

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G602	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  05/25/2012
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NAME OF PROVIDER OR SUPPLIER  ABILITIES SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 850 MAPLELEAF DR FRANKFORT, IN 46041
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W0000	<p>This visit was for the investigation of complaint #IN00107147.</p> <p>Complaint #IN00107147-Substantiated, Federal/state deficiencies related to the allegation are cited at W102, W104, W122, W149, W186, W240 and W331.</p> <p>Dates of Survey: 5/17, 5/18 and 5/25/12</p> <p>Facility Number: 001116 Provider Number: 15G602 Aim Number: 100245620</p> <p>Surveyors: Paula Chika, Medical Surveyor III-Team Leader Amber Bloss, Medical Surveyor III</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 6/1/12 by Ruth Shackelford, Medical Surveyor III.</p>	W0000		

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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W0102	<p>483.410 GOVERNING BODY AND MANAGEMENT The facility must ensure that specific governing body and management requirements are met.</p> <p>Based on observation, interview and record review, the facility failed to meet the Condition of Governing Body for 4 of 4 sampled clients (A, B, C and D) and for 3 additional clients (E, F and G). The governing body failed to ensure client B was not neglected in regard to falls. The governing body failed to ensure there were sufficient staff to meet the needs of clients A, B, C, D, E, F and G, and to ensure the facility had a van with a wheelchair lift to safely transport clients.</p> <p>Findings include:</p> <ol style="list-style-type: none"> <li>The governing body failed to ensure the facility met the Condition of Participation: Client Protections for 4 of 4 sampled clients (A, B, C and D) and for 3 additional clients (E, F and G). The governing body failed to ensure the facility implemented its policy and procedures to prevent neglect of client B in regard to falls with injuries. Please see W122.</li> <li>The governing body failed to ensure the facility implemented its policy and procedures to prevent neglect of client B in regard to falls which resulted in</li> </ol>	W0102	<p>In regard to W102 and the the consumer who was not monitored to prevent falls: ASI has improved its Incident Report tracking system to identify when a consumer crosses a threshold of three incidents of the same kind. These are reported to the agency's Human Rights Committee in an effort to identify prevention strategies. In regard to W102 and the concerns with a working lift in the van, the agency's Safety Committee has implemented a vehicle checklist system for daily checks. In response to the follow up letter dated June 20: The plan to prevent this consumer from falling is to comply with the recommendations his neurologist. This includes providing a helmet for his head. Staff are being trained this week on the signs of dementia to increase their awareness in dealing with this consumer. In addition, this consumer's line of sight protocol has been up-dated so that staff is within arm's reach when ambulating. The vehicle checklist is completed on each vehicle daily -- including the van lifts. These are reviewed daily by the agency's Safety Committee Chairperson who is the Director of Day and Placement Services.</p>	06/18/2012			

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	<p>injuries. The governing body failed to ensure the facility had sufficient staff to meet the health/safety needs of clients, and to ensure the facility had a safe way to transport clients to work and/or community outings. Please see W104.</p> <p>This federal tag relates to complaint #IN00107147.</p> <p>9-3-1(a)</p>		<p>Any deficiencies are sent for repair immediately. In response to the follow up letter dated June 25: The Maplewood van lift has been fixed and is in working order. The checklist for vehicle safety is completed daily before use and if a deficiency is noted that makes it unsafe to use, staff do not use it. There are additional vehicles at the day services location in Frankfort that can be used when a group home vehicle is in the shop. The up-dated high risk plan for the consumer in question has been re-written and staff in the group home and day services have been trained. They will be able to monitor compliance on a daily basis. In addition, the Maplewood IDT meets weekly and reviews consumer-specific concerns. This would be the regular forum to identify and address any questions that arise with compliance. In addition, ASI has added a second nurse so that will reduce the caseload of the nurse located in Clinton County to allow more hands-on nursing oversight of consumer plans.</p>		

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W0104	<p>483.410(a)(1) GOVERNING BODY 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) and for 3 additional clients (E, F and G), the facility's governing body failed to exercise general policy, budget and operating direction over the facility to ensure client B was not neglected in regard to falls. The governing body failed to exercise general policy, budget and operating direction over the facility to ensure there were sufficient staff to meet the needs of clients A, B, C, D, E, F and G, and to ensure the facility had a van with a wheelchair lift to safely transport clients.</p> <p>Findings include:</p> <p>1. During the 5/17/12 observation period between 3:15 PM and 4:32 PM, clients A, C, and F ambulated with roller walkers. Client E utilized a wheelchair for ambulation. Staff #4 and #5 physically assisted clients A, B, C, E and F to load/get up in a van that did not have a wheelchair lift. Staff #4 would pull the clients up into the van and staff #5 would push the clients up into the van by pushing on the clients' buttocks. When facility staff went to get client E in the</p>	W0104	<p>In regard to W104 and the the consumer who was not monitored to prevent falls: ASI has improved its Incident Report tracking system to identify when a consumer crosses a threshold of three incidents of the same kind. These are reported to the agency's Human Rights Committee in an effort to identify prevention strategies. In regard to W104 and the concerns with a working lift in the van, the agency's Safety Committee has implemented a vehicle checklist system for daily checks. In response to the follow up letter dated June 20: The plan to prevent this consumer from falling is to comply with the recommendations his neurologist. This includes providing a helmet for his head. Staff are being trained this week on the signs of dementia to increase their awareness in dealing with this consumer. In addition, this consumer's line of sight protocol has been up-dated so that staff is within arm's reach when ambulating. The vehicle checklist is completed on each vehicle daily -- including the van lifts. These are reviewed daily by the agency's Safety Committee Chairperson who is the Director of Day and Placement Services.</p>	06/18/2012

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	<p>van who was in a wheelchair, staff #5 stated, "This should be interesting. This is the first time we have tried to put her in this van." The facility staff had to get the client out of the wheelchair, have the client stand and lift her up into the van. When client F was being lifted and pushed up into the van, client F lost his balance and almost fell backwards, but staff #5 had a hold of the client and pushed him into the van. Interview with staff #5 on 5/17/12 at 4:35 PM indicated the facility had a van with a wheelchair lift, but it was in the shop. Staff #5 indicated the wheelchair lift/van had been in the shop for over a month. Staff #5 indicated they were using a mini van from the workshop, but it had to be returned.</p> <p>During the 5/18/12 observation period between 6:00 AM and 7:50 AM, staff #5 and #6 transported clients A, B, C, E, F and G to the workshop in the staffs' personal vehicles. The group home's van, which was not a wheelchair lift, was parked in the driveway. Interview with staff #5 on 5/18/12 at 7:49 AM indicated it was easier to get the clients in staffs' cars versus trying to get the clients into the van which did not have a lift. Clients A, B, C, E, F and G were loaded into 2 separate vehicles to be transported to work.</p>		<p>Any deficiencies are sent for repair immediately. In response to the follow up letter dated June 25: The Maplewood van lift has been fixed and is in working order. The checklist for vehicle safety is completed daily before use and if a deficiency is noted that makes it unsafe to use, staff do not use it. There are additional vehicles at the day services location in Frankfort that can be used when a group home vehicle is in the shop. The up-dated high risk plan for the consumer in question has been re-written and staff in the group home and day services have been trained. They will be able to monitor compliance on a daily basis. In addition, the Maplewood IDT meets weekly and reviews consumer-specific concerns. This would be the regular forum to identify and address any questions that arise with compliance. In addition, ASI has added a second nurse so that will reduce the caseload of the nurse located in Clinton County to allow more hands-on nursing oversight of consumer plans.</p>		

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	<p>Interview with staff #1 and the Qualified Developmental Disabilities Professional (QDDP) on 5/18/12 at 1:00 PM indicated the group home's van was in the shop so the lift could be replaced on the van. The QDDP indicated the group home was using the workshop mini van but they had to return the van to the workshop.</p> <p>2. The governing body failed to exercise general policy and operating direction over the facility to prevent neglect of client B in regards to falls. Please see W149.</p> <p>3. The governing body failed to exercise general policy, budget and operating direction over the facility to ensure the facility had sufficient staff to meet the health/safety needs of clients A, B, C, D, E, F and G. Please see W186.</p> <p>This federal tag relates to complaint #IN00107147.</p> <p>9-3-1(a)</p>						

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W0122	<p>483.420 CLIENT PROTECTIONS The facility must ensure that specific client protections requirements are met.</p> <p>Based on observation, interview and record review, the facility failed to meet the Condition of Participation: Client Protections for 1 of 4 sampled clients (B). The facility failed to implement its policy and procedures to prevent neglect of client B in regard to falls which resulted in injuries.</p> <p>Findings include:</p> <p>The facility failed to implement its policy and procedures to prevent neglect of client B in regard to falls which resulted in significant injuries. Please see W149.</p> <p>This federal tag relates to complaint #IN00107147.</p> <p>9-3-2(a)</p>	W0122	<p>In regard to W122 and the the consumer who was not monitored to prevent falls: ASI has improved its Incident Report tracking system to identify when a consumer crosses a threshold of three incidents of the same kind. These are reported to the agency's Human Rights Committee in an effort to identify prevention strategies. In regard to W122 and the concerns with a working lift in the van, the agency's Safety Committee has implemented a vehicle checklist system for daily checks. In response to the follow up letter dated June 20: The plan to prevent this consumer from falling is to comply with the recommendations his neurologist. This includes providing a helmet for his head. Staff are being trained this week on the signs of dementia to increase their awareness in dealing with this consumer. In addition, this consumer's line of sight protocol has been up-dated so that staff is within arm's reach when ambulating. The vehicle checklist is completed on each vehicle daily -- including the van lifts. These are reviewed daily by the agency's Safety Committee Chairperson who is the Director of Day and Placement Services. Any deficiencies are sent for</p>	06/18/2012	

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			<p>repair immediately. In response to the follow up letter dated June 25: The Maplewood van lift has been fixed and is in working order. The checklist for vehicle safety is completed daily before use and if a deficiency is noted that makes it unsafe to use, staff do not use it. There are additional vehicles at the day services location in Frankfort that can be used when a group home vehicle is in the shop. The up-dated high risk plan for the consumer in question has been re-written and staff in the group home and day services have been trained. They will be able to monitor compliance on a daily basis. In addition, the Maplewood IDT meets weekly and reviews consumer-specific concerns. This would be the regular forum to identify and address any questions that arise with compliance. In addition, ASI has added a second nurse so that will reduce the caseload of the nurse located in Clinton County to allow more hands-on nursing oversight of consumer plans.</p>		

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W0149	<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.</p> <p>Based on observation, interview and record review for 1 of 4 sampled clients (B), the facility failed to implement its policy and procedures to prevent neglect of a client in regard to falls which resulted in significant injuries.</p> <p>Findings include:</p> <p>The facility's reportable incident reports, internal incident reports and/or investigations were reviewed on 5/17/12 at 11:23 AM. The facility's internal investigations, reportable incident reports and/or investigations indicated the following:</p> <p>-1/2/12 Client B fell to the floor while having a seizure. The internal incident report indicated client B fell forward on to his face causing a cut to the right side of his forehead above his eyebrow area. The internal incident report indicated pressure was applied to the wound and the client was sent to a local hospital for evaluation and treatment.</p> <p>-2/11/12 "[Client B] was assisting staff [staff #2] with loading groceries into the vehicle in the parking lot of [name of</p>	W0149	<p>In regard to W149, the agency has improved its Incident Tracking system to more quickly identify when a consumer has had three same-type incidents. In addition, a second nurse is scheduled to start at the agency this month so that the caseload of the current nurse will be decreased. The goal is to be able to increase the nurse's involvement with the consumers for prevention strategies. The agency is also in the process of up-dating the format of the High Risk Plans so that prevention strategies are more strongly emphasized. In response to the follow up letter dated June 20: The plan to prevent this consumer from falling is to comply with the recommendations his neurologist. This includes providing a helmet for his head. Staff are being trained this week on the signs of dementia to increase their awareness in dealing with this consumer. In addition, this consumer's line of sight protocol has been up-dated so that staff is within arm's reach when ambulating. The vehicle checklist is completed on each vehicle daily -- including the van lifts. These are reviewed daily by the agency's Safety Committee Chairperson who is the Director</p>	06/18/2012	

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	<p>shopping center]. [Client B] lifted a bag from the cart and went to step around the cart and caught his foot on the wheel and fell forward. [Client B] hurriedly got to his feet and stated to [staff #2] that he was fine and want (sic) to get a coke. [Staff #2] noted blood running down [client B's] face and immediately got him in the car and drove [client B] back to the home. Staff [staff #3] immediately called [staff #1] who advised to take him directly to the Emergency Room (ER) and she would meet them there. [Client B] had 3 wounds on his face, 2 above his right eye and 1 on his right cheekbone. Immediate bruising seen in corner of right side of nose. Emergency Room doctor placed 5 dissolvable sutures in one wound above the eye and 2 in the other, and 4 in the wound on his cheekbone, 11 total sutures...Due to frequency of falls, manager discussed with guardian calling neurologist to evaluate for any causes, [staff #1], to call neurologist on Monday to schedule appointment...."</p> <p>-4/13/12 "[Staff #4] was taking [client B], and 2 other consumers on a walk. When they reached the end of the sidewalk [client B] advised [staff #4] that he was tired so they turned to come back. [Staff #4] had [client B] walk in front of her and other consumers as to keep an eye on him. [Client B] kept turning around stating he</p>		<p>of Day and Placement Services. Any deficiencies are sent for repair immediately. In response to the follow up letter dated June 25: The Maplewood van lift has been fixed and is in working order. The checklist for vehicle safety is completed daily before use and if a deficiency is noted that makes it unsafe to use, staff do not use it. There are additional vehicles at the day services location in Frankfort that can be used when a group home vehicle is in the shop. The up-dated high risk plan for the consumer in question has been re-written and staff in the group home and day services have been trained. They will be able to monitor compliance on a daily basis. In addition, the Maplewood IDT meets weekly and reviews consumer-specific concerns. This would be the regular forum to identify and address any questions that arise with compliance. In addition, ASI has added a second nurse so that will reduce the caseload of the nurse located in Clinton County to allow more hands-on nursing oversight of consumer plans.</p>				

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	<p>was worried that another consumer with a walker was going to run into him. [Staff #4] advised [client B] that he would be fine, she was ensuring that the consumer with a walker was a safe distance behind him and advised him he needed to keep an eye where he was walking. As they continued to walk, [client B] fell forward and hit his face on the concrete sidewalk. [Staff #4] ran to [client B] yelling his name, [client B] looked up at [staff #4] and asked her if he was alright. [Staff #4] yelled towards the group home for help, and called the manager [staff #1's] cell phone for help. [Staff #1] ran down to where they were and yelled for agency trainer [trainer #1] to get his car and come for help, (sic) [Client B] was on the ground with his face covered in blood. [Staff #1] advised [staff #4] to take other 2 consumers home and assisted [client B] into the car to go to the emergency room. [Client B] had scrape on the forehead above right eye and a laceration, a laceration under the right eye, scrape on top of nose going down to the upper lip, scrape on bottom of chin, laceration on inside of right pinky finger, and scrapes on top of left hand. Emergency room staff cleaned the lacerations, administered pain medication to [client B]. [Client B] received 3 sutures to the laceration under the right eye. No xray taken of nose due to swelling, advised to follow up with</p>			

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	<p>primary doctor or ear, nose, throat (ENT) doctor for nasal fracture. Sutures to be removed 4-23-12, follow up appointment scheduled with primary doctor and waiting for referral to ENT doctor at time this report completed. Staff to keep eye on [client B] and to be stand by assist when up ambulating."</p> <p>The facility's 4/12/12 internal Incident Report-Consumer indicated clients B, D and F went with staff for a walk. The internal incident report indicated the area where client B fell on the ground was "uneven." The internal incident report indicated client F was on a walker. The facility neglected to ensure sufficient staff were present to assist clients while walking in the community as client B had a history of falls/unsteady gait, client F was on a walker and client D had an elopement history.</p> <p>-5/12/12 "[Client B] was at a local park with staff for a cook out and was being walked to the restroom by staff [staff #5]. [Staff #5] was walking with [client B] with her arm looped through his when he lost his balance and fell forward. [Staff #5] had a hold of him by the arm and prevented him from falling face first. [Client B] fell to his knee. [Client B] was assisted up and continued on to the bathroom. [Staff #5] checked [client B]</p>						

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	<p>for injury and noted a scrape quarter size on his right knee...Staff will keep [client B] in their line of site (sic) and on longer distances be a stand by assist and loop arms with him for safety to lessen the severity of his falls."</p> <p>The facility's 5/12/12 internal incident report indicated client B fell while at a park out in the community when going to the park's bathroom.</p> <p>During the 5/17/12 observation period between 3:15 PM and 4:32 PM, at the group home (clients left to go out to eat and to the circus), there were 2 staff (staff #4 and #5) to 6 clients (A, B, C, E, F and G). Clients A, C and F had walkers and client E utilized a wheelchair. At 3:30 PM, client B stood from the dining room table and walked into the kitchen and placed his cup into the sink without staff watching/supervising the client when he ambulated. Staff #5 was in the kitchen washing dishes at the sink with her back to the dining room table and staff #4 was at the back of the house. When client B placed his cup in the sink, staff #5 turned to the client and asked client B where he was going. Staff #5 then walked/ followed client B to the living room where the client sat down in a recliner. At 3:50 PM, client B stood from the chair and started to walk off. Staff #5 held client B's hand</p>						

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	<p>as they walked. When client B returned to the chair, staff #5 walked behind the client without touching the client and/or holding the client's hand. At 4:17 PM, staff #4 held client B's hand as they walked down hallway to the side door to go outside.</p> <p>During the 5/18/12 observation period between 6:00 AM and 7:50 AM, at the group home, there were 2 staff (staff #5 and #6) to 6 clients (A, B, C, E, F and G) in the group home. At 6:19 AM, client B, who was sitting at the dining room table, stood and walked into the living room area to the recliner without staff assistance. Staff #5 and #6 were in the kitchen cooking breakfast. Staff #5 and #6 did not have client B in their line of sight. Client B then stood from the recliner and walked back to his bedroom. Staff #5 and #6 were still in the kitchen cooking with their backs to the dining/living room areas and did not see client B stand and walk down the hallway to his bedroom. Client B returned to the dining room table without staff seeing the client. Client B then stood from the dining room table again to walk into the living room before staff #5 saw the client ambulating without staff. At that time, staff #5 prompted client B to return to the dining room table. Staff #5 stated to client B "I have to keep an eye on you and</p>						

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	<p>I can't come over there." At 6:42 AM, staff held onto client B's arm while walking with client B to carry his plate to the kitchen. At 7:04 AM, staff #5 walked holding onto client B's arm while he ambulated/walked to the couch to sit down. At 7:10 AM, client B stood and walked without staff assistance. Staff #5 was in the kitchen at the sink with her back turned and staff #6 was passing the morning medications. At 7:12 AM, staff #6 walked into the living/dining room area and looked toward the couch. Staff #5 then turned and looked behind her, and did not see client B. Staff #5 then walked down the hallway to client B's bedroom to look for client B. Staff #5 told client B he was not to walk by himself. Staff #5 walked client B back to the living room area to the couch holding on to client B's arm. At 7:15 AM, staff #5 walked with her arm intertwined with client B's arm. At 7:22 AM, client B stood from the recliner and walked over to another recliner without staff as staff #5 was in the kitchen and staff #6 was still passing medications.</p> <p>Client B's record was reviewed on 5/18/12 at 10:10 AM. Client B's Continuity of Care sheets indicated the following:</p> <p>-12/6/11 Client B was evaluated for</p>						

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	<p>physical therapy (PT) due to "(decreased) Dynamic Balance (increased) Fall Risk." The form recommended client B have PT two times a week for 4 weeks to "improve functional ability."</p> <p>-1/2/12 Client B "...fell landing on face, (R) (right) eye laceration 8 sutures...."</p> <p>-2/11/12 Client B was seen in the emergency room due to facial lacerations from a fall. The attached 2/11/12 Discharge Instructions indicated client B received dissolving sutures.</p> <p>-2/16/12 Client B saw his neurologist for "increase in falls and check recent fall head injury. No signs of infection at trauma site-right eyebrow. Variable frequency of stumble, falls since he has been our patient...." Attached to the 2/16/12 form was a list of questions from the provider/facility which indicated the following:</p> <p>"[Client B] has had 3 falls with 2 of them being really bad falls in the past 2 months. One possibly due to drop seizure and the other 2 due to being very imbalanced and unsteady on his feet. He also seems to frequently repeat same questions over and over, and seems to not remember sometimes of already asking something. Can dementia be associated with</p>						

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	<p>imbalance? Yes if so, is there anything that can be done to help this? treat (sic) dementia/practice walking, try to prevent seizures with meds (sic). Is there anything that staff could be doing to help prevent the falls? Walk with assistance at least 4x (times) a day stay in practice. If not due to dementia, are there any other neurological causes for this? sometimes (sic) too much medicine. I don't think that's the case with [client B]."</p> <p>-3/9/12 Client B received balance, transfer and gait training by PT.</p> <p>-4/13/12 Client B was seen in the ER due to "Facial laceration, multiple abrasions, epistaxis (bleeding from nose). Laceration sutured-stitches out 10 days in ER or @ (at) family MD. May use neosynephrine spray for bleeding from nose. Follow up with ENT or family MD for further treatment of nasal injury...Staff to schedule follow up (with) doctor regarding nose injury...."</p> <p>-4/17/12 Client B saw his doctor for follow up to the ER visit on 4/13/12 and for possible nasal fracture. The note indicated "...await for nasal swelling to subside &amp; re-eval (re-evaluate). Suture removal 4-23-12."</p> <p>-4/27/12 Client B's sutures were removed</p>						

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	<p>from the right lower eyelid. The 4/27/12 note indicated "C/O (complaints of) falling asleep easily-all the time. Laceration (R) lower lid (with) sutures x 3. Sutures look good, laceration healed... [Name of Doctor] said to check with [client B's] neurologist about falling asleep that [name of neurologist] might want labs done."</p> <p>Client B's above mentioned Continuity of Care forms and/or record indicated the facility neglected to have client B's nasal injury/nose re-evaluated as recommended on 4/17/12, and/or have an ENT doctor look at the client's nose as recommended on 4/13/12.</p> <p>Client B's 11/19/11 Risk Profile indicated client B was a falls risk and visually impaired. Client B's 11/19/11 Care Plan indicated client B was ambulatory and was a "Risk for fall d/t (due to) Drop Seizures...."</p> <p>Client B's undated Falls Protocol indicated the following (not all inclusive):</p> <p>"If consumer falls, FIRST/IMMEDIATE thing to do is:</p> <p>1. 'Do NOT move the consumer. DO NOT let them move their head or body until assessment is done.</p>						

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	<p>2. Important to keep consumer calm and talk to them throughout your assessment...</p> <p>3. Assess consumer from head to toe for the following:</p> <ul style="list-style-type: none"> <li>a. Breathing...</li> <li>b. Conscious or confusion...</li> <li>c. Pain...</li> <li>d. Immobility...</li> <li>e. Bleeding...</li> <li>f. Redness...</li> <li>g. Bumps, abrasions, lacerations...</li> <li>h. Swelling...</li> <li>i. Take Vital Signs (blood pressure, pulse and respirations)</li> <li>j. Staff is to follow standard CPR (Cardiopulmonary Resuscitation) and First Aid training when giving care</li> <li>k. Notify Nurse immediately...</li> <li>l. If consumer has 'Loss of Consciousness,' Not breathing, Bleeding profusely, &amp; (and) has severe pain-CALL 911 and DO NOT MOVE CONSUMER!!!</li> <li>m. Fill out Fall Assessment at the time of the Fall as well as an Incident Report. Nurse will monitor and update at time of Fall and on Quarterly basis." Client B's undated fall protocol neglected to include any preventative measures to prevent client B from falling.</li> </ul> <p>Client B's 4/12 Line of Site (sic) Protocol indicated "[Client B] is a fall risk due to Seizures and progression of Dementia.</p>			

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	<p>The protocol indicated client B's line of site (sic) was defined as "...[Client B] needing to be in the site (sic) of staff at all times, except for the following:...Home: While [client B] is using the restroom...."</p> <p>The protocol indicated client B had to be in line of sight when the client walked down the hallway to the bathroom. The protocol also indicated "...While walking around the home [client B] only needs to be in staff line of site (sic)...." The protocol indicated when client B was bathing staff were to be present in the bathroom due to seizures and previous falls in the bathroom. The 4/12 protocol indicated "...When [client B] wishes to go on community outings that require walking a longer distance one staff is to remain with [client B] as a stand by assist during this time. If [client B] is walking on any surface that is not level and smooth then staff are to loop their arm through [client B's] to assist him to a smooth level surface to avoid him losing his balance and falling. Staff are to encourage [client B] to walk on the sidewalk and not the grass while outside his home or assist him through the yard. During sleep hours, staff will be checking on 2 hours to ensure that if he gets up to use the bathroom staff will keep him in their line of site (sic) while he ambulates across the hall to and from (sic). If at any time during this time (sic) [client B] looks</p>				

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	<p>to be unsteady on his feet, then staff are to stand by assist him to and from the bathroom...Neurologist stated...that [client B's] Dementia is quickly progressing and expects to see more falls. Staff are to at all times keep [client B] in their line of site (sic) and to be a stand by assist if he appears to be unsteady to avoid severity of future falls."</p> <p>Client B's 11/19/11 Care Plans and/or 10/19/11 Individual Support Plan (ISP) indicated the facility neglected to develop a care plan for the client's dementia and/or track symptoms of the client's dementia to determine if client B was decreasing in skills to ensure the client's safety.</p> <p>Client B's interdisciplinary team (IDT) notes indicated the following (not all inclusive):</p> <p>-1/25/12 "Stitches are still evident, but dissolving...[Client B] was very unsteady. Only time [staff #1] has noted was when he stands up too quickly...."</p> <p>-2/8/12 "[Client B] fell on 2-7-12 at home as he was leaving the house. Stitches were taken out by the nurse on 2-1-12 (he still had 4 left, they were to dissolve). Had a PT/OT eval in either Dec/Jan (December/January). Nothing ordered."</p>			

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	<p>-2/15/12 "[Client B] fell on 2-12-12 while at [name of shopping center] w/ (with) staff. He was in the parking lot helping w/ groceries. He went to the ER, had 11 total stitches. Had 3 abrasions. Going to neurologist tomorrow 2-16-12." The facility neglected to put any additional measures in place to prevent injuries from falls.</p> <p>-3/21/12 Client B was going to PT 1 to 2 times a week. The IDT note also indicated the neurologist "...Recommended that he (client B) needs to walk more so he doesn't forget how to walk. (...Staff at the home walk him to the corner &amp; back daily)."</p> <p>-4/17/12 "...3rd (third) fall in 2 months this was reported to [name of doctor] on 4-17-2012. [Name of neurologist] appt (appointment) on 5-22-2012! Last appt the DR. stated that his dementia is progressing quickly. His boots have been an issue as he does not walk well with him so his sister took them (sic). Talk (sic) about a gait belt. wheelchair, ([Name of neurologist] said no to a walker). After much discussion he will be in line of sight &amp; assisted with long distance...."</p> <p>-4/25/12 Client B's IDT would be reviewing the client's line of sight protocol.</p>						

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	<p>-5/9/12 "New line of sight...."</p> <p>Client B's above mentioned IDT notes, line of sight protocol, fall protocol and/or the client's 10/19/11 ISP neglected to specifically indicate how facility staff were to supervise/monitor the client to prevent client B from falling as line of sight would not prevent client B from falling/getting injured. Client B's above mentioned IDT notes and/or line of sight protocol did not specifically define stand by assist to ensure client B's safety. Client B's 4/17/12 IDT note and/or ISP neglected to indicate any documentation for not using/assessing client B for a gait belt and/or other assistive devices which could prevent client B from falling.</p> <p>Interview with staff #5 on 5/18/12 at 7:07 AM stated "One on one now with [client B]. One staff with [client B] when walking." When asked who required line of sight supervision, staff #5 stated "[Clients B and C]."</p> <p>Interview with the Qualified Developmental Disabilities Professional (QDDP) and staff #1 on 5/18/12 at 1:00 PM indicated client B had several falls with injuries and was a fall risk. The QDDP and staff #1 stated facility staff were to keep client B in line of sight when</p>			

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	<p>in the group home and use "stand by assist" if walking long distance. Staff #1 indicated it was not necessary for staff to hold onto the client when in the house. When asked what stand by assist meant, staff #1 stated "Be next to him. Stand by him and hold on to hand." Staff #1 and the QDDP indicated this was put in place after client B fell outside while walking. Staff #1 and the QDDP indicated facility staff should not have taken client B walking with 2 other clients on 4/13/12 as client B had a history of falls and another client was walking with a roller walker. When asked how line of sight was going to prevent client B from falling and/or getting injured, staff #1 stated "It won't. He hits hard (falls down hard)." Staff #1 indicated client B's dementia would continue to decline. QDDP and staff #1 indicated client B's current fall protocol did not have any preventative measures in place to prevent client B from falling. When asked if client B went to have his nose evaluated, staff #1 and the QDDP indicated the client had not yet seen an ENT doctor. Staff #1 indicated client B returned for a follow-up visit on 4/27/12 and the doctor evaluated the client's nose at that time. The QDDP and staff #1 indicated they could not locate any additional documentation the doctor evaluated the client's nose on 4/27/12. When asked if the client's IDT discussed</p>			

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	<p>the use of adaptive equipment (gait belt, walker, helmet, wheelchair) to assist/protect the client from being injured/falls, staff #1 and the QDDP indicated it was discussed on 4/17/12, but the discussion was not documented. The QDDP and staff #1 indicated facility staff were not tracking the symptoms of client B's dementia. The QDDP indicated client B did not have a protocol for dementia. Staff #1 stated "waiting to be set up." The QDDP indicated client B's IDT met weekly in regard to client B's falls.</p> <p>Interview with LPN #1 on 5/18/12 at 1:45 PM indicated client B had falls with injuries. LPN #1 indicated client B's care plans did not include a care plan for dementia. LPN #1 stated "I'm in the process of making one." LPN #1 indicated her computer was not working. LPN #1 also indicated she was in the process of updating client B's fall protocol. LPN #1 indicated client B had not seen an ear, nose and throat doctor to evaluate the client's nose.</p> <p>The facility's policy and procedures were reviewed on 5/17/12 at 11:18 AM. The facility's 11/09 Policy and procedure entitled Documentation and Reporting of Known &amp; unknown Injuries/Suspect of Incidents of Abuse, Neglect, Exploitation &amp; mistreatment, or the Violation of</p>				

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	<p>Individual's Rights indicated the facility would ensure the "...welfare and safety of others...."</p> <p>This federal tag relates to complaint #IN00107147.</p> <p>9-3-2(a)</p>						

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W0186	<p>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.</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) and for 3 additional clients (E, F and G), the facility failed to ensure the facility had sufficient staff to meet the safety needs of the clients.</p> <p>Findings include:</p> <p>The facility's reportable incident reports, internal incident reports and/or investigations were reviewed on 5/17/12 at 11:23 AM. The facility's 4/13/12 reportable incident indicated "[Staff #4] was taking [client B], and 2 other consumers on a walk. When they reached the end of the sidewalk [client B] advised [staff #4] that he was tired so they turned to come back. [Staff #4] had [client B] walk in front of her and other consumers as to keep an eye on him. [Client B] kept turning around stating he was worried that another consumer with a walker was going to run into him. [Staff #4] advised [client B] that he would be fine, she was</p>	W0186	In regard to W186, the agency is reviewing the licensure of Maplewood Group Home. In addition, the House Manager is working with the QDDP and the Active Treatment Schedules to ensure that consumer safety is always a priority. This includes not only in-house activities but also any outings. In response to the letter dated June 20, the house manager does the monthly schedule. This is done to ensure a safe staffing level. If staff should call off or for some reason the schedule be changed, the manger ensures that additoional staff (including her) are in the home.	06/18/2012	

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	<p>ensuring that the consumer with a walker was a safe distance behind him and advised him he needed to keep an eye where he was walking. As they continued to walk, [client B] fell forward and hit his face on the concrete sidewalk. [Staff #4] ran to [client B] yelling his name, [client B] looked up at [staff #4] and asked her if he was alright. [Staff #4] yelled towards the group home for help, and called the manager [staff #1's] cell phone for help. [Staff #1] ran down to where they were and yelled for agency trainer [trainer #1] to get his car and come for help, (sic) [Client B] was on the ground with his face covered in blood. [Staff #1] advised [staff #4] to take other 2 consumers home and assisted [client B] into the car to go to the emergency room. [Client B] had scrape on the forehead above right eye and a laceration, a laceration under the right eye, scrape on top of nose going down to the upper lip, scrape on bottom of chin, laceration on inside of right pinky finger, and scrapes on top of left hand. Emergency room staff cleaned the lacerations, administered pain medication to [client B]. [Client B] received 3 sutures to the laceration under the right eye. No xray taken of nose due to swelling advised to follow up with primary doctor or ear, nose, throat (ENT) doctor for nasal fracture. Sutures to be removed 4-23-12, follow up appointment</p>			

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	<p>scheduled with primary doctor and waiting for referral to ENT doctor at time this report completed. Staff to keep eye on [client B] and to be stand by assist when up ambulating."</p> <p>The facility's 4/12/12 internal Incident Report-Consumer indicated clients B, D and F went with staff for a walk. The internal incident report indicated the area where client B fell on the ground was "uneven." The internal incident report indicated client F was on a walker. The facility facility to ensure sufficient staff were present to assist clients while walking in the community as client B had a history of falls/unsteady gait, client F was on a walker and client D had an elopement history.</p> <p>The facility's reportable incident reports indicated the following in regard to client G:</p> <p>-4/11/12 Client G demonstrated physical aggression toward client E by hitting the client on the shoulder and grabbing client E's shirt which resulted in client E's shoulder being scratched.</p> <p>-4/27/12 Client G hit an unidentified peer in the chest as she walked by the client.</p> <p>-3/30/12 Client G became upset when</p>						

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	<p>facility staff asked the client to come and take her medications. The reportable incident report indicated client G stood up and slapped client F in the chest. The reportable incident report indicated "...Staff are reminded to stay between [client G] and other consumers...."</p> <p>During the 5/17/12 observation period between 3:15 PM and 4:32 PM, at the group home, there were 2 staff (staff #4 and #5) to 6 clients (A, B, C, E, F and G). Clients A, C and F had walkers and client E utilized a wheelchair. At 4:32 PM, the 2 facility staff left with clients A, B, C, E, F and G to go out to eat and to go to the circus in another city. The facility did not take an additional staff as client B required one staff's assistance while in the community due to falls which left 1 staff to supervise and assist clients A, C, E and F who utilized a walker and/or a wheelchair for ambulation.</p> <p>During the 5/18/12 observation period between 6:00 AM and 7:50 AM, at the group home, there were 2 staff (staff #5 and #6) to 6 clients (A, B, C, E, F and G) in the group home. During the observation period, clients A, B, C, E and F required staff to verbally prompt the clients to walk/use their walker and/or assist the clients to ambulate. Client B required staff assistance when ambulating</p>			

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	<p>as the client was to be in line of sight of staff and staff would at times physically assist the client. Clients A, C and F utilized roller walkers. Staff #5 and #6 would periodically verbally prompt clients A and F to keep their hands on their walker when ambulating. Facility staff would periodically push client E's wheelchair when they needed her to do something (take medications, dishes to the kitchen etc.). During the 5/18/12 observation period, facility staff attempted to get clients A, B, C, E, F and G to stay at the dining room table prior to breakfast as both staff were in the kitchen cooking breakfast.</p> <p>Client B's record was reviewed on 5/18/12 at 10:10 AM. Client B's Continuity of Care sheets indicated the following:</p> <p>-1/2/12 Client B "...fell landing on face, (R) (right) eye laceration 8 sutures..."</p> <p>-2/11/12 Client B was seen in the emergency room due to facial lacerations from a fall.</p> <p>-4/13/12 Client B was seen in the ER due to a fall which resulted in "Facial laceration, multiple abrasions, epistaxis (bleeding from the nose)."</p>			

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	<p>Client B's 11/19/11 Risk Profile indicated client B was a falls risk and visually impaired. Client B's 11/19/11 Care Plan indicated client B was ambulatory and was a "Risk for fall d/t (due to) Drop Seizures...."</p> <p>Client B's 4/12 Line of Site (sic) Protocol indicated "[Client B] is a fall risk due to Seizures and progression of Dementia. The protocol indicated client B's line of site (sic) was defined as "...[Client B] needing to be in the site (sic) of staff at all times, except for the following:...Home: While [client B] is using the restroom...." The protocol indicated client B had to be in line of sight when the client walked down the hallway to the bathroom. The protocol also indicated "...While walking around the home [client B] only needs to be in staff line of site(sic)...." The protocol indicated when client B was bathing staff were to be present in the bathroom due to seizures and previous falls in the bathroom. The 4/12 protocol indicated "...When [client B] wishes to go on community outings that require walking a longer distance one staff is to remain with [client B] as a stand by assist during this time. If [client B] is walking on any surface that is not level and smooth then staff are to loop their arm through [client B's] to assist him to a smooth level surface to avoid him losing</p>				

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	<p>his balance and falling. Staff are to encourage [client B] to walk on the sidewalk and not the grass while outside his home or assist him through the yard...Neurologist stated...that [client B's] Dementia is quickly progressing and expects to see more falls. Staff are to at all times keep [client B] in their line of site (sic) and to be a stand by assist if he appears to be unsteady to avoid severity of future falls."</p> <p>Client G's record was reviewed on 5/18/12 at 11:20 AM. Client G's Incident Report-Consumer indicated client G demonstrated aggression toward other clients on 5/11/12, 4/17/12 times 2, 4/11/12, 4/2/12, 3/29/12 and 3/21/12 times 2.</p> <p>Client A's record was reviewed on 5/18/12 at 11:36 AM. Client A's 11/19/11 Resident Care Plan indicated client A was at risk for falls. Client A's 6/14/11 Individual Support Plan (ISP) indicated client A utilized a walker to ambulate.</p> <p>Client D's record was reviewed on 5/18/12 at 11:40 AM. Client D's 2/2/11 behavior support plan (BSP) indicated "[Client D] does not have a formal diagnosis of PICA (eating inedible objects) but does occasionally try to eat</p>			

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	<p>the strings from his clothes, toenails, fingernails, etc.,)...." Client D's 2/2/11 BSP indicated client D would also attempt to leave the house.</p> <p>Client C's record was reviewed on 5/18/12 at 11:50 AM. Client's C's 6/11 ISP indicated client C utilized a roller walker to ambulate and would at times require staff assistance.</p> <p>Interview with staff #5 on 5/18/12 at 7:07 AM stated "One on one now with [client B]. One staff with [client B] when walking." When asked who required line of sight supervision, staff #5 stated "[Clients B and C]." Staff #5 indicated 2 staff worked in the evening and 2 staff worked in the morning when getting clients up and ready for work. Staff #5 indicated the facility was trying to get a third staff due to the needs of the clients.</p> <p>Interview with the Qualified Developmental Disabilities Professional (QDDP) and staff #1 on 5/18/12 at 1:00 PM indicated client B had several falls with injuries and was a fall risk. The QDDP and staff #1 indicated clients A and C were also fall risks. The QDDP and staff #1 stated facility staff were to keep client B in line of sight when in the group home and use "stand by assist" if walking long distance. Staff #1 and the</p>						

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	<p>QDDP indicated facility staff should not have taken client B walking with 2 other clients on 4/13/12 as client B had a history of falls and another client was walking with a roller walker. Staff #1 indicated clients B and C were to be kept in line of sight due to the clients being a fall risk. Staff #1 indicated client G was also to be kept in line of sight when the client started having behaviors. Staff #1 indicated client E required staff to assist to transfers, toileting the client and putting the client to bed. The QDDP and staff #1 indicated 2 staff worked during the evening shift and morning shift. The QDDP and staff #1 indicated 1 staff worked at night. When asked if the facility had looked at the staffing level at the group home, staff #1 and the QDDP stated "We realize people are taking more care." The QDDP indicated the facility had completed paper work to submit to the state for increased staffing hours/staff. The QDDP and staff #1 indicated staffing needed to increase at the group home to meet the needs of the clients and to keep them safe.</p> <p>This federal tag relates to complaint #IN00107147.</p> <p>9-3-3(a)</p>						

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W0240	<p>483.440(c)(6)(i) INDIVIDUAL PROGRAM PLAN The individual program plan must describe relevant interventions to support the individual toward independence.</p> <p>Based on observation, interview and record review for 1 of 4 sampled clients (B), the client's Individual Support Plan (ISP) failed to indicate what staff were to do to prevent client B from falling and/or clearly define how client B was to be monitored.</p> <p>Findings include:</p> <p>The facility's reportable incident reports, internal incident reports and/or investigations were reviewed on 5/17/12 at 11:23 AM. The facility's internal investigations, reportable incident reports and/or investigations indicated the following:</p> <p>-1/2/12 Client B fell to the floor while having a seizure. The internal incident report indicated client B fell forward on to his face causing a cut to the right side of his forehead above his eyebrow area. The internal incident report indicated pressure was applied to the wound and the client was sent to a local hospital for evaluation and treatment.</p> <p>-2/11/12 "[Client B] was assisting staff [staff #2] with loading groceries into the</p>	W0240	The consumer involved in this incident will have an up-dated ISP and High Risk Plan to ensure all areas are adequately addressed. In addition, the agency is changing the format of the High Risk Plan to ensure that prevention strategies are more strongly emphasized.	06/18/2012			

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	<p>vehicle in the parking lot of [name of shopping center]. [Client B] lifted a bag from the cart and went to step around the cart and caught his foot on the wheel and fell forward. [Client B] hurriedly got to his feet and stated to [staff #2] that he was fine and want (sic) to get a coke. [Staff #2] noted blood running down [client B's] face and immediately got him in the car and drove [client B] back to the home. Staff [staff #3] immediately called [staff #1] who advised to take him directly to the Emergency Room (ER) and she would meet them there, [Client B] had 3 wounds on his face, 2 above his right eye and 1 on his right cheekbone. Immediate bruising seen in corner of right side of nose. Emergency Room doctor placed 5 dissolvable sutures in one wound above the eye and 2 in the other, and 4 in the wound on his cheekbone, 11 total sutures...."</p> <p>-4/13/12 "[Staff #4] was taking [client B], and 2 other consumers on a walk. When they reached the end of the sidewalk [client B] advised [staff #4] that he was tired so they turned to come back. [Staff #4] had [client B] walk in front of her and other consumers as to keep an eye on him. [Client B] kept turning around stating he was worried that another consumer with a walker was going to run into him. [Staff #4] advised [client B] that he would be</p>			
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	<p>fine, she was ensuring that the consumer with a walker was a safe distance behind him and advised him he needed to keep an eye where he was walking. As they continued to walk, [client B] fell forward and hit his face on the concrete sidewalk. [Staff #4] ran to [client B] yelling his name, [client B] looked up at [staff #4] and asked her if he was alright. [Staff #4] yelled towards the group home for help, and called the manager [staff #1's] cell phone for help. [Staff #1] ran down to where they were and yelled for agency trainer [trainer #1] to get his car and come for help, (sic) [Client B] was on the ground with his face covered in blood. [Staff #1] advised [staff #4] to take other 2 consumers home and assisted [client B] into the car to go to the emergency room. [Client B] had scrape on the forehead above right eye and a laceration, a laceration under the right eye, scrape on top of nose going down to the upper lip, scrape on bottom of chin, laceration on inside of right pinky finger, and scrapes on top of left hand. Emergency room staff cleaned the lacerations, administered pain medication to [client B]. [Client B] received 3 sutures to the laceration under the right eye."</p> <p>The facility's 4/12/12 internal Incident Report-Consumer indicated clients B, D and F went with staff for a walk. The</p>			

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	<p>internal incident report indicated the area where client B fell on the ground was "uneven."</p> <p>-5/12/12 "[Client B] was at a local park with staff for a cook out and was being walked to the restroom by staff [staff #5]. [Staff #5] was walking with [client B] with her arm looped through his when he lost his balance and fell forward. [Staff #5] had a hold of him by the arm and prevented him from falling face first. [Client B] fell to his knee. [Client B] was assisted up and continued on to the bathroom. [Staff #5] checked [client B] for injury and noted a scrape quarter size on his right knee...Staff will keep [client B] in their line of site (sic) and on longer distances be a stand by assist and loop arms with him for safety to lessen the severity of his falls."</p> <p>The facility's 5/12/12 internal incident report indicated client B fell while at a park out in the community when going to the park's bathroom.</p> <p>During the 5/17/12 observation period between 3:15 PM and 4:32 PM, at the group home (clients left to go out to eat and to the circus), there were 2 staff (staff #4 and #5) to 6 clients (A, B, C, E, F and G). Clients A, C and F had walkers and client E utilized a wheelchair. At 3:30</p>			

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	<p>PM, client B stood from the dining room table and walked into the kitchen and placed his cup into the sink without staff watching/supervising the client when he ambulated. Staff #5 was in the kitchen washing dishes at the sink with her back to the dining room table and staff #4 was at the back of the house. When client B placed his cup in the sink, staff #5 turned to the client and asked client B where he was going. Staff #5 then walked/ followed client B to the living room where the client down in a recliner. At 3:50 PM, client B stood from the chair and started to walk off. Staff #5 held client B's hand as they walked. When client B returned to the chair, staff #5 walked behind the client without touching the client and/or holding the client's hand. At 4:17 PM, staff #4 held client B's hand as they walked down hallway to the side door to go outside.</p> <p>During the 5/18/12 observation period between 6:00 AM and 7:50 AM, at the group home, there were 2 staff (staff #5 and #6) to 6 clients (A, B, C, E, F and G) in the group home. At 6:19 AM, client B, who was sitting at the dining room table, stood and walked into the living room area to the recliner without staff assistance. Staff #5 and #6 were in the kitchen cooking breakfast. Staff #5 and #6 did not have client B in their line of</p>						

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	<p>sight. Client B then stood from the recliner and walked back to the his bedroom. Staff #5 and #6 were still in the kitchen cooking with their backs to the dining/living room areas and did not see client B stand and walk down the hallway to his bedroom. Client B returned to the dining room table without staff seeing the client. Client B then stood from the dining room table again to walk into the living room before staff #5 saw the client ambulating without staff. At that time, staff #5 prompted client B to return to the dining room table. Staff #5 stated to client B "I have to keep an eye on you and I can't come over there." At 6:42 AM, staff held onto client B's arm while walking with client B to carry his plate to the kitchen. At 7:04 AM, staff #5 walked holding onto client B's arm while he ambulated/walked to the couch to sit down. At 7:10 AM, client B stood and walked without staff assistance. Staff #5 was in the kitchen at the sink with her back turned and staff #6 was passing the morning medications. At 7:12 AM, staff #6 walked into the living/dining room area and looked toward the couch. Staff #5 then turned and looked behind her, and did not see client B. Staff #5 then walked down the hallway to client B's bedroom to look for client B. Staff #5 told client B to he was not to walk by himself. Staff #5 walked client B back to the living room</p>			

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	<p>area to the couch holding on to client B's arm. At 7:15 AM, staff #5 walked with her arm intertwined with client B's arm. At 7:22 AM, client B stood from the recliner and walked over to another recliner without staff as staff #5 was in the kitchen and staff #6 was still passing medications.</p> <p>Client B's record was reviewed on 5/18/12 at 10:10 AM. Client B's 11/19/11 Risk Profile indicated client B was a falls risk and visually impaired.</p> <p>Client B's undated Falls Protocol indicated the following (not all inclusive):</p> <p>"If consumer falls, FIRST/IMMEDIATE thing to do is:</p> <ol style="list-style-type: none"> <li>1. 'Do NOT move the consumer. DO NOT let them move their head or body until assessment is done.</li> <li>2. Important to keep consumer calm and talk to them throughout your assessment...</li> <li>3. Assess consumer from head to toe for the following:               <ol style="list-style-type: none"> <li>a. Breathing...</li> <li>b. Conscious or confusion...</li> <li>c. Pain...</li> <li>d. Immobility...</li> <li>e. Bleeding...</li> <li>f. Redness...</li> <li>g. Bumps, abrasions, lacerations...</li> </ol> </li> </ol>			

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	<p>h. Swelling...</p> <p>i. Take Vital Signs (blood pressure, pulse and respirations)</p> <p>j. Staff is to follow standard CPR (Cardiopulmonary Resuscitation) and First Aid training when giving care</p> <p>k. Notify Nurse immediately...</p> <p>l. If consumer has 'Loss of Consciousness,' Not breathing, Bleeding profusely, &amp; (and) has severe pain-CALL 911 and DO NOT MOVE CONSUMER!!!</p> <p>m. Fill out Fall Assessment at the time of the Fall as well as an Incident Report. Nurse will monitor and update at time of Fall and on Quarterly basis." Client B's undated fall protocol did not to include any preventative measures to assist staff to prevent client B's falls.</p> <p>Client B's 4/12 Line of Site (sic) Protocol indicated "[Client B] is a fall risk due to Seizures and progression of Dementia. The protocol indicated client B's line of site (sic) was defined as "...[Client B] needing to be in the site (sic) of staff at all times, except for the following:...Home: While [client B] is using the restroom..." The protocol indicated client B had to be in line of sight when the client walked down the hallway to the bathroom. The protocol also indicated "...While walking around the home [client B] only needs to be in staff line of site(sic)...." The</p>				

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	<p>protocol indicated when client B was bathing staff were to be present in the bathroom due to seizures and previous falls in the bathroom. The 4/12 protocol indicated "...When [client B] wishes to go on community outings that require walking a longer distance one staff is to remain with [client B] as a stand by assist during this time. If [client B] is walking on any surface that is not level and smooth then staff are to loop their arm through [client B's] to assist him to a smooth level surface to avoid him losing his balance and falling. Staff are to encourage [client B] to walk on the sidewalk and not the grass while outside his home or assist him through the yard. During sleep hours, staff will be checking on 2 hours to ensure that if he gets up to use the bathroom staff will keep him in their line of site (sic) while he ambulates across the hall to and from (sic). If at any time during this time (sic) [client B] looks to be unsteady on his feet, then staff are to stand by assist him to and from the bathroom...Neurologist stated...that [client B's] Dementia is quickly progressing and expects to see more falls. Staff are to at all times keep [client B] in their line of site (sic) and to be a stand by assist if he appears to be unsteady to avoid severity of future falls."</p> <p>Client B's 4/12 line of site (sic) protocol,</p>			

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	<p>fall protocol and/or the client's 10/19/11 ISP failed to specifically indicate how facility staff were to supervise/monitor the client to prevent client B from falling. Client B's line of sight protocol did not specifically define stand by assist to ensure client B's safety.</p> <p>Interview with the Qualified Developmental Disabilities Professional (QDDP) and staff #1 on 5/18/12 at 1:00 PM indicated client B had several falls with injuries and was a fall risk. The QDDP and staff #1 stated facility staff were to keep client B in line of sight when in the group home and use "stand by assist" if walking long distance. The staff #1 indicated it was not necessary for staff to hold onto the client when in the house. When asked what stand by assist meant, staff #1 stated "Be next to him. Stand by him and hold on to hand." Staff #1 and the QDDP indicated this was put in place after client B fell outside while walking. QDDP and staff #1 indicated client B's current fall protocol did not have any preventative measures in place to prevent client B from falling.</p> <p>Interview with LPN #1 on 5/18/12 at 1:45 PM indicated she was in the process of updating client B's fall protocol.</p> <p>This federal tag relates to complaint</p>				

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W0331	<p>483.460(c) NURSING SERVICES</p> <p>The facility must provide clients with nursing services in accordance with their needs.</p> <p>Based on record review and interview for 1 of 4 sampled clients (B), the facility's nursing services failed to meet/address the health needs of a client in regard to fall and dementia protocols.</p> <p>Findings include:</p> <p>The facility's reportable incident reports, internal incident reports and/or investigations were reviewed on 5/17/12 at 11:23 AM. The facility's internal investigations, reportable incident reports and/or investigations indicated the following:</p> <p>-1/2/12 Client B fell to the floor while having a seizure. The internal incident report indicated client B fell forward on to his face causing a cut to the right side of his forehead above his eyebrow area. The internal incident report indicated pressure was applied to the wound and the client was sent to a local hospital for evaluation and treatment.</p> <p>-2/11/12 "[Client B] was assisting staff [staff #2] with loading groceries into the vehicle in the parking lot of [name of shopping center]. [Client B] lifted a bag</p>	W0331	<p>ASI has hired a second nurse who is scheduled to start in June. The consumer caseloads will be distributed between the nurses to promote more involvement and care. A dementia training for DSP has been scheduled for June to address signs and responses in a more detailed manner. In response to the follow up letter dated June 20: The plan to prevent this consumer from falling is to comply with the recommendations his neurologist. This includes providing a helmet for his head. Staff are being trained this week on the signs of dementia to increase their awareness in dealing with this consumer. In addition, this consumer's line of sight protocol has been up-dated so that staff is within arm's reach when ambulating. The vehicle checklist is completed on each vehicle daily -- including the van lifts. These are reviewed daily by the agency's Safety Committee Chairperson who is the Director of Day and Placement Services. Any deficiencies are sent for repair immediately. In response to the follow up letter dated June 25: The Maplewood van lift has been fixed and is in working order. The checklist for vehicle safety is completed daily before use and if a deficiency is noted that makes it</p>	06/18/2012	

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	<p>from the cart and went to step around the cart and caught his foot on the wheel and fell forward. [Client B] hurriedly got to his feet and stated to [staff #2] that he was fine and want (sic) to get a coke. [Staff #2] noted blood running down [client B] face and immediately got him in the car and drove [client B] back to the home. Staff [staff #3] immediately called [staff #1] who advised to take him directly to the Emergency Room (ER) and she would meet them there, [Client B] had 3 wounds on his face, 2 above his right eye and 1 on his right cheekbone. Immediate bruising seen in corner of right side of nose. Emergency Room doctor placed 5 dissolvable sutures in one wound above the eye and 2 in the other, and 4 in the wound on his cheekbone, 11 total sutures...Due to frequency of falls, manager discussed with guardian calling neurologist to evaluate for any causes, [staff #1], to call neurologist on Monday to schedule appointment...."</p> <p>-4/13/12 "[Staff #4] was taking [client B], and 2 other consumers on a walk. When they reached the end of the sidewalk [client B] advised [staff #4] that he was tired so they turned to come back. [Staff #4] had [client B] walk in front of her and other consumers as to keep an eye on him. [Client B] kept turning around stating he was worried that another consumer with a</p>		<p>unsafe to use, staff do not use it. There are additional vehicles at the day services location in Frankfort that can be used when a group home vehicle is in the shop. The up-dated high risk plan for the consumer in question has been re-written and staff in the group home and day services have been trained. They will be able to monitor compliance on a daily basis. In addition, the Maplewood IDT meets weekly and reviews consumer-specific concerns. This would be the regular forum to identify and address any questions that arise with compliance. In addition, ASI has added a second nurse so that will reduce the caseload of the nurse located in Clinton County to allow more hands-on nursing oversight of consumer plans.</p>				

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	walker was going to run into him. [Staff #4] advised [client B] that he would be fine, she was ensuring that the consumer with a walker was a safe distance behind him and advised him he needed to keep an eye where he was walking. As they continued to walk, [client B] fell forward and hit his face on the concrete sidewalk. [Staff #4] ran to [client B] yelling his name, [client B] looked up at [staff #4] and asked her if he was alright. [Staff #4] yelled towards the group home for help, and called the manager [staff #1's] cell phone for help. [Staff #1] ran down to where they were and yelled for agency trainer [trainer #1] to get his car and come for help, (sic) [Client B] was on the ground with his face covered in blood. [Staff #1] advised [staff #4] to take other 2 consumers home and assisted [client B] into the car to go to the emergency room. [Client B] had scrape on the forehead above right eye and a laceration, a laceration under the right eye, scrape on top of nose going down to the upper lip, scrape on bottom of chin, laceration on inside of right pinky finger, and scrapes on top of left hand. Emergency room staff cleaned the lacerations, administered pain medication to [client B]. [Client B] received 3 sutures to the laceration under the right eye. No xray taken of nose due to swelling advised to follow up with primary doctor or ear, nose, throat (ENT)						

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	<p>doctor for nasal fracture. Sutures to be removed 4-23-12, follow up appointment scheduled with primary doctor and waiting for referral to ENT doctor at time this report completed."</p> <p>-5/12/12 "[Client B] was at a local park with staff for a cook out and was being walked to the restroom by staff [staff #5]. [Staff #5] was walking with [client B] with her arm looped through his when he lost his balance and fell forward. [Staff #5] had a hold of him by the arm and prevented him from falling face first. [Client B] fell to his knee. [Client B] was assisted up and continued on to the bathroom. [Staff #5] checked [client B] for injury and noted a scrape quarter size on his right knee...Staff will keep [client B] in their line of site (sic) and on longer distances be a stand by assist and loop arms with him for safety to lessen the severity of his falls."</p> <p>The facility's 5/12/12 internal incident report indicated client B fell while at a park out in the community when going to the park's bathroom.</p> <p>Client B's record was reviewed on 5/18/12 at 10:10 AM. Client B's 2/16/12 Continuity of Care sheets indicated client B saw his neurologist for "increase in falls and check recent fall head injury. No</p>						

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	<p>signs of infection at trauma site-right eyebrow. Variable frequency of stumble, falls since he has been our patient..." Attached to the 2/16/12 form was a list of questions from the provider/facility which indicated the following:</p> <p>"[Client B] has had 3 falls with 2 of them being really bad falls in the past 2 months. One possibly due to drop seizure and the other 2 due to being very imbalanced and unsteady on his feet. He also seems to frequently repeat same questions over and over, and seems to not remember sometimes of already asking something. Can dementia be associated with imbalance? Yes if so, is there anything that can be done to help this? treat (sic) dementia/practice walking, try to prevent seizures with meds (sic). Is there anything that staff could be doing to help prevent the falls? Walk with assistance at least 4x (times) a day stay in practice. If not due to dementia, are there any other neurological causes for this? sometimes (sic) too much medicine. I don't think that's the case with [client B]."</p> <p>-4/13/12 Client B was seen in the ER due to "Facial laceration, multiple abrasions, epistaxis (bleeding from nose). Laceration sutured-stitches out 10 days in ER or @ (at) family MD. May use neosynephrine spray for bleeding from</p>				

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	<p>nose. Follow up with ENT or family MD for further treatment of nasal injury...Staff to schedule follow up (with) doctor regarding nose injury...."</p> <p>-4/17/12 Client B saw his doctor for follow up to the ER visit on 4/13/12 and for possible nasal fracture. The note indicated "...await for nasal swelling to subside &amp; re-eval (re-evaluate). Suture removal 4-23-12."</p> <p>-4/27/12 Client B's sutures were removed from the right lower eyelid. The above mentioned Continuity of Care forms indicated the facility's nursing services failed to have client B's nasal injury/nose re-evaluated as recommended on 4/17/12, and/or have an ENT doctor look at the client's nose as recommended on 4/13/12.</p> <p>Client B's 11/19/11 Risk Profile indicated client B was a falls risk and visually impaired. Client B's 11/19/11 Care Plan indicated client B was ambulatory and was a "Risk for fall d/t (due to) Drop Seizures...."</p> <p>Client B's undated Falls Protocol indicated the following (not all inclusive):</p> <p>"If consumer falls, FIRST/IMMEDIATE thing to do is:</p>			

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	<p>1. 'Do NOT move the consumer. DO NOT let them move their head or body until assessment is done.</p> <p>2. Important to keep consumer calm and talk to them throughout your assessment...</p> <p>3. Assess consumer from head to toe for the following:</p> <ul style="list-style-type: none"> <li>a. Breathing...</li> <li>b. Conscious or confusion...</li> <li>c. Pain...</li> <li>d. Immobility...</li> <li>e. Bleeding...</li> <li>f. Redness...</li> <li>g. Bumps, abrasions, lacerations...</li> <li>h. Swelling...</li> <li>i. Take Vital Signs (blood pressure, pulse and respirations)</li> <li>j. Staff is to follow standard CPR (Cardiopulmonary Resuscitation) and First Aid training when giving care</li> <li>k. Notify Nurse immediately...</li> <li>l. If consumer has 'Loss of Consciousness,' Not breathing, Bleeding profusely, &amp; (and) has severe pain-CALL 911 and DO NOT MOVE CONSUMER!!!</li> <li>m. Fill out Fall Assessment at the time of the Fall as well as an Incident Report. Nurse will monitor and update at time of Fall and on Quarterly basis." Client B's undated fall protocol did not include any preventative measures to prevent client B from falling.</li> </ul>						

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	<p>Client B's 11/19/11 Care Plans and/or 10/19/11 Individual Support Plan (ISP) indicated the facility's nursing services failed to develop a care plan for the client's dementia and/or track symptoms of the client's dementia to determine if client B was decreasing in skills to ensure the client's safety.</p> <p>Interview with the Qualified Developmental Disabilities Professional (QDDP) and staff #1 on 5/18/12 at 1:00 PM indicated client B had several falls with injuries and was a fall risk. Staff #1 indicated client B's dementia would continue to decline. QDDP and staff #1 indicated client B's current fall protocol did not have any preventative measures in place to prevent client B from falling. When asked if client B went to have his nose evaluated, staff #1 and the QDDP indicated the client had not yet seen an ENT doctor. Staff #1 indicated client B returned for a follow-up visit on 4/27/12 and the doctor evaluated the client's nose at that time. The QDDP and staff #1 indicated they could not locate any additional documentation the doctor evaluated the client's nose on 4/27/12. The QDDP and staff #1 indicated facility staff were not tracking the symptoms of client B's dementia. The QDDP indicated client B did not have a protocol for dementia. Staff #1 stated "waiting to be</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G602		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  05/25/2012	
NAME OF PROVIDER OR SUPPLIER  ABILITIES SERVICES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 850 MAPLELEAF DR FRANKFORT, IN 46041			
(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>set up."</p> <p>Interview with LPN #1 on 5/18/12 at 1:45 PM indicated client B had falls with injuries. LPN #1 indicated client B's care plans did not include a care plan for dementia. LPN #1 stated "I'm in the process of making one." LPN #1 indicated her computer was not working. LPN #1 also indicated she was in the process of updating client B's fall protocol. LPN #1 indicated client B had not seen an ear, nose and throat doctor to evaluate the client's nose.</p> <p>This federal tag relates to complaint #IN00107147.</p> <p>9-3-6(a)</p>						