

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G613	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  05/12/2015
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W 0000  Bldg. 00	<p>This visit was for a full annual recertification and state licensure survey.</p> <p>Dates of survey: May 4, 6, 7, 8, 11 and 12, 2015.</p> <p>Provider Number: 15G613 AIMS Number: 10024650 Facility Number: 001177</p> <p>The following federal deficiencies also reflect state findings in accordance with 460 IAC 9.</p>	W 0000	I attempted to submit this plan of correction on Friday June 8th. After not hearing back I rechecked the site to find that deficiencies where there but did not get submitted. After adding dates deficiencies have now been submitted.	
W 0102  Bldg. 00	<p>483.410 GOVERNING BODY AND MANAGEMENT The facility must ensure that specific governing body and management requirements are met. Based on interview and record review,</p>	W 0102	It is now in place that all falls will	06/01/2015

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

TITLE

(X6) DATE

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

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	<p>the facility failed to meet the Condition of Participation: Governing Body for 1 of 3 sampled clients (#3). The governing body failed to implement its policy and procedures to ensure client #3 was free from neglect as the client experienced a pattern of multiple falls over the past 10 months. The governing body failed to ensure client #3's fall with severe injury was thoroughly investigated. The governing body failed to ensure the facility assessed client #3's pattern of falls and sufficient safeguards and measures were implemented to keep the falls from reoccurring.</p> <p>Findings include:</p> <p>1) For 1 of 3 sampled clients (#3), the governing body failed to exercise operating direction over the facility by failing to ensure its written policies and procedures to prevent abuse, neglect, and/or mistreatment of client #3 were implemented as written. The governing body failed to assess client #3's pattern of falls and implement necessary measures and safeguards to prevent them from reoccurring. The governing body failed to ensure a thorough investigation was conducted regarding client #3's fall on 5/4/15. Please see W104.</p> <p>2) The governing body failed to ensure</p>		<p>be thoroughly investigated by the on call "BDDS" pager staff, whether the fall was witnessed or not. A new process was implemented for falls and IR's this will aid in ensuring the IR has the correct information. It also puts the nurse responsible for contacting the guardian immediately when necessary. We have now implemented that there will be an IDT meeting after a pattern of 2 or more falls in a month's time with the Director, QIDP, and the nurse to determine what safeguards and measures can be implemented to keep the falls from reoccurring. Along with the IDT meeting all members of the clients team (PCP, behavior specialist, therapist) will be contacted as well. The nurse will continue to track all falls to see if there is a pattern. All staff have been retrained the client # 3 should always be in the line of sight so staff can immediately assist him with ambulating. Staff were retrained 6/1/2015 on usage of client # 3 gait belt stating it should be on during all waking hours. Administrative staff will perform a weekly pop in for the next 6 month's to ensure the staff are following instructions. Client #3 received a bed alarm on Wednesday June 3, 2015. This was put in place to alert staff if client #3 gets out of bed in the middle of the night in between bed checks.</p>	

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	<p>the facility met the Condition of Participation: Client Protections for 1 of 3 sampled clients (#3). The governing body failed to implement its policy and procedures to prevent neglect of client #3 in regard to the client having multiple falls in the past 10 months. The governing body failed to ensure safeguards and measures were implemented to keep the client from experiencing additional falls. The governing body failed to ensure a thorough investigation was conducted to determine the contributing circumstances regarding client #3's fall with severe injury. Please see W122.</p> <p>9-3-1(a)</p>			
W 0104 Bldg. 00	<p>483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility.</p>			

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	<p>Based on interview and record review for 1 of 3 sampled clients (#3), the governing body failed to exercise general policy and operating direction over the facility to ensure the client was not neglected in regard to the client experiencing multiple falls over a 10 month time period. The governing body failed to ensure the facility's Interdisciplinary Team (IDT) met to discuss safeguards necessary to minimize the frequency and severity of client #3's falls. The governing body failed to exercise general policy and operating direction over the facility to ensure a thorough investigation was completed in regard to an injury of unknown origin. The governing body failed to exercise general policy and operating direction over the facility to ensure corrective actions were implemented once the investigation was completed.</p> <p>Findings include:</p> <p>1) For 1 of 3 sampled clients (#3), the governing body failed to implement its policies and procedures to prevent neglect of client #3 regarding a pattern of multiple falls over the past 10 months including a fall on 5/4/15 which resulted in a laceration to the head requiring sutures. The facility neglected to provide sufficient staff to manage and supervise</p>	W 0104	<p>It is now in place that all falls will be thoroughly investigated by the on call "BDDS" pager staff, whether the fall was witnessed or not. A new process was implemented for falls and IR's this will aid in ensuring the IR has the correct information. It also puts the nurse responsible for contacting the guardian immediately when necessary. We have now implemented that there will be an IDT meeting after a pattern of 2 or more falls in a month's time with the Director, QIDP, and the nurse to determine what safeguards and measures can be implemented to keep the falls from reoccurring. Along with the IDT meeting all members of the clients team (PCP, behavior specialist, therapist) will be contacted as well. The nurse will continue to track all falls to see if there is a pattern. All staff have been retrained the client # 3 should always be in the line of sight so staff can immediately assist him with ambulating. Staff were retrained 5/4/2015 on usage of client # 3 gait belt stating it should be on during all waking hours. Administrative staff will perform a weekly pop in for the next 6 month's to ensure the staff are following instructions. It is now put into place that the Director or QIDP will oversee the schedule to ensure they are properly and safely staffed. Also put in place if there is ever direct care shortage in the home Admin.</p>	06/01/2015			

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	<p>client #3's according to his individual program plan. Please refer to W149.</p> <p>2) For 1 of 3 sampled clients (#3), the governing body failed to conduct a thorough investigation of an allegation of neglect. Please refer to W154.</p> <p>3) For 1 of 3 sampled clients (#3), the governing body failed to implement appropriate safeguards to prevent a pattern of multiple falls from reoccurring. Please refer to W157.</p> <p>9-3-1(a)</p>		<p>Staff will assist on shift to ensure they are safely staffed. The agency has since hired 3 full time and 1 part time staff to help assist in the home. Client #3 received a bed alarm on Wednesday June 3, 2015. This was put in place to alert staff if client #3 gets out of bed in the middle of the night in between bed checks.</p>	

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W 0122 Bldg. 00	483.420 CLIENT PROTECTIONS The facility must ensure that specific client protections requirements are met. Based on interview and record review for 1 of 3 sampled clients (client #3), the facility failed to meet the Condition of Participation: Client Protections. The facility failed to implement written policy	W 0122	Client #3 received a bed alarm on Wednesday June 3, 2015. This was put in place to alert staff if client #3 gets out of bed in the middle of the night in between bed checks.As of 06/05/2015 the	06/01/2015

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	<p>and procedures to prevent neglect of client #3 in regard to a pattern of multiple falls over the past 10 months. The facility failed to ensure sufficient safeguards to prevent client #3 from repeated falls and injuries. The facility failed to investigate a fall with serious injury (laceration of the head) from a 5/4/15 fall while client #3 was attempting to access the Group Home's wheelchair van.</p> <p>Findings include:</p> <p>1) For 1 of 3 sampled clients (#3), the facility failed to implement its policy and procedures to prevent neglect of client #3 in regard to a pattern of multiple falls, many with injuries, over the past 10 months at the group home as well as the facility's Day Program. The governing body failed to implement its policies and procedures to prevent neglect of client #3 regarding a pattern of multiple falls over the past 10 months including a fall on 5/4/15 which resulted in a laceration to the head requiring sutures. The facility neglected to provide sufficient staff to manage and supervise client #3's according to his individual program plan. Please see W149.</p> <p>2) The facility failed to thoroughly investigate a fall with severe injury (laceration of the head) to determine if</p>		<p>residential nurse has completed a head to toe assessment on all clients in the home. Going forward the nurse has created a schedule and spreadsheet to follow to ensure all assessments are completed. Director will follow up monthly with the nurse to oversee that this is being done. It is now in place that all falls will be thoroughly investigated by the on call "BDDS" pager staff, whether the fall was witnessed or not. A new process was implemented for falls and IR's this will aid in ensuring the IR has the correct information. It also puts the nurse responsible for contacting the guardian immediately when necessary. We have now implemented that there will be an IDT meeting after a pattern of 2 or more falls in a month's time with the Director, QIDP, and the nurse to determine what safeguards and measures can be implemented to keep the falls from reoccurring. Along with the IDT meeting all members of the clients team (PCP, behavior specialist, therapist) will be contacted as well. The nurse will continue to track all falls to see if there is a pattern. All staff have been retrained the client # 3 should always be in the line of sight so staff can immediately assist him with ambulating. Staff were retrained 5/4/2015 on usage of client # 3 gait belt stating it should be on during all waking</p>	

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	<p>neglect occurred. Please see W154.</p> <p>3) The facility failed to ensure sufficient safeguards were in place to prevent client #3 from experiencing repeated falls and injuries. The facility failed to ensure its Interdisciplinary Team (IDT) met to implement measures that would reduce the frequency and severity of client #3's falls. Please see W157.</p> <p>9-3-2(a)</p>		<p>hours. Administrative staff will perform a weekly pop in for the next 6 month's to ensure the staff are following instructions. It is now put into place that the Director or QIDP will oversee the schedule to ensure they are properly and safely staffed . Also put in place if there is ever direct care shortage in the home Admin. Staff will assist on shift to ensure they are safely staffed. The agency has since hired 3 full time and 1 part time staff to help assist in the home.</p>	

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W 0148 Bldg. 00	<p>483.420(c)(6) COMMUNICATION WITH CLIENTS, PARENTS &amp; The facility must notify promptly the client's parents or guardian of any significant incidents, or changes in the client's condition including, but not limited to, serious illness, accident, death, abuse, or unauthorized absence.</p> <p>Based on record review and interview for 1 of 3 sampled clients (#3), the facility failed to notify the client's guardian/mother of a fall with severe injury.</p> <p>Findings include:</p> <p>During record review of the facility's reportable incidents to the Bureau of Developmental Disabilities Services (BDDS) on 5/7/15 at 2:15 PM, a 5/5/15 Initial Incident Report indicated on 5/4/15 "staff was loading another consumer into the van and [client #3] did not wait for assistance like asked (sic). While buckling another consumer [client #3] attempted to get on the van and fell backwards on the concrete hitting the back of his head. Staff immediately assessed [client #3] and applied pressure</p>	W 0148	<p>It is now in place that all falls will be thoroughly investigated by the on call "BDDS" pager staff, whether the fall was witnessed or not. A new process was implemented for falls and IR's this will aid in ensuring the IR has the correct information. <u>It also puts the nurse responsible for contacting the guardian immediately when necessary.</u></p>	06/01/2015

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	<p>to the approximately 2 inch laceration. Staff then contacted nurse and called 911. [Client #3] was transported to ER (Emergency Room). Nurse was notified. [Client #3] was discharged with 5 stitches to the back of his head and is to follow up with PCP (Primary Care Physician) in 2-3 days and have stitches removed in 7 - 10 days. [Client #3] followed up with PCP and has been released back to workshop with no new orders and suture removal scheduled for May 12, 2015."</p> <p>During interview with the facility's Qualified Intellectual Disabilities Professional (QIDP) on 5/6/15 at 9:30 AM, she stated "I'm not aware that [client #3's] mother has been notified of his fall on Monday evening (5/4/15). We're so busy and so short staffed, I'm not sure if anyone has called her."</p> <p>Interview with Direct Staff Personnel #5 was completed on 5/7/15 at 5:15 PM. She stated "I finally called and informed [client #3's] mother a few hours ago of his 5/4/15 fall. She told me not to feel bad if I needed to report a behavior for him."</p> <p>Client #3's mother/guardian was interviewed on 5/12/15 at 9:45 AM. She indicated she was not notified until</p>			

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W 0149 Bldg. 00	<p>Thursday evening, 5/7/15, of her son's fall while attempting to board the wheelchair van. She stated "I really wish they (the facility) would call me immediately when any injury occurs. I don't care what time of the day it is."</p> <p>9-3-2(a)</p> <p>483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. Based on observation, interview and record review for 1 of 3 sampled clients (client #3), the facility failed to implement written policy and procedures to prevent neglect of client #3 in regard to a pattern of multiple falls over the past 10 months. The facility failed to ensure sufficient safeguards to prevent client #3 from repeated falls and injuries. The facility failed to investigate a fall with serious injury (laceration of the head) from a 5/4/15 fall while attempting to access the Group Home's wheelchair van.</p>	W 0149	<p>We have now implemented that there will be an IDT meeting after a pattern of 2 or more falls in a month's time with the Director, QIDP, and the nurse to determine what safeguards and measures can be implemented to keep the falls from reoccurring. Along with the IDT meeting all members of the clients team (PCP, behavior specialist, therapist) will be contacted as well. The nurse will continue to track all falls to see if there is a pattern. All staff have been retrained the client # 3 should always be in the line of</p>	06/01/2015

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	<p>Findings include:</p> <p>The 5/4/15 BDDS (Bureau of Developmental Disabilities Services) Report was reviewed on 5/6/15 at 2:30 PM. It indicated "staff was loading consumer into the van and [client #3] did not wait for assistance like asked. While staff was buckling another consumer, [client #3] attempted to get on the van and fell backwards onto the concrete hitting the back of his head. Staff immediately assessed [client #3] and applied pressure to the approximately 2 inch laceration. Staff then contacted nurse and called 911. [Client #3 was transported to ER (Emergency Room).</p> <p>Plan to Resolve (Immediate and Long Term).</p> <p>Nurse was notified. [Client #3] was discharged with 5 stitches to the back of the head and follow up with PCP (Primary Care Physician) in 2-3 days and have stitches removed in 7 to 10 days. [Client #3] followed up with PCP and has been released back to workshop with no new orders and suture removal scheduled for May 12, 15."</p> <p>Record review for client #3 was completed on 5/8/15 at 9:30 AM. The</p>		<p>sight so staff can immediately assist him with ambulating. Staff were retrained 5/4/2015 on usage of client # 3 gait belt stating it should be on during all waking hours. <b><u>Administrative staff will perform a weekly pop in for the next 6 month's to ensure the staff are following instructions.</u></b> Client #3 received a bed alarm on Wednesday June 3, 2015. This was put in place to alert staff if client #3 gets out of bed in the middle of the night in between bed checks.</p>	

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	<p>monthly nursing notes, not all inclusive, indicated the following:</p> <p>"7/28/14 - Review of chart. [Client #3] is scheduled for PT (Physical Therapy) eval for gait belt and walker on 7/31.</p> <p>9/19/14 - [Client #3] fell 9/16 while at [name of Day Program], no injuries documented, s/s (signs/symptoms) completed per [Day Program] staff,</p> <p>9/26/14 - on 9/22, [Client #3] fell again in home with no injuries noted, [Client #3] is having difficulty adjusting to walker, he also fell 9/29 while walking with no injuries noted (date of entire note is 9/26/14).</p> <p>12/18/14 - [Client #3] fell coming out of work center - he tripped over rug. 1¾ inch scratch on right side of forehead. No bruising or redness at this time. He also landed on right shoulder - no bruising, redness on shoulder noted.</p> <p>1/23/15 - [Client #3] was walking and slipped on floor and fell in kitchen, no injuries noted - instructed to monitor.</p> <p>1/30/15 - [Client #3] was getting off van at work shop and tripped over a rug. No injuries noted.</p> <p>2/20/15 -notified [name of doctor] of [client #3's] frequent falls and requested a PT/OT (Physical Therapy/Occupational Therapy) evaluation. Doctor ordered PT.</p> <p>3/6/15 - [Client #3] had a PT evaluation at [Name of Outpatient Physical Therapy</p>			

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	<p>Agency], recommended [client #3] to ambulate at home without a rolling walker, unless increase in falls, will be seen by PT 2 times a week for 4 weeks. 3/13/15- 3/8 report of possible fall, unsure if [client #3] actually fell or sat down on floor, right side of back is red and right side of buttock is red, instructed to monitor for bruising. On 3/9, Home Manager reported bruise on the right side the size of his palm - dark purple in color. Unable to assess to this time due to being at another home doing supervised med pass, will assess when client returns from transport. Received call from [name of Day Program] reporting bruise. Assessed bruise on right upper hip medical side 3 1/2 inch x 2 inch dark purple center with yellow outer edge. [Client #3] doesn't know what happened. 'Appears to be from when he plopped down in chair and hit wooden arm of chair. 'Will be reported.</p> <p>3/20/15 - On 3/16 staff reported [client #3] ran to bed and fell on right side, found on floor, no apparent injuries noted at this time. Order received to increase his Zyprexa dosage to 15 mg (milligrams) twice daily.</p> <p>3/31/15 - Received call from [name of Physical Therapy agency] to notify therapy authorization had been received. First appointment for therapy scheduled for 4/1. Group home staff reported</p>			

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	<p>multiple behaviors this weekend of plopping down hard in chair. Starting on 3/28 to this am 3/30. Assessed backside of [client #3] this morning at 7:45 AM - large dark purple bruise on center of lower back area with a 3 cm (centimeter) hard knot in center and small 2 cm scratch area from hitting arm of chair. Bruised area is approximately 5 " X 3 " . Bruising occurred from behavior on 3/28 which at the time no bruising was noted - but has appeared over time.</p> <p>4/10/15 - Consumer fell in dining room with no injuries noted.</p> <p>4/17/15 - PT continues - client very uncooperative at therapy today. Would not perform the majority of the exercises.</p> <p>"</p> <p>Interview with the facility Licensed Practical Nurse (LPN) was completed on 5/8/15 at 10:03 AM. She indicated Physical Therapy made a recommendation on July 31, 2014 for client #3 to begin utilizing a rolling walker and a gait belt. The LPN provided a form entitled GCARC Medical Therapy Therapist Note dated 7/31/14 that indicated "Evaluation completed. Recommend gait belt to be used all the time. Recommend rolling for ambulation."</p> <p>During morning observation at the Group</p>			

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	<p>Home on 5/7/15 between 5:30 AM and 8:15 AM, client #3 was observed to ambulate without the use of a walker but wearing a gait belt. Staff was not observed to provide assistance to the client at any times while he was ambulating. The client ambulated without assistance from an arm chair in the living room to the kitchen table where he sat down for breakfast.</p> <p>Record review of client #3 was completed on 5/7/15 at 9:30 AM. A form entitled Nurse's Instructions, dated 3/3/15 indicated "[client #3] had a physical therapy evaluation today. The therapist is recommending that he ambulate without the rolling walker with assist of caregivers unless [client #3] begins to have an increase in falls. If that happens, please resume using the rolling walker and caregiver assist. He will be attending PT (Physical Therapy) 2 x/week for 4 weeks. The therapist felt like the walker was a hindrance to his left foot and the way he turns the foot outward when he ambulates. The therapist felt like he may catch his foot on the walker. Please let me know of any falls." The form was signed by the facility Registered Nurse (RN).</p> <p>During interview with the LPN on 5/8/15 at 10:03 am, she indicated she was aware</p>			

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	<p>of the note from the Physical Therapist regarding the recommendation to discontinue use of client #3's walker. She stated "I don't think anyone has contacted the Physical Therapist to advise him that [client #3's] falls have increased since the 3/3/15 nursing note." She also stated "because of the staffing shortage in the home, it's almost impossible for staff to assist him everytime he attempts to get up. The staff is busy monitoring the other clients also."</p> <p>Interview with the QIDP (Qualified Intellectual Disabilities Professional) was completed on 5/7/15 at 2:45 PM regarding staffing at the Group Home. She indicated the group home is short staffed and the facility was actively interviewing for new Direct Staff Personnel.</p> <p>Please see W154. The facility failed to conduct a thorough investigation of an allegation of neglect for client #3.</p> <p>Please see W157. The facility failed to ensure sufficient corrective action was taken to address a pattern of falls for client #3.</p> <p>Please see W186. The facility failed to ensure sufficient staffing was deployed in the home to meet client needs for client</p>			

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	<p>#3.</p> <p>Record review of the facility's Abuse and Rights Violation Prohibition, dated 12/20/14, was completed on 5/12/15 at 2:20 PM. It indicated "GCARC's (Gibson County ARC) policy is to prevent abuse, neglect, exploitation, or mistreatment of consumers. It is also GCARC's policy to prevent violation of consumer rights. GCARC will monitor this policy through Quality Assurance Reviews compliance, observation, consumer complaints, incident reports, consumer and employee surveys, and investigations of allegations of abuse or rights' violations. If any allegations of abuse, neglect, exploitation, mistreatment, or violation of rights' arises an investigation will be conducted, an incident report will be filed and the following agencies will be informed: 1. APS/CPS (Adult Protective Services/Child Protective Services), 2. The consumer's legal representative if applicable, 3. Any person designated with the consumer, 4. The provider of case management services to the consumer, 5. BDDS (Bureau of Developmental Disabilities."</p> <p>9-3-2(a)</p>				

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W 0154 Bldg. 00	<p>483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated. Based on record review and interview for 1 of 3 sampled clients (#3), the facility failed to thoroughly investigate a fall with severe injury (laceration of the head).</p> <p>Findings include:</p> <p>Record review for client #3 was completed on 5/7/15 at 2:15 PM. An Incident Final Report to the State Agency, a BDDS (Bureau of Developmental Disabilities Services) report dated 5/5/15 indicated "staff was loading another consumer into the van and [client #3] did not wait for assistance like asked. While buckling another consumer [client #3] attempted to get on the van and fell backwards on the concrete hitting the back of his head. Staff immediately assessed [client #3] and applied pressure to an approximately 2 inch laceration. Staff then contacted nurse and called 911. [Client #3] was transported to ER (Emergency Room).</p>	W 0154	<p>It is now in place that all falls will be thoroughly investigated by the on call "BDDS" pager staff, whether the fall was witnessed or not. A new process was implemented for falls and IR's this will aid in ensuring the IR has the correct information. It also puts the nurse responsible for contacting the guardian immediately when necessary. We have now implemented that there will be an IDT meeting after a pattern of 2 or more falls in a month's time with the Director, QIDP, the QA, and the nurse to determine what safeguards and measures can be implemented to keep the falls from reoccurring. Along with the IDT meeting all members of the clients team (PCP, behavior specialist, therapist) will be contacted as well. The nurse will continue to track all falls to see if there is a pattern.</p>	06/01/2015

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	<p>Nurse was notified. [Client #3] was discharged with 5 stitches to the back of his head and is to follow up with his PCP (Primary Care Physician) in 2-3 days and have stitches removed in 7 - 10 days. [Client #3] followed up with PCP and has been released back to the workshop with no new orders and suture removal scheduled for May 12, 2015."</p> <p>During interview with the Assistant Residential Director and the Qualified Intellectual Disabilities Professional (QIDP) on 5/7/15 at 2:45 PM, both staff indicated client #3's fall was not investigated because it was visualized by Direct Support Personnel #5 (DSP). They indicated DSP #5 was on the facility's wheelchair van when client #3 fell while attempting to climb up the steps to the van.</p> <p>Interview with staff #5 (the only staff on duty at the group home on 5/4/15 at the time of client #3's fall) was completed on 5/7/2015 at 7:05 PM. She stated "I loaded all the other clients on the wheelchair van (clients #1, #2, #4, #5, and #6) and asked [client #3] to wait in the living room and I would come back to help him board the van. I then came back into the Group Home and did all my 'checks', checked to make sure all the lights were out, appliances turned off,</p>			

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	<p>and front door locked. When I was in the back of the group home I heard [client #3] run out the back door. By the time I was able to make it to the van on the back patio, I found [client #3] on the concrete next to the van with a laceration to the head. Blood was on the concrete. You can still see some of it here [points to two small dark red stains on the concrete]." Staff #5 indicated she did not see client #3 attempt to board the wheelchair van." She stated "I feel if we had more than one staff present when all clients are boarding the wheelchair van, accidents such as this could be avoided."</p> <p>In an interview with the QA (Quality Assurance) Manager on 5/8/2015 at 10:05 AM, she stated management interviewed staff #5 following client #3's 5/4/15 fall. The QA Manager stated when staff #5 told them (management) she was "doing her checks", it was assumed she was on the wheelchair van assisting the other clients secure their wheelchairs when client #3 attempted to access the van. As a result, the QA Manager indicated these events were those reported in the 5/5/15 BDDS report regarding client #3's 5/4/15 fall. She stated "if an investigation into [client #3's] 5/4/15 fall off the wheelchair van had been completed, it would have been determined that the events leading up to</p>			

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	[client #3's] fall were reported incorrectly on the BDDS report."  9-3-2(a)			
W 0157 Bldg. 00	483.420(d)(4) STAFF TREATMENT OF CLIENTS If the alleged violation is verified, appropriate corrective action must be taken. Based on interview and record review for 1 of 3 sampled clients (client #3), the facility failed to ensure sufficient safeguards to prevent client #3 from repeated falls and injuries.	W 0157	We have now implemented that there will be an IDT meeting after a pattern of 2 or more falls in a month's time with the Director, QIDP, the QA, and the nurse to determine what safeguards and measures can be implemented to keep the falls from reoccurring.	06/01/2015

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	<p>Findings include:</p> <p>During record review of the facility's reportable incidents to the Bureau of Developmental Disabilities Services (BDDS) on 5/4/15 at 12:35 PM, it indicated "staff was loading another consumer into the van and [client #3] did not wait for assistance like asked (sic). While buckling another consumer [client #3] attempted to get on the van and fell backwards on the concrete hitting the back of his head. Staff immediately assessed [client #3] and applied pressure to approximately 2 inch laceration. Staff then contacted nurse and called 911. [Client #3] was transported to ER. Nurse was notified. [Client #3] was discharged with 5 stitches to the back of his head and is to follow up with Primary Care Physician (PCP) in 2-3 days and have stitches removed in 7 - 10 days. [Client #3] followed up with PCP and be released back to workshop with no new orders and suture removal scheduled for May 12, 2015."</p> <p>Record review for client #3 was completed on 5/8/15 at 9:30 AM. The monthly nursing notes, not all inclusive, indicated the following:</p> <p>"7/28/14 - Review of chart. [Client #3] is scheduled for PT (Physical Therapy) eval</p>		<p>Along with the IDT meeting all members of the clients team (PCP, behavior specialist, therapist) will be contacted as well. The nurse will continue to track all falls to see if there is a pattern. All staff have been retrained the client # 3 should always be in the line of sight so staff can immediately assist him with ambulating. Staff were retrained 5/4/2015 on usage of client # 3 gait belt stating it should be on during all waking hours. Administrative staff will perform a weekly pop in for the next 6 month's to ensure the staff are following instructions. Client #3 received a bed alarm on Wednesday June 3, 2015. This was put in place to alert staff if client #3 gets out of bed in the middle of the night in between bed checks.</p>				

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	<p>for gait belt and walker on 7/31. 9/19/14 - [Client #3] fell 9/16 while at [name of Day Program], no injuries documented, s/s (signs/symptoms) completed per [name of Day Program] staff, 9/26/14 - on 9/22, [Client #3] fell again in home with no injuries noted, [Client #3] is having difficulty adjusting to walker, he also fell 9/29 while walking with no injuries noted (date of entire note is 9/26/14). 12/18/14 - [Client #3] fell coming out of work center - he tripped over rug. 1<sup>3</sup>/<sub>4</sub> inch scratch on right side of forehead. No bruising or redness at this time. He also landed on right shoulder - no bruising, redness on shoulder noted. 1/23/15 - [Client #3] was walking and slipped on floor and fell in kitchen no injuries noted - instructed to monitor. 1/30/15 - [Client #3] was getting off van at work shop and tripped over a rug. No injuries noted. 2/20/15 -notified [name of doctor] of [client #3's] frequent falls and requested a PT/OT (Physical Therapy/Occupational Therapy) evaluation. Doctor ordered PT. 3/6/15 - [Client #3] had a PT evaluation at [Name of Outpatient Physical Therapy Agency], recommended [client #3] to ambulate at home without a rolling walker, unless increase in falls, will be seen by PT 2 times a week for 4 weeks.</p>						

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	<p>3/13/15- 3/8 report of possible fall, unsure if [client #3] actually fell or sat down on floor, right side of back is red and right side of buttock is red, instructed to monitor for bruising. On 3/9, Home Manager reported bruise on the right side the size of his palm - dark purple in color. Unable to assess to this time due to being at another home doing supervised med pass, will assess when client returns from transport. Received call from [name of Day Program] reporting bruise. Assessed bruise on right upper hip medical side 3 1/2 inch x 2 inch dark purple center with yellow outer edge. [Client #3] doesn't know what happened. 'Appears to be from when he plopped down in chair and hit wooden arm of chair.' Will be reported.</p> <p>3/20/15 - On 3/16 staff reported [client #3] ran to bed and fell on right side, found on floor, no apparent injuries noted at this time. Order received to increase his Zyprexa dosage to 15 mg twice daily.</p> <p>3/31/15 - Received call from [name of Physical Therapy agency] to notify therapy authorization had been received. First appointment for therapy scheduled for 4/1. Group home staff reported multiple behaviors this weekend of plopping down hard in chair. Starting on 3/28 to this am 3/30. Assessed backside of [client #3] this morning at 7:45 AM - large dark purple bruise on center of</p>			

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	<p>lower back area with a 3 cm (centimeter) hard knot in center and small 2 cm scratch area from hitting arm of chair. Bruised area is approximately 5 " X 3 " . Bruising occurred from behavior on 3/28 which at the time no bruising was noted - but has appeared over time.</p> <p>4/10/15 - Consumer fell in dining room with no injuries noted.</p> <p>4/17/15 - PT continues - client very uncooperative at therapy today. Would not perform the majority of the exercises.</p> <p>"</p> <p>Interview with the facility LPN (Licensed Practical Nurse) was completed on 5/8/15 at 10:03 AM. She indicated Physical therapy made a recommendation on July 31, 2014 for client #3 to utilize a rolling walker and a gait belt. The LPN provide a form entitled GCARC Medical Therapy Therapist Note dated 7/31/14 that indicated "Evaluation completed. Recommend gait belt to be used all the time. Recommend rolling for ambulation."</p> <p>Record review of client #3 was completed on 5/7/15 at 9:30 AM. A form entitled Nurse's Instructions, dated 3/3/15 indicates "[client #3] had a physical therapy evaluation today. The therapist is recommending that he ambulate without the rolling walker with assist of</p>			

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	<p>caregivers unless [client #3] begins to have an increase in falls. If that happens, please resume using the rolling walker and caregiver assist. He will be attending PT (Physical Therapy) 2 x/week for 4 weeks. The therapist felt like the walker was a hindrance to his left foot and the way he turns the foot to ambulate. The therapist felt like he may catch his foot on the walker. Please let me know of any falls." The form was signed by the facility Registered Nurse (RN).</p> <p>During the interview with the LPN on 5/8/15 at 10:03 AM, she indicated physical therapy had not been informed of client #3's increased falls as they had requested. She also indicated client #3 had not been prompted by staff to resume the use of his walker as recommended in the 3/3/15 note from the Physical Therapist.</p> <p>9-3-2(a)</p>			

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W 0186  Bldg. 00	483.430(d)(1-2) DIRECT CARE STAFF The facility must provide sufficient direct care staff to manage and supervise clients in accordance with their individual program plans.  Direct care staff are defined as the present on-duty staff calculated over all shifts in a 24-hour period for each defined residential			

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	<p>living unit.</p> <p>Based on record review and interview for 1 of 3 sampled clients (#3), the facility failed to provide sufficient direct care staff during shifts to promote the safety and well-being of the clients in accordance with the client's needs.</p> <p>Findings include:</p> <p>During record review of the facility's reportable incidents to the Bureau of Developmental Disabilities (BDDS) on 5/4/15 at 12:35 PM, it indicated "staff was loading another consumer into the van and [client #3] did not wait for assistance like asked. While buckling another consumer [client #3] attempted to get on the van and fell backwards onto the concrete hitting the back of his head. Staff immediately assessed [client #3] and applied pressure to approximately 2 inch laceration. Staff then contacted nurse and called 911. [Client #3] was transported to ER (Emergency Room). Nurse was notified. [Client #3] was discharged with 5 stitches to the back of his head and is to follow up with PCP (Primary Care Physician) in 2-3 days and have stitches removed in 7 - 10 days. [Client #3] followed up with PCP and has been released back to the workshop with no new orders and suture removal scheduled for May 12, 2015."</p>	W 0186	<p>It is now put into place that the Director or QIDP will oversee the schedule to ensure they are properly and safely staffed . Also put in place if there is ever direct care shortage in the home Admin. Staff will assist on shift to ensure they are safely staffed. The agency has since hired 3 full time and 1 part time staff to help assist in the home.</p>	06/01/2015

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	<p>Interview with Direct Care Staff (DSP) #5 was completed on 5/7/15 at 5:20 PM. She indicated she was working alone on 5/4/15 at approximately 5 PM when client #3 had fallen out of the wheelchair van and received a laceration to the head. She stated "we frequently work short staffed, not to mention very long shifts. It's hard loading 4 clients in wheelchairs safely onto the wheelchair van, securing them, and then getting the other ambulatory clients on board, especially with the behaviors of [client #3] while working alone."</p> <p>Direct Care Staff #6 was interviewed on 5/7/15 at 5:30 PM. She indicated she has a note from her physician stating she can not work over 60 hours a week due to health problems. She stated "I like working with the clients in this home....We have to get more staff working in this home! Poor [Home Manager], he works mostly nights by himself. There are too many behaviors and clients in wheelchairs that require 2 staff on duty much of the time."</p> <p>The staffing schedule for the Group Home indicated on a form entitled R3 Schedule (8th Street Group Home) was reviewed on 5/8/15 at 2:15 pm. It indicated the following staffing schedule:</p>			

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	<p><u>Monday 5/4/2015</u></p> <p>Group Home Mgr 12:00 pm - 8:15 am 10:00 am - 12:00 pm 10:15 pm - 12:00 am</p> <p>Staff #6 off</p> <p>Staff #5 1:45 - 8:30 pm</p> <p><u>Tuesday 5/5/2015</u></p> <p>Group Home Mgr 12:00 am - 8:15 pm 10:15 pm - 12:00 am</p> <p>Staff #6 1:45 pm - 9:00 pm</p> <p>Staff #5 1:45 pm - 8:30 pm</p> <p><u>Wednesday 5/6/2015</u></p> <p>Group Home Mgr 12:00 am - 8:15 am 10:15 pm - 12:00 am</p> <p>Staff #6 1:45 pm - 9:00 am</p>			

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	<p>Staff #5 1:45 pm - 8:30 pm</p> <p><u>Thursday 5/7/2015</u></p> <p>Group Home Mgr 12:00 am - 8:15 am 10:15 pm - 12:00 am</p> <p>Staff #6 1:45 pm - 9:00 pm</p> <p>Staff #5 1:45 pm - 8:30 pm</p> <p><u>Friday 5/8/2015</u></p> <p>Group Home Mgr 12:00 am - 8:15 am 9:00 pm - 12:00 am</p> <p>Staff #6 1:45 pm - 9:00 pm</p> <p>Staff #5 1:45 pm - 8:30 pm</p> <p><u>Saturday 5/9/2015</u></p> <p>Group Home Mgr 12:00 am - 6:00 am 8:30 pm - 12:00 am</p>			

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	<p>Staff #6 6:00 am - 9:00 pm</p> <p>Staff #5 6:00 am - 8:30 pm</p> <p><u>Sunday 5/10/15</u></p> <p>Group Home Mgr 12:00 am - 8:00 am 8:30 pm - 12:00 am</p> <p>Staff #6 6:00 am - 9:00 pm</p> <p>Staff #5 6:00 am - 8:30 pm</p> <p>Interview with the QIDP (Qualified Intellectual Disabilities Professional) was completed on 5/7/15 at 2:45 PM regarding staffing at the Group Home. She indicated the group home is short staffed and the facility was actively interviewing for new Direct Staff Personnel.</p> <p>9-3-3(a)</p>			

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W 0336 Bldg. 00	<p>483.460(c)(3)(iii) NURSING SERVICES</p> <p>Nursing services must include, for those clients certified as not needing a medical care plan, a review of their health status which must be on a quarterly or more frequent basis depending on client need.</p> <p>Based on record review and interview for 3 of 3 sampled clients (#1, #2, and #3), the facility failed to provide a head to toe nursing assessment of the clients at least quarterly.</p> <p>Findings include:</p> <p>1) Record review for client #1 was completed on 5/8/15 at 10:45 AM. Client #1's medical record indicated his annual physical was completed on 2/5/15. There were no quarterly nursing assessments in the medical record during the 3 month</p>	W 0336	As of 06/05/2015 the residential nurse has completed a head to toe assessment on all clients in the home. Going forward the nurse has created a schedule and spreadsheet to follow to ensure all assessments are completed. Director will follow up monthly with the nurse to oversee that this is being done.	06/01/2015

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	<p>time period following the 2/5/15 annual physical for client #1. There were no quarterly nursing assessments available during the 6 month period prior to the 2/5/15 annual physical.</p> <p>Interview with the facility Licensed Practical Nurse (LPN) on 5/8/15 at 10:03 AM indicated there were no quarterly nursing assessments completed on client #1 during the months of August 2014 through November 2014 nor after the 2/5/15 annual physical until present.</p> <p>2) Record review for client #2 was completed on 5/8/15 at 11:56 AM. Client #2's medical record indicated his annual physical was completed on 2/16/15. There were no quarterly nursing assessments during the 8 month time period prior to the 2/16/15 annual physical.</p> <p>Interview with the facility LPN on 5/8/15 at 9:30 AM indicated while health care services does not perform a quarterly nursing assessment during the same quarter as the annual physical, there were no quarterly nursing assessments completed for client #2.</p> <p>3) Record review for client #3 was completed on 5/8/15 at 9:30 AM. Client #3's medical record indicated his last</p>			

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	<p>annual physical was completed on 4/15/14. There were no quarterly nursing assessments in the record.</p> <p>During review of client #3's medical record, client #3 was seen on 10/15/14 by his primary care physician. On a form entitled GCARC Medical Appointment Form for Health Care Services, it states "fasting bloodwork before next visit . B/P (Blood Pressure) 90/60, Pulse 68, Respirations 16, and Weight 175." The form signed by client #3's primary care physician did not indicate the client was given a complete head to toe assessment. There were no quarterly nursing assessments completed during the time period between August 2014 and the date of the record review (5/8/15).</p> <p>Interview with the facility LPN was completed on 5/8/15 at 10:03 AM. She stated "a quarterly nursing assessment was completed on 2/27/15." A form entitled GCARC Nursing Notes - February indicated "2/24/15-MD notified of concern over lack of BM's (Bowel Movements), [client #3's initials] assessed with hyperactive bowel sounds, slightly hard abdomen, and complaints of pain in abdomen. [Doctor] notified of status, instructed staff to give PRN (as needed) tonight and let me (nurse) know if any results in morning. Called home</p>			

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	<p>2/25/15 - no results, will have [client #3s initials] follow up today. Miralax ordered and Fleets enema x 1; had large BM before enema so enema changed to prn per MD (Medical Doctor); 2/26 - pharmacy consult with recommendations for TSH (Thyroid Stimulating Hormone) lab annually. MD notified." The nursing note was signed by the Registered Nurse. There was no head to toe physician and nursing assessment completed on client #3 at that time. The LPN stated the facility "recently decided to make appointments for the clients with their primary care physician every 3 months in lieu of the nurse having to complete a quarterly nursing assessment."</p> <p>9-3-6(a)</p>			