A] has late stage ur The facility must have evidence that all alleged violations are thoroughly investigated. Based on interview and record review for 1 of 5 allegations of abuse, neglect and/or injuries of unknown origin reviewed, the facility failed to conduct an investigation in regard to an allegation of neglect concerning client B.</p> <p>Findings include: The facility's reportable incident</p>	W0154	<p><i>What corrective action will be accomplished for these residents found to have been affected by the deficient practice? Facility policy and procedure for med errors was followed as written. It was confirmed at the time of the ER visit that the medications were not given. It was not substantiated by physician or labs that the missed doses resulted in seizure. Client has multiple break</i></p>	12/29/2011

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	<p>reports/investigations were reviewed on 11/16/11 at 12:15 PM. The facility's 11/4/11 reportable incident report indicated "[Client B] was taken to ER (emergency room) by ambulance due to having seizure for apprx. (approximately) 7min. (minutes). [Client B's] magnet was swiped. Seizure activity continued..."</p> <p>The 11/4/11 reportable incident report indicated client B's seizures stopped once IV fluids were started and the client did not have anymore seizures at the hospital. The reportable incident report indicated client B's dad picked the client up from the hospital and had staff pack his medications to go home for the weekend. The 11/4/11 reportable incident report indicated "...In the process of packing [client B's] meds, the staff found that [client B] had not received all of his AM meds on 11/4 (Phenytoin SOD (sodium) (seizure) ext (extended release) 100mg (milligrams) 2cap (capsules) and Zyprexa 2.5mg) (behavior). ON-Call notified the Nurse ON-Call of [client B's] outcome @ (at) the ER as well as the missed meds..."</p> <p>The facility's 11/4/11 reportable incident report did not indicate any additional information and/or documentation in regard to the allegation of possible neglect in regard to client B not receiving his seizure medications and going to the ER for seizures.</p>		<p>through seizures. Upon each seizure that requires ER intervention, his medication is reviewed and confirmed to have been administered accurately. St. Vincent New Hope will conduct investigations when an act or omission of duty is deemed the cause of harm or potential from harm to an individual. <i>How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken</i> All residents have the potential to be affected by this deficient practice. All resident records were reviewed to ensure that no incidents requiring investigation had gone without reporting or investigating. <i>What measure will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur</i> All associates working in this facility will be retrained on reporting and investigation guidelines, as well as medication administration requirements. Staff responsible for the error was disciplined and retrained at the time of the incident. <i>How the corrective action will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place and the date the systemic changes will occur.</i> Group Home TL and / or QMRP will review progress notes weekly to ensure that any future incident</p>		

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W0156	<p>Confidential interview B indicated facility staff who did not normally work in the home may have missed passing some of client B's medications. Confidential interview B stated "Depends on who is passing meds."</p> <p>Interview with staff #1 on 11/17/11 at 12:50 PM indicated client B did not receive all his morning medications at the 11/4/11 medication pass as the facility staff missed passing 2 of the client's pills. Staff #1 indicated she did not conduct an investigation in regard to an allegation of possible neglect. Staff #1 stated "I did not look at it as neglect."</p> <p>This federal tag is related to complaint #IN00099909.</p> <p>9-3-2(a) The results of all investigations must be reported to the administrator or designated representative or to other officials in accordance with State law within five working days of the incident.</p> <p>Based on interview and record review for 1 of 4 allegations of abuse, neglect and/or injuries of unknown origin reviewed, the facility failed to ensure all investigations were completed within 5 working days for client B.</p> <p>Findings include:</p>	W0156	<p>is addressed and investigated. Group Home QMRP will be onsite to monitor improvements 2 times per week minimum for the next 2 months. Group Home Director will be onsite weekly over the next month to provide onsite monitoring, care and oversight of improvements.</p> <p><i>What corrective action will be accomplished for these residents found to have been affected by the deficient practice? Facility policy and procedure for reporting was reviewed and remains appropriate. Team Leader was inefficient in the timeliness of monitoring ongoing reports and follow up reports. QMRP will submit and monitor ongoing</i></p>	12/29/2011	

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	<p>The facility's reportable incident reports and/or investigations were reviewed on 11/16/11 at 12:15 PM. The facility's 9/17/11 reportable incident report indicated "Bruise reported to TL (Team Leader) upon routine weekly phone call to parents. Bruise is on left cheek of buttocks just above thigh. Bruise is rectangular in shape, approx (approximately) 3" (inches) L (long) and 2" W (wide), color brownish/yellow...Team Leader informed by parent that Bruise (sic) was discovered by parent on 9/17/11 when they were changing [client B] at their home...." The reportable incident report indicated a preliminary investigation was started in regard to the injury of unknown origin.</p> <p>A 9/27/11 follow-up report indicated "Bruise appears to be healing within normal parameters. TL still conducting investigation as some staff who worked the 24-48 hrs (hours) prior to 9/17/11 are relief staff. TL awaiting statements."</p> <p>The facility's 11/8/11 Fall/Injury Investigation indicated the investigation in regard to the 9/17/11 injury of unknown origin was not completed until 11/8/11.</p> <p>Interview with administrative staff #1 and staff #1 on 11/22/11 at 10:45 AM</p>		<p>BDDS reports, timeliness of investigations. <i>How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken</i> All residents have the potential to be affected by this deficient practice. All residents records were reviewed to ensure that no incidents requiring investigation had gone without reporting and investigation. No other investigations fell beyond the required timeframe. <i>What measure will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur</i> All individuals working at this facility will be retrained on the reporting and investigation requirements as well as medication administration requirements. Investigation format was revised to be consistent with DDRS proposed template for investigations. This format will facilitate a more concise, yet thorough investigation. The timeframes for investigations will be reviewed as they are submitted to Group Home Director. Team Leader/QMRP will conduct weekly check of medications and MAR for accuracy. Staff will be reeducated on accurate med admin and documentation. How the corrective action will be monitored to ensure the deficient practice will not recur, what</p>				

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W0186	<p>indicated the incident occurred on 9/17/11. Administrative staff #1 indicated she reviewed the incident on 9/23/11. When asked if the investigation was completed on 9/23/11, administrative staff #1 indicated the 9/17/11 investigation was not conducted/completed within 5 working days. Staff #1 indicated she was waiting on additional statements before completing/finishing the investigation.</p> <p>9-3-2(a)</p> <p>The facility must provide sufficient direct care staff to manage and supervise clients in accordance with their individual program plans.</p> <p>Direct care staff are defined as the present on-duty staff calculated over all shifts in a 24-hour period for each defined residential living unit.</p> <p>Based on observation, interview and record review for 4 of 4 sampled clients (A, B, C and D), the facility failed to ensure sufficient numbers of staff worked during the morning, evening and/or weekend shifts to ensure clients had adequate supervision/monitoring to prevent potential falls of clients, who had a history of falls, and/or to meet the needs of clients.</p> <p>Findings include:</p>	W0186	<p>quality assurance program will be put into place and the date the systemic changes will occur. Team Leader/QMRP will continue to audit medication record in any event in which the individual goes to the hospital or needs other immediate care which may be caused by lack of proper administration. Team Leader/QMRP will conduct weekly med administration observation. Nurse Consultant will conduct medication administration observation at routine visits to home, no less than q 2 weeks.</p> <p><i>What corrective action will be accomplished for these residents found to have been affected by the deficient practice? Staff schedule was revised to identify 3 to 4 staff routinely for the times in which individuals are most in need of the majority of their staff hours. Staff schedule is attached. Staff schedule for 11/27/11 – 12/22/11 was reviewed by Group Home Director. It was compared to actual clockings to ensure that the home was staffed according to the shifts designated. It was</i></p>	12/29/2011	

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	<p>The facility's reportable incident reports, facility generated incident reports and/or investigations were reviewed on 11/16/11 at 12:15 PM. The facility's reportable incident reports, facility incident reports and/or investigations indicated the following:</p> <p>-9/20/11 "[Client D] had gone to his room after eating a snack to get ready for bed. He was coming out of his room down the hallway to living room when he tipped his wheelchair forward, causing him to fall on the floor. His seatbelt was on which caused the chair to come over on top of him. He did not have on his upper chest strap, which holds his torso up straight so he doesn't lean forward causing chair to topple. He skinned up the top off (sic) his nose and had a bloody nose, that requires standard first aid to be given by staff. Staff assisted him up and back into his wheelchair, treated his bloody and skinned nose...." The 9/20/11 reportable incident report indicated the fall occurred at 10:47 PM.</p> <p>The facility's 9/21/11 Fall/Injury Investigation indicated client D had a history of falls.</p> <p>-9/17/11 "[Client C] was walking through the living room and bumped his foot against housemates wheelchair and fell.</p>		<p>consistently staffed according to the revised schedule. Staff schedule does not designate but should also include the 35-40 hours of onsite presence of the Team Leader for the home. The Team Leader position often fluctuates between supervision, house management and direct support in daily care needs. Team Leaders document their time monthly and submit it to their manager. In the event of a call off, the home census, activities and client care needs will be considered as staffing is arranged at that time. <i>How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken</i> All residents have the potential to be affected by this deficient practice. All shifts were reviewed to have been filled as scheduled. What measure will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur Director and QMRP will monitor weekly schedule.How the corrective action will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place and the date the systemic changes will occur.Group Home QMRP will be onsite to monitor improvements 2 times per week minimum for the next 2 months. Group Home Director will be onsite weekly over</p>		

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	<p>When he fell he hit the area where he just previously had stitches removed from. - Nurse ON Call instructed staff to take [client C] to the ER...-Stitches were put back in laceration..." The reportable incident report indicated the incident occurred at 12:15 PM.</p> <p>The facility's 9/27/11 Fall/Injury Investigation indicated client C had a history of falls with injuries.</p> <p>-9/9/11 "[Client B] fell dining room while walking around the table (sic). His left foot caught in the wheel of another individuals wheelchair causing the fall. He fell down on his knees and hands and hit his forehead on the floor...He had a red mark on his forehead, right side just above the right eye...A previous injury w/ (with) scab on right knee had been re-opened and was bleeding..." The 9/9/11 reportable incident report indicated client B's mother wanted the staff to examine client B's feet for any injuries. The reportable incident report indicated the Team Leader checked client B's feet 3 different times on 9/9/11 and no swelling and/or bruising was noted to the client's feet. The 9/9/11 reportable incident report indicated "...Plan to arrange tables in dining room to allow more space between tables and wall (natural support) and matched up with small blue tape for</p>		the next month to provide onsite monitoring, care and oversight of improvements.		

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	<p>accuracy each time at meal time. Seating of individuals to be monitored by staff...."</p> <p>The reportable incident report indicated the incident occurred at 6:30 PM.</p> <p>The facility's 9/9/11 Fall/Injury Investigation indicated client B had a history of falls and had a fall on 8/27/11.</p> <p>-9/8/11 staff heard a "loud noise" from client C's bedroom. Client C was found on the floor in front of his chair with blood on the client's head. Client C was taken to a local emergency room (ER) due to a laceration above his left eyebrow which was 1 1/2 inches long and due to an abrasion on the client's left cheek area. The 9/8/11 reportable incident report indicated client C received stitches and his Tetanus was updated.</p> <p>-8/26/11 client B fell out of a chair and received a rug burn to both knees. The facility's 8/31/11 follow-up report indicated client B was walking around and tripped over the program books which were on the floor and the client's right shoe string was untied.</p> <p>-8/26/11 Occurrence Outside Practice Standards (OOPS) report indicated client B fell while he was walking around in the living room. The OOPS report indicated 2 staff were on duty at the time of the fall.</p>				

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	<p>One was in the kitchen and one was helping another client in the bathroom. The 8/26/11 OOPS report indicated the above mentioned fall was the second fall of the evening. The report indicated client B was not injured with the second fall.</p> <p>-8/25/11 client D was found to have bruising around his eye. During the investigation it was discovered client D fell in his bedroom and hit his eye. The facility's 8/29/11 Fall/Injury Investigation indicated staff did not witness the fall but assisted client D to get up off the floor. The investigation indicated a peer found client D on the floor as client D did not lock his wheelchair brakes and fell forward out of the wheelchair as the client leaned forward to get something. The facility's investigation indicated the incident occurred around 6:00 PM.</p> <p>-3/19/11 "While conducting a follow up body check on 03-19-2011, staff reported that [client B's] right ankle was swollen and bruising had appeared. STaff (sic) informed on call TL (Team Leader) and on call NC (Nurse Coordinator). Both parties agreed to have [client B] transported to the hospital ER for examinations (sic)...The follow up body check was being conducted due to falls that had happened on 03/18/2011...and the</p>				

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	<p>body check conducted 3/18/2011 revealed no injuries. X-rays were completed at the ER and revealed a fracture to his ankle...."</p> <p>During the 11/16/11 observation period between 3:10 PM and 7:10 PM, at the group home, there were 5 staff to 8 clients in the group home. Client C utilized a roller walker when ambulating as client C had an unsteady gait. Client C had injuries to the left side of his face. Client C's lip was swollen and scabbed over with small cuts/lacerations to his chin area which were red and scabbed over. Client C also had a laceration/bruise above his upper left eyebrow. At 5:15 PM, client C walked into the dining room area where client D was setting the dining room table. Client D was in a wheelchair and client C was utilizing his roller walker. Client C was walking to his bedroom and walked directly into the back of client D's wheelchair with his walker. Client D told client C to go around him. Client C did not walk around client D and continued to hit client D's wheelchair with his walker until client D moved out of client C's way. At 6:50 PM, client C was in his bedroom with the door open. Client C's walker was at the entrance of the client's bedroom door while client C was walking around his bedroom without the walker. When client C came out of his bedroom, client C grabbed his walker and moved at a fast</p>			

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	<p>pace, almost running over the surveyor. None of the 5 staff, who were working (staff #2, #3, #4, #5 and #6), were in the area to redirect client C to use his walker while ambulating in his bedroom and/or to encourage the client to slow down when using his walker. Client C did not wear and/or utilize a helmet during the observation period. During the above mentioned observation period clients A, B, C, F, G and H were in wheelchairs with 5 staff in the group home. Clients A, B, C, F, G and H required some physical assistance in toileting when the clients came home from the day service program.</p> <p>Client D's record was reviewed on 11/16/11 at 1:45 PM. Client D's 3/14/11 ISP (individual Support Plan (ISP) indicated client D's diagnoses included, but were not limited to, Bilateral Deafness, Epilepsy, Neurogenic Bladder, Osteopenia of Spine and Hip and Spastic Quadriplegia Features. Client D's ISP indicated the client utilized a wheelchair for mobility.</p> <p>Client C's record was reviewed on 11/17/11 at 4:08 PM. Client C's 11/16/11 Monthly Health Review indicated "... [Client C] fell in his room trying to get up without staff & walker. [Client C] has cuts on his lip. Ice & Bacitracin applied. Assessed [client C] today. Lip swollen</p>				

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	<p>with 2 cuts on lip & 1 on chin."</p> <p>Client C's 9/19/11 to 9/19/12 Methodology sheet indicated client C had an objective to use his walker in all situations during awake hours with staff physical assistance and/or cues. The 9/19/11 methodology sheet indicated "1. Staff will monitor [client C] during awake hours and ensure he has his walker available at all times. This includes when he is in his room sitting in his chair. His walker is to be placed in front of him while watching TV (leisure goal). 2. Staff will cue [client C] to use his walker any time he needs to walk any distance within the Group Home, at Day program or in the community. 3. If [client C] is out walking around without his walker, he will need staff to provide stand by assistance for any walking until his walker can be retrieved for him. 4. If [client C] is walking without his walker, staff is to ask him where his walker is and remind him he needs to have his walker with him for assistance, and provide stand by assistance until walker is retrieved. 5. Staff is to cue [client C] to use his walker to and from any area in the home; bathroom, kitchen, dining room, living room; and he is to use his walker to and from the van, at day program and in the community. 6. When [client C] is sitting at the dining room table, his walker is to</p>				

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	<p>be next to him in case he needs it. When [client C] is sitting in the living room, his walker is to be placed directly in front of him for him to use to help get him up...."</p> <p>Client C's 10/25/11 Individual Support Plan (ISP) indicated client C's diagnoses included, but were not limited to, Cerebral Palsy and Glaucoma.</p> <p>Client B's record was reviewed on 11/21/11 at 1:28 PM. Client B's 3/19/11 X-ray report indicated "There is evidence of a trimalleolar fracture. A spiral fracture is identified involving the distal fibular diaphysis. There is a mild degree of lateral and posterior displacement of the distal fracture fragment. A transverse fracture is identified in the base of the medial malleolus. There is a mild lateral displacement. There is a mildly displaced fracture through the dorsal aspect of the posterior malleolus...IMPRESSION: 1. Trimalleolar fracture."</p> <p>Client B's 11/10/11 Record of Seizure Observations indicated client B was walking and fell when the client had a seizure causing the client to hit his face. The seizure record indicated client B's magnet for his Vagal Nerve Stimulator (VNS) was used to stop the seizure.</p>				

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	<p>Client B's 10/7/11 seizure record indicated client B was walking and fell to the ground during a seizure. The seizure record did not indicate client B was injured when he fell.</p> <p>Client B's 10/11 physician's order indicated client B's diagnoses included, but were not limited to, Cerebral Palsy and Seizure disorder.</p> <p>Client A's record was reviewed on 11/21/11 at 10:52 AM. Client A's Individual Progress Notes indicated the following (not all inclusive):</p> <p>-11/21/11 at 6:40 AM, "[Client A] awake lying in bed when staff arrived. [Client A] looks a little flushed & (and) when staff asked how she was feeling [client A] stated she wasn't feeling well and also asked for water. She was a little restless throughout the nite (sic). Staff checked her temp and it was 99.9 When staff awakened [client A] to give shower [client A] refused which is so very not like [client A]. [Client A] is still in bed sleeping."</p> <p>-11/8/11 at 2:30 PM, client A indicated she did not want lunch.</p> <p>-11/7/11 at 9:36 AM, client A asked staff to call her sister as client A wanted her</p>			

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	<p>sister to know "...she (client A) was sick. Her sister plans to call back @ (at) 1:00 pm to speak (with) [staff #1], so [client A] can be seen by a doctor. [Client A] is still c/o (complaining of) pain and refusing to eat meals. Today she had a temp of 100.1 and was diaphoric. I (staff #9) called [LPN #2] and got voice mail, I (staff #9) left a message to see if [client A] could have something else for pain because the acetaminophen is not alleviation for pain (sic).</p> <p>-11/7/11 late entry for 11/6/11 at 9:23 AM, "Upon giving [client A] her medications she was c/o pain in her chest. [Client A] also had signs and symptoms of increased temp of 99.7, increased heart rate of 100 and diaphoresis (excessive sweating). I (staff #9) called on call nurse (LPN #2) and she said give her acetaminophen (PRN) (as needed medication) for pain. [Client A] appeared to be feeling better later in the day. [Client A] continues to gag throughout the day for the past week. [Client A] was unable to eat in the am. She ate no food for breakfast and small bits for lunch (sic)."</p> <p>-11/5/11 at 2:00 PM, "...[Client A] was gagging throughout meal. [Client A] was unable to eat breakfast & lunch...."</p>			

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	<p>-11/1/11 at 6:30 AM, "[Client A] asleep when staff arrived, she slept ok but not feeling well. Asked for water several times throughout nite (sic)..." The 11/1/11 note indicated client A did not have a temperature at that time.</p> <p>Client A's 10/11 physician's orders indicated client A's diagnoses, included, but were limited to, Athetoid Cerebral Palsy, Neurogenic Bladder, Bladder Cancer and Urinary Urgency. Client A's 4/8/11 ISP indicated the client utilized a wheelchair for mobility.</p> <p>The facility's staffing schedules and time cards were reviewed on 11/17/11 at 12:20 PM and on 11/26/11 at 8:08 AM. The facility's October and November 2011 time cards, of staff who worked in the home, indicated the following:</p> <p>-10/5/11 2 staff worked the evening shift (3 PM to 11 PM and 5 PM to 11 PM).</p> <p>-10/13/11 2 staff worked the morning shift (6 AM to 1:30 PM and 7 AM to 3 PM) (Clients leave for day program by 10 AM).</p> <p>-10/15/11 2 staff worked the evening shift (3 PM to 11 PM). Review of an 11/26/11 e-mail on 11/28/11 at 1 PM indicated no clients were on LOA (leave of absence)</p>						

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	<p>form the group home on this weekend day.</p> <p>-10/18/11 one staff in the group home from 3 PM to 5 PM. Two staff came in at 5 PM.</p> <p>-10/20/11 2 staff worked the evening shift (3 PM to 11 PM and a staff worked 3 PM to 7 AM the next morning).</p> <p>-10/22/11 2 staff worked during the day shift (8:00 AM to 10 AM and then 11 AM to 11:00 PM and a second staff worked 7 AM to 3 PM). 2 staff also worked the evening shift (11 AM to 11 PM and 3 PM to 11 PM). The facility's 11/26/11 e-mail indicated 1 client went on LOA on 10/22/11 (weekend day).</p> <p>-10/26/11 2 staff worked the morning shift (getting clients ready for work) 6 AM to 2 PM and 7 AM to 3 PM.</p> <p>-10/27/11 2 staff worked the morning/day shift (getting clients ready for work) 6 AM to 2 PM and 7 AM to 3 PM.</p> <p>-10/28/11 2 staff worked the morning shift (getting clients ready for work) 6 AM to 2 PM and 7 AM to 3 PM, and 2 staff worked the evening shift (3 PM to 11 PM and 3 PM to 8 PM).</p>				

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	<p>-11/4/11 2 staff worked the morning shift (getting clients ready for work) 7 AM to 9:25 AM and 7 AM to 3 PM.</p> <p>-11/5/11 2 staff worked the morning/day shift (7 AM to 3 PM) and 2 staff worked on the evening shift (3 PM to 11 PM and 3 PM to 10 PM). An 11/26/11 e-mail indicated 1 client was on LOA from the group home on this weekend day.</p> <p>-11/7/11 2 staff worked the morning shift (getting clients ready for work) 7 AM to 3 PM.</p> <p>-11/9/11 2 staff worked the morning shift (getting clients ready for work) 6 AM to 3 PM and 7 AM to 3 PM, and 2 staff worked the evening shift (3 PM to 11 PM).</p> <p>-11/11/11 2 staff worked the morning shift (getting clients ready for work) 6 AM to 3 PM and 7 AM to 10:30 PM.</p> <p>-11/14/11 2 staff worked the morning shift (getting clients ready for work) 6 AM to 11 AM and 7 AM to 3 PM.</p> <p>Interview with staff #2 on 11/16/11 at 5:38 PM indicated client B, C and D were at risk for falls. Staff #1 indicated clients B, C and D had a history of falls. Staff #2 stated client C was "not stable." Staff #2</p>				

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	<p>indicated client C utilized a walker but still had falls. Staff #2 indicated the facility had been short of staff and staff #2 had complained about that in the past. Staff #2 indicated the facility had added a fourth staff person due to the needs of the clients in the group home about 6 to 7 months ago. Staff #2 indicated 4 staff did not always work when other staff called off and/or did not come in.</p> <p>Interview with staff #6 on 11/16/11 at 6:10 PM indicated client C was at risk for falls. Staff #6 indicated client C had received injuries from a recent fall. Staff #6 indicated when 4 staff worked, the facility had sufficient staff to meet the needs of the clients.</p> <p>Interview with staff #3 on 11/16/11 at 6:17 PM indicated client D did not sleep good at night due to Insomnia. Staff #3 indicated there were 6 wheelchair clients (A, B, C, D, F, G and H) in the group home and client A required a lot attention due to her medical needs. Staff #3 indicated there had been times when only 2 staff to worked when all 8 clients were in the group home awake. Staff #3 indicated the facility had been working 3 staff on the morning/day shifts and evening shift. Staff #3 stated "We are suppose to have 4." When asked if the facility had sufficient staff to meet the</p>				

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	<p>needs of the clients, staff #3 stated "Not really if people don't pick up shifts." Staff #3 indicated the facility was short staffed as there were several vacancies open at the group home.</p> <p>Interview with staff #4 on 11/16/11 at 6:25 PM indicated they did not feel the facility had sufficient staff to meet the needs of the clients. Staff #4 indicated it would vary from 3 to 4 staff who worked the evening shift. Staff #4 stated there had been "a lot of call offs."</p> <p>Interview with staff #8 on 11/16/11 at 6:35 PM indicated client C had a history of falls and a walker was put in place to assist the client. Staff #8 indicated client D had problems with sleeping during the night and also was at risk for falls. Staff #8 indicated the facility was to have 4 staff working when clients were awake. When asked if the facility had enough staff to meet the needs of the clients, staff #8 stated "Not all the time. We need 4 staff due to the needs of the clients."</p> <p>Interview with staff #5 on 11/16/11 at 7:02 PM indicated staff #5 did not normally work at this group home, but was filling in as the group home was short staffed.</p> <p>Confidential interview A indicated the</p>				

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	<p>group home would sometimes be short of staff. Confidential interview A stated one Sunday, there was no staff to work in the group home and the facility "Had to scramble to get staff."</p> <p>Interview with staff #7 on 11/17/11 at 6:05 AM indicated she was busy at night working the night shift between 11 AM to 7 AM. Staff #7 indicated she had to do the cleaning of the group home at night and toilet client A every 2 hours due to her urine incontinence. Staff #7 indicated client A had been having some pain at night due to her procedure on 11/16/11 and she had to give her Tylenol for pain during the night. Staff #7 indicated she would have to listen for clients B, C and D to assist them when they got up at night to get up and/or go to the bathroom so the clients would not fall. Staff #7 indicated she would have to listen for clients C and D as they liked to try and get up on their own without any assistance. Staff #7 stated there were several clients who had falls at the group home, but client C "fell much more." Staff #7 stated "[Client C] is unstable when walking. If anything in way, he will go down. He does not walk around." Staff #7 indicated client C fell in the living room, bedroom and in the bathroom in the past.</p> <p>Interview with staff #1 on 11/17/11 at</p>				

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	<p>12:15 PM indicated she worked from 3 PM to 7 PM last Thursday (11/10/11). When asked if staff #1 worked/covered shifts in the group home, staff #1 stated "I cover medical appointments and van runs." Staff #1 did not provide any additional documentation and/or information on days she worked as staff in the group home.</p> <p>Interview with administrative staff #1, the Qualified Mental Retardation Professional (QMRP), staff #1 and LPN #2 on 11/22/11 at 10:45 AM indicated clients B, C and D had a history of falls with injuries. The QMRP, staff #1 and LPN #2 stated facility staff should monitor the clients when ambulating and/or provide "stand by assist." Staff #1 and LPN #2 indicated client B had seizures and would fall to the ground. Staff #1 and LPN #2 indicated client A had a procedure for bladder cancer check and was having some medical issues. Staff #1 indicated client D would stay up at night until about 10:30 PM to 11 PM. Staff #1 stated staff had to "tuck him in at night." Staff #1 indicated client D had falls as he would lean forward out of his wheelchair trying to get something and then fall. When asked how many staff were working when client D fell on 9/3/11 and 9/20/11, staff #1 stated "Should have been 2." When asked what the staffing ratio was for the</p>				

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W0189	<p>clients in the group home, administrative staff #1 indicated 2 to 3 staff worked the morning and evening shifts. Administrative staff #1 indicated 1 staff worked at night. Administrative staff #1 indicated the group home was short of staff as the facility had recently terminated staff for doing home work and using cell phones while working. Administrative staff #1 indicated they were attempting to address the staffing issues and adjust schedules to ensure there were enough staff to meet the needs of the clients. Administrative staff #1 stated the facility would "fluctuate staff" depending on how many clients were in the group home and/or went on LOA with family.</p> <p>This federal tag relates to complaint #IN00099909.</p> <p>9-3-3(a) The facility must provide each employee with initial and continuing training that enables the employee to perform his or her duties effectively, efficiently, and competently. Based on observation, interview and record review for 1 of 4 sampled clients (D), the facility failed to ensure all staff were trained in regard to applying a gait belt restraint/harness to ensure the safety of the client.</p> <p>Findings include:</p>	W0189	<p><i>What corrective action will be accomplished for these residents found to have been affected by the deficient practice? PT reevaluated client D on 12/21/11 to properly assess seating and use of supports while awaiting approval for custom seating and new wheelchair. Recommendations will be</i></p>	12/29/2011	

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	<p>During the 11/16/11 observation period between 3:10 PM and 7:10 PM, at the group home, client D ambulated/sat in a wheelchair with his seat belt on and a gait belt strapped across his chest which fastened at the back of the wheelchair with a metal buckle. The gait belt was placed high on the client's chest, was located directly under the client's arm pits and fastened near the top sides of the back of the wheelchair. Client D could not move/lean forward. The gait belt was positioned high up on the client's chest (near shoulder area) and tight.</p> <p>During the 11/17/11 observation period between 5:55 AM and 9:45 AM, at the group home, client D was up ambulating in the wheelchair at 5:55 AM. Client D had his seat/lap belt across his upper thighs on his wheelchair and the gait belt was across the client's waist area and fastened/buckled at the back of the wheelchair. The gait belt buckle was fastened across the back middle part of the wheelchair. Client D was able to lean forward when he ambulated in his wheelchair. At 7:31 AM, staff #2 was prompted to adjust client D's gait belt. Staff #2 moved/placed the gait belt up, across client D's middle chest and a lap tray was placed on the client's wheelchair.</p>		<p>reviewed by IDT and implementation timeframe will be identified. As of 12/22/11 wheelchair is expected for approval from Medicaid, anticipated in the next 2 weeks. IDT will review 12/21 PT recommendations by 12/29 and identify appropriate procedures for safety. <i>How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken</i> All residents with a fall risk have the potential to be affected by this deficient practice. All residents are reassessed for Fall Risk and High Risk Plans for Falls updated to new format as applicable. <i>What measure will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur</i> Group Home QMRP will review weekly status of wheelchair and positioning for individuals in the home to assess that support plans continue to be effective. How the corrective action will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place and the date the systemic changes will occur. Group Home QMRP will be onsite to monitor improvements 2 times per week minimum for the next 2 months. Group Home Director will be onsite weekly over the next month to provide onsite</p>		

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	The facility's reportable incident reports, facility generated incident reports and/or investigations were reviewed on 11/16/11 at 12:15 PM. The facility's 9/20/11 reportable incident report indicated "[Client D] had gone to his room after eating a snack to get ready for bed. He was coming out of his room down the hallway to the living room when he tipped his wheelchair forward, causing him to fall on the floor. His seatbelt was on which caused the chair to come over on top of him. He did not have on his upper chest strap, which holds his torso up straight so he doesn't lean forward causing chair to topple. He skinned up the top off (sic) his nose and had a bloody nose, that requires standard first aid to be given by staff. Staff assisted him up and back into his wheelchair, treated his bloody and skinned nose...." The 9/20/11 reportable incident report indicated "...1. 30 minute checks put in place for staff to know [client D's] whereabouts and document what he is doing. 2. Temporary gait belt chest strap put into place around [client D's] upper torso and around the back of his wheelchair where it will fasten. - [Client D's] chest strap that is on his wheelchair has worn out Velcro. New chest strap has been ordered and is arriving and to be installed on 9/28/11 by DME (Durable Medical Equipment) facilitator. Gait belt strap will only be		monitoring, care and oversight of improvements.				

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	<p>used until new buckle chest strap is put in place...Back up plan will be attaching straps to wheelchair tray that snaps in the back so [client D] cannot get it off without assistance. This will only be used if the gait belt chest strap doesn't work. After new chest strap arrives and is installed on Sept (September) 28, a picture will be taken of [client D] and how he should be properly sitting in his chair with seat belt and chest strap attached...."</p> <p>An attached 10/10/11 Training Roster indicated staff #7, #9, #12 and #13 had not been trained to correctly apply client D's gait belt strap/harness.</p> <p>Interview with the Qualified Mental Retardation Professional (QMRP), staff #1, LPN #1 and administrative staff #1 on 11/22/11 at 10:45 AM indicated client D had a history of falls. The QMRP and staff #1 indicated the gait belt was put in place after the 9/20/11 fall which resulted in injuries. Administrative staff #1, staff #1 and the QMRP indicated staff were trained in regard to how apply the gait belt chest harness/restraint on 10/10/11. Administrative staff #1 and the QMRP indicated all staff should have been trained.</p> <p>This federal tag relates to complaint</p>				

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W0210	<p>#IN00099909.</p> <p>9-3-3(a) 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 observation, interview and record review for 1 of 4 sampled clients (D), the client's interdisciplinary team (IDT) failed to obtain an accurate assessment in regard to a gait belt being used as a chest harness/restraint to keep a client sitting up straight in a wheelchair and to not lean forward/fall.</p> <p>Findings include:</p> <p>During the 11/16/11 observation period between 3:10 PM and 7:10 PM, at the group home, client D ambulated/sat in a wheelchair with his seat belt on and a gait belt strapped across his chest which fastened at the back of the wheelchair with a metal buckle. The gait belt was placed high on the client's chest, was located directly under the client's arm pits and fastened near the top sides of the back of the wheelchair. Client D could not move/lean forward. The gait belt was positioned high up on the client's chest (near shoulder area) and tight.</p> <p>During the 11/17/11 observation period</p>	W0210	<p><i>What corrective action will be accomplished for these residents found to have been affected by the deficient practice? See also W189PT reevaluated client D on 12/21/11 to properly assess seating and use of supports while awaiting approval for custom seating and new wheelchair. Recommendations will be reviewed by IDT and implementation timeframe will be identified. As of 12/22/11 wheelchair is expected for approval from Medicaid, anticipated in the next 2 weeks. IDT will review 12/21 PT recommendations by 12/29 and identify appropriate procedures for safety. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken All residents with a fall risk have the potential to be affected by this deficient practice. All residents are reassessed for Fall Risk and High Risk Plans for Falls updated to new format as applicable. What measure will be put into place or what systemic changes the facility will make to ensure</i></p>	12/29/2011	

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	<p>between 5:55 AM and 9:45 AM, at the group home, client D was up ambulating in the wheelchair at 5:55 AM. Client D had his seat/lap belt across his upper thighs on his wheelchair and the gait belt was across the client's waist area and fastened/buckled at the back of the wheelchair. The gait belt buckle was fastened across the back middle part of the wheelchair. Client D was able to lean forward when he ambulated in his wheelchair. At 7:31 AM, staff #2 was prompted to adjust client D's gait belt. Staff #2 moved/placed the gait belt up, across client D's middle chest and a lap tray was placed on the client's wheelchair.</p> <p>The facility's reportable incident reports, facility generated incident reports and/or investigations were reviewed on 11/16/11 at 12:15 PM. The facility's 9/20/11 reportable incident report indicated "[Client D] had gone to his room after eating a snack to get ready for bed. He was coming out of his room down the hallway to the living room when he tipped his wheelchair forward, causing him to fall on the floor. His seatbelt was on which caused the chair to come over on top of him. He did not have on his upper chest strap, which holds his torso up straight so he doesn't lean forward causing chair to topple. He skinned up the top off (sic) his nose and had a bloody nose, that</p>		<p><i>that the deficient practice does not recur</i> Group Home QMRP will review weekly status of wheelchair and positioning for individuals in the home to assess that support plans continue to be effective. How the corrective action will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place and the date the systemic changes will occur. Group Home QMRP will be onsite to monitor improvements 2 times per week minimum for the next 2 months. Group Home Director will be onsite weekly over the next month to provide onsite monitoring, care and oversight of improvements.</p>				

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	<p>requires standard first aid to be given by staff. Staff assisted him up and back into his wheelchair, treated his bloody and skinned nose...." The 9/20/11 reportable incident report indicated "...1. 30 minute checks put in place for staff to know [client D's] whereabouts and document what he is doing. 2. Temporary gait belt chest strap put into place around [client D's] upper torso and around the back of his wheelchair where it will fasten. - [Client D's] chest strap that is on his wheelchair has worn out Velcro. New chest strap has been ordered and is arriving and to be installed on 9/28/11 by DME (Durable Medical Equipment) facilitator. Gait belt strap will only be used until new buckle chest strap is put in place...Back up plan will be attaching straps to wheelchair tray that snaps in the back so [client D] so [client D] cannot get it off without assistance. This will only be used if the gait belt chest strap doesn't work. After new chest strap arrives and is installed on Sept (September) 28, a picture will be taken of [client D] and how he should be properly sitting in his chair with seat belt and chest strap attached. TL (Team Leader) put some PT (physical therapy) exercises in place to help strengthen upper body and legs."</p> <p>Client D's record was reviewed on 11/16/11 at 1:45 PM. Client D's 3/14/11</p>				

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	<p>Individual Support Plan (ISP) indicated client D had an objective to sit back in his wheelchair and wear seatbelt securely fastened in his wheelchair during awake hours.</p> <p>Client D's 5/13/11 Medical Appointment/New Order Form indicated client D was evaluated by OT and/or PT on 5/13/11. The form indicated "OT (occupational therapy) evaluation completed. PT (patient) demonstrated the ability to tie, button, complete simple puzzles, write his first name, decreased crossing midline and fine motor coordination. Good basic functional skills. No further OT recommended at this time."</p> <p>Client D's 9/13/11 IDT (interdisciplinary team) note indicated client D's last PT evaluation indicated "...no further recommendations at this time...New Chest Harness ordered & (and) approved. PT/OT eval on an as needed basis...." Client D's 9/13/11 IDT note and/or 3/14/11 ISP did not indicate the facility obtained an accurate assessment in regard to the use of the gait belt chest strap to ensure the appropriate equipment/chest harness was being utilized to prevent the client from falling/leaning forward in his wheelchair.</p>				

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	<p>Interview with the Qualified Mental Retardation Professional (QMRP), staff #1, LPN #1 and administrative staff #1 on 11/22/11 at 10:45 AM indicated client D had a history of falls. The QMRP and staff #1 indicated the gait belt was put in place after the 9/20/11 fall which resulted in injuries. The QMRP and staff #1 stated the use of the gait belt was to be "temporary" until client D received a new chest harness for his wheelchair. Staff #1 indicated client D was not able to remove the gait belt chest harness on his own. LPN #1, staff #1, the QMRP and administrative staff #1 indicated the wheelchair tray was used for safety to prevent the client from leaning forward and falling out of the wheelchair. LPN #1 indicated the client's doctor wrote an order to obtain a PT/OT evaluation on 11/11/11. LPN #1, staff #1, the QMRP and administrative staff #1 indicated PT and/or OT had not assessed client D in regard to the use of a chest harness for positioning and/or assess the use of the gait belt being used as a chest harness to ensure the appropriate chest harness/restraint was used.</p> <p>This federal tag relates to complaint #IN00099909.</p> <p>9-3-4(a)</p>				

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W0227	<p>The individual program plan states the specific objectives necessary to meet the client's needs, as identified by the comprehensive assessment required by paragraph (c)(3) of this section.</p> <p>Based on observation, interview and record review for 2 of 4 sampled clients (B and C), the clients' Individual Support Plans (ISPs) failed to address the client's identified training needs.</p> <p>Findings include:</p> <p>1. During the 11/17/11 observation period between 5:55 AM and 9:45 AM, at the group home, client B did not want to take his morning medications which included his seizure medications. Client B walked away from staff and refused to take his medications. Staff #3 attempted to verbally coax the client into the medication room and bribed the client by offering the client large M and M candies. At one point, staff #3 went to the medication closet and retrieved some M and M candies and placed them in a medication cup. The staff then held one out in front of the client to get the client to walk to the medication room. Client B followed for a short distance and then turned around to walk away. Staff #3 then showed the client the M and M to try and get the client to the medication room with no luck. Staff #3 then gave the client 1 M and M candy and showed the</p>	W0227	<p><i>What corrective action will be accomplished for these residents found to have been affected by the deficient practice? Client B has a history of refusing medication. He has not missed any doses of medication due to his refusals. The IDT will identify a specific protocol for all staff to follow when he indicates initial refusal of medication. All staff working in the facility will be trained on the protocol for refusals. Client D has a program implemented to train safe use of walker. All staff to be retrained on this program. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken All residents with a fall risk have the potential to be affected by this deficient practice. All residents goals will be reviewed to ensure program plan is properly addressing deficit areas. ISPs will be updated according to identified needs. What measure will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur Group Home QMRP will review program implementation weekly. How the corrective action will be monitored to ensure the deficient practice</i></p>	12/29/2011	

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	<p>client a second M and M while backing up toward the medication room with client B following.</p> <p>Client B's record was reviewed on 11/21/11 at 1:28 PM. Client B's 6/27/11 ISP and/or 10/31/09 Behavior Support Plan indicated client B's identified need in regard to medication refusals had not been addressed.</p> <p>Interview with staff #2 on 11/16/11 at 3:35 PM indicated client B would sometimes refuse to take his medications.</p> <p>Interview with staff #7 on 11/17/11 at 6:05 AM indicated client B would refuse to take his medications. Staff #7 indicated she would try to give client B his seizure medications first so he would get them in his system and not have a seizure. Staff #7 stated "He will take 2 to 3 pills and then refuse. He will spit pills out and refuse to take again." Staff #7 indicated she thought client B had a plan in place to address the client's medication refusals. Staff #7 indicated staff should wait 30 minutes and then try again and if he refused, try letting a different staff administer the medications to him.</p> <p>Interview with administrative staff #1, staff #1, The Qualified Mental Retardation professional (QMRP) and</p>		<p>will not recur, what quality assurance program will be put into place and the date the systemic changes will occur. Group Home QMRP will be onsite to monitor improvements 2 times per week minimum for the next 2 months. Group Home Director will be onsite weekly over the next month to provide onsite monitoring, care and oversight of improvements.</p>		

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	<p>LPN #1 on 11/22/11 at 10:45 AM indicated client B had refused to take his medications in the past. Staff #1 and administrative staff #1 indicated they were not aware the client was still refusing his medications. Administrative staff #1, the QMRP and staff #1 indicated in the past, the client had a program in place which addressed the client's medication refusals, but had since been removed as the client was no longer having problems with taking his medications. Administrative staff #1 indicated the program would need to be started again.</p> <p>2. During the 11/16/11 observation period between 3:10 PM and 7:10 PM, at the group home, client C utilized a roller walker when ambulating as client C had an unsteady gait. At 5:15 PM, client C walked into the dining room area where client D was setting the dining room table. Client D was in a wheelchair and client C was utilizing his roller walker. Client C was walking to his bedroom and walked directly into the back of client D's wheelchair with his walker. Client D told client C to go around him. Client C did not walk around client D and continued to hit client D's wheelchair with his walker until client D moved out of client C's way. At 6:50 PM, client C was in his bedroom with the door open. Client C's walker was</p>						

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	<p>at the entrance of the client's bedroom door while client C was walking around his bedroom without the walker. When client C came out of his bedroom, client C grabbed his walker and moved at a fast pace, almost running over the surveyor. None of the 5 staff, who were working (staff #2, #3, #4, #5 and #6), were in the area to redirect client C to use his walker while ambulating in his bedroom and/or to encourage the client to slow down when using his walker.</p> <p>The facility's reportable incident reports and/or investigations were reviewed on 11/16/11 at 12:15 PM. The facility's reportable incident reports/investigations indicated on 9/17/11 "[Client C] was walking through the living room and bumped his foot against housemates wheelchair and fell. When he fell he hit the area where he just previously had stitches removed from. - Nurse ON Call instructed staff to take [client C] to the ER...-Stitches were put back in laceration...."</p> <p>The facility's 9/27/11 follow-up report indicated client C tripped over a bag of blocks that were dropped in the floor by a peer. The follow-up report indicated client C "...caught his foot in the wheel of the wheelchair. [Client C] landed directly on the floor on his face and began</p>						

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	<p>bleeding immediately...."</p> <p>Client C's record was reviewed on 11/17/11 at 4:08 PM. Client C's 9/17/11 Monthly Health Reviews indicated client C fell when he tripped over a peer's wheelchair. Client C reopened the injury to the right eye.</p> <p>Client C's 9/19/11 to 9/19/12 Methodology sheet indicated client C had an objective to use his walker in all situations during awake hours with staff physical assistance and/or cues.</p> <p>Client C's 10/25/11 Individual Support Plan (ISP) indicated did not specifically address client C's identified need of walking into things/over things.</p> <p>Interview with staff #2 on 11/16/11 at 5:38 PM indicated client C had a history of falls. Staff #2 stated client C was "not stable." Staff #2 indicated client C utilized a walker but still had falls.</p> <p>Interview with staff #6 on 11/16/11 at 6:10 PM indicated client C was at risk for falls. Staff #6 indicated client C had received injuries from a recent fall.</p> <p>Interview with staff #7 on 11/17/11 at 6:05 AM indicated she was told client C received the injuries from a fall on</p>				

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	<p>11/15/11. Staff #7 stated there were several clients who had falls at the group home, but client C "fell much more." Staff #7 stated "[Client C] is unstable when walking. If anything in way, he will go down. He does not walk around." Staff #7 indicated client C fell in the living room, bedroom and in the bathroom in the past. Staff #7 indicated she would have to listen for him getting up at night to assist the client as he could fall trying to go to the bathroom. Staff #7 indicated client C required staff supervision when others were around and the client was ambulating with his walker.</p> <p>Confidential interview A stated client C had been "falling a lot lately." Confidential interview A indicated client C recently fell 3 different times and injured himself in the same areas and had to go to the hospital for treatment/stitches. When asked why client C was falling, confidential interview A stated "He does not look where he is going half the time."</p> <p>Interview with administrative staff #1, the Qualified Mental Retardation Professional (QMRP), staff #1 and LPN #2 on 11/22/11 at 10:45 AM indicated client C had a history of falls with injuries. Staff #1 and the QMRP indicated client C had an objective to use his walker when awake. Staff #1 and the QMRP indicated</p>				

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W0252	<p>client C's 10/25/11 ISP did not address client C's identified need of walking into things/others.</p> <p>This federal tag relates to complaint #IN00099909.</p> <p>9-3-4(a) Data relative to accomplishment of the criteria specified in client individual program plan objectives must be documented in measurable terms.</p> <p>Based on interview and record review for 1 of 4 sampled clients (D), the facility failed to document recommended 30 minute checks on a client to ensure the client had his seat belt on and gait belt on his chest to prevent falls.</p> <p>Findings include:</p> <p>The facility's reportable incident reports, facility generated incident reports and/or investigations were reviewed on 11/16/11 at 12:15 PM. The facility's 9/20/11 reportable incident report indicated "[Client D] had gone to his room after eating a snack to get ready for bed. He was coming out of his room down the hallway to living room when he tipped his wheelchair forward, causing him to fall on the floor. His seatbelt was on which caused the chair to come over on top of him. He did not have on his upper chest</p>	W0252	<p><i>What corrective action will be accomplished for these residents found to have been affected by the deficient practice? All staff will be retrained on the program data expectations for facility. The High Risk Plans for falls will be revised to identify needed safety measures for wheelchair safety. See also W189 and W210PT reevaluated client D on 12/21/11 to properly assess seating and use of supports while awaiting approval for custom seating and new wheelchair. Recommendations will be reviewed by IDT and implementation timeframe will be identified. As of 12/22/11 wheelchair is expected for approval from Medicaid, anticipated in the next 2 weeks. IDT will review 12/21 PT recommendations by 12/29 and identify appropriate procedures for safety. How the facility will identify other residents having the potential to be affected by the</i></p>	12/29/2011	

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	<p>strap, which holds his torso up straight so he doesn't lean forward causing chair to topple. He skinned up the top off (sic) his nose and had a bloody nose, that requires standard first aid to be given by staff. Staff assisted him up and back into his wheelchair, treated his bloody and skinned nose...." The 9/20/11 reportable incident report indicated "...1. 30 minute checks put in place for staff to know [client D's] whereabouts and document what he is doing...."</p> <p>Client D's record was reviewed on 11/17/11 at 1:45 PM. Client D's Safety Checks indicated the 30 minute checks during waking hours and they were started on 9/22/11. At the bottom of the Safety Checks staff were to check the client's seat belt to ensure it is on and "tightened," and check to ensure the "chest strap/belt secured." The Safety Checks indicated no 30 minute checks were completed on 10/1, 10/5, 10/6, 10/7, 10/12, 10/13, 10/15, 10/16 and from 11/1 to 11/16/11.</p> <p>The Safety Checks further indicated facility staff did not document 30 minute for the entire day (partial checks done) on 9/30, 10/2, 10/4, 10/8, 10/9, 10/10, 10/11, 10/14, 10/17, 10/18, 10/20, 10.21, 10/23, 10/29 and 10/30/11.</p> <p>Interview with administrative staff #1,</p>		<p><i>same deficient practice and what corrective action will be taken</i> All residents with a fall risk have the potential to be affected by this deficient practice. All residents goals will be reviewed to ensure program plan is properly addressing deficit areas. ISPs will be updated according to identified needs. <i>What measure will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur</i> Group Home QMRP will review program implementation weekly. How the corrective action will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place and the date the systemic changes will occur. Group Home QMRP will be onsite to monitor improvements 2 times per week minimum for the next 2 months. Group Home Director will be onsite weekly over the next month to provide onsite monitoring, care and oversight of improvements.</p>		

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W0318	<p>staff #1, LPN #1 and the Qualified Mental Retardation Professional (QMRP) on 11/22/11 at 10:45 AM indicated 30 minute checks were put in place after the client fell on 9/20/11. The QMRP and staff #1 indicated facility staff were to still be completing the 30 minute checks on client D to ensure the client had his gait belt strap across his chest and to have his seatbelt on when in the wheelchair ambulating.</p> <p>This federal tag relates to complaint #IN00099909.</p> <p>9-3-4(a) The facility must ensure that specific health care services requirements are met.</p> <p>Based on observation, interview and record review, the facility failed to meet the Condition of Participation: Health care Services for 3 of 4 sampled clients (A, B and C). The facility's health care services failed to meet the healthcare needs of clients in regard to addressing/developing health care plans for a client who had a history of cancer and was still undergoing procedures/treatments, to update fall prevention plans, to review and/or monitor a client's health status, to ensure test procedure results were obtained, to follow/address recommended orders, to monitor staff to ensure they completed</p>	W0318	<p>See W331 See W368 See W369</p>	12/29/2011	

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	<p>health documentation and/or informed the nurse of health issues as needed. The facility's health care services failed to ensure all ordered medications were administered as ordered, to ensure all medications were administered without error and to ensure significant medical appointments/procedures were kept when scheduled as the facility's health services failed to ensure all staff understood basic medical terminology and acronyms.</p> <p>Findings include:</p> <p>1. The facility's health care services failed to ensure the facility's nursing services met the health needs of the clients. The facility's health care services failed to ensure recommended procedures were completed timely for a client who had cancer, failed to develop and/or update clients' fall assessments/health/risk plans, and failed to ensure results of a bone density test was present in a chart. The facility's health care services failed to follow up on a recommendation to obtain a cat scan in a timely manner, failed to ensure facility staff documented seizure events, and/or failed to monitor/complete monthly health status summaries/reviews of a client with significant medical needs for clients A, B and C. Please see W331.</p> <p>2. The facility's health care services failed</p>				

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W0331	<p>to ensure staff administered medications as ordered for clients A and B. Please see W368.</p> <p>3. The facility's health care services failed to ensure all medications were administered without error for client B. Please see W369.</p> <p>This federal tag relates to complaint #IN00099909.</p> <p>9-3-6(a) The facility must provide clients with nursing services in accordance with their needs. Based on observation, interview and record review for 3 of 4 sampled clients (A, B and C), the facility's nursing services failed to meet the health needs of the clients. The nursing services failed to ensure recommended procedures were completed timely for a client who had cancer, failed to develop and/or update clients' fall assessments/health/risk plans, and failed to ensure results of a bone density test was present in a chart. The facility's nursing services failed to follow up on a recommendation to obtain a cat scan in a timely manner, failed to ensure facility staff documented seizure events, and/or failed to monitor/complete monthly health status summaries/reviews of a client with significant medical needs.</p>	W0331	<p><i>What corrective action will be accomplished for these residents found to have been affected by the deficient practice? All individuals, including clients A, B, and C will be reassessed risk of falls using the attached Fall Risk Assessment form1. Individuals scored 0, 1, or 2 will be categorized as low risk2. Individuals scored as 3 or greater will be categorized as high riskRisk Interventions to be determined by IDT after assessment may include, but not limited to:1. Training to staff upon hire and annually on fall prevention plan, risk and specific risk plan protocols for individual.2. Bed rail needs assessed and identified if appropriate3. Furniture in room assessed for safety and to</i></p>	12/29/2011	

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	<p>Findings include:</p> <p>1. During the 11/16/11 observation period between 3:10 PM and 7:10 PM, client A arrived at the group home at 5:09 PM. Client A was in a wheelchair which was pushed by staff. Client A was pale in color in her face. While client A was eating her dinner at 6:05 PM, client A began making a gagging noise. Interview with staff #8 on 11/16/11 at 6:05 PM indicated client A's gagging was due to a procedure she had earlier in the day. Staff #8 then handed client A Ensure to drink.</p> <p>During the 11/17/11 observation period between 5:55 AM and 9:45 AM, at the group home, client A's bedroom door was closed at 5:55 AM. Client A stayed in her room in bed for most of the observation period. At 8:02 AM, staff #3 took client A's morning medications to the client's bedroom to administer. Client A was laying on her back covered up. Staff #3 woke the client, uncovered her to some extent and lifted the client up in the bed. Staff #3 also placed pillows behind the client's back to sit the client up for her medications. Client A told staff #3 she was not feeling well. Client A made a grimace facial expression as if client A was in pain when staff #3 lifted the client up in the bed. Client A started gagging when the pills were placed in her mouth.</p>		<p>prevent obstacles or injury risks.4. Room free of obstacles.5. Night light to be on in room (evenings and night)6. Bed in low position unless care is being delivered, unless medically contraindicated.7. Wheelchair locked when in stationary position.8. Wheelchair belt, tray secured9. Utilize assistive devices as ordered (glasses, cane, walker)10. St. Vincent New Hope Fall Risk Plan completed and implemented. 11. Order for PT/OT evaluate and treat upon admission, annually and upon change in status.12. Pharmacy review of medications quarterly13. Toileting assistance or cues every 2 hours 14. Assess need for electronic monitoring (bed alarm, chair alarm)15. Non skid footwear16. Assess and identify ambulation support needs (1:1, gait belt, etc.)A Post Fall IDT review in the event of a fall to evaluate cause of fall, current interventions or changes needed to treatment plan will be implemented. The format for this report was drafted from the BQIS (formerly Outreach Services) resource material. The IDT will investigate each fall and designate changes to treatment plan, if any on the IDT investigation form as well as timelines and responsible party for the implementation.St. Vincent New Hope High Risk Plan format was reviewed and changed using the BQIS (formerly Outreach</p>		

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	<p>Staff #3 gave client A water to drink as the client was making a gagging sound/motion. At 9:35 AM, when client A was eating her breakfast, client A started making a gagging sound/noise and motion.</p> <p>Client A's record was reviewed on 11/21/11 at 10:52 AM. Client A's Individual Progress Notes indicated the following (not all inclusive):</p> <p>-10/31/11 at 7:50 PM, "...Staff cut [client A's] food in small pieces to prevent 'gagging' that's been occurring. Staff cued her to take small bites & take sip as needed. [Client A] requested to go to bed after dinner and c/o (complained of) throat pain...."</p> <p>-11/1/11 at 6:30 AM, "[Client A] asleep when staff arrived, she slept ok but not feeling well. Asked for water several times throughout nite (sic)..." The 11/1/11 note indicated client A did not have a temperature at that time.</p> <p>-11/5/11 at 2:00 PM, "...[Client A] was gagging throughout meal. [Client A] was unable to eat breakfast & lunch. Staff gave her Ensure...."</p> <p>-11/7/11 late entry for 11/6/11 at 9:23 AM, "Upon giving [client A] her</p>		<p>Services) template to better organize, coordinate and identify support needs for individuals with Risk Plan interventions. All risk plans were reviewed and updated. High Risk Plan for Cancer related illness or treatment needs will be developed with physician at appointment on 12/23/11. CT Scan was completed for Client C. CT Scan was reviewed by neurology with mother on 12/20/11. All staff will be trained on High Risk Plans<i>How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken</i> All residents have the potential to be affected by this deficient practice. All residents will be reassessed for corrective action and revision of High Risk Plan as noted above. Nurse consultant and QMRP will review that all other appointments, follow up and needed reports have been received. This audit will identify needed appointments. All needed appts to be scheduled by 12/29, actual appt based on physician availability. Staff will be given a quiz on medical terminology and a reference sheet will be located in the MAR. Nurse consultant and Team Leader will give direction to staff in written, lay terms for procedure preparations. <i>What measure will be put into place or what systemic changes the facility will make to</i></p>		

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	<p>medications she was c/o pain in her chest. [Client A] also had signs and symptoms of increased temp of 99.7, increased heart rate of 100 and diaphoresis (excessive sweating). I (staff #9) called on call nurse (LPN #2) and she said give her acetaminophen (PRN) (as needed medication) for pain. [Client A] appeared to be felling better later in the day. [Client A] continues to gag throughout the day for the past week. [Client A] was unable to eat in the am. She ate no food for breakfast and small bits for lunch (sic)."</p> <p>-11/7/11 at 9:36 AM, client A asked staff to call her sister as client A wanted her sister to know "...she (client A) was sick. Her sister plans to call back @ (at) 1:00 pm to speak (with) [staff #1], so [client A] can be seen by a doctor. [Client A] is still c/o (complaining of) pain and refusing to eat meals. Today she had a temp of 100.1 and was diaphoric. I (staff #9) called [LPN #2] and got voice mail, I (staff #9) left a message to see if [client A] could have something else for pain because the acetaminophen is not alleviation for pain (sic)."</p> <p>-11/8/11 at 2:30 PM, client A indicated she did not want lunch.</p> <p>-11/21/11 at 6:40 AM, "[Client A] awake</p>		<p><i>ensure that the deficient practice does not recur</i> High Risk Plans will be reviewed annually with IDT. Post Fall IDT investigation of any fall event within the year. Walker use will be monitored weekly with data review by QMRP. Nurse consultant will develop a monthly appt list for facility. It will be submitted to Team Leader and Director. Team Leader will be responsible to schedule all needed appts and submit schedule of appts to nurse consultant within 1 week. <i>How the corrective action will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place and the date the systemic c changes will occur.</i> Group Home Director will track all falls to monitor recurrence, effectiveness of plans or needed changes. Human Rights Committee will review all fall investigations and trends by individual to monitor effectiveness or recurring issues to address. How the corrective action will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place and the date the systemic changes will occur. Group Home Director will review nursing notes monthly for accuracy and thorough documentation of health care needs as well as compliance with appointment scheduling. Group Home Director will review High</p>		

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	<p>lying in bed when staff arrived. [Client A] looks a little flushed & (and) when staff asked how she was feeling [client A] stated she wasn't feeling well and also asked for water. She was a little restless throughout the nite (sic). Staff checked her temp and it was 99.9 When staff awakened [client A] to give shower [client A] refused which is so very not like [client A]. [Client A] is still in bed sleeping."</p> <p>Client A's Medical Appointment/New Order Forms indicated the following (not all inclusive):</p> <p>-11/5/10 client A had a pelvic ultrasound completed and was diagnosed with Positional Urinary Incontinence.</p> <p>-11/16/10 ultrasound showed a "...mass in pelvis along post wall of bladder...."</p> <p>-12/13/10 will schedule cystoscopy of bladder due to mass</p> <p>-1/6/11 "Procedure Cystoscopy, transurethral Resection of Bladder Tumor Findings: 2-3 cm Papillary Bladder Tumor...."</p> <p>-4/2/11 pathology report indicated malignancy of tumor not identified. The note indicated "Need to schedule</p>		<p>Risk Plan revisions for all individuals in the facility. Group Home QMRP will be onsite to monitor improvements 2 times per week minimum for the next 2 months. Group Home Director will be onsite weekly over the next month to provide onsite monitoring, care and oversight of improvements.</p>		

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	<p>surveillance cysto (cystoscopy) in 3 months in OR (operating room)."</p> <p>-10/6/11 "F/U (follow-up) Bladder CA (cancer) Procedure-Cysto, Bladder Biopsy, RT (right) Ureteral Stent Findings- Papillary Lesion RT UO (urethral orifice) Rec (recommend) Await Path (pathology) Cysto 3 mos (months)."</p> <p>-10/18/11 unable to tolerate office cystoscopy stent removal procedure will do under general anesthesia.</p> <p>-11/10/11 "Dysphagia, Recent UTI (Urinary Tract Infection)."</p> <p>-11/15/11 seen doctor for physical examination. The form indicated client A was having a speech & swallowing problem since cystoscopy. The form also indicated client A was to have the stent removed on 11/16/11.</p> <p>Client A's Health Care Coordination Monthly Health Reviews indicated the following (not all inclusive):</p> <p>-1/6/11 had a cystoscopy transurethral resection of a bladder tumor performed. The note indicated "The results revealed a 2-3 cm papillary bladder tumor...." The note indicated another procedure would be done to stage the carcinoma.</p>				

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	<p>-1/13/11 scheduled for surgery to stage the carcinoma on 1/28/11.</p> <p>-2/10/11 urinalysis ordered by doctor due to increase incontinence of urine and stool.</p> <p>-2/15/11 received call from doctor's nurse who indicated "...the histology came back on biopsy and [client A] has late stage urethial carcinoma (bladder cancer)...." The note indicated the doctor was wanting to speak with the agency and the family on 2/18/11.</p> <p>-2/18/11 "Attended appointment at [name of doctor's] office with TL, Manager, Staff-family available per speaker phone. [Name of doctor] explained: removed tumors from bladder in procedure on 1/28/11. The tumors were high grade but not in muscle at this time. This type of tumor can be very invasive and aggressive. One option of 6 week outpatient treatment is really not an option for [client A] because she is unable to hold the treatment in her bladder long enough for it to be effective. At some point she may have to have bladder removed and urostomy bag placed. For right now, family and staff agreed with the option of rechecking the bladder in two months for regrowth of tumors and to</p>			

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	<p>make decisions at that time based on the results. [Client A] was also present for the appointment."</p> <p>-3/9/11 episodes of increased incontinence documented.</p> <p>-4/21/11 "Cystoscopy done at [name of hospital] per [name of doctor]. [Name of doctor's nurse] called and said that the results are normal and they will call group home with a date to repeat in three months."</p> <p>-10/6/11 followed up with doctor for bladder cancer and right uteral stent placed. To return in 3 months for cysto procedure.</p> <p>-10/29/11 "Spoke to ST (staff) @ house about [client A] c/o pain. VSS (vital signs) 110/70 R (respiration) 18 T (temperature) 98.1. Ok to give tylenol (pain). not (sic) wanting to eat. Continue to monitor & encourage fluids."</p> <p>-11/7/11 at 8:00 AM, staff called and reported client A complained of pain, was not wanting to eat, gagging on food and had increased thirst. The note indicated the nurse called the doctor's office and instructed staff to call and schedule an appointment.</p>			

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	<p>-11/7/11 at 9:00 AM, spoke with staff at doctor's office and they want her to go to ER. The note indicated the client was transported to ER by staff.</p> <p>-11/8/11 "...Client was discharged yesterday from ER. r/t (related to) UTI (Urinary Tract Infection). N.O. (new order) for cephalexin 500 mg (milligrams) 3 times a day started."</p> <p>-11/10/11 client A unable to tolerate stent removal in office. Stent removal rescheduled.</p> <p>-11/16/11 "Client had cysto uteral stents removed by [name of doctor] via outpatient. Client tolerated well. N.O. Amoxicillin (antibiotic) 875 mg po (by mouth) BID (two times a day)."</p> <p>-11/21/11 at 6:00 PM, nurse assessed client at group home.</p> <p>Client A's 7/28/11 Quarterly Nursing Physical Assessment indicated client A's cystoscopy was rescheduled for 9/1/11. The facility's nursing services failed to ensure client A kept and completed her recommended cystoscopy procedures every 3 months as client A did not have her cystoscopy procedure in 7/11 and/or 9/1/11 as rescheduled. Client A's nursing notes indicated the facility's nursing</p>				

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	<p>services did not document anything in regard to client A's bladder cancer (history of) and/or health status related to the bladder cancer in 5/11, 6/11, 8/11 and 9/11.</p> <p>Client A's 10/11 physician's orders indicated client A's diagnoses, included, but were limited to, Athetoid Cerebral Palsy, Neurogenic Bladder, Bladder Cancer and Urinary Urgency.</p> <p>Client A's 6/7/11 IDT(interdisciplinary team) note indicated "[Client A] had first of four preventative cystoscopies done on 4/22/11. The doctor did not find any more evidence of Bladder Cancer. [Client A] has to undergo a procedure every 4 months for the first year for cancer check. She will still have urinary urgency and continues to wear pull up style attends for assistance in this. [Client A] still voids on toilet as usual and is to be encouraged to do so...."</p> <p>Client A's 6/7/11 IDT note, 1/3/11 health risk plans and/or 4/8/11 ISP indicated the facility's nursing services did not address and/or include a health risk plan which addressed the client's Bladder cancer. The facility's nursing services failed to indicate what facility staff were to look for and/or monitor to ensure any changes with client A's health status would be</p>				

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	<p>immediately reported to medical professionals/nursing services.</p> <p>Interview with staff #3 on 11/16/11 at 6:17 PM indicated client A had surgery done on 11/16/11 due to the client's bladder cancer. Staff #3 indicated client A had the surgery/procedure done every 3 months. When asked how client A was doing, staff #3 stated "She gags a lot and runs a fever." Staff #3 indicated client A had not been feeling well for about a week and a half. Staff #3 indicated client A had not been eating well and at times, would run a temperature.</p> <p>Interview with staff #4 on 11/16/11 at 6:25 PM stated client A had been "real sick for 1 week and a half. Went to hospital today."</p> <p>Interview with staff #8 on 11/16/11 at 6:35 PM stated client A was "Not well. Had surgery to remove stent today. Cancer gone. We keep taking her there every 3 months." Staff #8 indicated client A had not been eating well for the past 3 weeks. Staff #8 indicated they would give client A Ensure but it made her nauseous. Staff #8 indicated a Barium Swallow Study was going to be completed next week.</p> <p>Interview with staff #7 on 11/17/11 at</p>				

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	<p>6:05 AM stated she would have to change client A every 2 hours at night due to the client's "heavy flow of urine." Staff #7 indicated she gave the client a PRN for pain due to the procedure she had yesterday.</p> <p>Interview with administrative staff #1, the Qualified Mental Retardation Professional (QMRP), staff #1 and LPN #2 on 11/22/11 at 10:45 AM indicated client A was diagnosed with bladder cancer in 1/11. LPN #2 stated client A "complained of frequent pain and urination." LPN #2 indicated a bladder resection was done in 1/11 and client A was to have a cystoscopy performed every 3 months to look at any lesion, remove and to do biopsies. LPN #2, staff #1 and the QMRP stated the family and doctor felt this was the "least evasive treatment option to be done." When asked if client A had the cystoscopy procedure was done in 7/11 or 8/11 as ordered, LPN #2 stated "No. She missed her appointment and rescheduled." When asked why she missed her appointment, staff #1 stated "Staff did not know what NPO (nothing by mouth) meant. [Client A] received her breakfast and medications." Staff #1 indicated she had left the message in the staff log for client A to be NPO. Staff #1 stated "I did not clarify what NPO is in staff log." Staff #1 and LPN #2 indicated facility</p>				

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	<p>staff had not been retrained in regard to NPO and/or other nursing acronyms to ensure staff understood the common nursing terminologies to ensure client care/treatments. LPN #2 indicated, prior to the stent procedure (11/16/11), client A had been sick. LPN #2 stated client A had been "lethargic, complaining of pain when swallowing and running a temp." LPN #2 indicated client A's doctor was called on 11/7/11 and he wanted her sent out to the ER to be checked. LPN #2 indicated facility staff should notify the nurse on call if client A gagged at meals. LPN #2 indicated facility staff did not document client A's gagging, but had brought it up to the doctor at the 11/10/11 doctor's appointment, and the doctor ordered a Barium Swallow Study which was being completed today. LPN #2 indicated facility staff should not allow client A to continue to eat if she started gagging while eating. When asked if the client should be given fluids to drink, when she gagged, LPN #2 stated "No fluids." When asked what facility staff should be watching/monitoring for client A, LPN #2 stated "increased temperature, lethargic and pain." LPN #2 indicated the client did not have a risk plan in place which addressed client A's Bladder Cancer, and/or plan in place which told facility staff what to monitor to ensure any changes with client A's health status</p>			

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	<p>would be immediately reported to medical professionals/nursing services.</p> <p>2. The facility's reportable incident reports and/or investigations were reviewed on 11/16/11 at 12:15 PM. The facility's reportable incident reports/investigations indicated the following:</p> <p>-9/8/11 staff heard a "loud noise" from client C's bedroom. Client C was found on the floor in front of his chair with blood on the client's head. Client C was taken to a local emergency room (ER) due to a laceration above his left eyebrow which was 1 1/2 inches long and due to an abrasion on the client's left cheek area. The 9/8/11 reportable incident report indicated client C received stitches and his Tetanus was updated.</p> <p>-9/17/11 "[Client C] was walking through the living room and bumped his foot against housemates wheelchair and fell. When he fell he hit the area where he just previously had stitches removed from. - Nurse ON Call instructed staff to take [client C] to the ER...-Stitches were put back in laceration...."</p> <p>The facility's 9/27/11 follow-up report indicated "...[Client C] met with Neurologist (routine exam scheduled) on</p>				

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	<p>9/20/11, recommended CAT scan...."</p> <p>The facility's 9/27/11 Fall/Injury Investigation indicated client C had a history of falls with injuries.</p> <p>-10/20/11 "[Client C] arrived at Day Services and entered the restroom. Staff entered a few minutes later and found that [client C] had fallen on the ground in the restroom. He had been utilizing his walker, and he was wearing his leg braces. He was conscious, but had two head lacerations, and bleeding and bruising on his cheek and mouth. Nurse consultant assisted with first aid and an ambulance was called. [Client C] was transported to the Emergency Room via ambulance...."</p> <p>The facility's 11/8/11 follow-up report indicated client C received steri strips to his laceration on his left forehead and Bacitracin (antibiotic ointment) was to be applied to the laceration to client C's left cheekbone which did not require stitches. The follow-up report indicated client C also had a laceration along the client's gum line which did not require any type of treatment as it would heal on its own.</p> <p>During the 11/16/11 observation period between 3:10 PM and 7:10 PM, at the group home, client C utilized a roller</p>			

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	<p>walker when ambulating as client C had an unsteady gait. Client C had injuries to the left side of his face. Client C's lip was swollen and scabbed over with small cuts/lacerations to his chin area which were red and scabbed over. Client C also had a laceration/bruise above his upper left eyebrow.</p> <p>Client C's record was reviewed on 11/17/11 at 4:08 PM. Client C's Monthly Health Reviews indicated the following (not all inconclusive):</p> <p>-8/5/11 client C fell at camp on 8/4/11. Client C received facial swelling around his eye and cheek bone with lacerations.</p> <p>-9/8/11 fell on 9/7/11 and went to ER due to laceration to the above his left eye.</p> <p>-9/17/11 client C fell when he tripped over a peer's wheelchair. Client C reopened injury to right eye.</p> <p>-9/20/11 "...N.O. (new order) CT head d/t (due to) head trauma...Family does not want client to undergo CT scan does not feel client will tolerate procedure. MD (medical doctor) notified. Will continue to monitor."</p> <p>-10/14/11 client C had "scaring above (L) (left) r/t (related to) injuries...."</p>			

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	<p>-10/20/11 "Client fell @ (at) group home & (and) was sent to the ER for facial lacerations. Dermabond used."</p> <p>-11/15/11 spoke to doctor in regard to CT scan as parents want to know if it can be done with sedation. The note indicated the doctor ordered the CAT scan with general anesthesia.</p> <p>-11/16/11 "[Client C] fell @ day program walking to the van. 0 (zero) injuries. [Client C] fell in his room trying to get up without staff & walker. [Client C] has cuts on his lip. Ice & Bacitracin applied. Assessed [client C] today. Lip swollen with 2 cuts on lip & 1 on chin."</p> <p>-11/17/11 "[Client C] fell @ Day Program leaning to the side of chair trying to get up. 0 injuries noted. Instructed staff to monitor [client C] for swelling, pain, dizziness, change in mental status...Instructed staff to complete 30 min (minute) checks & to allow [client C] to sit in chairs with arms on them."</p> <p>-11/18/11 "Correction to client's fall on 11/17 @ Day Services. Client fell getting to sit down on chair with no arms (sic). Client is to have stand by assist (with) transfers and should have walker (with) in reach."</p>			

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	<p>Client C's 9/20/11 Medical Appointment/New Order form indicated "Continues frequent falls, worse past mo (month)...Will (check) CT head to r/o (rule out) SDH (subdural hematoma)." Client C's typed 9/20/11 neurological evaluation indicated "The patient had improved his gait significantly. He was using a walker regularly. However, he has gone downhill again in last month, and he has had 3 falls. Two were out of a chair when the chair broke, but he is a little bit less steady on his feet. Reauthorization of physical therapy has been requested...Recommendations: because of the recurrent head trauma, I am very concerned that he may be at risk for a subdural hematoma or intracranial pathology of other type. I think a noncontrast CAT scan should be performed. We will make an additional intervention decisions based on clinical course..."</p> <p>Client C's 10/25/11 ISP and/or record indicated the facility's nursing services failed to address, in a timely manner, a doctor's recommendation to obtain a CAT scan due to the recent head injuries client C received due to the falls. The facility's nursing services also failed to ensure a fall prevention plan was put in place prior to 11/15/11 as client C had a history of falls.</p>				

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	<p>Interview with staff #2 on 11/16/11 at 5:38 PM indicated client C had a history of falls. Staff #2 stated client C was "not stable." Staff #2 indicated client C utilized a walker but still had falls.</p> <p>Interview with staff #6 on 11/16/11 at 6:10 PM indicated client C was at risk for falls. Staff #6 indicated client C had received injuries from a recent fall.</p> <p>Interview with staff #3 on 11/16/11 at 6:17 PM indicated client C fell two times on 11/15/11. Staff #3 indicated client C fell at the day program and in the group home.</p> <p>Interview with staff #5 on 11/16/11 at 7:02 PM indicated client C had a history of falls with injuries. Staff #5 indicated he was not sure how client C received the injuries to his face as client C did not have the injuries when staff #5 worked on 11/14/11.</p> <p>Interview with staff #7 on 11/17/11 at 6:05 AM indicated she was told client C received the injuries from a fall on 11/15/11. Staff #7 stated there were several clients who had falls at the group home, but client C "fell much more." Staff #7 stated "[Client C] is unstable when walking. If anything in way, he will</p>			

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	<p>go down. He does not walk around."</p> <p>Confidential interview A stated client C had been "falling a lot lately." Confidential interview A indicated client C recently fell 3 different times and injured himself in the same areas and had to go to the hospital for treatment/stitches.</p> <p>Interview with administrative staff #1, the Qualified Mental Retardation Professional (QMRP,) staff #1 and LPN #2 on 11/22/11 at 10:45 AM indicated client C had a history of falls with injuries. LPN #2 indicated client C fell 3 times last week (twice on 11/15/11 and on 11/17/11). LPN #2 indicated client C fell at the day program on 11/17/11 and the client had his walker beside him, but was not using it. LPN #2 and staff #1 indicated client C had not had the CAT scan completed as recommended by the neurologist. LPN #2 indicated the doctor was concerned about the client have a subdural hematoma due to the recent falls with head injuries. Staff #1 indicated the CAT scan which was recommended in 9/11 was scheduled to be completed on 12/2/11. Staff #1 stated the "family declined it." LPN #2 indicated a fall prevention plan was put in place on 11/15/11 after the client had 3 falls with injuries which required a trip to the ER. LPN #2 indicated client C fell and hit the</p>						

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	<p>back of his head at the day program last week. LPN #2 indicated she updated client C's 11/15/11 fall plan on 11/18/11 to include the use of a helmet, stand by assist and 30 minute safety checks. Staff #1, the QMRP and LPN #2 indicated client C did not have a fall plan prior to 11/15/11. The QMRP, LPN #2 and staff #1 indicated client C's 11/18/11 fall prevention plan did not indicate how facility/workshop staff were to monitor the client to prevent any further falls/injuries.</p> <p>3. The facility's reportable incident reports, facility's incident report and/or investigations were reviewed on 11/16/11 at 12:15 PM. The facility's reportable incident reports, facility incident reports and/or investigations indicated the following:</p> <p>-9/9/11 "[Client B] fell dining room while walking around the table (sic). His left foot caught in the wheel of another individuals wheelchair causing the fall. He fell down on his knees and hands and hit his forehead on the floor...He had a red mark on his forehead, right side just above the right eye...A previous injury w/ (with) scab on right knee had been re-opened and was bleeding...."</p> <p>The facility's 9/9/11 Fall/Injury</p>				

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	<p>Investigation indicated client B had a history of falls and had a fall on 8/27/11.</p> <p>-8/26/11 client B fell out of a chair and received a rug burn to both knees. The facility's 8/31/11 follow-up report indicated client B was walking around and tripped over the program books which were on the floor and the client's right shoe string was untied.</p> <p>-8/26/11 Occurrence Outside Practice Standards (OOPS) report indicated client B fell while he was walking around in the living room. The OOPS report indicated 2 staff were on duty at the time of the fall. One was in the kitchen and one was helping another client in the bathroom. The 8/26/11 OOPS report indicated the above mentioned fall was the second fall of the evening.</p> <p>-3/19/11 "While conducting a follow up body check on 03-19-2011, staff reported that [client B's] right ankle was swollen and bruising had appeared. STaff (sic) informed on call TL (Team Leader) and on call NC (Nurse Coordinator). Both parties agreed to have [client B] transported to the hospital ER for examinations (sic)...The follow up body check was being conducted due to falls that had happened on 03/18/2011...and the body check conducted 3/18/2011 revealed</p>				

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	<p>no injuries. X-rays were completed at the ER and revealed a fracture to his ankle...."</p> <p>The 6/2/11 follow up report indicated client B was kept in the hospital for 15 days and then discharged to a nursing home for rehabilitation.</p> <p>Client B's record was reviewed on 11/21/11 at 1:28 PM. Client B's 3/19/11 X-ray report indicated "There is evidence of a trimalleolar fracture. A spiral fracture is identified involving the distal fibular diaphysis. There is a mild degree of lateral and posterior displacement of the distal fracture fragment. A transverse fracture is identified in the base of the medial malleolus. There is a mild lateral displacement. There is a mildly displaced fracture through the dorsal aspect of the posterior malleolus...IMPRESSION: 1. Trimalleolar fracture."</p> <p>Client B's 3/19/11 medical consultation indicated client B had a "...history of multiple falls, especially with his recent seizure episodes. He basically fell at the group home and was found by staff to be on the floor unable to ambulate...." The 3/19/11 medical consult indicated surgery was going to be performed due to the fracture.</p> <p>Client B's 7/5/11 Occupational Therapy</p>				

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	<p>notes indicated client B was referred for services due to the client's "...R (right) ankle fx (fracture) approx (approximate) 5 days of intermittent falls in March 2011...."</p> <p>Client B's 10/11 physician's order indicated client B's diagnoses included, but were not limited to, Cerebral Palsy and Seizure disorder.</p> <p>Client B's 10/13/11 Medical Appointment/New Order form indicated a Bone Density test/study was completed for bone disease on 10/13/11. Client B's 10/11 and/or 11/11 Health care Coordination Monthly Reviews indicated the facility's nursing services failed to obtain the results of the ordered/completed Bone Density test to determine if client B had any bone disease which would put the client at risk for fractures due to his falls.</p> <p>Client B's 1/3/11 Fall Prevention Plan indicated client B had 2 recent falls with injuries which required medical treatment in a 3 month period. The 1/3/11 plan indicated 911 was to be called, CPR initiated and/or first aid was to be initiated if the client was "gravely ill" and/or unresponsive. The 1/3/11 fall plan indicated "...If a person is in the act of falling---</p>				

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	<p>-Try to ease person to floor or seating if possible</p> <p>-Do not attempt to stop fall by grabbing person by arms or clothing.</p> <p>Observe person after the fall for any injuries and treat accordingly</p> <p>If you are able to assist person up from floor, do so using proper body mechanics</p> <p>If you are unable to assist person up from floor, call Team Leader or On-Call for assistance...." The 1/3/11 fall plan indicated client B's medication would be monitored and his falls documented. The fall plan also indicated "Other preventative measures: Wheelchair may be used when notably unsteady. [Client B] will not tolerate gait belt. Staff utilize stand by assistance while walking."</p> <p>Client B's 6/27/11 ISP indicated the facility's nursing services failed to update client B's 1/3/11 fall prevention plan since the client fell and fractured his ankle in 3/11 and had falls (with and without seizures/injuries) on 8/26/11, 9/9/11, 10/7/11 and 11/10/11.</p> <p>Interview with administrative staff #1, the Qualified Mental Retardation Professional (QMRP), staff #1 and LPN #2 on 11/22/11 at 10:45 AM indicated client B had a history of falls and had 2 falls since fracturing his ankle in 3/11. When asked</p>						

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	<p>if client B's IDT had addressed the client's falls and/or updated the client's fall plan since his fracture in 3/11, staff #1 and the QMRP indicated client B had a gait belt, wheelchair, alarm and stand by assist when he first returned to the group home. LPN #2 indicated client B's 1/11 fall plan needed to be updated. LPN #2 indicated she did not have the result of client B's bone density study in the record. LPN #2 stated "We do not have a copy of the results. It went directly to his doctor."</p> <p>4. The facility's reportable incident reports/investigations were reviewed on 11/16/11 at 12:15 PM. The facility's 11/4/11 reportable incident report indicated "[Client B] was taken to ER (emergency room) by ambulance due to having seizure for apprx. (approximately) 7min. (minutes). [Client B's] magnet was swiped. Seizure activity continued...."</p> <p>Client B's record was reviewed on 11/21/11 at 1:28 PM. Client B's 11/2011 Record of Seizure Observations indicated the facility staff did not document any information and/or complete a seizure record on client B's 11/4/11 seizure.</p> <p>Interview with LPN #2 on 11/122/11 at 10:45 AM indicated client B was sent out to the ER on 11/4/11 due to seizures. LPN #2 indicated a seizure record should</p>				

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W0368	<p>have been filled out by staff. LPN #2 indicated she was not able to locate a seizure record for the 11/4/11 seizure event.</p> <p>This federal tag relates to complaint #IN00099909.</p> <p>9-3-6(a) The system for drug administration must assure that all drugs are administered in compliance with the physician's orders. Based on interview and record review for 2 of 4 sampled clients (A and B), the facility failed to ensure staff administered medications as ordered.</p> <p>Findings include:</p> <p>1. The facility's reportable incident reports/investigations were reviewed on 11/16/11 at 12:15 PM. The facility's 11/4/11 reportable incident report indicated "[Client B] was taken to ER (emergency room) by ambulance due to having seizure for apprx. (approximately) 7min. (minutes). [Client B's] magnet was swiped. Seizure activity continued...." The 11/4/11 reportable incident report indicated client B's seizures stopped once IV fluids were started and the client did not have anymore seizures at the hospital. The reportable incident report indicated client B's dad picked the client up from</p>	W0368	<p><i>What corrective action will be accomplished for these residents found to have been affected by the deficient practice?</i></p> <p>The 2 noted medications that were identified in the BDDS report related to Client B seizure and ER were confirmed as not given.</p> <p>The other circled medications were audited as indicated in report. The QMRP had indicated that the meds had been given, but documentation was lacking in all other instances.</p> <p><i>What measure will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur</i></p> <p>Team Leader/QMRP will conduct weekly check of medications and MAR for accuracy.</p> <p>Staff will be reeducated on accurate med admin and documentation.</p> <p><i>How the corrective action will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into</i></p>	12/29/2011			

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	<p>the hospital and had staff pack his medications to go home for the weekend. The 11/4/11 reportable incident report indicated "...-In the process of packing [client B's] meds, the staff found that [client B] had not received all of his AM meds on 11/4 (Phenytoin SOD (sodium) (seizure) ext (extended release) 100mg (milligrams) 2cap (capsules) and Zyprexa 2.5mg) (behavior). ON-Call notified the Nurse ON-Call of [client B's] outcome @ (at) the ER as well as the missed meds...."</p> <p>Client B's 11/11 Medication Administration Record (MAR) was reviewed on 11/17/11 at 9:14 AM. Client B's 11/11 MAR indicated the following:</p> <p>-11/1/11 Protonix (reflux) 40 milligrams daily at 5 PM was initialed and circled. There was no documentation on the back of the MAR to indicate if the client received the medication or not.</p> <p>-11/4/11 client B's Phenytoin Sodium EXT 100 mg 2 capsules at 9 AM were initialed and circled. The back of the 11/11/ MAR indicated "Med (Phenytoin) not given." On 11/4/11, the MAR indicated client B did not receive Zyprexa 2.5 milligrams at 9 AM as well.</p> <p>-11/4/11 client B received Atenolol (blood pressure) 25 milligrams once daily. The</p>		<p><i>place and the date the systemic c changes will occur.</i></p> <p>Team Leader/QMRP will continue to audit medication record in any event in which the individual goes to the hospital or needs other immediate care which may be caused by lack of proper administration.</p> <p>Team Leader/QMRP will conduct weekly med administration observation.</p> <p>Nurse Consultant will conduct medication administration observation at routine visits to home, no less than q 2 weeks.</p>		

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NAME OF PROVIDER OR SUPPLIER ST VINCENT NEW HOPE INC			STREET ADDRESS, CITY, STATE, ZIP CODE 9001 N HOLLIDAY DR INDIANAPOLIS, IN46260		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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	
	<p>11/11 MAR indicated client B's blood pressure and heart rate were to be checked before giving the medication. The 11/11 MAR indicated "Hold if SBP (upper blood pressure number) < (less than) 100 HR (heart rate) < 70." Staff did not take client B's blood pressure and/or heart rate prior to administering the medication. Also on 11/11/11, there was no documentation/initials staff took the client's blood pressure and/or HR prior to giving the Atenolol on 11/11/11.</p> <p>-11/7/11 client B's Phenytoin Sodium EXT 100 mg 2 capsules at 9 AM, Polyethylene Glycol Powder (constipation) 1 capful (17 grams) in 8 ounces of liquid daily at 8:30 PM, Valporic Acid (seizures) 250 milligrams 3 capsules at 8:30 PM and Vitamin B-6 at 8:30 PM were all initialed and circled. The back of the 11/11 MAR did not indicate if client B received the medication or not. The 11/11 MAR indicated client C did not receive his Vitamin C 500 milligrams (calcium supplement) daily at breakfast as the back of the MAR indicated "med not given."</p> <p>Interview with staff #1 on 11/17/11 at 12:50 PM indicated client B did not receive his Phenytoin and Zyprexa on 11/4/11 as the staff missed administering those 2 pills.</p>				

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	<p>Interview with the Qualified Mental Retardation Professional (QMRP) and LPN #2 on 11/22/11 at 10:45 AM indicated circles on the MAR with initials meant the client did not receive/get the medication. The QMRP indicated after the 11/4/11 incident occurred she went to the group home and did an audit of the clients' medications. The QMRP indicated not all of client B's medications were given on 11/7/11 as well. Some were given and not documented and some were not given. The QMRP indicated she thought she documented on the back of the MAR if the medications were given or not. The QMRP indicated she did not know if facility staff administered client B's 9 AM Phenytoin on 11/7/11 and/or administered client B's Polyethylene, Valporic Acid and/or Vitamin B-6 at the 8:30 PM medication pass on 11/7/11.</p> <p>2. Client A's 11/11 Medication Administration Record (MAR) was reviewed on 11/17/11 at 9:14 AM. Client A's 11/11 MAR indicated on 11/11/11 staff initials were circled on the 11/11 MAR for the following medications:</p> <p>-Flonase 0.05% spray 1 spray in each nostril at 7 AM for decongestant relief</p> <p>-Zanaflex 2 milligrams 3 tablets at 7 AM</p>				

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W0369	<p>for spasticity</p> <p>-Vitamin C 1 capsule at 7 AM supplement</p> <p>The back of the 11/11 MAR did not indicate client A received the above mentioned medications.</p> <p>Interview with the QMRP and LPN #2 on 11/22/11 at 10:45 AM indicated circles on the MAR with initials meant the client did not receive/get the medication.</p> <p>This federal tag relates to complaint #IN00099909.</p> <p>9-3-6(a) The system for drug administration must assure that all drugs, including those that are self-administered, are administered without error.</p> <p>Based on observation, interview and record review for 1 of 38 medications administered, the facility failed to ensure all medications were administered without error for client B.</p> <p>Findings include:</p> <p>During the 11/17/11 observation period between 5:55 AM and 9:45 AM, at the group home, staff #3 administered client B's morning medications. Client B did not receive Vitamin B-6 (supplement) as</p>	W0369	<p>See Also W368 <i>What corrective action will be accomplished for these residents found to have been affected by the deficient practice?</i> Staff will be reeducated on medication administration and medication error guidelines will continue to be followed, including retraining, disciplinary action, up to and including termination. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken All other meds were determined to have been given as ordered. What</p>	12/29/2011			

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	<p>ordered.</p> <p>Client B's 11/11 Medication Administration Record (MAR) was reviewed on 11/17/11 at 9:05 AM. The 11/11 MAR indicated client B should have received Vitamin B-6 100 milligrams at 8:00 AM. Client B did not receive the Vitamin B-6 at the morning medication pass even though staff #3 had initialed the MAR.</p> <p>Client B's record was reviewed on 11/21/11 at 1:28 PM. Client B's 10/3/11 physician's order indicated client B received Vitamin B-6 100 milligrams two times a day.</p> <p>Interview with staff #3 on 11/17/11 at 9:40 AM indicated she did not administer client D's Vitamin B-6 at the medication pass. Staff #3 checked the back of client D's Vitamin B-6 bubble pack and realized she had not administered the medication as there was no date of 11/17/11 written next to an empty slot with the staff's initials.</p> <p>This federal tag relates to complaint #IN00099909.</p> <p>9-3-6(a)</p>		<p>measure will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur Team Leader/QMRP will conduct weekly check of medications and MAR for accuracy.How the corrective action will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place and the date the systemic changes will occur.Team Leader/QMRP will conduct weekly med administration observation.Nurse Consultant will conduct medication administration observation at routine visits to home, no less than q 2 weeks.</p>		