STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G079	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 10/04/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVING CENTER-NORTH WILLOW	2002 W 86TH ST INDIANAPOLIS, IN 46260

(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
W000000	This visit was for the investigation of complaint #IN00136892. Complaint #IN00136892-Substantiated, Federal and state deficiencies related to the allegation(s) are cited at W149, W240 and W331. Dates of survey: 9/25, 9/26, 9/27 and 10/4/13 Facility Number: 000622 Provider Number: 15G079 AIMS Number: 100272170 Survey Team: Paula Chika, QIDP-TC These deficiencies also reflect state findings in accordance with 410 IAC 16.2. Quality Review completed 10/16/13 by Ruth Shackelford, QIDP.	W000000		

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

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

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W000149	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 (B), the facility failed to implement its policy and procedures to prevent neglect/abuse of client B in regard to being restrained to the toilet with a gait belt. Findings include: The facility's reportable incident reports were reviewed on 9/25/13 at 12:32 PM. The facility's 9/20/13 reportable incident report indicated "[Client B] has an abrasion of unknown origin on his back (previously reported). As part of that investigation, [the Director of Nursing (DON)], Director of Nursing Services, went to [client B's] room to assess the abrasion. [The DON] found [client B] on the toilet with a gait belt loosely around his waist, but also hooked around the plumbing fixture. [Client B] was sitting comfortably on the toilet, with his legs crossed, humming to himself. He remained seated this way after the gait belt was disengaged and showed no signs of distress. The abrasion on [client B's] back does appear to be from the gait belt rubbing on his back. [Certified Nursing	W000149	POC event ID F89P11 10-4-13 W149IIn addition to a competency test recently completed on what not to do for staff convenience which addresses restraint which is inappropriate, staff have been trained in proper use of a gait belt, reasons for it. Any resident who regularly uses a gait belt has it on the CNA assignment sheet and has an order for it. QRMP training completed that if gait belt is regularly needed it is to be part of ISP and included in client specific training and on CNA assignment sheet. The ISP outlines specific use of the gait belt. Nursing trained that order needed for regular gait belt use. In addition to requesting an order for Client B for regular gait belt usage, Nurses are observing for appropriate gait belt usage on the floor and completing follow up when needed. This includes resident B. An IDT is an amendment of the ISP. IIAny resident might be at risk for this deficient practice. IIIIn addition to a competency test recently completed on what not to do for staff convenience which addresses restraint which is inappropriate, staff have been trained in proper use of a gait belt, reasons for it. Any resident	11/03/2013

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	Aide (CNA) #1], CNA, was assigned to [client B] and said that she did place the gait belt around [client B] and the plumbing. She said that she does not generally work with [client B], but had seen the belt used before so assumed it was protocol (it is not). She was not able to say who or when she had seen this. She was suspended pending the completion of our internal investigation. [LPN #1], LPN, was interviewed. She said that she was aware of the use of the gait belt - but that when it had been used she had felt it was being used as a safety measure (sic). When asked if similar safety measures were used for anyone else, she said that she has heard that staff use the gait belt in a similar fashion with [client C]. [LPN #1] was suspended pending the completion of our internal investigation. [CNA #2] was also working and is a regular staff on the unit. When questioned she said that she has seen the gait belt in the bathroom, but did not think about it. She did say that she had either seen or heard of the gait belt being used for [client B] and for [client C]. She said she is not aware of the belt being used for anyone else. She is suspended pending completion of the internal investigation...The reportable incident		who regularly uses a gait belt has it on the CNA assignment sheet and has an order for it. QRMP training completed that if gait belt is regularly needed it is to be part of ISP and included in client specific training and on CNA assignment sheet. The ISP outlines specific times or schedule of use. Nursing trained that order needed for regular gait belt use. In addition to requesting an order for regular gait belt usage, Nurses are observing for appropriate gait belt usage on the floor and completing follow up when needed. An IDT is an amendment of the ISP. IVQMRP staff complete audits three times per week that include observing appropriate gait belt usage. Also quarterly reviews include observation of gait belt usage when it is part of the ISP including schedule of use. Program Directors assure that regular use of gait belt has an order and is part of the ISP and orders are done when a gait belt is regularly used. An IDT is an amendment of the ISP. Completed by 11-3-13	

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	report indicated CNA #3 was also suspended as the staff normally worked with client B. The reportable incident report indicated CNA #3 did not work on 9/20/13. The reportable incident report indicated "...All staff directly involved have been suspended pending the completion of our internal investigation. Inservice training on appropriate gait belt usage has been initiated throughout the building. Training on Abuse and Neglect Reporting has also been initiated...." CNA #1's 9/20/13 witness statement indicated she had seen the gait belt used on client B in the past. CNA #1 stated "...I heard [client B] in the bathroom. Helped him got him off the toilet (sic). Maybe 3 months ago...." CNA #1 indicated, in the past, she did not know which staff utilized the gait belt with the client while on the toilet. CNA #1's 9/20/13 witness statement indicated client B "Will jump around on you." CNA #1's witness statement indicated client B "...jumps off toilet, runs down hallway naked & throws BM (bowel movement) down the hall. He could use an order for gait belt when walking for safety." LPN #1's undated witness statement indicated the gait had been used, in the past, when client B had "runny stools" as the client "...has slipped & (and) fallen in			

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	stool-it's really a safety thing...." LPN #1's statement indicated she had "...Seen both on him & on him with toilet." The facility's 9/17/13 reportable incident report indicated "Resident presented with dry scabbed abrasion to outer right back. Nursing notified, and area scabbed and resolving. No further signs of injury noted or observed. No signs of discomfort noted or observed." The facility's undated Unknown Injury Investigation indicated client B did not have a history of falls but was at risk for falls due to "frequent stools and possibility of falls." The undated investigation indicated the "...Day and evening staff report using a gait belt at times during walking program to prevent falling as resident enjoys jumping about, and sometimes resists. Staff from all shifts deny observing any falls or client to client events which may have caused injury. DON as well as HRC (Human Rights Committee) Director/Client advocate both report abrasion appears to be a friction injury which is likely caused due to the gait belt rubbing against skin...The team agrees that the area to the right side of the back is likely a result of the gait-belt rubbing against the skin. Staff will monitor when using gait belt for assistance to prevent gait belt from			

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	contacting the skin...Staff will be advised not to use gait belt unless necessary for protection...." Client B's record was reviewed on 9/26/13 at 11:31 AM. Client B's 8/13 physician's orders indicated client B's diagnoses included, but were not limited to, Profound Intellectual Disability, Autism, Recurrent Seizures, Cataract, Myopia, Exotropia and Scoliosis Idiopathic. Client B's 8/13 physician's orders indicated the facility failed to obtain a doctor's order for the use of a gait belt as client B did not have a doctor's order to use a gait belt. Client B's 8/7/13 Head to Toe Nursing (quarterly) Assessment did not indicate client B required the use of a gait belt when ambulating, toileting and/or safety. Client B's 9/17/13 nursing progress note indicated client B's brother took client B out for a ride. The note indicated it was client B's brother who discovered the abrasion on client B's back. Client B's nursing progress notes and/or record did not indicate client B required the use of a gait belt for ambulation, transfers and/or safety. Client B's 3/4/13 Physical Therapy (PT) Screen Form indicated there had been no			

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	change in client B's condition and no recent change in the client's "safety status." The PT screen indicated client B was "...indep (independent) (with) amb (ambulation) otherwise, No functl (functional) decline." The PT screen did not indicate client B required the use of a gait belt and/or any other assistive device. Client B's 2/7/13 Individual Support Plan (ISP) indicated client B did not require the use of any adaptive equipment except a Dycem Pad and a divided plate. Client B's 2/7/13 ISP indicated "...MONITOR: Safety/Fall Risk PROGRAM: Keep environment well lit and free from clutter, orientation to new room and roommates, assist client with mobility as needed (sic)...." Client B's 10/28/12 risk plan indicated client B was "At risk for falls related to: Wandering, New environment, History of falls...." Client B's 10/28/12 risk plan did not indicate client B required the use of a gait belt while ambulating, transfers, toileting, and/or indicate when staff were to use a gait belt to assist the client to ambulate/transfer for safety. Client B's 1/17/13 Behavior Support Plan (BSP) indicated "...He is independently ambulatory, but is considered a fall risk as he does not watch where he is			

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	walking,...." Client B's BSP indicated client B demonstrated AWOL (leaving supervised area) and resistance behavior regarding medical appointments. Client B's ISP did not indicate any additional behaviors the client demonstrated. Client B's 10/17/12 IDT (interdisciplinary team) note indicated client B was not independent in toileting. Client B's record indicated client B's IDT failed to meet after the 9/20/13 incident in regard to the restraint and/or gait belt usage. Interview with CNA #3 on 9/26/13 at 10:45 AM indicated clients B and C used a gait belt on 2 south. CNA #3 indicated a gait belt was used to assist the clients to ambulate and/or to do transfers. Interview with CNA #4 on 9/26/13 at 11:00 AM indicated she did not know which clients required the use of a gait belt on 2 south. CNA #4 indicated they were new to the hallway. CNA #4 indicated the gait belts were in a closet located in the classroom on the top shelf. Interview with LPN #3 on 9/26/13 at 11:12 AM indicated she was not aware of staff using a gait belt while toileting clients. LPN #2 indicated gait belts should be used with clients who had a doctor's order, and the gait belts should be			

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	removed after ambulating and/or transferring the client. Interview with LPN #2 on 9/26/13 at 11:14 AM indicated client B required the use of a gait belt when he ambulated and during transfers. Interview with LPN #3 on 9/26/13 at 11:17 AM indicated client B did not have an order for the use of a gait belt. LPN #3 indicated gait belts should only be used with clients who had an order. Interview with administrative staff #3 on 9/26/13 at 12:27 PM stated the facility was in the process of conducting an investigation in regard to client B's "improper use of a gait belt." Administrative staff #3 indicated she was re-interviewing CNA and nursing staff who had been suspended. Administrative staff #3 indicated client B did not have an order for the use of a gait belt in his record. Administrative staff #3 stated client B could have receive the abrasion due to laying up against the "hard rail in the hallway" and/or from the gait belt. Interview with administrative staff #4 on 9/26/13 at 12:30 PM indicated client B had a gait belt tied around his waist. Administrative staff #4 indicated the gait belt was then tied around the plumbing			

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	fixture. Administrative staff #4 stated "I almost did not see it." Administrative staff #4 indicated client B's bedroom was at the far end of the hallway away from where anyone would see him. Interview with Qualified Intellectual Disabilities Professional (QIDP) #1 on 9/26/13 at 2:15 PM indicated client B should not be left unattended on the toilet. QIDP #1 stated client B was "a potential risk for falls" as client B would "get up running off the toilet." When asked when a gait belt was to be used with the client, QIDP stated "No doctor order officially. Seizure very severe. Can use if in danger." QIDP stated client B was assessed by the PT for a gait belt but "PT did not find a need for a gait belt." When asked if client B's IDT had met to review the gait belt incident/usage, QIDP stated "No." QIDP #1 indicated he was not aware CNAs were using a gait belt to keep client B on the toilet. QIDP #1 indicated client B had a toileting goal to sit on the toilet for 15 minutes. Interview with administrative staff #4 on 9/26/13 at 2:25 PM indicated she was not aware any client was being placed on a toilet with a gait belt. Administrative staff #4 indicated CNA #1 had worked on the day shift as a regular staff person for a year.			

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	Interview with the DON on 9/26/13 at 2:50 PM indicated she and administrative staff #4 went up to see client B's abrasion on his back due to the 9/17/13 injury of unknown source investigation. The DON indicated they went to client B's classroom looking for the client and they were told the client was in his room. The DON stated client B was in the bathroom located in his bedroom sitting on the toilet "Indian style." The DON indicated when client B was asked to lean forward so they could check his back, that was when they noticed the gait belt around client B's back with the gait belt going around the plumbing of the toilet. The DON indicated she then came downstairs to get administrative staff #1 to come and look at the gait belt around the client and plumbing. The DON stated the gait belt was "loose on him and he had full movement." The DON indicated gait belts should not be used to restrain clients to the toilet. The facility's policy and procedures were reviewed on 9/25/13 at 12:28 PM. The facility's May 2001 policy entitled Reporting Alleged Violations indicated "...It is the policy of this facility to take appropriate steps to prevent the occurrence of abuse, neglect, injuries of unknown source...." The facility's policy			

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	defined "...Abuse is the willful infliction of injury, unreasonable confinement,...." The facility's policy defined "...Neglect means failure to provide goods and services necessary to avoid physical harm,...." This federal tag relates to complaint #IN00136892. 9-3-2(a)			

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W000240	483.440(c)(6)(i) INDIVIDUAL PROGRAM PLAN The individual program plan must describe relevant interventions to support the individual toward independence. Based on observation, interview and record review for 2 of 3 sampled clients (B and C), the clients' Individual Support Plans failed to indicate how facility staff were to specifically assist the clients to ambulate, and/or indicate when a gait belt was to be utilized to aid in the clients' mobility. Findings include: 1. The facility's reportable incident reports were reviewed on 9/25/13 at 12:32 PM. The facility's 9/20/13 reportable incident report indicated "[Client B] has an abrasion on unknown origin on his back (previously reported). As part of that investigation, [the Director of Nursing (DON)], Director of Nursing Services, went to [client B's] room to assess the abrasion. [The DON] found [client B] on the toilet with a gait belt loosely around his waist, but also hooked around the plumbing fixture. [Client B] was sitting comfortably on the toilet, with his legs crossed, humming to himself. He remained seated this way after the gait belt was disengaged and showed no signs of distress. The abrasion on [client B's] back does appear to be from the gait belt	W000240	W240IIn addition to a competency test recently completed on what not to do for staff convenience which addresses restraint which is inappropriate, staff have been trained in proper use of a gait belt, reasons for it. Any resident who regularly uses a gait belt has it on the CNA assignment sheet and has an order for it. QRMP training completed that if gait belt is regularly needed it is to be part of ISP and included in client specific training and on CNA assignment sheet. The ISP outlines specific use of the gait belt. Nursing trained that order needed for regular gait belt use. Nursing trained that order needed for regular gait belt use. In addition to requesting an order for Client B for regular gait belt usage, Nurses are observing for appropriate gait belt usage on the floor and completing follow up when needed. An IDT is an amendment of the ISP.All this includes resident B. IIAny resident might be at risk for this deficient practice. IIIIn addition to a competency test recently completed on what not to do for staff convenience which addresses restraint which is inappropriate, staff have been trained in proper use of a gait	11/03/2013

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	rubbing on his back. [Certified Nursing Aide (CNA) #1], CNA, was assigned to [client B] and said that she did place the gait belt around [client B] and the plumbing. She said that she does not generally work with [client B], but had seen the belt used before so assumed it was protocol (it is not)...[LPN #1], LPN, was interviewed. She said that she was aware of the use of the gait belt - but that when it had been used she had felt it was being used as a safety measure (sic)... [CNA #2] was also working and is a regular staff on the unit. When questioned she said that she has seen the gait belt in the bathroom, but did not think about it. She did say that she had either seen or heard of the gait belt being used for [client B] and for [client C]. She said she is not aware of the belt being used for anyone else...." CNA #1's 9/20/13 witness statement indicated she had seen the gait belt used on client B in the past. CNA #1 stated "...I heard [client B] in the bathroom. Helped him got him off the toilet (sic). Maybe 3 months ago...." CNA #1 indicated, in the past, she did not know which staff utilized the gait belt with the client while on the toilet. CNA #1's 9/20/13 witness statement stated client B "Will jump around on you." CNA #1's witness statement indicated client B		belt, reasons for it. Any resident who regularly uses a gait belt has it on the CNA assignment sheet and has an order for it. QRMP training completed that if gait belt is regularly needed it is to be part of ISP and included in client specific training and on CNA assignment sheet. The ISP outlines specific times or schedule of use. Nursing trained that order needed for regular gait belt use. Nursing trained that order needed for regular gait belt use. In addition to requesting an order for regular gait belt usage, Nurses are observing for appropriate gait belt usage on the floor and completing follow up when needed. An IDT is an amendment of the ISP. IVQMRP staff complete audits three times per week that include observing appropriate gait belt usage. Also quarterly reviews include observation of gait belt usage when it is part of the ISP including schedule of use. Program Directors assure that regular use of gait belt has an order and is part of the ISP and orders are done when a gait belt is regularly used. An IDT is an amendment of the ISP. Completed by 11-3-13	

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NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-NORTH WILLOW		STREET ADDRESS, CITY, STATE, ZIP CODE 2002 W 86TH ST INDIANAPOLIS, IN 46260	

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	"...jumps off toilet, runs down hallway naked & throws BM (bowel movement) down the hall. He could use an order for gait belt when walking for safety." LPN #1's undated witness statement indicated the gait had been used, in the past, when client B had "runny stools" as the client "...has slipped & (and) fallen in stool-it's really a safety thing...." LPN #1's statement indicated she had "...Seen both on him & on him with toilet." The facility's 9/17/13 reportable incident report indicated "Resident presented with dry scabbed abrasion to outer right back. Nursing notified, and area scabbed and resolving. No further signs of injury noted or observed. No signs of discomfort noted or observed." The facility's undated Unknown Injury Investigation indicated client B did not have a history of falls but was at risk for falls due to "frequent stools and possibility of falls." The undated investigation indicated the "...Day and evening staff report using a gait belt at times during walking program to prevent falling as resident enjoys jumping about, and sometimes resists...." Client B's record was reviewed on 9/26/13 at 11:31 AM. Client B's 2/7/13			

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	Individual Support Plan (ISP) indicated client B did not require the use of any adaptive equipment except a Dycem Pad and a divided plate. Client B's 2/7/13 ISP indicated "...MONITOR: Safety/Fall Risk PROGRAM: Keep environment well lit and free from clutter, orientation to new room and roommates, assist client with mobility as needed (sic)...." Client B's 10/28/12 risk plan indicated client B was "At risk for falls related to: Wandering, New environment, History of falls...." Client B's 10/28/12 risk plan did not indicate client B required the use of a gait belt while ambulating, transfers, toileting, and/or indicate how facility staff were to assist the client with mobility/to ambulate as needed. 2. Client C's record was reviewed on 9/26/13 at 12:15 PM. Client C's 8/13 physician's orders indicated client C had an order to to use a gait belt for ambulation with staff as needed. Client C's 3/17/13 fall risk plan indicated client C was to have a fall mat on the client's bedroom floor while the client was sleeping and/or resting. The fall plan indicated client C was to wear footwear to prevent falls and to "Keep the environment well lit and free of clutter."			

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	Client C's 3/21/13 ISP indicated client C had an objective to learn to ambulate safely by walking to the exit door on North hall with physical guidance. The 3/17/13 fall risk plan, 3/21/13 ISP objective and/or the 8/13 physician's order did not specifically indicate when facility staff were to utilize/assist client C to ambulate with a gait belt. Interview with CNA #3 on 9/26/13 at 10:45 AM indicated clients B and C used a gait belt on 2 south. CNA #3 indicated a gait belt was used to assist the clients to ambulate and/or to do transfers. Interview with LPN #3 on 9/26/13 at 11:12 AM indicated gait belts should be used with clients who had a doctor's order, and the gait belts should be removed after ambulating and/or transferring the client. Interview with LPN #2 on 9/26/13 at 11:14 AM indicated client B required the use of a gait belt when he ambulated and during transfers. Interview with Qualified Intellectual Disabilities Professional (QIDP) #1 on 9/26/13 at 2:15 PM indicated, at times, gait belts were with clients B and C to assist the clients to ambulate and/or transfer safely. QIDP #1 stated client B			

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	was "a potential risk for falls" as client B would "get up running off the toilet." When asked when a gait belt was to be used with the client, QIDP stated "No doctor order officially. Seizure very severe. Can use if in danger." QIDP indicated client C had a PRN order for the use of a gait belt. QIDP indicated client C had a walking program/objective. QIDP stated the use of gait used to be a part of client C's objective, but he must have "deleted" it from the objective. QIDP indicated client B and C's ISPs did not specifically indicate when and/or how facility staff were to use a gait belt to assist the clients to ambulate. This federal tag relates to complaint #IN00136892. 9-3-4(a)			

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W000331	483.460(c) NURSING SERVICES The facility must provide clients with nursing services in accordance with their needs. Based on interview and record review for 1 of 3 sampled clients (B), the facility's nursing services failed to monitor the use of a gait belt by the facility staff. The nursing services failed to obtain an order for the use of a gait belt which was being used to assist the client to ambulate/transfer for safety. Findings include: The facility's reportable incident reports were reviewed on 9/25/13 at 12:32 PM. The facility's 9/20/13 reportable incident report indicated "[Client B] has an abrasion on unknown origin on his back (previously reported). As part of that investigation, [the Director of Nursing (DON)], Director of Nursing Services, went to [client B's] room to assess the abrasion. [The DON] found [client B] on the toilet with a gait belt loosely around his waist, but also hooked around the plumbing fixture. [Client B] was sitting comfortably on the toilet, with his legs crossed, humming to himself. He remained seated this way after the gait belt was disengaged and showed no signs of distress. The abrasion on [client B's] back does appear to be from the gait belt rubbing on his back. [Certified Nursing	W000331	W331IIn addition to a competency test recently completed on what not to do for staff convenience which addresses restraint which is inappropriate, staff have been trained in proper use of a gait belt, reasons for it. Any resident who regularly uses a gait belt has it on the CNA assignment sheet and has an order for it. QRMP training completed that if gait belt is regularly needed it is to be part of ISP and included in client specific training and on CNA assignment sheet. The ISP outlines specific use of the gait belt. Nursing trained that order needed for regular gait belt use. In addition to requesting an order for Client B for regular gait belt usage, Nurses are observing for appropriate gait belt usage on the floor and completing follow up when needed. An IDT is an amendment of the ISP.This includes resident B. IIAny resident might be at risk for this deficient practice. IIIIn addition to a competency test recently completed on what not to do for staff convenience which addresses restraint which is inappropriate, staff have been trained in proper use of a gait belt, reasons for it. Any resident who regularly uses a gait belt has it on the CNA assignment sheet	11/03/2013

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	Aide (CNA) #1], CNA, was assigned to [client B] and said that she did place the gait belt around [client B] and the plumbing. She said that she does not generally work with [client B], but had seen the belt used before so assumed it was protocol (it is not)...[LPN #1], LPN, was interviewed. She said that she was aware of the use of the gait belt - but that when it had been used she had felt it was being used as a safety measure (sic)...." CNA #1's 9/20/13 witness statement indicated she had seen the gait belt used on client B in the past. CNA #1 stated "...I heard [client B] in the bathroom. Helped him got him off the toilet (sic). Maybe 3 months ago...." CNA #1 indicated, in the past, she did not know which staff utilized the gait belt with the client while on the toilet. CNA #1's 9/20/13 witness statement stated client B "Will jump around on you." CNA #1's witness statement indicated client B "...jumps off toilet, runs down hallway naked & throws BM (bowel movement) down the hall. He could use an order for gait belt when walking for safety." LPN #1's undated witness statement indicated the gait had been used, in the past, when client B had "runny stools" as the client "...has slipped & (and) fallen in stool-it's really a safety thing...." LPN		and has an order for it. QRMP training completed that if gait belt is regularly needed it is to be part of ISP and included in client specific training and on CNA assignment sheet. The ISP outlines specific times or schedule of use. Nursing trained that order needed for regular gait belt use. In addition to requesting an order for regular gait belt usage, Nurses are observing for appropriate gait belt usage on the floor and completing follow up when needed. An IDT is an amendment of the ISP. IVQMRP staff complete audits three times per week that include observing appropriate gait belt usage. Also quarterly reviews include observation of gait belt usage when it is part of the ISP including schedule of use. Program Directors assure that regular use of gait belt has an order and is part of the ISP and orders are done when a gait belt is regularly used. An IDT is an amendment of the ISP. Completed by 11-3-13	

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	#1's statement indicated she had "...Seen both on him & on him with toilet." The facility's 9/17/13 reportable incident report indicated "Resident presented with dry scabbed abrasion to outer right back. Nursing notified, and area scabbed and resolving. No further signs of injury noted or observed. No signs of discomfort noted or observed." The facility's undated Unknown Injury Investigation indicated client B did not have a history of falls but was at risk for falls due to "frequent stools and possibility of falls." The undated investigation indicated the "...Day and evening staff report using a gait belt at times during walking program to prevent falling as resident enjoys jumping about, and sometimes resists... DON as well as HRC (Human Rights Committee) Director/Client advocate both report abrasion appears to be a friction injury which is likely caused due to the gait belt rubbing against skin...The team agrees that the area to the right side of the back is likely a result of the gait-belt rubbing against the skin. Staff will monitor when using gait belt for assistance to prevent gait belt from contacting the skin...Staff will be advised not to use gait belt unless necessary for protection...."			

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	Client B's record was reviewed on 9/26/13 at 11:31 AM. Client B's 8/13 physician's orders indicated client B's diagnoses included, but were not limited to, Profound Intellectual Disability, Autism, Recurrent Seizures, Cataract, Myopia, Exotropia and Scoliosis Idiopathic. Client B's 8/7/13 Head to Toe Nursing (quarterly) Assessment did not indicate client B required the use of a gait belt when ambulating, toileting and/or for safety. Client B's 9/17/13 nursing progress note indicated client B's brother took client B out for a ride. The note indicated it was client B's brother who discovered the abrasion on client B's back. Client B's nursing progress notes and/or record did not indicate client B required the use of a gait belt for ambulation, transfers and/or safety. Client B's 8/13 physician's orders and/or record indicated the facility's nursing services failed to obtain a doctor's order for the use of a gait belt as client B did not have a doctor's order to use a gait belt for mobility, transfers and/or safety. Client B's 3/4/13 Physical Therapy (PT) Screen Form indicated there had been no			

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	change in client B's condition and no recent change in the client's "safety status." The PT screen indicated client B was "...indep (independent) (with) amb (ambulation) otherwise, No functl (functional) decline." The PT screen did not indicate client B required the use of a gait belt and/or any other assistive device. Client B's 2/7/13 Individual Support Plan (ISP) indicated client B did not require the use of any adaptive equipment except a Dycem Pad and a divided plate. Client B's 2/7/13 ISP indicated "...MONITOR: Safety/Fall Risk PROGRAM: Keep environment well lit and free from clutter, orientation to new room and roommates, assist client with mobility as needed (sic)...." Client B's 10/28/12 risk plan indicated client B was "At risk for falls related to: Wandering, New environment, History of falls...." Client B's 10/28/12 risk plan did not indicate client B required the use of a gait belt while ambulating, transfers, toileting, and/or indicate when staff were to use a gait belt to assist the client to ambulate/transfer for safety. Interview with CNA #3 on 9/26/13 at 10:45 AM indicated clients B and C used a gait belt on 2 south. CNA #3 indicated a gait belt was used to assist the clients to			

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	ambulate and/or to do transfers. Interview with LPN #3 on 9/26/13 at 11:12 AM indicated gait belts should be used with clients who had a doctor's order, and the gait belts should be removed after ambulating and/or transferring the client. Interview with LPN #2 on 9/26/13 at 11:14 AM indicated client B required the use of a gait belt when he ambulated and during transfers. Interview with LPN #3 on 9/26/13 at 11:17 AM indicated client B did not have an order for the use of a gait belt. LPN #3 indicated gait belts should only be used with clients who had an order. Interview with administrative staff #3 on 9/26/13 at 12:27 PM indicated client B did not have an order for the use of a gait belt in his record. Interview with Qualified Intellectual Disabilities Professional (QIDP) #1 on 9/26/13 at 2:15 PM indicated client B should not be left unattended on the toilet. QIDP #1 stated client B was "a potential risk for falls" as client B would "get up running off the toilet." When asked when a gait belt was to be used with the client, QIDP stated "No doctor order officially.			

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	Seizure very severe. Can use if in danger." This federal tag relates to complaint #IN00136892. 9-3-6(a)			