

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G763	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 12/19/2013
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NAME OF PROVIDER OR SUPPLIER TRANSITIONAL SERVICES SUB LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 114 S CHESTNUT ST HUNTINGBURG, IN 47542
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W000000	<p>This visit was for the investigation of Complaint #IN00140003.</p> <p>Complaint #IN00140003: Substantiated, Federal and state deficiencies related to the allegations are cited at W102, W104, W122, W149, W154, W240 and W331.</p> <p>Unrelated deficiency cited.</p> <p>Dates of Survey: 12/12, 12/13 and 12/19/13.</p> <p>Facility number: 012289 Provider number: 15G763 AIM number: 100249380</p> <p>Surveyor: Paula Chika, QIDP-TC</p> <p>These federal deficiencies also reflect state findings in accordance with 460 IAC 9.</p> <p>Quality review completed December 27, 2013 by Dotty Walton, QIDP.</p>	W000000		
W000102	<p>483.410 GOVERNING BODY AND MANAGEMENT The facility must ensure that specific governing body and management requirements are met.</p>			

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

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

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	<p>Based observation, interview and record review the facility failed to meet the Condition of Participation: Governing Body for 2 of 3 sampled clients (A and B). The governing body failed to exercise general policy and operating direction over the facility to ensure the facility did not neglect client A, and to ensure the facility conducted thorough investigations in regard to client A and B's falls.</p> <p>Findings include:</p> <ol style="list-style-type: none"> The governing body failed to exercise general operating direction to ensure the facility met the Condition of Participation: Client Protections for 2 of 4 sampled clients (A and B). The governing body failed to ensure written policies and procedures were implemented to prevent neglect of client A in regard to a fracture received from a fall, and/or to prevent potential harm of the client. The governing body failed to ensure written policy and procedures were implemented to conduct thorough investigations in regard to fall incidents for clients A and B. Please see W122. The governing body failed to ensure the facility implemented its policy and procedures to prevent neglect of client A in regard to falls which resulted in a 	W000102	<p>Management staff were retrained on completing thorough investigations in regards to falls or potential neglect or abuse on 1/6/14. The Program Director was also retrained on completing investigations and submitting the findings to the administrator within five working days. The Program Director will meet with the Area Director weekly to review all incidents and investigations. The Area Director will ensure that all needed investigations are completed for any incidents that require them. All future investigations will be reviewed for completeness and thoroughness by the Area Director and/or Quality Assurance Specialist or other designee. Staff in the home will be retrained on completing the Immediate Investigation of Injury form following an incident. The Program Director will review this form and complete investigations as required. Persons Responsible: Home Manager, Program Director, Area Director, Quality Assurance Specialist</p>	01/18/2014	

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W000104	<p>fracture, and/or failed to put in place protective measures/supervision to prevent potential injuries and/or harm to the client. The governing body failed to ensure the facility implemented its policy and procedures to conduct thorough investigations of falls with clients A and B. Please see W104.</p> <p>This federal tag relates to complaint #IN00140003.</p> <p>9-3-1(a)</p> <p>483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility. Based observation, interview and record review for 2 of 4 sampled clients (A and B), the facility's governing body failed to exercise general policy and operating direction over the facility to ensure the facility did not neglect client A, and to ensure the facility conducted thorough investigations in regard to client A and B's falls.</p> <p>Findings include:</p> <p>1. The governing body failed to exercise general policy and operating direction over the facility to ensure the facility</p>	W000104	<p>Management staff were retrained on completing thorough investigations in regards to falls or potential neglect or abuse on 1/6/14. The Program Director was also retrained on completing investigations and submitting the findings to the administrator within five working days. The Program Director will meet with the Area Director weekly to review all incidents and investigations. The Area Director will ensure that all needed investigations are completed for any incidents that require them. All future investigations will be reviewed for completeness and thoroughness by the Area</p>	01/18/2014

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W000122	<p>implemented its policy and procedures to prevent neglect of client A in regard to falls which resulted in a fracture, and/or failed to put in place protective measures/supervision to prevent potential injuries and/or harm to the client. The governing body failed to exercise general policy and operating direction over the facility to ensure the facility implemented its policy and procedures to conduct thorough investigations of falls with clients A and B. Please see W149.</p> <p>2. The governing body failed to exercise general policy and operating direction over the facility to ensure the facility conducted thorough investigations regarding falls with injuries for clients A and B. Please see W154.</p> <p>This federal tag relates to complaint #IN00140003.</p> <p>9-3-1(a)</p> <p>483.420 CLIENT PROTECTIONS The facility must ensure that specific client protections requirements are met. Based on observation, interview and record review, the facility failed to meet the Condition of Participation: Client Protections for 2 of 4 sampled clients (A</p>	W000122	<p>Director and/or Quality Assurance Specialist or other designee. Staff in the home will be retrained on completing the Immediate Investigation of Injury form following an incident. The Program Director will review this form and complete investigations as required. Persons Responsible: Home Manager, Program Director, Area Director, Quality Assurance Specialist</p> <p>Management staff were retrained on completing thorough investigations in regards to falls or potential neglect or abuse on 1/6/14. The Program Director</p>	01/18/2014			

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	<p>and B). The facility failed to implement its written policies and procedures to prevent neglect of client A in regard to a fracture received from a fall, and/or to prevent potential harm of the client as client A had a history of fractures. The facility failed to implement its written policy and procedures to conduct thorough investigations in regard to fall incidents for clients A and B.</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. The facility failed to implement its policy and procedures to prevent neglect of client A in regard to falls which resulted in a fracture, and/or failed to put in place protective measures/supervision to prevent potential injuries and/or harm to the client. The facility failed to implement its policy and procedures to conduct thorough investigations of falls with clients A and B. Please see W149. 2. The facility failed to conduct thorough investigations regarding falls with injuries for clients A and B. Please see W154. <p>This federal tag relates to complaint #IN00140003.</p> <p>9-3-2(a)</p>		<p>was also retrained on completing investigations and submitting the findings to the administrator within five working days. The Program Director will meet with the Area Director weekly to review all incidents and investigations. The Area Director will ensure that all needed investigations are completed for any incidents that require them. All future investigations will be reviewed for completeness and thoroughness by the Area Director and/or Quality Assurance Specialist or other designee. Staff in the home will be retrained on completing the Immediate Investigation of Injury form following an incident. The Program Director will review this form and complete investigations as required. Persons Responsible: Home Manager, Program Director, Area Director, Quality Assurance Specialist</p>		

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W000149	<p>483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. Based on observation, interview and record review for 2 of 4 sampled clients (A and B), the facility neglected to implement its policy and procedures to prevent neglect of client A in regard to falls which resulted in a fracture, and/or neglected to put in place protective measures/supervision to prevent potential injuries and/or harm to the client as the client had a history of fractures. The facility neglected to implement its written policy and procedures to conduct thorough investigations of falls with clients A and B.</p> <p>Findings include:</p> <p>1. During the 12/12/13 observation period between 5:35 PM and 10:00 PM, at the group home, client A was in a wheelchair with a blue cast on the client's right arm. Client A moved around the group home with staff pushing the wheelchair and/or by moving the wheelchair with his feet. At 6:44 PM, while client A was seated at the dining room table, client A</p>	W000149	<p>Management staff were retrained on completing thorough investigations in regards to falls or potential neglect or abuse on 1/6/14. The Program Director was also retrained on completing investigations and submitting the findings to the administrator within five working days. The Program Director will meet with the Area Director weekly to review all incidents and investigations. The Area Director will ensure that all needed investigations are completed for any incidents that require them. All future investigations will be reviewed for completeness and thoroughness by the Area Director and/or Quality Assurance Specialist or other designee. Staff in the home will be retrained on completing the Immediate Investigation of Injury form following an incident. The Program Director will review this form and complete investigations as required. The IDT met for Client A on 1/3/14 and on Client B on 1/2/14 to review their Fall Protocols and changes were made as needed. Client A's ISP and Risk Plan were updated to include changes based on the IDT and current safety needs.</p>	01/18/2014
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	<p>attempted to try and pull his cast off. Client A was redirected from touching/pulling at the cast. Staff #5 wheeled client A to the bathroom and stayed in the bathroom with client A. When staff wheeled client A out of the bathroom, client A was returned to the dining room table. Client A then moved himself away from the table and moved his wheelchair, with his feet, to the living room area. Client A wore white tube socks (without shoes) which were not non-slip socks. Client A was heading back towards the bathroom. Qualified Intellectual Disabilities Professional (QIDP) #1 asked client A where he was going and directed staff #3 to assist client A to the bathroom. Staff #3 assisted client A in the bathroom and then came out of the bathroom leaving client A in the bathroom unsupervised. After which, client A was placed in his bed for the night. Client A had half bed rails on his bed, and the client was lying on his back while sleeping.</p> <p>The facility's reportable incident reports, internal incident reports and/or investigations were reviewed on 12/12/13 at 1:30 PM. The facility's reportable incident reports, internal incident reports and/or investigations indicated the following:</p>		<p>Staff in the home were trained on these updated plans on 1/7/2014. Staff in the home were retrained on Fall Protocols for Client A and B on 1/7/14. Staff will be retrained on the Abuse/Neglect Policy. The Home Manager and/or Program Director will check documentation in the home on a weekly basis to ensure it is completed accurately. Administrative staff will complete a Home Observation Sheet weekly when in the home for six weeks to ensure that staff are following the Fall Protocols accurately for the safety of the clients in the home and retrain staff or give corrective action as needed. Persons Responsible: Home Manager, Program Director, Area Director, Nurse</p>		

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	<p>-3/11/13 "At 10am on 3/11/13, [client A] lost his balance and fell. It did not result in discernable injury....Upon investigating, [client A] showed no signs of injury. However, [client A] initially and briefly had complaints of pain that may or may not have been related to the fall--it is unclear because [client A] had (sic) limited communication skills and suffers from chronic pain...." The reportable incident indicated the client was taken to the emergency room as a "precaution" and an X-ray was completed which showed no fractures, but client A did develop a bruise (location not indicated).</p> <p>The facility's 3/18/13 follow-up report indicated client A's fall protocol was being reviewed and staff would be retrained.</p> <p>-6/5/13 at 12:00 AM, "Staff was assisting another individual when [client A] was needing to use the restroom. [Client A] has a bedside commode but refused to use it as he didn't want to have a BM (bowel movement) in the bedside commode. [Client A] was walking to the restroom using his walker when he got his feet tangled in it and fell to the floor. Staff assisted him to get up and checked him for any injuries and only saw a reddened area on his elbow.</p>						

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	<p>Preventative Measures to be put into place for [client A] are the following: The home will utilize night lights [Client A] will be prompted not to rush [Client A] will be prompted to use his walker at all times Staff will keep all areas free of clutter [Client A] will wear non-skid footwear [Client A] will keep personal items within reach especially during the night Staff will assist the client on and off the van for transport Staff will provide stand-by assistance as needed."</p> <p>The facility's 6/5/13 internal incident report indicated "[Client A] fell while ambulating to the bathroom. He did not appear to have any injuries at the time."</p> <p>-6/6/13 at 5:30 PM, "[Client A] had fallen earlier in the day and he appeared to not have an injury at that time and he went to his Day Program. While at Day Program [client A] made complaints of his arm hurting. Staff took [client A] to be seen by a physician at the [name of medical facility]. He was x-rayed and did not have any injuries. The physician stated t (sic) that he appeared to have a contusion. He did not prescribe any further treatment for [client A]. Continue to monitor [client A] and to (sic) continue to follow his fall</p>				

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	<p>protocol."</p> <p>The facility's 7/2/13 follow-up report indicated client A only fell one time on 6/5/13 and complained of pain on 6/6/13.</p> <p>-8/10/13 at 1:40 PM, "[Client A] had gone into the dining room to sit at the table. When he went to sit down he missed the chair and sat on the floor. He was checked for injuries by staff and there were no apparent injuries...Review fall protocol for revision."</p> <p>The facility's 10/25/13 follow-up report indicated if any further falls occurred, the client's fall protocol would be revised.</p> <p>-8/10/13 at 5:00 PM, "[Client A] was using his walker to go the restroom when he fell. Staff checked him for injuries. There was no apparent injuries but due to this being the second fall of the day [client A] was taken to the ER (emergency room) for an evaluation...The ER doctor said if this continues then have an MRI done as precaution...[Client A] is to have stand by assistance while ambulating. Nurse to review fall protocol...."</p> <p>The facility's 10/25/13 follow-up report</p>			

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	<p>indicated the same preventative measures as indicated in the above mentioned 6/5/13 incident. The follow-up report indicated "Stand by assistance was provided."</p> <p>-8/14/13 at 10:15 PM, "[Client A] fell from his bed while trying to get up. Staff found him sitting on the floor after the fall. There are no injuries reported."</p> <p>The facility's 10/26/13 follow-up report indicated "Protocol reviewed and is appropriate. [Client A] has not had any further falls since this incident...."</p> <p>The facility's 8/14/13 internal incident report indicated staff reported client A "...was unsteady getting of bed to use the restroom...."</p> <p>-11/11/13 at 12:00 PM, "[Client A] was at the dining room table when he pushed up with his hand on the table to stand and he fell on his bottom beside the table. He had not taken any steps and staff stated that he was weak due to having vomiting and diarrhea the previous day. [Client A] did have his walker at the time. Staff examined [client A] and he did not appear to have any bruising or injuries at the time of the fall. Due to being weak staff gave [client A] standby assistance until he</p>				

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	<p>was able to use his walker by himself."</p> <p>The facility's 11/11/13 Indiana Mentor Immediate Investigation of Injury indicated client A did not require any treatment. The investigation also indicated the facility's nurse instructed the staff to check the client for injuries. The investigation indicated there were no environmental dangers which may have caused the injury. The investigation indicated client A's fall protocol was updated on 11/14/13. The facility's 11/11/13 Immediate Investigation of Injury neglected to indicate specifically how client A fell and/or if he hit his arm when he fell, The 11/11/13 investigation neglected to indicate staff were interviewed and/or if any clients were interviewed. The 11/11/13 investigation also neglected to indicate if any additional protective measures were put in place.</p> <p>-11/13/13 "At 5 am the morning of 11/13/13 staff were assisting [client A] in dressing when they noticed the underside of wrists (sic) and arm appeared to be swollen. Staff notified group home RN and were instructed to take [client A] to the emergency room for an evaluation. [Client A] was diagnosed with a fracture of (sic) left arm underneath the plate he has in his</p>				

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	<p>arm from a previous fracture. [Client A] is to see an Orthopedic MD (medical doctor) on 11/14/13 to have the fracture evaluated for possible surgery. An order for a PRN (as needed) wheelchair has been obtained due (sic) [client A] will not be able to use his walker at this time. At this time it is unknown how the fracture occurred and an investigation is underway. [Client A] has a current high risk plan for Potential for Fractures due to Osteoporosis (weak/brittle bones), and a High Risk plan for Falls. The group home RN is requesting a repeat DEXA (test of bone density) scan to be completed to measure [client A's] bone density. She is also consulting with (sic) physician to inquire if [client A] needs a different osteoporosis medication. The nurse will review all high risk plans to evaluate if any need to be revised, and the IDT (interdisciplinary team) will meet to discuss and make any necessary plan changes."</p> <p>The facility's 11/15/13 Summary of Internal Investigation Report indicated "On 11/11/13 [staff #6] reported that [client A] had a fall at the dining room table in which he scraped his right arm. The scrape was minor and there were no other visible signs of injury. [Staff #6] also reports that she is unaware of any other possible reasons for the injury...."</p>						

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	<p>The facility's investigation indicated when client A was taken to the ER for evaluation staff reported the doctor indicated client A had "...two breaks, one in his wrist under the plate and hardware and one in his arm...." The facility's investigation indicated client A was taken to the orthopedic doctor on 11/15/13 and the doctor indicated "...there is only a clean break in the arm and that the area in the wrist is from an old fracture...." The facility's 11/15/13 investigation indicated "...Conclusion: [Client A's] fall on 11/11/13 in which he scratched his right arm appears to (sic) caused a fracture." The facility's investigation did not indicate/describe how client A fell and/or scraped his arm as the initial report indicated client A had no injuries. The facility's 11/15/13 investigation also neglected to indicate any additional measures/supervision were put in place to prevent any potential falls.</p> <p>-11/14/13 at 10:15 PM, "[Client A] was heard by staff to have a fall in his room on 11/14/13. Staff entered his room and found [client A] next to his bed. Staff evaluated [client A] for injuries. [Client A] had a quarter sized bruise on his elbow and did not appear to have any further injuries. Ice was applied to the area. The following measures have been</p>				

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	<p>implemented: Bed cane/safety bar obtained to put on bed to help [client A] to get up with support. Audio monitor put into place, 15 minute checks when [client A] is in his room at night. [Client A] had a physician's appointment on 11/15/13 already scheduled [client A] was examined and no further injuries were noted (sic).</p> <p>The facility's 11/14/13 internal incident report indicated "internal investigation underway."</p> <p>The facility's 11/14/13 Indiana Mentor Immediate Investigation of Injury neglected to indicate which arm was injured/bruised, and neglected to indicate how/why the client fell trying to get out of bed.</p> <p>The facility's 11/15/13 follow-up report indicated client A saw the orthopedic doctor and "...was placed in a short armed cast for 3 weeks and is to followup in 3 weeks to see how the fracture is healing. The orthopedist stated it was a cleanbreak (sic) and that surgery is not required at this time. [Client A] due to not being able to put weight on the arm is using a wheelchair for ambulation until the arm is healed. All Fall risk plans have been updated. Audio monitor has been placed in [client</p>				

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	<p>A's] room so that staff can hear if he tries to ambulate without his W/C (wheelchair). 15 minute checks have been put into place when [client A] is in his room. Bed cane/safety bar has been obtained until the bedrail that was ordered arrives. Continue to monitor all health needs...."</p> <p>-12/10/13 at 1:10 PM, "[Client A] had gone to the bathroom without asking staff to help him and he fell and scraped his shoulder. He was checked by staff and did not appear to have (sic) any further injuries. [Client A] resumed his normal activities of the day with no further incidents. [Client A] saw [name of orthopedist] on 12/11/13 and he was asked about OT (Occupational Therapy) and PT (Physical Therapy) evaluation for [client A]. [Name of orthopedist] stated that he didn't want to do the evaluations until the cast that [client A] had received on 11/13/13 was removed in 3 weeks. [Name of orthopedist] also stated that he wanted [client A] to attend a Bone Density clinic that was opening in January." The 12/10/13 reportable incident report neglected to indicate if the facility was conducting an investigation in regard to possible neglect in regard to staffing, and/or failed to indicate any additional measures were put in place to</p>						

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	<p>supervise/monitor client A outside the bedroom to prevent potential falls and/or injuries.</p> <p>Client A's record was reviewed on 12/12/13 at 7:55 PM. Client A's Medical Appointment Forms indicated the following:</p> <p>-11/14/13 Client A was seen for "Broken arm into (sic) two places." The form indicated client A's doctor referred the client to an Orthopedist for consultation and treatment.</p> <p>-11/15/13 "11-15-13 Use wheelchair x (times) 3 weeks. -Currently have order for w/c (wheelchair) x 2 months in effect. The Orthopedist note indicated "Fx (fracture (R) (right) Ulna (bone in forearm). Cast 6 weeks, (change) in 3 (weeks). Clarification: [Name of orthopedist] states will address possible need for repeat DEXA Scan & (and) Fosamax (osteoporosis) change after cast is completely removed." Cast care instructions were attached to the 11/15/13 form.</p> <p>-12/11/13 "Cast for 3 weeks and move fingers as tol (tolerated). RTO (return to office) 3 wks (weeks) for cast off xray & PT/OT referral. Consider referral to Healthy Bone Clinic in January (2014)."</p>			

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	<p>Client A's Health Care Coordination/Monthly Health Reviews indicated the following (not all inclusive):</p> <p>-11/11/13 "...Today (11/11)staff (sic) called to report [client A] fell while getting up from dining room table to use restroom, a nickel size scratch was noted to Rt (right) wrist and no signs of other injury were noted at that time. Staff were instructed to continue to monitor for any signs of developing injury."</p> <p>-11/13/13 "6:30a-Home manager reports swelling to Rt wrist this am (morning) that had previously not been present and [client A] is displaying guarding of Rt wrist this am, instructed to take him to emergency room for evaluation."</p> <p>-11/13/13 "10:53am-Home manager reports xray has shown a Rt wrist fracture at the site of a previous Rt wrist fracture repair. Wrist was splinted and arm placed in a sling and ice pack to be applied as instructed in ER. Home manager also getting a wheelchair order as [client A] will be unable to use his walker at this time."</p> <p>-11/15/13 3p-On 11/14 at 10:15pm staff reported that [client A] fell getting up</p>			
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	<p>...only injury noted was small bruise to L (left) elbow, advised to monitor for any developing injuries..." Client A's record and/or 11/13 nursing notes indicated the facility's nurse did not assess the client after he fell on 11/14/13 as the client already had a fractured wrist from a 11/13/13 fall.</p> <p>A 12/10/13 Fall Assessment indicated direct care staff completed the fall assessment. The fall assessment indicated the body position at the time of the fall was blank. The fall assessment indicated the client was going to the bathroom when he fell. The assessment indicated the client was standing and walking and the wheelchair was checked. The 12/10/13 assessment indicated the path was free from obstructions and client A had slippers on. The assessment indicated the client received a scratch and the facility's nurse made a 12/12/13 notation at the bottom of the assessment indicating client A saw his doctor on 12/11/13. The 12/12/13 notation at the bottom indicated the nurse examined the client on 12/12/13 which indicated "My exam shows 5 small scrapes to posterior Rt shoulder, able to move arm w/out (without) signs of distress."</p> <p>A 11/14/13 Fall Assessment indicated</p>				

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	<p>an assessment was completed by direct care staff. The fall assessment indicated the body position at the time of the fall was blank. The fall assessment indicated the facility's RN documented at the bottom of the assessment "11/15/13 No s/s (signs/symptoms) of acute injury noted on exam." The assessment indicated client A had socks on, path was free of obstructions, light was on and the client was using his walker, gait belt and wheelchair.</p> <p>An 11/11/13 Fall Assessment indicated facility direct care staff filled out the assessment. The assessment indicated the body position at the time of the fall was blank. The 11/11/13 assessment indicated the facility's RN documented at the bottom of the assessment "11/11/13- No acute signs of injury per staff report. 11/13/13 Staff report swelling to Rt wrist & guarding behavior-sent to ER for eval (evaluation) - Xray shows fracture Rt wrist. To F/U (follow up) (with) orthopedist 11/14/13."</p> <p>Client A's 12/1/13 physician's orders indicated "Fosamax 70 milligrams by mouth weekly with 8 ounces of water 30 minutes before meal and medications and remain upright for 30 minutes for bone growth."</p>			

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	<p>Client A's 15 minute checks sheets indicated 15 minute checks were started on 11/15/13 and staff were to document 15 minute checks "anytime [client A] is in his room." Client A's 15 minute checks indicated staff were to initial each 15 minute check. Client A's 15 minute check sheets indicated facility staff drew lines down the form instead of initialing each 15 minute time frame on the following dates:</p> <p>-11/16/13 from 7:15 PM until 11:45 PM -11/17/13 from 8:30 PM until 9:15 PM -11/18/13 from 7:00 PM until 11:45 PM -11/19/13 from 12:00 AM until 5:00 AM -11/20/13 from 4:00 PM until 11:30 PM -11/21/13 from 8:00 PM until 12:45 PM -11/22/13 from 9:00 PM until 11:45 PM -11/24/13 from 8:30 PM until 10:00 PM, 12:00 AM until 5:45 AM -11/25/13 from 8:30 PM until 11:30 PM -11/26/13 from 7:45 PM until 11:45 PM -11/27/13 from 8:15 PM until 11:45 PM -11/28/13 from 8:15 PM until 9:30 PM -11/29/13 from 8:00 PM until 11:45 PM -11/30/13 from 8:00 PM until 11:45 PM -12/1/13 from 8:15 PM until 4:45 AM -12/2/13 from 2:00 PM until 4:00 PM, 8:45 PM until 11:45 PM -12/3/13 from 9:15 PM until 11:45 PM -12/4/13 from 8:30 PM until 11:45 PM</p>						

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	<p>-12/5/13 from 8:00 PM until 11:45 PM no 15 minute checks were documented and from 12:15 AM until 4:45 AM a line was drawn through the 15 minute checks</p> <p>-12/6/13 from 12:15 AM until 5:45 AM</p> <p>-12/8/13 no 15 minute checks documented from 12:00 AM until 6:00 AM</p> <p>-12/9/13 from 8:15 PM until 11:45 PM</p> <p>-12/10/13 from 8:15 PM until 11:45 PM</p> <p>-12/11/13 from 8:15 PM until 11:45 PM</p> <p>Client A's Daily Support Records (DSR) indicated the following:</p> <p>-12/12/13 "[Client A] got up, yelled & screamed for coffee & tea kept getting out of wheelchair and walking...."</p> <p>-12/11/13 "[Client A] got up, took meds, ate, had shower, (sic) went to see [name of orthopedist] had cast changed. Ate lunch, took nap, yelled off & (and) on all day. Kept trying to walk w/(with) out using his wheelchair."</p> <p>-12/9/13 Staff #6 documented 2 hour bed checks were conducted on the shift from 12:00 PM and 12:00 AM.</p> <p>-12/6/13 Staff #6 documented 2 hours bed checks were done between 12 AM and 9:00 AM.</p>			

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	<p>-12/7/13 Staff #6 documented 2 hour bed checks were done between 12:00 PM and 12:00 AM.</p> <p>-11/29/13 Staff #7 documented 2 hour bed checks were done between 12:00 AM and 7 AM.</p> <p>Client A's 1/23/13 Risk Management Assessment and Plan indicated client A was "Very unsteady on his feet, does use a walker to get around. Staff are to monitor physical movement and assist as needed for transfers." The risk management plan indicated client A had Osteoporosis and received medication for the condition.</p> <p>Client A's 11/13/13 Fall Protocol indicated the following Preventative Measures: "-Assist [client A] in moving around the home and getting on and off the van using a wheelchair. -Assist [client A] with all activities of daily living; toileting, bathing, oral care, dressing. -Assist [client A] by using a gait belt (if ordered) or a sheet tied at the waist anytime (sic) he is on his feet to steady him when: transferring to and from the wheelchair to the bed; transferring from the wheelchair to the commode- See</p>						

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	<p>Gait Belt Procedure.</p> <p>-Staff will keep all areas free of clutter.</p> <p>-[Client A] will wear non-skid footwear.</p> <p>-[Client A] will keep personal items within reach especially during the night.</p> <p>-[Client A] will encourage [client A] to use the restroom before bedtime and before leaving in the van...." Client A's 11/13/13 Fall Protocol did not specifically indicate how facility staff were to assist client A to toilet, bathe, dress and/or provide oral care to client A to prevent potential falls/injuries.</p> <p>Client A's 11/13/13 Altered Mobility due to Rt wrist fracture Protocol indicated facility staff were to do the following:</p> <p>"Assist [client A] in moving around the house using a wheelchair.</p> <p>Assist [client A] with all activities of daily living; toileting, bathing, oral care, dressing.</p> <p>Assist [client A] by using a gait belt (if ordered) or a sheet tied at the waist anytime he is on his feet to steady him when transferring to and from the wheelchair to the bed; transferring from the wheelchair to the commode- See gait belt procedure."</p> <p>Client A's record indicated the following IDT Meeting Notes:</p>				

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	<p>-10/11/12 "IDT met to review [client A's] Fall Protocol and agreed that it appropriately addresses falls. Staff are being re-trained on fall prevention techniques."</p> <p>-11/15/13 "Team met to discuss measures to put into place to help prevent falls for [client A], HRC (Human Rights Committee) approval has been requested and approved to put the following into place. (sic)</p> <ol style="list-style-type: none"> 1. Audio monitor when in his room. 2. Bed rails to prevent falls from bed. 3. Wheelchair for ambulation. 4. Gait belt to assist (with transfers)." 5. 15 minute checks when in his room...." <p>-12/12/13 "Client A] saw [name of doctor], orthopedic surgeon on 12/11/13. [Name of doctor] was asked about doing an OT & PT referral & [name of doctor] says that he is going to recheck [client A] in 3 weeks & will complete referral then. The team agrees to follow [name of doctor's] recommendations. [Client A's] protocols were reviewed & appear appropriate. Protections will be reviewed again in 3 weeks after [client A] sees [name of doctor] again. It was also requested that [name of doctor] consider a DEXA Scan & changing</p>						

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	<p>[client A's] Fosamax to something that might work better. [Name of doctor] going to consider referral to Healthy bone clinic opening in January to address these issues."</p> <p>Client A's record indicated the client's IDT/facility neglected to meet and review all falls prior to client A's 11/13/13 fracture to ensure protective measures were put in place prior to 11/15/13 to prevent the fracture/fall. Client A's 12/12/13 IDT note indicated the facility/IDT neglected to put any additional measures in place on how client A was to be supervised/monitored when outside his bedroom to prevent falls in the bathroom and other parts of the house. Client A's 12/12/13 IDT note and/or 1/23/13 Individual Support Plan (ISP) neglected to indicate client A's identified need of getting up and walking with the fractured arm.</p> <p>The facility's time cards were reviewed on 12/13/13 at 12:10 PM. The facility's 12/10/13 time cards and schedule indicated 3 facility staff were working in the group home at the time client A fell on 12/10/13 at 1:10 PM. The facility's time cards indicated 2 staff worked most evening shifts with 7 clients who resided in the group home.</p> <p>Interview with administrative staff #1</p>						

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	and QIDP #1 on 12/12/13 at 3:05 PM and on 12/13/13 at 11:30 AM indicated 15 minute checks, audio monitor and bed rails were put in place on 11/15/13 after client A fell on 11/14/13. QIDP #1 indicated client A fell on 11/11/13 which resulted in a fracture identified on 11/13/13. QIDP #1 indicated client A was placed in a wheelchair on 11/13/13 when it was discovered he had a fracture. When asked if client A's IDT met after the above mentioned falls prior to 11/11/13, administrative staff #1 and QIDP #1 indicated the home had undergone changes in the QIDP and they were not able to locate any additional IDTs in regard to client A's falls. When shown client A's 15 minute checks, QIDP #1 and administrative staff #1 indicated facility staff were not filling out the 15 minute checks right. QIDP #1 indicated facility staff were to initial each 15 minute space instead of drawing a line threw the spaces. QIDP #1 and administrative staff #1 indicated they were not aware facility staff documented they were doing 2 hour bed checks on client A's DSRs. Interview with administrative staff #1 and QIDP #1 indicated they were not aware client A was getting up from his wheelchair to ambulate. QIDP #1 indicated client A ambulated with a walker prior to the fracture but was now to ambulate with a			
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	wheelchair as the client was not to put pressure on his arm. QIDP #1 and administrative staff #1 indicated client A had Osteoporosis and the facility was concerned the client's Fosamax was no longer working. Administrative staff #1 stated due to client A being "fragile," client A was going to be evaluated for a medically fragile home on 12/23/13. Administrative staff #1 and QIDP #1 indicated the facility was still in the process of investigating client A's 12/10/13 fall. Administrative staff #1 stated the facility was "just investigating to see how he fell." Administrative staff #1 and QIDP #1 indicated they did not know what the 3 staff were doing the day client A fell on 12/10/13. QIDP #1 originally indicated 2 staff were at the group home on 12/10/13. QIDP #1 indicated 2 staff and the manager worked on 12/10/13. QIDP #1 indicated all 7 clients were home that day due to the weather. Administrative staff #1 and QIDP #1 indicated QIDP #1 was conducting the investigation. Administrative staff #1 and QIDP #1 indicated they were not investigating the fall as possible neglect. In regard to the 11/11/13 fall, administrative staff #1 indicated facility staff did not see client A hit his arm when he fell, but client A did have a scratch on his right arm. Administrative staff #1 and QIDP #1				

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	<p>indicated no additional clients were interviewed. QIDP #1 and administrative staff #1 indicated the client's IDT did not discuss how client A should be supervised/monitored after the 12/10/13 fall.</p> <p>Interview with staff #2 on 12/12/13 at 7:10 PM stated: "As [client A] gets older he gets in a hurry. Will lose balance." Staff #2 indicated client A had fractured the same wrist a year ago when the client stood up and bumped his arm on a rail in the bathroom. Staff #2 stated "Real easy for him to get a fracture." Staff #2 indicated client A could push himself with his feet to ambulate, but client A required assistance when in the bathroom to toilet.</p> <p>Interview with QIDP #1 on 12/12/13 at 7:18 PM indicated client A was being monitored with an audio monitor.</p> <p>Interview with staff #1 on 12/12/13 at 7:19 PM indicated she worked the day client A fell on 12/10/13. When asked where was staff, staff #1 could not give a specific answer in regard to what she was doing on 12/10/13. Staff #1 stated "One staff was with [client F] and one staff was with [client B]." When asked where staff #1 was located, staff #1 stated "I was outside door shoveling</p>			
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	<p>snow or in the office at that time." Staff #1 indicated 3 staff and 7 clients were at the group home when client A fell. Staff #1 stated client A "Wheeled self into bathroom, heard a thud and bumped shoulder (sic)." When asked how facility staff were to monitor/supervise the client, staff #1 stated "We monitor closely. Trying to be more aware."</p> <p>Interview with staff #3 on 12/12/13 at 8:54 PM indicated client A had not fallen while she worked but she heard of a couple of falls the client had at night. Staff #3 indicated one staff had to assist with transfers and 15 minute checks were to be completed when client A was in his bedroom. Staff #3 stated "He will get up and try to get coffee and tea. He will scoot up a little bit in his wheelchair as if he is trying stand."</p> <p>Interview with staff #5 on 12/12/13 at 9:45 PM indicated client A fell a couple of months ago when she was working. Staff #5 stated when she got to the room, client A looked "confused." Staff #5 indicated client A fell one other time when he slid off the bed as the client missed the bed. Staff #5 stated "He worries me so. He is getting up there (in age)." Staff #5 indicated staff were supposed to monitor the client when he was in his bedroom and do 15 minute</p>				

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	<p>checks. Staff #5 indicated she would monitor the client when he was on the toilet and when he showered. Staff #5 stated "He has a habit of getting up out of wheelchair and away from walker (sic)." Staff #5 indicated normally 2 staff worked in the evening and they were to use a gait belt with the client when transferring. Staff #5 stated "When he has fallen, he has been hard to get him up. He fights once on floor." Staff #5 indicated a monitor was kept in his bedroom. Staff #5 indicated she caught him one time trying to unplug the audio monitor.</p> <p>Interview with RN #1 on 12/13/13 at 10:25 AM indicated client A had a history of falls. RN #1 stated client A's old DEXA scan indicated client A was a "Moderate risk for fractures." When asked what that meant, RN #1 stated "50/50 chance he could fracture if fall (sic)." RN #1 indicated facility staff should stay with the client when he was in the bathroom to ensure the client did not try to stand without staff and fall. RN #1 stated client A's fall protocols would need to be more specific on how staff were to "assist" the client. RN #1 indicated client A was being monitored with 15 minute checks. RN #1 indicated she updated client A's protocols on 11/13/13. RN #1 stated she put a</p>			

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	<p>"Potential for Fracture Protocol due to Osteoporosis and PKU (nutritional deficit) diagnosis in place," a fall protocol and right wrist fracture and an "Altered Mobility due to Rt wrist fracture protocol in place." RN #1 indicated she put in place a gait belt procedure and facility staff were trained on 11/13/13.</p> <p>Interview with staff #4 on 12/13/13 at 11:50 AM, by phone, indicated she was working on 12/10/13 when client A fell. Staff #4 indicated 3 staff were working at the time. Staff #4 stated "I was in bedroom with [client F] helping him get dirty clothes together. I heard him (client A) fall. I took off running and [staff #6] was in bedroom with [client B] (sic)." Staff #4 indicated she did not know if staff #1 was outside or in the office area. Staff #4 stated when she heard him fall, she was in "panic mode." Staff #4 stated she reached client A first and he was in the bathroom lying on the floor on his "[bottom] with his shoulders resting up against wall diagonally. He was almost under (sic) sink." When asked where was client A's right arm, staff #4 stated "Laying on stomach." Staff #4 indicated client A was in the dining room, sitting at the table, when she went with client F to his bedroom. Staff #4</p>				

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	<p>stated client A was "dozing off, playing with his beads." Staff #4 indicated she was in client F's bedroom for 10 to 15 minutes. Staff #4 indicated all 7 clients were home from work.</p> <p>The facility's policy and procedures were reviewed on 12/12/13 at 1:50 PM. The facility's April 2011 policy entitled Quality Risk Management indicated "Indiana Mentor promotes high quality of service and seeks to protect individuals receiving Indiana Mentor Services through oversight of management procedures and company operations, close monitoring of service delivery and through a process of identifying, evaluating and reducing risk to which individuals are exposed...." The April 2011 policy indicated "...Indiana Mentor is committed to ensuring the individuals we serve are provided with a safe and quality living environment..." The April 2011 policy indicated the facility would conduct investigations in regard to allegations of neglect and/or injuries of unknown source.</p> <p>2. The facility failed to conduct thorough investigations in regard to client A and B's falls. Please see W154.</p> <p>This federal tag relates to complaint</p>				

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W000154	<p>#IN00140003.</p> <p>9-3-2(a)</p> <p>483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated. Based on interview and record review review for 2 of 5 allegations of abuse and/or neglect reviewed, the facility failed to conduct thorough investigations in regard to client A and B's falls.</p> <p>Findings include:</p> <p>1. The facility's reportable incident reports, internal incident reports and/or investigations were reviewed on 12/12/13 at 1:30 PM. The facility's reportable incident reports, internal incident reports and/or investigations indicated the following:</p> <p>-11/11/13 at 12:00 PM, "[Client A] was at the dining room table when he pushed up with his hand on the table to stand and he fell on his bottom beside the table. He had not taken any steps and staff stated that he was weak due to having vomiting and diarrhea the</p>	W000154	Management staff were retrained on completing thorough investigations in regards to falls or potential neglect or abuse on 1/6/14. The Program Director was also retrained on completing investigations and submitting the findings to the administrator within five working days. The Program Director will meet with the Area Director weekly to review all incidents and investigations. The Area Director will ensure that all needed investigations are completed for any incidents that require them. All future investigations will be reviewed for completeness and thoroughness by the Area Director and/or Quality Assurance Specialist or other designee. Staff in the home will be retrained on completing the Immediate Investigation of Injury form following an incident. The Program Director will review this form and complete investigations as required. The IDT met for Client A on 1/3/14 and on Client B	01/18/2014	

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	<p>previous day. [Client A] did have his walker at the time. Staff examined [client A] and he did not appear to have any bruising or injuries at the time of the fall. Due to being weak staff gave [client A] standby assistance until he was able to use his walker by himself."</p> <p>The facility's 11/11/13 Indiana Mentor Immediate Investigation of Injury indicated client A did not require any treatment. The investigation also indicated the facility's nurse instructed the staff to check the client for injuries. The investigation indicated there were no environmental dangers which may have caused the injury. The investigation indicated client A's fall protocol was updated on 11/14/13. The facility's 11/11/13 Immediate Investigation of Injury neglected to indicate specifically how client A fell and/or if he hit his arm when he fell. The 11/11/13 investigation failed to indicate staff were interviewed and/or if any clients were interviewed.</p> <p>-11/13/13 "At 5 am the morning of 11/13/13 staff were assisting [client A] in dressing when they noticed the underside of wrists (sic) and arm appeared to be swollen. Staff notified group home RN and were instructed to take [client A] to the emergency room</p>		<p>on 1/2/14 to review their Fall Protocols and changes were made as needed. Client A's ISP and Risk Plan were updated to include changes based on the IDT and current safety needs. Staff in the home were trained on these updated plans on 1/7/2014. Staff in the home were retrained on Fall Protocols for Client A and B on 1/7/14. Staff will be retrained on the Abuse/Neglect Policy. The Home Manager and/or Program Director will check documentation in the home on a weekly basis to ensure it is completed accurately. Administrative staff will complete a Home Observation Sheet weekly when in the home for six weeks to ensure that staff are following the Fall Protocols accurately for the safety of the clients in the home and retrain staff or give corrective action as needed. Persons Responsible: Home Manager, Program Director, Area Director, Nurse</p>		

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	<p>(ER) for an evaluation. [Client A] was diagnosed with a fracture of left arm underneath the plate he has in his arm from a previous fracture. [Client A] is to see an Orthopedic MD (medical doctor) on 11/14/13 to have the fracture evaluated for possible surgery. An order for a PRN (as needed) wheelchair has been obtained due [client A] will not be able to use his walker at this time. At this time it is unknown how the fracture occurred and an investigation is underway...."</p> <p>The facility's 11/15/13 Summary of Internal Investigation Report indicated "On 11/11/13 [staff #6] reported that [client A] had a fall at the dining room table in which he scraped his right arm. The scrape was minor and there were no other visible signs of injury. [Staff #6] also reports that she is unaware of any other possible reasons for the injury...." The facility's investigation indicated when client A was taken to the ER for evaluation staff reported the doctor indicated client A had "...two breaks, one in his wrist under the plate and hardware and one in his arm...." The facility's investigation indicated client A was taken to the orthopedic doctor on 11/15/13 and the doctor indicated "...there is only a clean break in the arm and that the area in the wrist is from an</p>						

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	<p>old fracture...." The facility's 11/15/13 investigation indicated "...Conclusion: [Client A's] fall on 11/11/13 in which he scratched his right arm appears to have caused a fracture." The facility's investigation did not indicate/describe how client A fell and/or scraped his arm as the initial report indicated client A had no injuries.</p> <p>-11/14/13 at 10:15 PM, "[Client A] was heard by staff to have a fall in his room on 11/14/13. Staff entered his room and found [client A] next to his bed. Staff evaluated [client A] for injuries. [Client A] had a quarter sized bruise on his elbow and did not appear to have any further injuries. Ice was applied to the area. The following measures have been implemented.: Bed cane/safety bar obtained to put on bed to help [client A] to get up with support. Audio monitor put into place, 15 minute checks when [client A] is in his room at night. [Client A] had a physician's appointment on 11/15/13 already scheduled [client A] was examined and no further injuries were noted (sic)."</p> <p>The facility's 11/14/13 internal incident report indicated "internal investigation underway."</p> <p>The facility's 11/14/13 Indiana Mentor</p>			

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	<p>Immediate Investigation of Injury failed to indicate which arm was injured/bruised, and failed to indicate how/why the client fell trying to get out of bed.</p> <p>-12/10/13 at 1:10 PM, "[Client A] had gone to the bathroom without asking staff to help him and he fell and scraped his shoulder. He was checked by staff and did not appear to have (sic) any further injuries. [Client A] resumed his normal activities of the day with no further incidents. [Client A] saw [name of orthopedist] on 12/11/13 and he was asked about OT (Occupational Therapy) and PT (Physical Therapy) evaluation for [client A]. [Name of orthopedist] stated that he didn't want to do the evaluations until the cast that [client A] had received on 11/13/13 was removed in 3 weeks. [Name of orthopedist] also stated that he wanted [client A] to attend a Bone Density clinic that was opening in January." The 12/10/13 reportable incident report failed to indicate if the facility was conducting an investigation in regard to possible neglect in regard to staffing.</p> <p>Client A's record was reviewed on 12/12/13 at 7:55 PM. Client A's 1/23/13 Risk Management Assessment and Plan indicated client A was "Very unsteady</p>			

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	<p>on his feet, does use a walker to get around. Staff are to monitor physical movement and assist as needed for transfers." The risk management plan indicated client A had Osteoporosis (weak/brittle bones) and received medication for the condition.</p> <p>The facility's time cards were reviewed on 12/13/13 at 12:10 PM. The facility's 12/10/13 time cards and schedule indicated 3 facility staff were working in the group home at the time client A fell on 12/10/13 at 1:10 PM.</p> <p>Interview with administrative staff #1 and QIDP (Qualified Intellectual Disabilities Professional) #1 on 12/12/13 at 3:05 PM and on 12/13/13 at 11:30 AM indicated the facility was still in the process of investigating client A's 12/10/13 fall. Administrative staff #1 stated the facility was "just investigating to see how he fell." Administrative staff #1 and QIDP #1 indicated they did not know what the 3 staff were doing the day client A fell on 12/10/13. QIDP #1 originally indicated 2 staff were at the group home on 12/10/13. QIDP #1 indicated 2 staff and the manager worked on 12/10/13. QIDP #1 indicated all 7 clients were home that day due to the weather. Administrative staff #1 and QIDP #1 indicated QIDP #1 was</p>				

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	<p>conducting the investigation.</p> <p>Administrative staff #1 and QIDP #1 indicated they were not investigating the fall as possible neglect. In regard to the 11/11/13 fall, administrative staff #1 indicated facility staff did not see client A hit his arm when he fell, but client A did have a scratch on his right arm.</p> <p>Administrative staff #1 and QIDP #1 indicated no additional clients were interviewed.</p> <p>Interview with staff #1 on 12/12/13 at 7:19 PM indicated she worked the day client A fell on 12/10/13. When asked where was staff, staff #1 could not give a specific answer in regard to what she was doing on 12/10/13. Staff #1 stated "One staff was with [client F] and one staff was with [client B]." When asked where staff #1 was located, staff #1 stated "I was outside door shoveling snow or in the office at that time." Staff #1 indicated 3 staff and 7 clients were at the group home when client A fell. Staff #1 stated client A "Wheeled self into bathroom, heard a thud and bumped shoulder (sic)."</p> <p>Interview with RN #1 on 12/13/13 at 10:25 AM indicated client A had a history of falls. RN #1 stated client A's old DEXA (bone density test) can indicated client A was a "Moderate risk</p>				

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	<p>for fractures." When asked what that meant, RN #1 stated "50/50 chance he could fracture if fall (sic)."</p> <p>Interview with staff #4 on 12/13/13 at 11:50 AM, by phone, indicated she was working on 12/10/13 when client A fell. Staff #4 indicated 3 staff were working at the time. Staff #4 stated "I was in bedroom with [client F] helping him get dirty clothes together. I heard him (client A) fall. I took off running and [staff #6] was in bedroom with [client B]." Staff #4 indicated she did not know if staff #1 was outside or in the office area. Staff #4 stated when she heard him fall, she was in "panic mode." Staff #4 stated she reached client A first and he was in the bathroom lying on the floor on his "[bottom] with his shoulders resting up against wall diagonally. He was almost under sink." When asked where was client A's right arm, staff #4 stated "Laying on stomach." Staff #4 indicated client A was in the dining room, sitting at the table, when she went with client F to his bedroom. Staff #4 stated client A was "dozing off playing with his beads." Staff #4 indicated she was in client F's bedroom for 10 to 15 minutes. Staff #4 indicated all 7 clients were home from work.</p> <p>2. The facility's reportable incident</p>			
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	<p>reports, internal incident reports and/or investigations were reviewed on 12/12/13 at 1:30 PM. The facility's 10/19/13 reportable incident report indicated "[Client B] was found by staff on the floor of the kitchen. [Client B] stated that she fell and staff did not see her fall. Staff checked her for injuries at the time of the fall and she did not appear to have any. The nurse was notified of the fall. The next morning [client B] was observed to have a black eye. The nurse directed her to put ice on it...."</p> <p>The facility's 10/19/13 internal incident report indicated "Internal Investigation Underway."</p> <p>The facility's 10/19/13 Indiana Mentor Immediate Investigation of Injury indicated the facility did not conduct a thorough investigation in regard to client B's fall and injury as staff and/or client interviews were not conducted. The facility's investigation also did not indicate how client B was found on the floor, and/or where/what staff were doing when client B fell in the kitchen to ensure sufficient staffing and supervision.</p> <p>Interview with administrative staff #1 and QIDP #1 on 12/13/13 at 3:05 PM</p>			

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W000227	<p>indicated no additional clients were interviewed. QIDP #1 and administrative staff #1 indicated the facility did not conduct a formal investigation. Administrative staff #1 indicated an Immediate Investigation of Injury was conducted. Administrative staff #1 indicated the facility's investigation did not indicate how many staff were working and/or where the staff were located within the group home when client B fell in the kitchen. QIDP #1 and administrative staff #1 indicated the group home had open areas as the living room, dining room and kitchen could be seen from each room. Administrative staff #1 indicated staff were interviewed in regard to client B's fall.</p> <p>This federal tag relates to complaint #IN00140003.</p> <p>9-3-2(a)</p> <p>483.440(c)(4) INDIVIDUAL PROGRAM PLAN The individual program plan states the specific objectives necessary to meet the client's needs, as identified by the comprehensive assessment required by paragraph (c)(3) of this section. Based on observation, interview and record review for 1 of 4 sampled clients</p>	W000227	The IDT met for Client C on 1/2/14 to discuss proper use of his 4 prong cane. Client C's ISP	01/18/2014			

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	<p>(C), the client's Individual Support Plan (ISP) failed to address the client's identified training need in regard to using a cane.</p> <p>Findings include:</p> <p>During the 12/12/13 observation period between 5:35 PM and 10:00 PM, at the group home, client C utilized a 4 prong cane for ambulation. Client C would carry the cane where it did not touch the floor when walking/taking long strides. Client C continued to carry the cane even when staff verbally prompted the client to keep the cane on the floor when he walked.</p> <p>The facility's reportable incident reports, internal incident reports and/or investigations were reviewed on 12/12/13 at 1:30 PM. The facility's reportable incident reports, internal incident reports and/or investigations indicated the following:</p> <p>-11/22/13 Client C was outside on the deck smoking a cigarette when he "...lost his footing and fell onto his bottom...." The reportable incident report indicated client C was not injured.</p> <p>-9/21/13 Client C fell getting out of bed to use the bathroom when he tripped on</p>		<p>and Risk Plan were updated to include changes including adding a training objective on proper use of his cane for ambulation. Staff in the home were retrained on Client C's updated plans on 1/7/14. The Home Manager and Program Director will review this training objective at least monthly to monitor for success or needed revisions.</p>				

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W000240	<p>a pile of clothes in his room. The reportable incident report indicated the clothes "cushioned his fall."</p> <p>Client C's record was reviewed on 12/12/13 at 9:28 PM. Client C's 6/24/13 ISP indicated client C was at risk for falls. Client C's 6/24/13 ISP did not indicate the client received training in regards to properly using his cane to prevent falls.</p> <p>Interview with staff #1 on 12/12/13 at 7:19 PM indicated client C had received training in regard to his cane at a previous placement. Staff #1 indicated client C's ISP did not include a formal objective/training in the proper use of his cane.</p> <p>9-3-4(a)</p> <p>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 1 of 4 sampled clients (A), the client's Individual Support Plan (ISP) failed to indicate how facility staff were to monitor/supervise the client to prevent potential falls as the client had a history of falls with fracture.</p>	W000240	Client A's ISP and Risk Plan were updated to include changes based on an IDT completed 1/3/14. Staff in the home were trained on these updated plans and his updated Fall Protocol on 1/7/14. Administrative staff will complete a Home Observation Sheet weekly when in the home	01/18/2014			

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	<p>Findings include:</p> <p>During the 12/12/13 observation period between 5:35 PM and 10:00 PM, at the group home, client A was in a wheelchair with a blue cast on the client's right arm. Client A moved around the group home with staff pushing the wheelchair and/or by moving the wheelchair with his feet. At 6:44 PM, while client A was seated at the dining room table, client A attempted to try and pull his cast off. Client A was redirected from touching/pulling at the cast. Staff #5 wheeled client A to the bathroom and stayed in the bathroom with client A. When staff wheeled client A out of the bathroom, client A was returned to the dining room table. Client A moved himself away from the table and moved his wheelchair, with his feet, to the living room area. Client A wore white tube socks (without shoes) which were not non-slip socks. Client A was heading back towards the bathroom. Qualified Intellectual Disabilities Professional (QIDP) #1 asked client A where he was going and directed staff #3 to assist client A to the bathroom. Staff #3 assisted client A in the bathroom and then came out of the bathroom leaving client A in the bathroom unsupervised.</p>		<p>for six weeks to ensure that staff are following the Fall Protocols accurately for the safety of the clients in the home and retrain staff or give corrective action as needed.</p>		

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	<p>After which, client A was placed in his bed for the night. Client A had bed rails half the length of the bed, and the client was lying on his back while sleeping.</p> <p>The facility's reportable incident reports, internal incident reports and/or investigations were reviewed on 12/12/13 at 1:30 PM. The facility's reportable incident reports, internal incident reports and/or investigations indicated the following:</p> <p>-3/11/13 "At 10am on 3/11/13, [client A] lost his balance and fell. It did not result in discernable injury....Upon investigating, [client A] showed no signs of injury. However, [client A] initially and briefly had complaints of pain that may or may not have been related to the fall--it is unclear because [client A] had (sic) limited communication skills and suffers from chronic pain...." The reportable incident indicated the client was taken to the emergency room as a "precaution" and an X-ray was completed which showed no fractures, but client A did develop a bruise (location not indicated).</p> <p>-6/5/13 at 12:00 AM, "Staff was assisting another individual when [client A] was needing to use the restroom. [Client A] has a bedside commode but</p>			

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	<p>refused to use it as he didn't want to have a BM (bowel movement) in the bedside commode. [Client A] was walking to the restroom using his walker when he got his feet tangled in it and fell to the floor. Staff assisted him to get up and checked him for any injuries and only saw a reddened area on his elbow. Preventative Measures to be put into place for [client A] are the following: The home will utilize night lights [Client A] will be prompted not to rush [Client A] will be prompted to use his walker at all times Staff will keep all areas free of clutter [Client A] will wear non-skid footwear [Client A] will keep personal items within reach especially during the night Staff will assist the client on and off the van for transport Staff will provide stand-by assistance as needed."</p> <p>The facility's 6/5/13 internal incident report indicated "[Client A] fell while ambulating to the bathroom. He did not appear to have any injuries at the time."</p> <p>-6/6/13 at 5:30 PM, "[Client A] had fallen earlier in the day and he appeared to not have an injury at that time and he went to his Day Program. While at Day Program [client A] made complaints of his arm hurting. Staff took [client A] to</p>			

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	<p>be seen by a physician at the [name of medical facility]. He was x-rayed and did not have any injuries. The physician stated t (sic) that he appeared to have a contusion. He did not prescribe any further treatment for [client A]. Continue to monitor [client A] and to continue to follow his fall protocol."</p> <p>The facility's 7/2/13 follow-up report indicated client A only fell one time on 6/5/13 and complained of pain on 6/6/13.</p> <p>-8/10/13 at 1:40 PM, "[Client A] had gone into the dining room to sit at the table. When he went to sit down he missed the chair and sat on the floor. He was checked for injuries by staff and there were no apparent injuries...Review fall protocol for revision."</p> <p>The facility's 10/25/13 follow-up report indicated if any further falls occurred, the client's fall protocol would be revised.</p> <p>-8/10/13 at 5:00 PM, "[Client A] was using his walker to go the restroom when he fell. Staff checked him for injuries. There was (sic) no apparent injuries but due to this being the second fall of the day [client A] was taken to the ER (emergency room) for an</p>			

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	<p>evaluation...The ER doctor said if this continues then have an MRI done as (sic)precaution...[Client A] is to have stand by assistance while ambulating. Nurse to review fall protocol..."</p> <p>The facility's 10/25/13 follow-up report indicated the same preventative measures as indicated in the above mentioned 6/5/13 incident. The follow-up report indicated "Stand by assistance was provided."</p> <p>-8/14/13 at 10:15 PM, "[Client A] fell from his bed while trying to get up. Staff found him sitting on the floor after the fall. There are no injuries reported."</p> <p>The facility's 10/26/13 follow-up report indicated "Protocol reviewed and is appropriate. [Client A] has not had any further falls since this incident...."</p> <p>The facility's 8/14/13 internal incident report indicated staff reported client A "...was unsteady getting of bed to use the restroom...."</p> <p>-11/11/13 at 12:00 PM, "[Client A] was at the dining room table when he pushed up with his hand on the table to stand and he fell on his bottom beside the table. He had not taken any steps and staff stated that he was weak due to</p>			

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	<p>having vomiting and diarrhea the previous day. [Client A] did have his walker at the time. Staff examined [client A] and he did not appear to have any bruising or injuries at the time of the fall. Due to being weak staff gave [client A] standby assistance until he was able to use his walker by himself."</p> <p>-11/13/13 "At 5 am the morning of 11/13/13 staff were assisting [client A] in dressing when they noticed the underside of wrists (sic) and arm appeared to be swollen. Staff notified group home RN and were instructed to take [client A] to the emergency room for an evaluation. [Client A] was diagnosed with a fracture of left arm underneath the plate he has in his arm from a previous fracture. [Client A] is to see an Orthopedic MD (medical doctor) on 11/14/13 to have the fracture evaluated for possible surgery. An order for a PRN (as needed) wheelchair has been obtained due [client A] will not be able to use his walker at this time (sic). At this time it is unknown how the fracture occurred and an investigation is underway. [Client A] has a current high risk plan for Potential for Fractures due to Osteoporosis (weak/brittle bones), and a High Risk plan for Falls. The group home RN is requesting a repeat DEXA (test of bone density) scan to be</p>			

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	<p>completed to measure [client A's] bone density. She is also consulting with physician to inquire if [client A] needs a different osteoporosis medication. The nurse will review all high risk plans to evaluate if any need to be revised, and the IDT (interdisciplinary team) will meet to discuss and make any necessary plan changes."</p> <p>The facility's 11/15/13 Summary of Internal Investigation Report indicated "On 11/11/13 [staff #6] reported that [client A] had a fall at the dining room table in which he scraped his right arm. The scrape was minor and there were no other visible signs of injury. [Staff #6] also reports that she is unaware of any other possible reasons for the injury...." The facility's investigation indicated when client A was taken to the ER for evaluation staff reported the doctor indicated client A had "...two breaks, one in his wrist under the plate and hardware and one in his arm...." The facility's investigation indicated client A was taken to the orthopedic doctor on 11/15/13 and the doctor indicated "...there is only a clean break in the arm and that the area in the wrist is from an old fracture...." The facility's 11/15/13 investigation indicated "...Conclusion: [Client A's] fall on 11/11/13 in which he scratched his right arm appears to have</p>			

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	<p>caused a fracture."</p> <p>-11/14/13 at 10:15 PM, "[Client A] was heard by staff to have a fall in his room on 11/14/13. Staff entered his room and found [client A] next to his bed. Staff evaluated [client A] for injuries. [Client A] had a quarter sized bruise on his elbow and did not appear to have any further injuries. Ice was applied to the area. The following measures have been implemented: Bed cane/safety bar obtained to put on bed to help [client A] to get up with support. Audio monitor put into place, 15 minute checks when [client A] is in his room at night. [Client A] had a physician's appointment on 11/15/13 already scheduled [client A] was examined and no further injuries were noted (sic)."</p> <p>The facility's 11/15/13 follow-up report indicated client A saw the orthopedic doctor and "...was placed in a short armed cast for 3 weeks and is to followup in 3 weeks to see how the fracture is healing. The orthopedist stated it was a cleanbreak (sic) and that surgery is not required at this time. [Client A] due to not being able to put weight on the arm is using a wheelchair for ambulation until the arm is healed. All Fall risk plans have been updated. Audio monitor has been placed in [client</p>			

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	<p>A's] room so that staff can hear if he tries to ambulate without his W/C (wheelchair). 15 minute checks have been put into place when [client A] is in his room. Bed cane/safety bar has been obtained until the bedrail that was ordered arrives. Continue to monitor all health needs...."</p> <p>-12/10/13 at 1:10 PM, "[Client A] had gone to the bathroom without asking staff to help him and he fell and scraped his shoulder. He was checked by staff and did not appear to have (sic) any further injuries. [Client A] resumed his normal activities of the day with no further incidents. [Client A] saw [name of orthopedist] on 12/11/13 and he was asked about OT (Occupational Therapy) and PT (Physical Therapy) evaluation for [client A]. [Name of orthopedist] stated that he didn't want to do the evaluations until the cast that [client A] had received on 11/13/13 was removed in 3 weeks. [Name of orthopedist] also stated that he wanted [client A] to attend a Bone Density clinic that was opening in January (2014)." The 12/10/13 reportable incident report did not indicate any additional measures were put in place to supervise/monitor client A outside the bedroom to prevent potential falls and/or injuries.</p>			

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	<p>Client A's record was reviewed on 12/12/13 at 7:55 PM. Client A's 1/23/13 Risk Management Assessment and Plan indicated client A was "Very unsteady on his feet, does use a walker to get around. Staff are to monitor physical movement and assist as needed for transfers." The risk management plan indicated client A had Osteoporosis and received medication for the condition.</p> <p>Client A's record indicated the following IDT Meeting Notes:</p> <p>-10/11/12 "IDT met to review [client A's] Fall Protocol and agreed that it appropriately addresses falls. Staff are being re-trained on fall prevention techniques."</p> <p>-11/15/13 "Team met to discuss measures to put into place to help prevent falls for [client A], HRC (Human Rights Committee) approval has been requested and approved to put the following into place. (sic)</p> <ol style="list-style-type: none"> 1. Audio monitor when in his room. 2. Bed rails to prevent falls from bed. 3. Wheelchair for ambulation. 4. Gait belt to assist (with transfers)." 5. 15 minute checks when in his room...." <p>-12/12/13 "Client A] saw [name of</p>						

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	<p>doctor], orthopedic surgeon on 12/11/13. [Name of doctor] was asked about doing an OT & PT referral & [name of doctor] says that he is going to recheck [client A] in 3 weeks & will complete referral then. The team agrees to follow [name of doctor's] recommendations. [Client A's] protocols were reviewed & appear appropriate. Protections will be reviewed again in 3 weeks after [client A] sees [name of doctor] again. It was also requested that [name of doctor] consider a DEXA Scan & changing [client A's] Fosamax to something that might work better. [Name of doctor] going to consider referral to Healthy bone clinic opening in January to address these issues."</p> <p>Client A's 12/12/13 IDT note indicated the facility failed to put any additional measures in place on how client A was to be supervised/monitored when outside his bedroom to prevent falls in the bathroom and other parts of the house.</p> <p>Interview with administrative staff #1 and QIDP #1 on 12/12/13 at 3:05 PM and on 12/13/13 at 11:30 AM indicated 15 minute checks, audio monitor and bed rails were put in place on 11/15/13 after client A fell on 11/14/13. QIDP #1 indicated client A fell on 11/11/13 which resulted in a fracture being</p>			

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W000331	<p>identified on 11/13/13. QIDP #1 indicated client A was placed in a wheelchair on 11/13/13 when it was discovered he had a fracture. When asked if client A's IDT met after the above mentioned falls prior to 11/11/13, administrative staff #1 and QIDP #1 indicated the home had undergone changes in the QIDP and they were not able to locate any additional IDTs in regard to client A's falls. QIDP #1 and administrative staff #1 indicated the client's IDT did not discuss how client A should be supervised/monitored after the 12/10/13 fall.</p> <p>This federal tag relates to complaint #IN00140003.</p> <p>9-3-4(a)</p> <p>483.460(c) NURSING SERVICES The facility must provide clients with nursing services in accordance with their needs. Based on observation, interview and record review for 1 of 4 sampled clients (A), the facility's nursing services failed to monitor/develop risk plans which specifically indicated how facility staff were to assist the client in daily living activities, hygiene and toileting to prevent falls. The facility's RN failed to assess the client after falls.</p>	W000331	<p>The IDT met for Client A on 1/3/14 to review his Fall Protocols and changes were made as needed to include specifically how facility staff are to assist Client A to toilet, bathe, dress and/or provide oral care to prevent falls/injuries. Client A's ISP and Risk Plan were updated to include changes based on an IDT completed 1/3/14. Staff in the home were</p>	01/18/2014			

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	<p>Findings include:</p> <p>During the 12/12/13 observation period between 5:35 PM and 10:00 PM, at the group home, client A was in a wheelchair with a blue cast on the client's right arm. Client A moved around the group home with staff pushing the wheelchair and/or by moving the wheelchair with his feet. At 6:44 PM, while client A was seated at the dining room table, client A attempted to try and pull his cast off. Client A was redirected from touching/pulling at the cast. Staff #5 wheeled client A to the bathroom and stayed in the bathroom with client A. When staff wheeled client A out of the bathroom, client A was returned to the dining room table. Client A moved himself away from the table and moved his wheelchair, with his feet, to the living room area. Client A wore white tube socks (without shoes) which were not non-slip socks. Client A was heading back towards the bathroom. Qualified Intellectual Disabilities Professional (QIDP) #1 asked client A where he was going and directed staff #3 to assist client A to the bathroom. Staff #3 assisted client A in the bathroom and then came out of the bathroom leaving client A in the bathroom unsupervised.</p>		<p>trained on these updated plans and his updated Fall Protocol on 1/7/14. The Home Manager and/or Program Director will check documentation in the home on a weekly basis to ensure it is completed accurately. Administrative staff will complete a Home Observation Sheet weekly when in the home for six weeks to ensure that staff are following the Fall Protocols accurately for the safety of the clients in the home and retrain staff or give corrective action as needed.</p>	

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	<p>After which, client A was placed in his bed for the night. Client A had bed rails (half length of the bed) on his bed, and the client was lying on his back while sleeping.</p> <p>The facility's reportable incident reports, internal incident reports and/or investigations were reviewed on 12/12/13 at 1:30 PM. The facility's reportable incident reports, internal incident reports and/or investigations indicated the following (not all inclusive):</p> <p>-11/11/13 at 12:00 PM, "[Client A] was at the dining room table when he pushed up with his hand on the table to stand and he fell on his bottom beside the table. He had not taken any steps and staff stated that he was weak due to having vomiting and diarrhea the previous day. [Client A] did have his walker at the time. Staff examined [client A] and he did not appear to have any bruising or injuries at the time of the fall. Due to being weak staff gave [client A] standby assistance until he was able to use his walker by himself."</p> <p>The facility's 11/11/13 Indiana Mentor Immediate Investigation of Injury indicated client A did not require any treatment. The investigation also</p>						

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	<p>indicated the facility's nurse instructed the staff to check the client for injuries. The investigation indicated there were no environmental dangers which may have caused the injury. The investigation indicated client A's fall protocol was updated on 11/14/13.</p> <p>-11/13/13 "At 5 am the morning of 11/13/13 staff were assisting [client A] in dressing when they noticed the underside of wrists (sic) and arm appeared to be swollen. Staff notified group home RN and were instructed to take [client A] to the emergency room for an evaluation. [Client A] was diagnosed with a fracture of left arm underneath the plate he has in his arm from a previous fracture. [Client A] is to see an Orthopedic MD (medical doctor) on 11/14/13 to have the fracture evaluated for possible surgery. An order for a PRN (as needed) wheelchair has been obtained due [client A] will not be able to use his walker at this time (sic). At this time it is unknown how the fracture occurred and an investigation is underway. [Client A] has a current high risk plan for Potential for Fractures due to Osteoporosis (weak/brittle bones), and a High Risk plan for Falls. The group home RN is requesting a repeat DEXA (test for bone density) scan to be completed to measure [client A's] bone</p>			

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	<p>density. She is also consulting with physician to inquire if [client A] needs a different osteoporosis medication. The nurse will review all high risk plans to evaluate if any need to be revised, and the IDT (interdisciplinary team) will meet to discuss and make any necessary plan changes."</p> <p>The facility's 11/15/13 Summary of Internal Investigation Report indicated "On 11/11/13 [staff #6] reported that [client A] had a fall at the dining room table in which he scraped his right arm. The scrape was minor and there were no other visible signs of injury. [Staff #6] also reports that she is unaware of any other possible reasons for the injury...." The facility's investigation indicated when client A was taken to the ER for evaluation staff reported the doctor indicated client A had "...two breaks, one in his wrist under the plate and hardware and one in his arm...." The facility's investigation indicated client A was taken to the orthopedic doctor on 11/15/13 and the doctor indicated "...there is only a clean break in the arm and that the area in the wrist is from an old fracture...."</p> <p>-11/14/13 at 10:15 PM, "[Client A] was heard by staff to have a fall in his room on 11/14/13. Staff entered his room and</p>			

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	<p>found [client A] next to his bed. Staff evaluated [client A] for injuries. [Client A] had a quarter sized bruise on his elbow and did not appear to have any further injuries. Ice was applied to the area. The following measures have been implemented: Bed cane/safety bar obtained to put on bed to help [client A] to get up with support. Audio monitor put into place, 15 minute checks when [client A] is in is room at night. [Client A] had a physician's appointment on 11/15/13 already scheduled [client A] was examined and no further injuries were noted (sic)."</p> <p>The facility's 11/15/13 follow-up report indicated client A saw the orthopedic doctor and "...was placed in a short armed cast for 3 weeks and is to followup in 3 weeks to see how the fracture is healing. The orthopedist stated it was a cleanbreak (sic) and that surgery is not required at this time. [Client A] due to not being able to put weight on the arm is using a wheelchair for ambulation until the arm is healed. All Fall risk plans have been updated. Audio monitor has been placed in [client A's] room so that staff can hear if he tries to ambulate without his W/C (wheelchair). 15 minute checks have been put into place when [client A] is in his room. Bed cane/safety bar has been</p>			

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	<p>obtained until the bedrail that was ordered arrives. Continue to monitor all health needs...."</p> <p>-12/10/13 at 1:10 PM, "[Client A] had gone to the bathroom without asking staff to help him and he fell and scraped his shoulder. He was checked by staff and did not appear to have (sic) any further injuries. [Client A] resumed his normal activities of the day with no further incidents. [Client A] saw [name of orthopedist] on 12/11/13 and he was asked about OT (Occupational Therapy) and PT (Physical Therapy) evaluation for [client A]. [Name of orthopedist] stated that he didn't want to do the evaluations until the cast that [client A] had received on 11/13/13 was removed in 3 weeks. [Name of orthopedist] also stated that he wanted [client A] to attend a Bone Density clinic that was opening in January (2014)."</p> <p>Client A's record was reviewed on 12/12/13 at 7:55 PM. Client A's Medical Appointment Forms indicated the following:</p> <p>-11/14/13 Client A was seen for "Broken arm into (sic) two places." The form indicated client A's doctor referred the client to an Orthopedist for consultation and treatment.</p>			

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	<p>-11/15/13 "11-15-13 Use wheelchair x (times) 3 weeks. -Currently have order for w/c (wheelchair) x 2 months in effect. The Orthopedist note indicated "Fx (fracture (R) (right) Ulna (bone in forearm). Cast 6 weeks, (change) in 3 (weeks)." Clarification: [Name of orthopedist] states will address possible need for repeat DEXA Scan & (and) Fosamax (osteoporosis) change after cast is completely removed." Cast care instructions were attached to the 11/15/13 form.</p> <p>-12/11/13 "Cast for 3 weeks and move fingers as tol (tolerated). RTO (return to office) 3 wks (weeks) for cast off xray & PT/OT referral. Consider referral to Healthy Bone Clinic in January."</p> <p>Client A's Health Care Coordination/Monthly Health Reviews indicated the following (not all inclusive):</p> <p>-11/11/13 "...Today (11/11)staff (sic) called to report [client A] fell while getting up from dining room table to use restroom, a nickel size scratch was noted to Rt (right) wrist and no signs of other injury were noted at that time. Staff were instructed to continue to monitor for any signs of developing injury."</p>			

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	<p>-11/13/13 "6:30a-Home manager reports swelling to Rt wrist this am that had previously not been present and [client A] is displaying guarding of Rt wrist this am, instructed to take him to emergency room for evaluation (sic)."</p> <p>-11/13/13 "10:53am-Home manager reports xray has shown a Rt wrist fracture at the site of a previous Rt wrist fracture repair. Wrist was splinted and arm placed in a sling and ice pack to be applied as instructed in ER. Home manager also getting a wheelchair order as [client A] will be unable to use his walker at this time."</p> <p>-11/15/13 3p-On 11/14 at 10:15pm staff reported that [client A] fell getting up ...only injury noted was small bruise to L (left) elbow, advised to monitor for any developing injuries...." Client A's record and/or 11/13 nursing notes indicated the facility's nurse did not assess the client after he fell on 11/14/13 as the client already had a fractured wrist from an 11/13/13 fall.</p> <p>Client A's 1/23/13 Risk Management Assessment and Plan indicated client A was "Very unsteady on his feet, does use a walker to get around. Staff are to monitor physical movement and assist as</p>						

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	<p>needed for transfers." The risk management plan indicated client A had Osteoporosis and received medication for the condition.</p> <p>Client A's 11/13/13 Fall Protocol indicated the following Preventative Measures:</p> <ul style="list-style-type: none"> "-Assist [client A] in moving around the home and getting on and off the van using a wheelchair. -Assist [client A] with all activities of daily living; toileting, bathing, oral care, dressing. -Assist [client A] by using a gait belt (if ordered) or a sheet tied at the waist anytime he is on his feet to steady him when: transferring to and from the wheelchair to the bed; transferring from the wheelchair to the commode- See Gait Belt Procedure. -Staff will keep all areas free of clutter. -[Client A] will wear non-skid footwear. -[Client A] will keep personal items within reach especially during the night. -[Client A] will encourage [client A] to use the restroom before bedtime and before leaving in the van..." Client A's 11/13/13 Fall Protocol did not specifically indicate how facility staff were to assist client A to toilet, bathe, dress and/or provide oral care to client A to prevent potential falls/injuries. 			

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	<p>Client A's 11/13/13 Altered Mobility due to Rt wrist fracture Protocol indicated facility staff were to do the following:</p> <p>"Assist [client A] in moving around the house using a wheelchair. Assist [client A] with all activities of daily living; toileting, bathing, oral care, dressing. Assist [client A] by using a gait belt (if ordered) or a sheet tied at the waist anytime he is on his feet to steady him when transferring to and from the wheelchair to the bed; transferring from the wheelchair to the commode- See gait belt procedure."</p> <p>Interview with RN #1 on 12/13/13 at 10:25 AM indicated client A had a history of falls. RN #1 stated client A's old DEXA scan indicated client A was a "Moderate risk for fractures." When asked what that meant, RN #1 stated "50/50 chance he could fracture if fall (sic)." RN #1 indicated facility staff should stay with the client when he was in the bathroom to ensure the client did not try to stand without staff and fall. RN #1 stated client A's fall protocols would need to be more specific on how staff were to "assist" the client. RN #1 indicated she updated client A's protocols on 11/13/13.</p>			

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