

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G520	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/18/2015
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NAME OF PROVIDER OR SUPPLIER DUNGARVIN INDIANA LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 6386 ELLSWORTH PL MERRILLVILLE, IN 46410
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W 0000 Bldg. 00	<p>This visit was for the investigation of complaint #IN00178955.</p> <p>Complaint #IN00178955: Substantiated, Federal and state deficiencies related to the allegation(s) are cited at W102, W104, W122, W149, W153, W154, W156, W318 and W331.</p> <p>Unrelated deficiency cited.</p> <p>Survey dates: 8/5, 8/6, 8/7 and 8/18/15.</p> <p>Facility Number: 001034 Provider Number: 15G520 AIM Number: 100245230</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9.</p>	W 0000		
W 0102 Bldg. 00	<p>483.410 GOVERNING BODY AND MANAGEMENT The facility must ensure that specific governing body and management requirements are met.</p> <p>Based on interview and record review, the governing body failed to meet the Condition of Participation: Governing Body for 1 of 4 sampled clients (A) and for 1 additional client (G). The governing body failed to exercise general policy and operating direction over the facility to</p>	W 0102	All staff at the facility will be retrained by 09/17/15 on the Dungarvin policy and procedure pertaining to Abuse/Neglect. The QIDP will be retrained by 09/17/15 on the expectation that all allegations of abuse/neglect must be reported to state	09/17/2015

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

TITLE

(X6) DATE

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

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	<p>ensure client A was not neglected in regard to falls. The governing body failed to exercise general policy and operating direction over the facility to ensure the facility reported allegations of abuse/neglect to state authorities; conducted thorough investigations and to ensure the facility completed investigations within 5 business days. The governing body failed to ensure the facility met the healthcare needs of a client.</p> <p>Findings include:</p> <p>1. The governing body failed to ensure the facility met the Condition of Participation: Client Protections for clients A and G. The governing body failed to ensure the facility implemented its written policy and procedures to prevent neglect of client A in regard to falls which resulted in jury to the client. The governing body failed to ensure the facility reported an allegation of neglect to state authorities in regard to client A's seizure/fall. The governing body failed to ensure the facility conducted a thorough investigation in regard to an allegation of staff to client neglect/abuse, and in regard to an allegation of verbal abuse. The governing body failed to ensure the facility investigations in regard to allegations of abuse and/or neglect</p>		<p>authorities within 24 hours. The QIDP will be retrained by 09/17/15 on how to conduct thorough investigations and the requirement that investigations are to be completed within 5 business days, with results sent to the administrator and state officials. The QIDP will also be retrained by 09/17/15 on how to properly store the incident reports and investigation packets in order to be readily available when requested upon for review. This will ensure that there is a reproducible system in place. By 09/17/15, the QIDP and Area Director will create a new investigation summary tool to use specifically when any individual at the facility has a fall. The new investigation tool pertaining to a fall will be used to assess if the fall was related to a staff error for not following protocol or risk plan, change in medication, a change in medical status, or an environmental concern. Within 5 business days, this investigation summary will be attached to an internal incident report (pertaining to a fall) and/or the formal incident report (pertaining to a fall with injury) that is submitted to the state officials for review. Going forward, all completed investigation summaries pertaining to a fall will also be reviewed by the QIDP and the facility nurse on a weekly basis at their weekly facility medical</p>	

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	<p>were completed in 5 business days. Please see W122.</p> <p>2. The governing body failed to ensure the facility met the Condition of Participation: Health Care Services for client A. The governing body failed to ensure the facility's Health Care Services met the healthcare and nursing needs of each client who resided at the facility. Please see W318.</p> <p>3. The governing body failed to ensure the facility implemented its written policies and procedures to prevent neglect of client A in regard to falls and/or falls which resulted in significant injuries/fractures. The governing body failed to ensure the facility reported an allegation of possible neglect in regard to a fractured jaw to state officials (Bureau of Developmental Disabilities Services and/or to Adult Protective Services (APS) as the facility did not have a reproducible system in place. The governing body failed to ensure the facility implemented its written policy and procedures to conduct thorough investigations in regard to client A's falls to ensure the client was not neglected, and to investigate an allegation of staff to client verbal abuse regarding client G. The governing body failed to ensure the facility completed investigations within 5</p>		<p>support team meeting. The agenda and minutes of the meeting are submitted by the facility nurse to the Nursing Services Director and the Area Director on a weekly basis for additional monitoring and quality assurance. The facility nurse will be retrained on the standards pertaining to health care services at the facility by 09/17/15. The training will include the expectation that nursing services should assess, monitor and document the health care needs of all individuals residing at the facility. An aspect of that documentation is ensuring that all medical records from appointments and hospitalizations are obtained and clarification on orders is sought for any discrepancies. In addition, the facility nurse will be retrained by 09/17/15 on the expectation that risk plans are to be created and/or revised when an individual has a change in medical condition in order that the staff may be trained on how to properly provide care and treatment to the individual. An audit will be conducted by 09/17/15 by the QIDP and/or facility nurse to ensure that each individual in the facility has current risk plans in place. If any risk plans are needed, they will be created/revised and updated by 09/25/17 and all staff will be trained on the updated plans by 10/2/15 (if needed). The QIDP</p>	

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	<p>business days to report the results to the administrator and to state officials.</p> <p>The governing body failed to ensure the facility reported an allegation of neglect regarding client A's fractured jaw to the state officials (Bureau of Developmental Disabilities Services (BDDS) and/or to Adult Protective Services). The governing body failed to ensure the facility conducted an investigation and/or conducted thorough investigations in regard to allegations of abuse, neglect and/or injuries of unknown source for clients A and G. The governing body failed to ensure the facility completed an investigation in regard to staff to client abuse within 5 working days for client A.</p> <p>The governing body failed to ensure its nursing services met the health care needs of clients. The governing body failed to ensure its nursing services assessed, monitored and/or documented assessments of client A. The governing body failed to ensure nursing services developed a risk plan for the client's clavicle fracture to ensure staff knew how to care for the client, and/or failed to revise the client's risk plans as needed. The governing body failed to ensure its nursing services obtained clarification and/or documentation of a doctor's statement in regard to the client's</p>		<p>and the facility nurse will be retrained by 09/17/15 on the expectation that physician's orders are required for all adaptive equipment needs and uses for each individual in the facility. An audit will be conducted by 09/17/15 by the QIDP (or designee) on the adaptive equipment orders for all individuals residing in the facility. This audit will ensure that orders are on file for all adaptive equipment uses/needs for each individual in the facility. Going forward, incident reports, risk plans and physician's orders are to be reviewed weekly at the QIDP and Facility Nurse medical support team meeting. The facility nurse forwards the agenda/minutes of the meeting to the Nursing Services Director and the Area Director on a weekly basis for additional monitoring and quality assurance.</p> <p>Update:</p> <p>We have looked at the role of the QIDP as the primary investigator and if that may detract from other duties of the QIDP. When each incident is reported, there is a discussion to identify who the best person is to assign to the investigation given current duties. If the QIDP is not able to successfully investigate and manage their other duties, then we assign it to someone else to</p>	

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W 0104 Bldg. 00	<p>fracture. The governing body failed to ensure its nursing services obtained a physician's order in regard to the use of a gait belt for client A. Please see W104.</p> <p>This federal tag relates to complaint #IN00178955.</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 on interview and record review for 1 of 4 sampled clients (A) and for 1 additional client (G), the governing body failed to exercise general policy and operating direction over the facility to ensure client A was not neglected in regard to falls. The governing body failed to exercise general policy and operating direction over the facility to ensure the facility reported allegations of abuse/neglect to state authorities; conducted thorough investigations and to ensure the facility completed investigations within 5 business days. The governing body failed to exercise general policy and operating direction over the facility to ensure a client's healthcare needs were met.</p>			W 0104	<p>investigate. We may not have always reassigned the investigations, but it is a valid concern that we should be evaluating for each allegation.</p> <p>All staff at the facility will be retrained by 09/17/15 on the Dungarvin policy and procedure pertaining to Abuse/Neglect. The QIDP will be retrained by 09/17/15 on the expectation that all allegations of abuse/neglect must be reported to state authorities within 24 hours. The QIDP will be retrained by 09/17/15 on how to conduct thorough investigations and the requirement that investigations are to be completed within 5 business days, with results sent to the administrator and state officials. The QIDP will also be retrained by 09/17/15 on how to properly store the incident reports and investigation packets in order to be readily available when requested upon for review. This will ensure that there is a reproducible system in place.</p>		09/17/2015

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	<p>Findings include:</p> <p>The governing body failed to exercise general policy and operating direction over the facility to ensure the facility implemented its written policies and procedures to prevent neglect of client A in regard to falls and/or falls which resulted in significant injuries/fractures. The governing body failed to exercise general policy and operating direction over the facility to report an allegation of possible neglect in regard to a fractured jaw to state officials (Bureau of Developmental Disabilities Services and/or to Adult Protective Services (APS) as the facility did not have a reproducible system in place. The governing body failed to exercise general policy and operating direction over the facility to ensure the facility implemented its written policy and procedures to conduct thorough investigations in regard to client A's falls to ensure the client was not neglected, and to investigate an allegation of staff to client verbal abuse regarding client G. The governing body failed to exercise general policy and operating direction over the facility to ensure the facility completed investigations within 5 business days to report the results to the administrator and to state officials. Please see W149.</p>		<p>By 09/17/15, the QIDP and Area Director will create a new investigation summary tool to use specifically when any individual at the facility has a fall. The new investigation tool pertaining to a fall will be used to assess if the fall was related to a staff error for not following protocol or risk plan, change in medication, a change in medical status, or an environmental concern. Within 5 business days, this investigation summary will be attached to an internal incident report (pertaining to a fall) and/or the formal incident report (pertaining to a fall with injury) that is submitted to the state officials for review. Going forward, all completed investigation summaries pertaining to a fall will also be reviewed by the QIDP and the facility nurse on a weekly basis at their weekly facility medical support team meeting. The agenda and minutes of the meeting are submitted by the facility nurse to the Nursing Services Director and the Area Director on a weekly basis for additional monitoring and quality assurance. The facility nurse will be retrained on the standards pertaining to health care services at the facility by 09/17/15. The training will include the expectation that nursing services should assess, monitor and document the health care needs of all individuals residing at the</p>		

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	<p>2. The governing body failed to exercise general policy and operating direction over the facility to ensure the facility reported an allegation of neglect regarding client A's fractured jaw to the state officials (Bureau of Developmental Disabilities Services (BDDS) and/or to Adult Protective Services). Please see W153.</p> <p>3. The governing body failed to exercise general policy and operating direction over the facility to ensure the facility conducted an investigation and/or conducted thorough investigations in regard to allegations of abuse, neglect and/or injuries of unknown source for clients A and G. Please see W154.</p> <p>4. The governing body failed to exercise general policy and operating direction over the facility to ensure the facility completed an investigation in regard to staff to client abuse within 5 working days for client A. Please see W156.</p> <p>5. The governing body failed to exercise general policy and operating direction over the facility to ensure its nursing services met the health care needs of clients. The governing body failed to exercise general policy and operating direction over the facility to ensure its nursing services assessed, monitored</p>		<p>facility. An aspect of that documentation is ensuring that all medical records from appointments and hospitalizations are obtained and clarification on orders is sought for any discrepancies. In addition, the facility nurse will be retrained by 09/17/15 on the expectation that risk plans are to be created and/or revised when an individual has a change in medical condition in order that the staff may be trained on how to properly provide care and treatment to the individual. An audit will be conducted by 09/17/15 by the QIDP and/or facility nurse to ensure that each individual in the facility has current risk plans in place. If any risk plans are needed, they will be created/revised and updated by 09/25/17 and all staff will be trained on the updated plans by 10/2/15 (if needed). The QIDP and the facility nurse will be retrained by 09/17/15 on the expectation that physician's orders are required for all adaptive equipment needs and uses for each individual in the facility. An audit will be conducted by 09/17/15 by the QIDP (or designee) on the adaptive equipment orders for all individuals residing in the facility. This audit will ensure that orders are on file for all adaptive equipment uses/needs for each individual in the facility. Going forward, incident reports, risk</p>	

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W 0122 Bldg. 00	<p>and/or documented assessments of client A; developed a risk plan for the client's clavicle fracture to ensure staff knew how to care for the client, and/or to ensure its nursing services revised the client's risk plans as needed. The governing body failed to exercise general policy and operating direction over the facility to ensure its nursing services obtained clarification and/or documentation of a doctor's statement in regard to the client's fracture. The governing body failed to exercise general policy and operating direction over the facility to ensure its nursing services obtained a physician's order in regard to the use of a gait belt for client A. Please see W331.</p> <p>This federal tag relates to complaint #IN00178955.</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 interview and record review, the facility failed to meet the Condition of Participation: Client Protections for 1 of 4 sampled clients (A) and for 1</p>	W 0122	<p>plans and physician's orders are to be reviewed weekly at the QIDP and Facility Nurse medical support team meeting. The facility nurse forwards the agenda/minutes of the meeting to the Nursing Services Director and the Area Director on a weekly basis for additional monitoring and quality assurance.</p> <p>Update:</p> <p>We have looked at the role of the QIDP as the primary investigator and if that may detract from other duties of the QIDP. When each incident is reported, there is a discussion to identify who the best person is to assign to the investigation given current duties. If the QIDP is not able to successfully investigate and manage their other duties, then we assign it to someone else to investigate. We may not have always reassigned the investigations, but it is a valid concern that we should be evaluating for each allegation.</p> <p>All staff at the facility will be retrained by 09/17/15 on the Dungarvin policy and procedure pertaining to Abuse/Neglect. The QIDP will be retrained by</p>	09/17/2015

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	<p>additional client (G). The facility failed to implement its written policy and procedures to prevent neglect of client A in regard to falls which resulted in injury to the client. The facility failed to report an allegation of neglect to state authorities in regard to client A's seizure/fall. The facility failed to conduct a thorough investigation in regard to an allegation of staff to client neglect/abuse and in regard to an allegation of verbal abuse. The facility failed to ensure all investigations in regard to allegations of abuse and/or neglect were completed in 5 business days.</p> <p>Findings include:</p> <ol style="list-style-type: none"> The facility failed to implement its written policies and procedures to prevent neglect of client A in regard to falls which resulted in significant injuries/fractures, and/or falls without injuries. The facility failed to report all falls/allegation of possible neglect in regard to a fractured jaw to state officials (Bureau of Developmental Disabilities Services and/or to Adult Protective Services (APS) as the facility did not have a reproducible system in place. The facility failed to implement its written policy and procedures to conduct thorough investigations in regard to client A's falls to ensure the client was not 		<p>09/17/15 on the expectation that all allegations of abuse/neglect must be reported to state authorities within 24 hours. The QIDP will be retrained by 09/17/15 on how to conduct thorough investigations and the requirement that investigations are to be completed within 5 business days, with results sent to the administrator and state officials. The QIDP will also be retrained by 09/17/15 on how to properly store the incident reports and investigation packets in order to be readily available when requested upon for review. This will ensure that there is a reproducible system in place. By 09/17/15, the QIDP and Area Director will create a new investigation summary tool to use specifically when any individual at the facility has a fall. The new investigation tool pertaining to a fall will be used to assess if the fall was related to a staff error for not following protocol or risk plan, change in medication, a change in medical status, or an environmental concern. Within 5 business days, this investigation summary will be attached to an internal incident report (pertaining to a fall) and/or the formal incident report (pertaining to a fall with injury) that is submitted to the state officials for review. Going forward, all completed investigation summaries pertaining to a fall will also be</p>	

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W 0149	<p>neglected, and to investigate an allegation of staff to client verbal abuse regarding client G. The facility also failed to ensure results of all investigations were completed within 5 business days and reported to the administrator and to state officials. Please see W149.</p> <p>2. The facility failed to report an allegation of neglect regarding client A's fractured jaw to the state officials (Bureau of Developmental Disabilities Services (BDDS) and/or to Adult Protective Services). Please see W153.</p> <p>3. The facility failed to conduct an investigation and/or failed to conduct thorough investigations in regard to allegations of abuse, neglect and/or injuries of unknown source reviewed for clients A and G. Please see W154.</p> <p>4. The facility failed to complete an investigation in regard to staff to client abuse within 5 working days for client A. Please see W156.</p> <p>This federal tag relates to complaint #IN00178955.</p> <p>9-3-2(a)</p> <p>483.420(d)(1) STAFF TREATMENT OF CLIENTS</p>		<p>reviewed by the QIDP and the facility nurse on a weekly basis at their weekly facility medical support team meeting. The agenda and minutes of the meeting are submitted by the facility nurse to the Nursing Services Director and the Area Director on a weekly basis for additional monitoring and quality assurance.</p> <p>Update:</p> <p>We have looked at the role of the QIDP as the primary investigator and if that may detract from other duties of the QIDP. When each incident is reported, there is a discussion to identify who the best person is to assign to the investigation given current duties. If the QIDP is not able to successfully investigate and manage their other duties, then we assign it to someone else to investigate. We may not have always reassigned the investigations, but it is a valid concern that we should be evaluating for each allegation.</p>				

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Bldg. 00	<p>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. Based on interview and record review for 1 of 4 sampled clients (A) and for 1 additional client (G), the facility neglected to implement its written policies and procedures to prevent neglect of client A in regard to falls which resulted in significant injuries/fractures, and/or falls without injuries. The facility neglected to report all falls/allegation of possible neglect in regard to a fractured jaw to state officials (Bureau of Developmental Disabilities Services and/or to Adult Protective Services (APS) as the facility neglected to have a reproducible system to provide the reportable incident report. The facility neglected to implement its written policy and procedures to conduct thorough investigations in regard to client A's falls to ensure the client was not neglected, and to investigate an allegation of staff to client verbal abuse regarding client G. The facility also failed to ensure all results of investigations were completed within 5 business days to the administrator and/or to state officials.</p> <p>Findings include:</p> <p>1. The facility's reportable incident reports and/or investigations were</p>	W 0149	<p>All staff at the facility will be retrained by 09/17/15 on the Dungarvin policy and procedure pertaining to Abuse/Neglect. The QIDP will be retrained by 09/17/15 on the expectation that all allegations of abuse/neglect must be reported to state authorities within 24 hours. The QIDP will be retrained by 09/17/15 on how to conduct thorough investigations and the requirement that investigations are to be completed within 5 business days, with results sent to the administrator and state officials. The QIDP will also be retrained by 09/17/15 on how to properly store the incident reports and investigation packets in order to be readily available when requested upon for review. This will ensure that there is a reproducible system in place. By 09/17/15, the QIDP and Area Director will create a new investigation summary tool to use specifically when any individual at the facility has a fall. The new investigation tool pertaining to a fall will be used to assess if the fall was related to a staff error for not following protocol or risk plan, change in medication, a change in medical status, or an environmental concern. Within 5 business days, this investigation summary will be attached to an internal incident</p>	09/17/2015

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	<p>reviewed on 8/5/15 at 2:40 PM. The facility's reportable incident reports and/or investigations indicated the following (not all inclusive):</p> <p>-5/16/15 "[Client A] had a laceration on the back of her head due to falling off of her bed and into the dresser. [Client A] was taken to the ER (emergency room) per the nurse on call. The Doctor in the emergency room put three staples in [client A's] head. The ER doctor requested that [client A] follow-up with her doctor in one week. Staff will continue to monitor [client A] and make sure that she get the best medical care possible when needed."</p> <p>The facility's 6/2/15 follow-up report to the 5/6/15 reportable incident report indicated client A had fallen in her bedroom attempting to watch a movie. The facility's reportable incident report indicated "To prevent future injuries the area around [client A's] bed had been padded. [Client A's] dresser also now has edge bumpers in place...."</p> <p>-7/13/15 "[Client A] had a series of back to back seizures, which is not normal for her. Typically [client A] has one seizure and may have more later in in the day, but not repeatedly following each other. [Client A's] doctor was contacted but she</p>		<p>report (pertaining to a fall) and/or the formal incident report (pertaining to a fall with injury) that is submitted to the state officials for review. By 09/17/15 the QIDP and Area Director will create a communication checklist to include questions related to incidents, falls, and injuries of an individual that may have occurred prior to attending day program or while at the day program. The communication book for each individual will be exchanged between the residential provider and the day service provider. Going forward, all completed investigation summaries pertaining to a fall will also be reviewed by the QIDP and the facility nurse on a weekly basis at their weekly facility medical support team meeting. The agenda and minutes of the meeting are submitted by the facility nurse to the Nursing Services Director and the Area Director on a weekly basis for additional monitoring and quality assurance. The facility nurse will be retrained on the standards pertaining to health care services at the facility by 09/17/15. The training will include the expectation that nursing services should assess, monitor and document the health care needs of all individuals residing at the facility. An aspect of that documentation is ensuring that all medical records from</p>	

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	<p>could not be seen on the 13th. [Client A] was taken to [name of hospital] for an evaluation. Her seizure medication was increased and she was referred back to her neurologist...."</p> <p>-7/22/15 "When [client A] arrived home from Workshop, she came into the site and set (sic) on the sofa next to this staff (Program Director-PD #2). [Client A] leaned her head towards staff shoulder. Staff asked her what was wrong and she began to cry and say her right arm was hurting. She said her right elbow was hurting as well. Staff calmed her down and asked her to sit straight up and left her head up. [Client A] did and stopped crying. Staff then told her to do what staff does. Staff held out her arms in front of her and asked [client A] to do the same. She did, but was favoring the right arm. Staff raised both arms straight up and asked [client A] to do the same. [Client A] raised the left arm but not the right arm. Staff asked her to do her right arm and [client A] said, 'I can't. It hurts.' Staff told her to try and she said, 'I can't.' By then the staff that transported (sic) was coming in the door and said that [client A] reported it happened at workshop. Staff noticed that she had a lump on her right shoulder. Staff said the Workshop staff denied [client A] falling at workshop. However [client A] was</p>		<p>appointments and hospitalizations are obtained and clarification on orders is sought for any discrepancies. The facility nurse will pursue online charting options (electronic medical record) available through each individuals medical provider so that a high quality continuum of care of is maintained. In addition, the facility nurse will be retrained by 09/17/15 on the expectation that risk plans are to be created and/or revised when an individual has a change in medical condition in order that the staff may be trained on how to properly provide care and treatment to the individual. An audit will be conducted by 09/17/15 by the QIDP and/or facility nurse to ensure that each individual in the facility has current risk plans in place. If any risk plans are needed, they will be created/revised and updated by 09/25/17 and all staff will be trained on the updated plans by 10/2/15 (if needed). The interdisciplinary team for each individual will meet a minimum of twice per year (quarterly if needed) to review prior incident reports, goal progression, risk plans and any other concerns. Revisions and updates will be made (as needed) and all facility staff will be retrained on any new or revised goals and risk plans within 7 days. The QIDP and the facility nurse will be retrained by 09/17/15 on the expectation</p>	

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	adamant that someone by the name of [day program staff #3] had pushed her down and hurt her arm at workshop. Staff reached for [client A's] right arm and she pulled away. Staff told her to wait and let her look at it. When staff pulled her blouse down, she had a lump about the size of a half a golf ball on her shoulder about two inches from her neck. Staff advised the transport staff to call the nurse immediately because it appeared to be a dislocation. Another staff called the On-call Nurse and On-call PD. The nurse instructed staff to take [client A] to ER (emergency room). At approximately 5:3pm (sic) staff transported [client A] to [name of hospital]. [Client A] was still favoring her right arm and did not want it touched. [Client A] was called to the back around 7:30 p.m. The doctor saw [client A] and said to undress her to her waist for x-rays to be taken. The Xray showed that she had a fracture of the clavicle...Dungarvin began an investigation today (7/23/15) (sic) all 3 Dungarvin staff was (sic) interviewed that came in contact with [client A] prior to attending [name of day program]. All staff indicated that she (client A) was not in any pain and did not have any falls nor incidents. [Client A] was taken to see her hematologist [name of doctor] on July 22, 2015 before taking her to day program and her arm was not fractured or		that physician's orders are required for all adaptive equipment needs and uses for each individual in the facility. An audit will be conducted by 09/17/15 by the QIDP (or designee) on the adaptive equipment orders for all individuals residing in the facility. This audit will ensure that orders are on file for all adaptive equipment uses/needs for each individual in the facility. Going forward, incident reports, risk plans and physician's orders are to be reviewed weekly at the QIDP and Facility Nurse medical support team meeting. The facility nurse forwards the agenda/minutes of the meeting to the Nursing Services Director and the Area Director on a weekly basis for additional monitoring and quality assurance. Update: We have looked at the role of the QIDP as the primary investigator and if that may detract from other duties of the QIDP. When each incident is reported, there is a discussion to identify who the best person is to assign to the investigation given current duties. If the QIDP is not able to successfully investigate and manage their other duties, then we assign it to someone else to investigate. We may not have always reassigned the investigations,	

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	<p>dislocated and had blood drawn in that exact same arm by the assistant.</p> <p>Dungarvin has requested internal incident reports from [name of day program] on 7/23/15 and has not received them yet. [Client A] will remain in Dungarvin care until a full investigation is completed by [name of day program] regarding the allegation made by [client A] against a staff member by the name of '[day program staff #3].' [Client A's] story has not changed and she is adamant regarding [day program staff #3] pushing her down and pressing on her head while down on the floor."</p> <p>The facility's 7/30/15 follow-up to the 7/22/15 reportable incident report indicated "After speaking with day program staff it was determined there was a staff named '[nick name of DP staff #3].' His real name is [DP staff #3]. At this time it is not clear if [DP staff #3] was suspended. The day program is stating that there was no incident at all regarding [client A]. They are stating that [client A] came in with the injury. However, [client A] had a doctor's appointment that morning and then went to the hospital for lab work. [Client A's] injury is extensive enough that a medical professional would have noticed it. [Client A] is scheduled to have her procedure completed during the week of</p>		<p>but it is a valid concern that we should be evaluating for each allegation.</p>	

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	<p>8/3/2015, once her doctor schedules it... [Client A] has not returned to the day program. She is being singled staff at home to prevent any further irritation of the injury. The Program Director of residential services has reached out to the day program for an investigation summary and is awaiting a response."</p> <p>The facility's 7/23 and 7/24/15 attached investigation statements consisted of interviews with client A and staff at the group home which indicated the following (not all inclusive):</p> <p>-7/23/15 PD #2 indicated client A was interviewed on 7/24/15 at the group home. Client A's witness statement indicated "[Client A] was asked what happened to her? She stated that [DP staff #3] pushed her down and hurt her arm. [Client A] was then asked where was at day program building when this happen (sic)? She replied that she was in the class room watching a movie. [Client A] was asked if anyone was around and she replied yes, clients. [Client A] was asked if her arms were up just before the fall. Yes replied that she (sic) 'I don't remember honey.' [Client A] was asked if this happen (sic) this week or last week and stated 'last week.' [Client A] was asked did this happen on the same day [staff #4] took her to get her blood work</p>			

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	<p>or the day her gate (sic) belt broke. She replied 'the day I got my blood work.' [Client A] then stated that she did not want to see [DP staff #3] anymore. We talked about her guardian for a while and then I went back to ask her. (sic) Who (sic) hurt her arm and she replied [DP staff #3]. I (PD #2) asked [client A] if [DP staff #3] try to help her the day her gate (sic) belt broke and she replied yes. [Client A] was asked did someone keep her from falling down the day her hat (sic) belt broke and she replied 'Yes.' She was asked who and she said '[DP staff #3].' [Client A] was asked if [DP staff #3] did by accident and she stated 'no he was hitting my shoulder like crazy.' "</p> <p>-7/23/15 Witness statement by staff #5 indicated on Wednesday 7/21/15 on the midnight shift, staff #5 indicated staff #5 assisted client A to complete her hygiene and dress for the morning. Staff #5's witness statement indicated client A did not have any injuries and/or complaints of pain with her arm. Staff #5's witness statement indicated when staff #5 came back in on 7/22/15 at midnight, client A was at the hospital. Staff #5's witness statement indicated staff #5 asked client A what happened when client A returned to the group home. The statement indicated "...she then spoke of a person named [nick name for DP staff #3] had</p>			

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	<p>pushed her down at workshop. staff (sic) then asked was he or she a client or staff and she replied that he's a client..."</p> <p>-Staff #4's 7/23/15 witness statement indicated staff #4 took client A to her hematologist appointment on 7/22/15. Staff #5's 7/23/15 statement indicated client A's arm "...was not fractured or dislocated. [Client A] got blood drawn in that exact same arm by the assistant..." Staff #5's witness statement indicated "...I also know that on July 13, 2015 [client A] was taken to the emergency room due to having seizures since Friday July 10, 2015 that starting (sic) at the day program on into the weekend and while she was there they checked her arm and it only had a carpet burn and they said nothing was broken/fractured. She has seen a couple of Drs (doctors) since the time her day program has stated they told about [client A] falling and there wasn't (sic) any concerns then (sic)." The facility's 7/22/15 reportable incident report and/or attached witness statements indicated the facility neglected to conduct a thorough investigation in regard to client A's fractured shoulder. There were no additional interviews, conclusion and/or recommendations attached to the reportable incident report as of 8/5/15.</p> <p>The day program's Immediate</p>			

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	<p>Investigation of Injury reports, reportable incident reports and/or investigations were reviewed on 8/5/15 at 11:45 AM. The day program's incident reports, reportable incident reports and/or investigations indicated the following:</p> <p>-7/17/15 "On 7-17-15 I (day program staff #6) assisted [client A] to the bathroom @ (at) that time while [client A] was sitting on the toilet. she complained that her right arm was hurting her. I asked her what happened, [client A] stated she fell @ home and broke her arm. I told her PD (Program Director at Day Program-DPPD)- and she called [PD #1]. [PD #1] stated to [DPPD] that [client A] was faking. [Client A] stated that she fell @ home previous to today on 7-16-15. No treatment provided because [DPPD] contacted [PD #1] @ Dungarvin- [PD #1] stated that [client A] was faking because another client had a broken limb in the house an (sic) [client A] wanted the same attention that staff (sic) was getting. [PD #1] states that she already filed a BDDS (Bureau of Developmental Disabilities Services) report and [client A] had been to the doctor regarding the injury she is alleging. She (PD #1) also states that she will include [DPPD] in any future BDDS report regarding [client A]."</p>			

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	<p>-7/20/15 "[Day program staff #5] took [client A] to bathroom and [client A] asked for privacy. [Day program staff #5] lefted (sic) out of the bathroom. [Client A] was seen walking out by herself. Staff C (day program staff #3) saw her falling and dived under her breaking...." The day program's incident report indicated client A's "Gait belt broke (C) staff (day program staff #3) dived under [client A] to break fall. [Client A] was coming from bathroom. (C) staff (day program staff #3) was coming from maintenance room by the bathroom."</p> <p>-The day program's 7/28/15 Summary of Internal Investigation Report regarding the facility's above mentioned 7/22/15 reportable incident report indicated day program staff #3 was suspended pending the outcome of the investigation for client A's allegation of staff to client abuse. The day program's investigation indicated all day program staff, clients at the day program, client A and one direct care staff from the group home were interviewed. The day program's investigation indicated client A was interviewed by phone with residential staff (staff #4). The investigation indicated "...This writer (Quality Assurance staff #1) asked [client A] what happened. [Client A] with (sic)</p>			

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	<p>something that was not understandable with the exception of '[nick name of day program staff #3].' This writer asked her to repeat if she could, when she did it sounded as if she said that 'me and [name of staff #3], she fell.' This writer asked [client A] if she fell and she said 'yeah.' The staff person with her during the call interjected, 'No remember what you said happened. Someone pushed you down.' This writer asked her if she had gone to the bathroom and fell coming out of the bathroom and [client A] repeated 'in the bathroom, fell and [day program staff #3] helped me.' This writer heard [staff #4], interrupt [client A] a second time and stating 'no, she is asking how you hurt your neck, remember, you said that [name of day program staff #3] pushed you down.' [Client A] responded 'yeah, she had asked for help in the bathroom and he pushed her down.' This writer asked [client A] who pushed her down-Did [name of day program staff #3] push you down and she said, 'He didn't.' [Client A] stated that "he pulled her belt to help her.' This writer asked if her gait belt broke and the staff present (staff #4) said 'yes, but that was a different day.' At this time, [staff #4] said, 'This is what happened the other time when she was interviewed; she began to get upset and not making sense.' This writer asked if she felt it would be</p>			

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	<p>better to talk with her in person and she said, 'It probably wouldn't be any different.' [Staff #4] then said '[Client A] has said that [name of day program staff #3] pushed her from the beginning and hasn't changed her story'...."</p> <p>The day program's 7/28/15 investigation indicated the "[Day Program Coordinator (DPC)] stated that when [client A] is walking, staff should always be with her to hold on to her gait belt...." The undated interview indicated "...[DPC] day program staff were to stay near the bathroom so the staff could hear client A call for them when she was ready to leave the bathroom. The DPC undated interview indicated "...[DPC] stated that she has not seen or received any reports of any staff pushing [client A] down or holding her down. [DPC] stated that on Wednesday, July 22nd [day program staff #4] noticed a large lump/bruise on [client A's] right shoulder and brought it to her (DPC) attention. [DPC] stated that she notified her supervisor, [DPPD] of this the afternoon on July 22nd and was instructed to notify [client A's] residential staff when they picked her up which she did...." The DPC undated witness statement indicated "...that [client A] had not complained to her about her arm hurting, but she (client A) had complained to [day program staff #4] that</p>			

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	<p>her arm was hurting on Friday, July 17th..." prior to her fall at the day program on 7/20/15.</p> <p>The day program's 7/28/15 investigation indicated day program staff #4 was interviewed on an unknown date. Day program staff's undated interview indicated client A required staff assistance to ambulate with a gait belt. DP staff #4 statement indicated client A would sometimes request privacy when the client was using the bathroom. DP staff #4 statement indicated "...When she does that, staff stays near the bathroom to listen for her to call for them. [DP staff #4] stated that on the day that [client A's] gait belt broke, Monday July 20th [DP staff #5] had assisted her (client A) to the restroom and [client A] asked for privacy so she stepped out of the bathroom. [DP staff #4] stated that [client A] came out of the bathroom and started to fall but [DP staff #3] was coming out of the men's bathroom and grabbed [client A's] gait belt and it broke and he ended up underneath her breaking her fall. [DP staff #4] stated that on Friday, July 17th, she (DP staff #4) was in the bathroom with [client A] when [client A] said that her right arm was hurting and she seemed to be favoring it, holding it to her body. [DP staff #4] stated that she asked what happened and [client A] said that she had</p>			
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	<p>fallen out of bed at home and broke her arm...[Client A] complained about her arm hurting most of the day and ever since that day she has been crankier..." DP staff #4's witness statement indicated DP staff #4 reported client A's complaints of her arm to her DPPD who called PD #1 about client A's arm pain on 7/17/15.</p> <p>The day program's 7/28/15 investigation indicated "...[DP staff #5] stated that she had taken her (client A) to the bathroom on Monday, July 20th and left the bathroom while she was using it to do something else. [DP staff #5] stated that [client A] didn't call for staff but came out on her own and [DP staff #3] was near so he went to grab her gait belt and it broke when he grabbed it but he was able to land under her breaking her fall. [DP staff #5] stated that she doesn't think that [client A] hit the wall or the floor..." DP staff #5's undated witness summary/statement indicated client A had complained of her arm prior to her fall on 7/20/15. DP staff #5's summary/witness statement indicated client A came to the workshop on 7/17/15 with a Band-aid on her arm which covered "an abrasion." DP staff #5's undated statement indicated "[Client A] had said that she fell out of bed. [Client A] did not say when she fell out</p>			

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	<p>of bed..."</p> <p>The day program's 7/28/15 investigation indicated "[DPPD] stated that staff should always be assisting the clients who have gait belts. [DPPD] stated that [client A] has a gait belt due to her fall risk and seizure risk. [DPPD] stated that on July 17th, 2015 [DP staff #6] came out of the bathroom and asked her to come and look at [client A's] arm. [DPPD] stated that she did attempt some range of motion exercises with [client A] and [client A] was not able to raise her right arm at the shoulder. [DPPD] stated that she called [PD #1], Dungarvin Manager twice...[DPPD] stated that she did receive a call from [PD #1] a few minutes later and [DPPD] told her about [client A's] favoring her arm and saying that she had fallen at home and broke her arm. [DPPD] stated that [PD #1] said that [client A] was faking it because another client at the home had a broken limb and [client A] wanted the same type of attention the other client was receiving. [DPPD] stated that [PD #1] said that [client A] did have a seizure on the 16th which had already been BDDS reported. [DPPD] stated that she did not receive the BDDS report and requested that [PD #1] send it to her which she said she would as well as sending future BDDS reports to her. [DPPD] stated that</p>			
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	[DP staff #6] was a witness to the phone call. [DPPD] stated that on Monday, July 20th the Day Program had a fish fry. [DPPD] stated while supervising the cooking she asked [DP staff #3] to get some gloves from the storage area located near the restrooms. [DPPD] stated that she looked up and observed [client A] stumbling out of the bathroom as [DP staff #3] was coming out of the storage room. [DPPD] said she told [DP staff #3] to grab [client A's] gait belt. [DPPD] stated when [DP staff #3] grabbed the belt it broke and he positioned himself under her quickly so she did not fall to the ground. [DPPD] stated from her perspective, [client A] did not fall and [DP staff #3] was maybe on his knees with her leaning against him. [DPPD] stated that on Wednesday, July 22nd towards the end of business [DPC] called her to report [client A] had a lump on her back near the shoulder area. [DPPD] stated she told [DPC] to make sure to point it out to [client A's] residential staff when they picked up her up. [DPPD] stated that she was still on the phone with [DPC] when [client A's] residential staff arrived. [DPPD] stated she has not observed [client A's] residential staff walk with her when she is ambulating during drop off or pick up so she (DPPD) has directed the [name of day program] staff to assist [client A] in and out of the			

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	<p>building...."</p> <p>The day program's 7/28/15 investigation indicated "...[DP staff #3] stated that on Monday, July 20th he was in the storage room and as he was coming out [client A] was coming out of the bathroom she started to fall (sic). [DP staff #3] stated that he grabbed her gait belt, but the belt snapped and broke. [DP staff #3] stated he successfully positioned himself t (sic) under [client A] to keep her from falling. [DPS staff #3] stated that he asked her if she was ok and he did not see any injury. [DP staff #3] stated [client A] had already been complaining about her arm the week prior and her residential staff had said that she was faking it...[DP staff #3] stated that [client A] had come out if the bathroom on her own but he thinks that [DP staff #5] was in the bathroom with her initially...[DP staff #3] stated that he really did not have contact with [client A] on Wednesday, July 22nd as he was doing some cleaning that [DPPD] had asked him to do...[DP staff #3] stated that he would never push a client down and there would be no reason for him to hold [client A] on the ground and push her head in any manner...[DP staff #3] stated that she (client A) doesn't identify other staff by name but calls him cuckoo-bird, rarely does she use [DP staff #3]. [DP staff #3] stated that her</p>			

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	<p>Dungarvin staff does know his name because he went to school with some of them."</p> <p>The day program's 7/28/15 investigation indicated client H, a client at the day program indicated she knew who client A was and he (client H) did not see anyone push client A. The facility's 7/28/15 investigation indicated "[client I] stated that he was has not seen any staff push [client A] or anyone else."</p> <p>The day program's 7/28/15 investigation summary indicated "...Conclusion: Evidence could not be found to support the allegation of abuse. Evidence could not be found to determine the cause of [client A's] broken collarbone however there is evidence to support that [client A] had complained on Friday, July 17th of her right arm hurting and said that she had fallen at home and broke her arm on which was reported to her residential supervisor on July 17th (sic). Evidence supports that [client A] did ambulate from the bathroom on Monday, July 20th however witness statements support that she did not actually fall hitting any hard surface. Evidence supports that [client A's] fall risk protocol from Dungarvin does not indicate that [client A] should be assisted with ambulation unless she appears to be lethargic or weak although</p>			

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	<p>at Day Program they have been trained to assist her at all times with ambulation."</p> <p>The day program's undated Recommendations resulting from an Investigation indicated facility staff were going to be retrained in regard to abuse and/or neglect policy and procedures, and to "Review protocol's (sic) for clients with gait belts to ensure they are specific to the needs of those clients in regards to gait belt use. Train staff on any changes."</p> <p>The day program's 8/5/15 Inservice training Reports were reviewed on 8/5/15 at 2:09 PM. The day program's inservice record indicated all day program staff were retrained on abuse and neglect and the use of gait belts on 8/5/15 at 8:00 AM.</p> <p>Client A's hospital records were reviewed on 8/6/15 at 10:15 AM. Client A's hospital records indicated the following hospitalizations and/or ER trips (not all inclusive):</p> <p>-3/27/15 Emergency department (ED) Note indicated "Patient to ED per [name of ambulance company] for unsteady gate (sic) and altered mental status that staff noticed about 1100 (11:00 AM) today. Staff states that patient fell outside</p>			

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	<p>daycare center this morning, but are unsure who witnessed the fall or how the patient fell. Patient denies pain at this time. Staff states that patient's speech is slower than normal and that she seems not as alert as normal. Patient awake, oriented x (times) 4. Respirations unlabored."</p> <p>Client A's 3/27/15 History of present Illness indicated "...She (client A) apparently had a fall outside this morning. Details of this are not clear, however. She was noted to have some gait instability which staff apparently did not think much of it initially. However, she is also demonstrating a change in her mentation. Her caregiver states that normally she is awake, very talkative and very active. She is mostly just lying in bed now. Caretaker states this is very unusual behavior for her. She does wear a helmet normally. No increased seizure activity has been noted."</p> <p>Client A's 3/27/15 Cat Scan, of the client's head, was performed with "No acute abnormality with no intracranial bleeding...." Client A's ED note indicated client A improved while in the hospital's ER and it was decided the client would be released and followed by the client's doctor.</p>			

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	<p>-5/16/15 Client A's 5/16/15 ED Arrival Information indicated "Patient fell at home and hit head on dresser. Chief Complaint Fall, head Injury Diagnosis: Laceration of scalp."</p> <p>Client A's 5/16/15 History indicated "...She was in bed and fell out striking the back of her head against the dresser. Staff is with patient stating there was no loss of consciousness. She's been acting at her baseline. No vomiting. She (sic) occurred just prior to arrival in the emergency department." Client A's 5/16/15 Ed Note indicated 3 staples were placed in the back of client A's head. Client A's 5/16/15 ED note indicated "...Care giver states that the fall was unwitnessed...."</p> <p>-5/22/15 Client A's 5/22/15 Emergency Department Encounter indicated client A came to the ER "...with complaints of a seizure today. She wears a helmet and did not have her helmet on when she had her seizure. She fell and hit her mouth on the stove. She presents with some gingival bleeding to the right lower canine of her mouth...During this examination of this patient, other medical conditions were considered as possible causes of this patient's complaint including but not limited to 1. Mandibular fracture 2. Dental injury...."</p>			

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	<p>Client A's 5/22/15 Radiology/Procedures indicated a Cat Scan of client A's jaw was performed. The radiology report indicated "There is a fracture involving the alveolar ridge of the mandible extending below the roots of the four mandibular incisor teeth...Impression: Fracture involving the alveolar ridge of the anterior aspect of the mandible." Client A's 5/22/15 ED Note indicated client A was admitted to the hospital where the client was placed on a soft diet, an intravenous antibiotic (infection), and to have an oral surgery consult.</p> <p>Client A's 5/24/15 Progress Note, by the oral surgeon, indicated "Fell and hit mouth on the stove. Bleeding and mild. History of seizures. Fracture involving the alveolar ridge of the anterior aspect of the mandible. Mandible displaced. No surgery. Pt (patient) is (sic) been eating well. No pain. Soft diet 3 weeks. Follow up at the office in week." Client A was discharged back to the group home on 5/24/15. Review of the facility's reportable incident reports and/or investigations from 5/1/15 to 8/5/15 indicated the facility neglected to report the fall/allegation of possible neglect to state officials as no reportable incident report was provided.</p>			

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	<p>-5/28/15 Client A went to the hospital to have the staples removed from the back of her head.</p> <p>-7/22/15 Client A "...is brought to the ER by caseworker after noticing patient had a deformity to right clavicle. Per caseworker. Patient states headache in adult daycare center and noticed injury when they went to pick her up. Patient now complaining of right shoulder and right elbow pain...." The ED Provider Note indicated "...Right shoulder: Decreased range of motion secondary to pain. Pain with palpitation. Swelling and erythema over mid clavicle. Right elbow: Mild swelling. No erythema or obvious deformity. Decreased range of motion secondary to pain...Diagnosis management comments: Dx (diagnosis) Right clavicular fracture Rx: (prescription) Tylenol 500 mg (milligrams) (pain) Tx (treatment): Right shoulder immobilizer Patient will be referred to orthopedics, [name of doctor]...."</p> <p>Client A's 7/22/15 ED Note indicated "...Care giver states patient is 'favoring' right arm and told her she feel (sic) when leaving her adult daycare today. Patient is mentally challenged and is poor historian...." Client A's hospital X-rays indicated the doctors ordered an xray of</p>			

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	<p>the client's chest, right elbow and the client's right shoulder. Client A's 5/22/15 Radiology results of the client's elbow indicated "...IMPRESSION: Negative right elbow (no fracture/dislocation). Client A's 5/22/15 right shoulder X-ray indicated "...Impression: Fracture right clavicle..." Client A's 5/22/15 chest X-ray indicated "...IMPRESSION: 1. Interval increased displacement of right midclavicular fracture. Consideration for surgical fixation is suggested. 2. Negative for acute cardiopulmonary abnormality."</p> <p>Client A's 8/5/15 Orthopedic Surgery History And Physical (H&P) indicated "[Client A] is a 38 y.o. (year old) female admitted on 8/5/2015...with history of mental retardation and seizures presents with a right clavicle fracture approximately 2-3 weeks duration (week of 7/13/15 or 7/20/15). The fracture is displaced and therefore I (orthopedic surgeon) recommend open reduction internal fixation of the fracture." The H&P indicated client A would be admitted for observation. Client A's 8/5/15 orthopedic surgery note indicated "Patient was brought into the OR (operating room) for open reduction internal fixation of right clavicle fracture. Once patient was placed under general anesthesia by (sic) fully examine the</p>			

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	<p>fracture and found that the fracture was essentially stable with no crepitus (grating, cracking or popping sounds)...An x-ray was obtained and did not show any significant change from the initial x-ray but based on the clinical examination and the patient's general condition I've elected to not proceed with open reduction internal fixation of the clavicle because it appears to be clinically healed. Therefore this time we will continue with conservative care and allow the patient be (sic) discharged to home."</p> <p>Client A's record was reviewed on 8/6/15 at 1:53 PM. Client A's General Event Reports (GERs) indicated the following (not all inclusive):</p> <p>-6/2/15 "[Client A] left bathroom after taken (sic) medication went in [client C's] room squeeze pass (sic) [client C] while she was in the door way in wheel chair and fell on the floor staff pick her off the floor and change her clothes she had solid (sic) on her self (sic)...no visible injuries (sic)."</p> <p>-7/3/15 "[Client A] turned around to go take her bib to her room. Her housemate was preparing to put the dishes in the dishwasher. [Client A] tripped over the dishwasher hood and fell on her bottom."</p>			

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	<p>The GER indicated client A was not injured.</p> <p>-7/13/15 "staff (sic) was dressing [client A] and noticed a (sic) open scare (sic) on her right arm above her elbow...[Client A] has been having a series of seizures since Friday (sic). [Client A] must have hurt her arm and scraped the skin off during the time frame." Review of the facility's reportable incident reports and/or investigations from 5/15 to 8/5/15 indicated the facility neglected to conduct a thorough investigation of client's A injury of unknown source.</p> <p>-7/16/15 "[Client A] was unloading the van and she was struggling to get out. Staff was supervising and assisting [client A] but she didn't want help. Staff told [client A] that we needed to help her. [Client A] wrestled with staff and [client A] ended up on the ground coming out. Other staff came over to assist getting [client A] up. Staff looked at [client A's] knees and there were no injuries."</p> <p>-7/21/15 "[Client A] had got (sic) from sitting in a chair and went into the kitchen. About 5 p.m., she was standing in the kitchen addressing staff and was prompted to leave the kitchen and she would not. She stood over by the pantry</p>			

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	<p>area and about 3 minutes later went into a seizure. It lasted 15 seconds. She was not hurt. Her breathing was normal. She said she could not get up when prompted. She appeared weakened, but it could have been her being stubborn too...."</p> <p>-7/22/15 "[Client A] was being picked up from workshop and [client A] came to staff and she said she hurt herself because she fell and then her day program staff walked up when they over heard her and said they didn't know what happened to her they just so happened to notice it.... [Client A] has a big swollen knot on her right shoulder [client A] told staff she fell at workshop and that it hurts to move her arm." The GER indicated "...[Client A] will be taken to the hospital. [Client A] will be watched closely and help with walking holding he (sic) gait belt."</p> <p>-7/22/15 Another 7/22/15 entry indicated "...Staff asked the [name of workshop] staff if [client A] had fallen and hurt herself and they said she did not. [Client A] said she did fall and hurt her arm...."</p> <p>Client A's Appointment and/or consultation Forms indicated the following (not all inclusive):</p> <p>-7/13/15 Client A went to the ER. The 7/13/15 consultation form indicated</p>			

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	<p>"[Client A] has drop seizures and when she does she has one seizure and that is it. Today she had five seizures back to back and [client A] never has repeat seizures. She is coming in for evaluation." Client A's 7/13/15 Appointment form indicated client A's medications were increased after the hospital consulted with the client's Neurologist. The 7/13/15 appointment/consult form indicated a chest Xray was also completed on 7/13/15.</p> <p>-7/14/15 Client A saw her cardiologist regarding the client's pacemaker. The 7/14/15 appointment form indicated "The phlebotomist tried to take blood but was unable to get any from [client A]. The doctor waited on her and stated for her to stay on the same meds (medications) and her follow up appointment is...."</p> <p>-7/22/15 at 10:30 AM, client A went to an Oncologist appointment. Client A's 7/22/15 Appointments form indicated "[Client A] saw [name of oncologist] he gave me (staff #6) a copy of her labwork (sic) and also wanted to know if her seizures meds (sic) or does she have sleep apnea and wants her to see her primary dr (doctor)...."</p> <p>-7/22/15 at 6:00 PM, "[Client A] is being taken to the hospital because upon</p>			

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	<p>picking her up from Day program she said her arm hurt and when staff looked her shoulder was swollen and she couldn't move her arm without pain."</p> <p>-7/24/15 "[Client A] is seeing [name of orthopedic doctor] as a follow up from her ER visit. She was diagnosed with a closed right clavicular fracture...He said she needs surgery to repair her clavicular fracture and they would contact us Tuesday to let us know when."</p> <p>Client A's T-Logs (progress notes) indicated the following (not all inclusive):</p> <p>-7/13/15 at 7:00 AM, "When staff (staff #2) arrived [client A] was sitting on the couch. [Client A] greeted staff and asked to take a bath. Staff complied and helped [client A]. Staff noticed a open scrape on her right arm above her elbow. [Client A] told staff she fell but it still hurts. Staff called on call PD and completed a GER report...."</p> <p>7/14/15 at 9:36 PM, "...[Client A] stood up about 10 minutes later and when staff asked, 'Where are you going, sit down and watch TV.' [Client A] just stood in the living room. In about 40 seconds, she fell to the floor in a seizure. It was about 2:50 p.m. It lasted about 45 seconds.</p>			

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	<p>Staff made sure she was okay and she began to pull out of it. She was breathing heavily and had urinated on herself. Staff asked 'Are you okay?' [Client A] said, 'I can't get up.' Staff was rubbing [client A's] back and telling her to just lay there and relax. [Client A] had not taken a hard fall and there was no apparent injuries. [Client A] already had a sore on her right elbow. When staff asked her to try and get up, she said, 'My elbow hurt.' There was no blood coming from the sore. Staff presumed she had landed on that arm and that because there was a sore, this is why she said her elbow hurt. Staff was able to move the arm and [client A] got up with staff assistance...."</p> <p>-7/16/15 When client A came home from the day program, "...[Client A] then collapsed to the floor in a seizure. It lasted about 15 seconds. Staff asked if she was okay. [Client A] said her elbow hurt. She has a sore on her elbow and has been stating that her elbow hurts for the past two days. It is a sore that is healing...."</p> <p>-7/19/15 "[Client A] was check (sic) every 1 hour (sic) she was yelling for the staff several time (sic) about getting up and dress (sic). She woke up her roommate several times yelling. [Client A] has a scrape on her right elbo (sic) that</p>			

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	<p>she got during a fall several days ago...."</p> <p>-7/20/15 "...During dinner [client A's] housemate bagged (sic) up into her on accident. [Client A] fell back and had a seizure. Staff asked [client A] if she was ok. [Client A] told staff her elbow hurted (sic). Staff checked [client A] (sic) no visual injuries. Staff contacted the pd (PD) and nurse on call...."</p> <p>-7/22/15 at 11:08 PM, client A arrived home and was complaining of her right arm hurting. The T-Log indicated the staff who had transported client A home indicated "...[client A] said she fell at the workshop and she has a lump on her right shoulder. Staff said the Workshop staff denied [client A] fell at their site, but [client A] said she did and hurt her arm. Staff reached for [client A's] right arm and she pulled away...When staff pulled her blouse down, she had a lump about the size of a half a golf ball on her shoulder about two inches from her neck...." The T-Log indicated when the client was at the hospital, "...We finished the x-rays and returned to our booth in ER. The doctor came in about 15 minutes later and stated it was a fracture of the clavicle and asked what happened. Staff explained and [client A] said, 'I fell and hurt my arm.' The doctor stated he wanted her not to move the arm and that</p>			

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	<p>she ABSOLUTELY CANNOT FALL. The doctor said if she falls, she could puncture her lung. The doctor said he wanted her to have an appointment with and (sic) orthopedic surgeon, [name of doctor] ASAP (as soon as possible)...."</p> <p>-7/24/15 "[Client A] seen (sic) [name of orthopedic doctor] about her fractured clavicular (sic). [Name of orthopedic doctor] stated that when [client A] went to the hospital on July 13th and had a Xray it showed up then but no one read the Xray to let staff know so when she had that fall at day program that just pushed her shoulder to pop out. [Client A] will need surgery...." Client A's T-Logs and/or record indicated the facility's nurse neglected to assess, monitor and/or document any assessments regarding client A's falls and/or fractures in the client's record. The facility neglected to obtain clarification/documentation by the doctor in regard to there being a possible fracture on 7/13/15.</p> <p>Client A's 3/3/14 Annual IPP (Individual Program Plan) Health Summary (current one in record) indicated client A's diagnoses included, but were not limited to, Cerebral palsy, Grand Mal Seizures, Multiple Sclerosis and Abnormal Gait Disorder.</p>			

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	<p>Client A's 3/30/15 Seizure Management Plan (SMP) indicated client A had "Drop Seizures" which could be triggered by "...Loud noises, sun light, sudden changes in her environment and being frightened have been known to cause her to have a seizure...." Client A's seizure risk plan indicated client A was to wear a helmet "to help prevent possible injury during a seizure. Staff will assist [client A] with ADL's (Adult Daily Living) as needed. They will remain in the bathroom when she is taking a bath and outside the door with the door ajar when she is in shower. Staff will be ready to act quickly if she were (sic) to have a Seizure...." The risk plan indicated when client A had a seizure, facility staff were to check the client for injuries and provide first aid. The risk plan indicated once the seizure was over facility staff were to notify the nurse and/or on call nurse.</p> <p>Client A's 3/30/15 Fall Risk Plan indicated client A was to wear a gait belt at all times when out of bed. The 3/30/15 fall risk plan indicated "...During episodes of weakness or lethargy, Staff will assist [client A] with walking by walking next to her, holding on to the gait belt. Staff may have to assist [client A] with getting in or out of a car, stand by assist may be necessary at times. To</p>			

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	<p>decrease risk of falls, [client A] will have a bed alarm in place on her bed to remind her to ask for assistance with getting out of bed...Staff to remind [client A] to slow down when moving too quickly. Staff to remind [client A] to wear her hard shell helmet at all times to protect her head during a seizure/fall...Staff will assist [client A] with showers and use a shower chair...."</p> <p>Client A's IDT (interdisciplinary team) Members in Attendance at team meeting (IDT notes) indicated client A's IDT met on 1/21/15 and 4/3/15. Client A's above mentioned IDT notes and 3/4/14 Individual Support Plan (ISP), current one in the chart, indicated the facility neglected to meet and review the client's increased number of falls/falls which resulted in injuries/fractures, and/or neglected to meet, review/revise client A's 3/30/15 fall risk plan to ensure it met the needs of the client. The facility neglected to review how facility staff should assist client A to ambulate with the gait belt as client A was continuing to have falls. The facility neglected to develop a risk plan in regard to client A's fractured shoulder to ensure continuity of care when bathing and/or dressing to prevent further injury. Client A's ISP and/or record indicated the facility neglected to have an assessment and/or</p>			

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	<p>doctor's order in regard to the use of a gait belt for client A.</p> <p>Interview with DPC on 8/5/15 at 11:25 AM and at 12:12 PM indicated client A had attended their day program since September 2014. DPC indicated client A had not returned to the day program since the client fractured her shoulder. DPC indicated she was not at the day program the day client A fell. DPC indicated DP staff #3 was suspended when the allegation of abuse was made. DPC indicated 8/5/15 was DP staff #3's first day back as the allegation of abuse was not substantiated. DP staff #3 indicated 4 other staff were present when client A fell. DPC stated "The lump was noticed toward the end of the day." DPC indicated the lump found on client A's shoulder and client A's fall were on two different days. When asked if there was an incident with client A on the day the lump was found, DPC stated "No ma'am." DPC stated client A was to wear her gait belt "at all times." DPC indicated client A's plan did not indicate staff had to assist client A to ambulate with her gait belt at all times. DPC stated "But we (day program staff) are with clients with gait belts at all times."</p> <p>Interview with DP staff #7 on 8/5/15 at 11:38 AM indicated she did not know</p>			

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	<p>how client A injured her shoulder. DP staff #7 stated "She (client A) told me she fell out of bed on the 16th or 17th." DP staff #7 indicated client A had a history of falls and seizures. DP staff #7 indicated she worked the day client A fell at the day program, but she was outside with another client. DP staff #7 indicated she had not witnessed any abuse with clients at the day program.</p> <p>Interview with DP staff #2 on 8/5/15 at 11:38 AM indicated she did not work the day client A fell at the day program. When asked if client A had a history of falls, DP staff #2 stated "Not that I know of." DP staff #2 indicated she did not know how client A injured her shoulder. DP staff #2 indicated she had not witnessed any day program staff abusing client A.</p> <p>Interview with DP staff #6 on 8/5/15 at 11:42 AM indicated facility staff was to assist client A to ambulate with her gait belt. When asked if the staff had witnessed any abuse of clients, DP staff #6 stated "There was when I first started here. Staff is gone." DP staff #6 indicated she had worked at the day program since November 2014. DP staff #6 indicated she worked the day the lump was found on client A's shoulder. DP staff #6 she did not know how client A</p>			

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	<p>hurt her shoulder. DP staff #6 indicated client A had a history of falls. DP staff #6 stated "She (client A) has not had too many falls here. Transport staff (group home staff) do not hold on to her gait belt when walking in (day program)."</p> <p>Interview with DP staff #3 on 8/5/15 at 11:45 AM indicated client A had a history of falls. DP staff #3 indicated he did not know how client A fractured her shoulder. DP staff #3 indicated he was working the day client A fell at the day program. DP staff #3 stated "When she was getting ready to fall, I jumped in and broke the fall." DP staff #3 indicated client A was coming out of the bathroom and DP staff #3 was in the utility closet. DP staff #3 stated "I seen she was going to fall. I jumped in front of her and we fell to ground together." When asked was staff with client A when she was in the bathroom, DP staff #3 stated "The utility closet is next to the bathroom. Someone yelled [client A] is coming out and I ran to her." DP staff #3 indicated when he grabbed client A's gait belt, the belt broke. DP Staff #3 stated "It snapped." DP staff #3 indicated he had been working at the day program for 2 years. DP staff #3 indicated he did not abuse client A. Day Program staff #3 indicated client A had complained of her arm hurting prior to her fall at the day</p>			

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	<p>program.</p> <p>Interview with DP staff #5 on 8/5/15 at 11:55 AM stated she worked the day client A fell coming out of the bathroom, and the day a "lump" was found on client A's shoulder. DP staff #5 indicated she was the staff who placed client A on the toilet in the bathroom. DP staff #5 indicated client A did not want her to stay in the bathroom with client A. DP staff #5 indicated she returned to her group and client A was to call when she was ready to leave the bathroom. DP staff #5 indicated they assisted client A to ambulate with the gait belt due to the client's seizures and falls. DP staff #5 indicated DP staff #3 was in the utility room which is next to the bathroom. DP staff #5 stated "She (client A) got up no sooner than I left. She was coming out of the bathroom. [DP staff #3] grabbed her gait belt and the gait belt broke where the plastic was at." DP staff #5 indicated DP staff #3 tried to break client A's fall. DP staff #5 stated "She has been falling a lot lately at the group home." DP staff #5 indicated client A told her she had fallen out of the bed. DP staff #5 indicated client A had complained of her arm hurting prior to her fall at the day program.</p> <p>Interview with the DP Area Director</p>			

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	(DPAD) and DPPD on 8/5/15 at 12:05 PM stated client A's group home indicated client A had a "broken collar bone." The DPAD and the DPPD indicated the day program conducted an investigation in regard to the allegation of abuse by DP staff #3. The DPPD stated the allegation of abuse "could not be substantiated." DPPD indicated they could not determine if client A fractured her shoulder at the day program. DPPD stated "She (client A) fell on his body (DP staff #3)." DPPD stated client A "came out of bathroom. [DP staff #3] caught her during a fall." DPPD indicated client A had complained of her arm hurting prior to the fall at the workshop. DPPD stated on "7/17/15 staff noted different gait walking. I mentioned it to Dungarvin staff." DPPD stated client A told her "She fell up against a dresser." DPAD and DPPD indicated the day program's investigation had just been completed and the day program staff had been retrained on client A's use of the gait belt and abuse and neglect. DPPD and DPAD indicated the facility had not received the day program's investigation results as of 8/5/15 as the day program's investigation was completed on 8/4/15. The DPPD and DPAD indicated the facility and the day program were to send BDDS reports to each other. When asked if the facility had copies of the incident			

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	<p>reports, the DPPD stated "No only send IR (incident reports) if requested." The DPPD indicated DP staff #3 was suspended pending the outcome of the investigation. DPPD indicated client A fell at the group home and received sutures to the back of her head. DPPD stated client A was brought into the day program the next day and DPPD "sent her back home."</p> <p>Interview with staff #2 on 8/5/15 at 5:32 PM indicated client A was to have surgery on her shoulder on 8/5/15. Staff #2 indicated client A was to stay at the hospital 24 hours after the surgery. Staff #2 stated client A told her her shoulder got injured because a day program staff "pushed her down." Staff #2 indicated client A had a history of seizures and falls. Staff #2 stated client A would have seizures which caused the client to "fall and hurt herself." Staff #2 indicated client A came home from the day program pointing to her shoulder. Staff #2 indicated the client saw her doctor the day before the 7/22/15 incident. Staff #2 indicated the doctor would have seen the injury. When asked if client A would fall out of her bed, staff #2 stated "Not aware of her falling out bed." Staff #2 indicated client A wore a gait belt. Staff #2 stated facility staff used the gait belt when client A was "off balance or after [client A] had</p>			

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	<p>a seizure."</p> <p>Interview with staff #1 on 8/5/15 at 5:40 PM stated client A wore a gait belt for an "unsteady gait." Staff #1 stated "We are supposed to hold her when walking but sometimes impossible with other ladies." Staff #1 indicated client A would have falls with her seizures. Staff #1 stated client A recently "kept having seizures and fell." When asked if client A had received injuries from the falls, staff #1 stated "She didn't, just kept having seizures." Staff #1 stated client A had a "hairline fracture then but her shoulder was not dislocated." Staff #1 stated the group home did not find out client A had a fracture until her "shoulder came out of place." Staff #1 stated the doctor/hospital "Did not say anything at the time they did the X-ray until she went to the hospital this time." When asked if client A had a history of falling out of the bed, staff #1 stated "Not that I know of. It occurred 1 time." When asked if client A received any injuries from her falling out of the bed, staff #1 stated "No she didn't." Staff #1 stated client A fell and received "a rug burn" on her elbow. Staff #1 indicated the fall occurred at the day program. Staff #1 indicated the facility's nurse came to the group home and checked client A.</p>			

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	<p>Interview with client D on 8/5/15 at 5:55 PM indicated client D was client A's roommate. Client D indicated client A would have falls in the bedroom. When asked if client A hurt herself, client D stated "Yeah. She hit her elbow. Fell out of bed."</p> <p>Interview with PD on 8/6/15 at 3:19 PM, by phone, indicated she was aware of client A's elbow injury. PD indicated she was told client A had an injury on her right elbow. PD stated "I do not know when exact elbow injury occurred. So many seizures occurred around the same time." PD #1 indicated the facility did not conduct an investigation in regard to client A's elbow injury. PD #1 indicated the facility reported client A's 5/22/15 fractured jaw to BDDS. PD #1 indicated she would locate the BDDS report. PD #1 indicated the facility did not conduct an investigation in regard to neglect for the 5/22/15 incident as client A did not have her helmet on at the time of the seizure/fall. PD #1 indicated the facility just received the day program's investigation of the 7/22/15 allegation of staff to client abuse on 8/5/15. PD #1 indicated she would need to review the day program's investigation to complete the facility's investigation. PD #1 stated "They [day program agency] have never allowed me to interview their staff."</p>			

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	<p>[Name of day program/agency] policy. We can't ensure a thorough investigation." PD #1 indicated the day program would communicate with Dungarvin via e-mail. PD #1 indicated this was the first time the day program gave Dungarvin an investigation the day program had completed. PD #1 indicated the Orthopedic surgeon told facility staff, at the doctor's appointment on 7/24/15, client A's X-ray taken on 7/13/15 indicated a fracture. PD #1 stated "the X-ray was not read" before the client had returned home. PD #1 indicated she was not told of the 7/13/15 previous fracture on 7/13/15. PD #1 indicated the facility's nurse did not follow-up on the 7/13/15 information relayed at the doctor's office. PD #1 stated the facility did not follow up "unless they give us a print out." PD #1 indicated the labs and/or X-rays may have been ordered by the client's doctor on 7/13/15. PD #1 did not know if the facility's nurse assessed client A's elbow/rug burn. PD #1 indicated client A's gait belt broke at the day program and it was returned back to the group home. PD #1 indicated she spoke with the day program about them paying for the gait belt. PD #1 stated "We never discussed how it got broken." PD #1 indicated she added the gait belt to client A's risk plans. PD #1 indicated she would attempt to look for the gait belt doctor's order. PD</p>			

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	<p>#1 did not provide any additional information/gait belt order. PD #1 indicated client A's risk plans would need to be revised in regard to when/how staff were to use client A's gait belt. PD #1 indicated any IDT meetings would be in the client's record. PD #1 stated "We met whenever falls occurred."</p> <p>Interview with staff #3 on 8/6/15 at 5:40 PM indicated she was not sure if the facility had a risk plan for the care of client A's clavicle fracture. When asked how facility staff assisted client A to change/dress without injuring her arm, staff #3 stated "I assist her very slowly." Staff #3 indicated client A's orthopedic surgeon indicated surgery was not needed. Staff #3 stated "it is healing nicely without surgery."</p> <p>Interview with nurse staff #1 on 8/6/15 at 6:02 PM indicated client A had a history of falls and now had a fractured clavicle. Nurse staff #1 indicated she had assessed/seen client A since client A fractured her clavicle. When asked if nurse staff #1 documented her assessment, nurse staff #1 stated "I think so. They should be in the T-Logs health." Nurse staff #1 indicated she saw the client on 7/23/15 and 7/24/15. Nurse staff #1 stated "I was glad I sent her out (7/22/15)." Nurse staff #1 indicated she</p>			

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	<p>was told client A had a previous fracture before 7/22/15. Nurse staff #1 stated "Someone saw it on My Chart." Nurse staff #1 indicated she could not access client A's My Chart information. Nurse staff #1 indicated the previous nurse could. Nurse staff #1 indicated the facility was attempting to gain access. Nurse staff #1 indicated she did not obtain clarification in regards to what a staff reported on 7/24/15. Nurse staff #1 indicated she had not developed a risk plan for client A's acute injury/fracture of clavicle. Nurse staff #1 stated she was "She (nurse staff #1) was going to do after (client A's) surgery." Nurse staff #1 indicated facility staff were to assist the client to dress and shower. Nurse staff #1 indicated client A's ISP and/or risk plans did not specifically indicate how facility staff was to care for client A's fractured shoulder. Nurse staff #1 indicated client A had been refusing to wear the sling for her arm. Nurse staff #1 indicated client A was at the hospital for surgery on the client's shoulder, but the doctor decided not to do the surgery.</p> <p>2. The facility failed to report an allegation of neglect regarding client A's fractured jaw to the state officials (Bureau of Developmental Disabilities Services (BDDS) and/or to Adult Protective Services). Please see W153.</p>			

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	<p>3. The facility failed to conduct an investigation and/or failed to conduct thorough investigations in regard to allegations of abuse, neglect and/or injuries of unknown source reviewed for clients A and G. Please see W154.</p> <p>4. The facility failed to complete an investigation in regard to staff to client abuse within 5 working days for client A. Please see W156.</p> <p>The facility's policy and procedures were reviewed on 8/5/15 at 2:16 PM. The facility's 6/1/15 policy entitled Policy and Procedure Concerning Abuse, Neglect and Exploitation indicated "Dungarvin believes that each individual believes that each individual has the right to be free from mental, emotional and physical abuse in his/her daily life...Abuse, neglect or exploitation of the individuals' served is strictly prohibited in any Dungarvin service delivery setting. All persons working for the organization and/or providing services to individuals are mandated by law to report suspected abuse, neglect, or exploitation...." The facility's 6/1/15 policy indicated "Neglect is defined as failure to provide appropriate care, supervision or training, failure to provide food and medical services as needed. failure to provide a</p>			

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W 0153 Bldg. 00	<p>safe, clean and sanitary environment and failure to provide medical supplies/safety equipment as indicated in the individual's Individual Support plan (ISP)...." The facility's 6/1/15 policy indicated "...Within 24 hours of knowledge of the suspected or actual abuse, neglect, or exploitation, the PD, AD (Area Director) or senior director will report the incident to the Bureau of Developmental Disabilities Services...The program director, area director or senior director or his/her delegate will conduct a thorough investigation of any alleged, suspected or actual abuse, neglect, or exploitation. Within five business days, the results and/or status of the investigation will be reported to the administrator...."</p> <p>This federal tag relates to complaint #IN00178955.</p> <p>9-3-2(a)</p> <p>483.420(d)(2) STAFF TREATMENT OF CLIENTS The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures. Based on interview and record review for 1 of 6 allegations of abuse, neglect and/or injuries of unknown source reviewed, the facility failed to report an allegation of</p>	W 0153	All staff at the facility will be retrained by 09/17/15 on the Dungarvin policy and procedure pertaining to Abuse/Neglect. The QIDP will be retrained by	09/17/2015

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	<p>neglect regarding client A's fractured jaw to the state officials (Bureau of Developmental Disabilities Services (BDDS) and/or to Adult Protective Services) in accordance with state law.</p> <p>Findings include:</p> <p>Client A's hospital records were reviewed on 8/6/15 at 10:15 AM. Client A's hospital records indicated client A went to the emergency room (ER) on 5/22/15. Client A's 5/22/15 Emergency Department Encounter indicated client A came to the ER "...with complaints of a seizure today. She wears a helmet and did not have her helmet on when she had her seizure. She fell and hit her mouth on the stove. She presents with some gingival bleeding to the right lower canine of her mouth...During this examination of this patient, other medical conditions were considered as possible causes of this patient's complaint including but not limited to 1. Mandibular fracture 2. Dental injury...."</p> <p>Client A's 5/22/15 Radiology/Procedures indicated a Cat Scan of client A's jaw was performed. The radiology report indicated "There is a fracture involving the alveolar ridge of the mandible extending below the roots of the four mandibular incisor teeth...Impression:</p>		<p>09/17/15 on the expectation that all allegations of abuse/neglect must be reported to state authorities within 24 hours. The QIDP will be retrained by 09/17/15 on how to conduct thorough investigations and the requirement that investigations are to be completed within 5 business days, with results sent to the administrator and state officials. The QIDP will also be retrained by 09/17/15 on how to properly store the incident reports and investigation packets in order to be readily available when requested upon for review. This will ensure that there is a reproducible system in place. By 09/17/15, the QIDP and Area Director will create a new investigation summary tool to use specifically when any individual at the facility has a fall. The new investigation tool pertaining to a fall will be used to assess if the fall was related to a staff error for not following protocol or risk plan, change in medication, a change in medical status, or an environmental concern. Within 5 business days, this investigation summary will be attached to an internal incident report (pertaining to a fall) and/or the formal incident report (pertaining to a fall with injury) that is submitted to the state officials for review. Update: Client A's injury was immediately reported to the administrator and to state officials. (IR</p>	

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	<p>Fracture involving the alveolar ridge of the anterior aspect of the mandible." Client A's 5/22/15 ED Note indicated client A was admitted to the hospital where the client was placed on a soft diet, an intravenous antibiotic (infection), and to have an oral surgery consult.</p> <p>Client A's 5/24/15 Progress Note, by the oral surgeon, indicated "Fell and hit mouth on the stove. Bleeding and mild. History of seizures. Fracture involving the alveolar ridge of the anterior aspect of the mandible. Mandible displaced. No surgery. Pt (patient) is (sic) been eating well. No pain. Soft diet 3 weeks. Follow up at the office in week." Client A was discharged back to the group home on 5/24/15.</p> <p>The facility's reportable incident reports and/or investigations were reviewed on 8/5/15 at 2:40 PM. The facility's reportable incident reports and/or investigations were reviewed from 5/1/15 to 8/5/15. The facility's reportable incident reports and/or investigations indicated the facility failed to report the 5/22/15 fall/allegation of possible neglect to state officials as no reportable incident report was provided.</p> <p>Interview with PD (Program Director) on 8/6/15 at 3:19 PM, by phone, indicated</p>		#695148). The incident occurred on 5/22/15 and was reported on 5/23/15. A copy of the IR which was submitted was not turned in to the surveyor. As stated above, the QIDP will be retrained by 09/17/15 on how to properly store the incident reports and investigation packets in order to be readily available when requested upon for review. This will ensure that there is a reproducible system in place.				

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W 0154 Bldg. 00	<p>the facility reported client A's 5/22/15 fractured jaw to BDDS. PD #1 indicated she would locate the BDDS report. PD #1 did not provide any additional documentation and/or a BDDS report to indicate client A's 5/22/15 fall/fracture had been reported to state officials.</p> <p>This federal tag relates to complaint #IN00178955.</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.</p> <p>Based on interview and record review for 4 of 6 allegations of abuse, neglect and/or injuries of unknown source reviewed, the facility failed to conduct an investigation and/or failed to conduct thorough investigations in regard to allegations of abuse, neglect and/or injuries of unknown source reviewed for clients A and G.</p> <p>Findings include:</p> <p>1. The facility's reportable incident reports and/or investigations were reviewed on 8/5/15 at 2:40 PM. The facility's 7/22/15 reportable incident report indicated "When [client A]</p>	W 0154	<p>All staff at the facility will be retrained by 09/17/15 on the Dungarvin policy and procedure pertaining to Abuse/Neglect. The QIDP will be retrained by 09/17/15 on the expectation that all allegations of abuse/neglect must be reported to state authorities within 24 hours. The QIDP will be retrained by 09/17/15 on how to conduct thorough investigations and the requirement that investigations are to be completed within 5 business days, with results sent to the administrator and state officials. The QIDP will also be retrained by 09/17/15 on how to properly store the incident reports and investigation packets in order</p>	09/17/2015

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	<p>arrived home from Workshop, she came into the site and set (sic) on the sofa next to this staff (Program Director-PD #2). [Client A] leaned her head towards staff shoulder. Staff asked her what was wrong and she began to cry and say her right arm was hurting. She said her right elbow was hurting as well. Staff calmed her down and asked her to sit straight up and left her head up. [Client A] did and stopped crying. Staff then told her to do what staff does. Staff held out her arms in front of her and asked [client A] to do the same. She did, but was favoring the right arm. Staff raised both arms straight up and asked [client A] to do the same. [Client A] raised the left arm but not the right arm. Staff asked her to do her right arm and [client A] said, 'I can't. It hurts.' Staff told her to try and she said, 'I can't.' By then the staff that transported (sic) was coming in the door and said that [client A] reported it happened at workshop. Staff noticed that she had a lump on her right shoulder. Staff said the Workshop staff denied [client A] falling at workshop. However [client A] was adamant that someone by the name of [day program staff #3] had pushed her down and hurt her arm at workshop. Staff reached for [client A's] right arm and she pulled away. Staff told her to wait and let her look at it. When staff pulled her blouse down, she had a lump</p>		<p>to be readily available when requested upon for review. This will ensure that there is a reproducible system in place. By 09/17/15, the QIDP and Area Director will create a new investigation summary tool to use specifically when any individual at the facility has a fall. The new investigation tool pertaining to a fall will be used to assess if the fall was related to a staff error for not following protocol or risk plan, change in medication, a change in medical status, or an environmental concern. Within 5 business days, this investigation summary will be attached to an internal incident report (pertaining to a fall) and/or the formal incident report (pertaining to a fall with injury) that is submitted to the state officials for review. By 09/17/15 the QIDP and Area Director will create a communication checklist to include questions related to incidents, falls, and injuries of an individual that may have occurred prior to attending day program or while at the day program. The communication book for each individual will be exchanged between the residential provider and the day service provider. Going forward, all completed investigation summaries pertaining to a fall will also be reviewed by the QIDP and the facility nurse on a weekly basis at their weekly facility medical</p>	

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	<p>about the size of a half a golf ball on her shoulder about two inches from her neck. Staff advised the transport staff to call the nurse immediately because it appeared to be a dislocation. Another staff called the On-call Nurse and On-call PD. The nurse instructed staff to take [client A] to ER (emergency room). At approximately 5:3pm (sic) staff transported [client A] to [name of hospital]. [Client A] was still favoring her right arm and did not want it touched. [Client A] was called to the back around 7:30 p.m. The doctor saw [client A] and said to undress her to her waist for x-rays to be taken. The Xray showed that she had a fracture of the clavicle...Dungarvin began an investigation today (7/23/15) (sic) all 3 Dungarvin staff was (sic) interviewed that came in contact with [client A] prior to attending [name of day program]. All staff indicated that she (client A) was not in any pain and did not have any falls nor incidents. [Client A] was taken to see her hematologist [name of doctor] on July 22, 2015 before taking her to day program and her arm was not fractured or dislocated and had blood drawn in that exact same arm by the assistant. Dungarvin has requested internal incident reports from [name of day program] on 7/23/15 and has not received them yet. [Client A] will remain in Dungarvin care until a full investigation is completed by</p>		<p>support team meeting. The agenda and minutes of the meeting are submitted by the facility nurse to the Nursing Services Director and the Area Director on a weekly basis for additional monitoring and quality assurance. The facility nurse will be retrained on the standards pertaining to health care services at the facility by 09/17/15. The training will include the expectation that nursing services should assess, monitor and document the health care needs of all individuals residing at the facility. An aspect of that documentation is ensuring that all medical records from appointments and hospitalizations are obtained and clarification on orders is sought for any discrepancies. The facility nurse will pursue online chart options (electronic medical record) that may available through each individuals medical provider so that a high quality continuum of care of is maintained. Going forward, the facility nurse will review all discharges with the medical center nurse at the time of the discharge. In addition, the QIDP and facility nurse will review all medical discharge information within one business day. The on-call nurse or on-call QIDP will be available for immediate consultation if the discharge occurs after business hours. All follow-up directives will be completed within the designated</p>	

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	<p>[name of day program] regarding the allegation made by [client A] against a staff member by the name of '[day program staff #3].' [Client A's] story has not changed and she is adamant regarding [day program staff #3] pushing her down and pressing on her head while down on the floor."</p> <p>The facility's 7/30/15 follow-up to the 7/22/15 reportable incident report indicated "After speaking with day program staff it was determined there was a staff named '[nick name of DP staff #3].' His real name is [DP staff #3]. At this time it is not clear if [DP staff #3] was suspended. The day program is stating that there was no incident at all regarding [client A]. They are stating that [client A] came in with the injury. However, [client A had a doctor's appointment that morning and then went to the hospital for lab work. [Client A's] injury is extensive enough that a medical professional would have noticed it. [Client A] is scheduled to have her procedure completed during the week of 8/3/2015, once her doctor schedules it... [Client A] has not returned to the day program. She is being singled staff at home to prevent any further irritation of the injury. The Program Director of residential services has reached out to the day program for an investigation</p>		<p>timeframe established by the physician's orders.</p> <p>Update:</p> <p>We have looked at the role of the QIDP as the primary investigator and if that may detract from other duties of the QIDP. When each incident is reported, there is a discussion to identify who the best person is to assign to the investigation given current duties. If the QIDP is not able to successfully investigate and manage their other duties, then we assign it to someone else to investigate. We may not have always reassigned the investigations, but it is a valid concern that we should be evaluating for each allegation.</p>	

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	<p>summary and is awaiting a response."</p> <p>The facility's 7/23 and 7/24/15 attached investigation statements consisted of interviews with client A and staff at the group home which indicated the following (not all inclusive):</p> <p>-7/23/15 PD #2 indicated client A was interviewed on 7/24/15 at the group home. Client A's witness statement indicated "[Client A] was asked what happened to her? She stated that [DP staff #3] pushed her down and hurt her arm. [Client A] was then asked where was at day program building when this happen (sic)? She replied that she was in the class room watching a movie. [Client A] was asked if anyone was around and she replied yes, clients. [Client A] was asked if her arms were up just before the fall. Yes replied that (sic) she 'I don't remember honey.' [Client A] was asked if this happen (sic) this week or last week and stated 'last week.' [Client A] was asked did this happen on the same day [staff #4] took her to get her blood work or the day her gate (sic) belt broke. She replied 'the day I got my blood work.' [Client A] then stated that she did not want to see [DP staff #3] anymore. We talked about her guardian for a while and then I went back to ask her. (sic) Who (sic) hurt her arm and she replied [DP</p>			

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	<p>staff #3]. I (PD #2) asked [client A] if [DP staff #3] try (sic) to help her the day her gate (sic) belt broke and she replied yes. [Client A] was asked did someone keep her from falling down the day her hat (sic) belt broke and she replied 'Yes.' She was asked who and she said '[DP staff #3]'. [Client A] was asked if [DP staff #3] did by accident and she stated 'no he was hitting my shoulder like crazy.' "</p> <p>-7/23/15 Witness statement by staff #5 indicated on Wednesday 7/21/15 on the midnight shift, staff #5 indicated staff #5 assisted client A to complete her hygiene and dress for the morning. Staff #5's witness statement indicated client A did not have any injuries and/or complaints of pain with her arm. Staff #5's witness statement indicated when staff #5 came back in on 7/22/15 at midnight, client A was at the hospital. Staff #5's witness statement indicated staff #5 asked client A what happened when client A returned to the group home. The statement indicated "...she then spoke of a person named [nick name for DP staff #3] had pushed her down at workshop. staff (sic) then asked was he or she a client or staff and she replied that he's a client...."</p> <p>-Staff #4's 7/23/15 witness statement indicated staff #4 took client A to her</p>			

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	<p>hematologist appointment on 7/22/15. Staff #4's 7/23/15 statement indicated client A's arm "...was not fractured or dislocated. [Client A] got blood drawn in that exact same arm by the assistant..." Staff #5's witness statement indicated "...I also know that on July 13, 2015 [client A] was taken to the emergency room due to having seizures since Friday July 10, 2015 that starting at the day program on into the weekend and while she was there they checked her arm and it only had a carpet burn and they said nothing was broken/fractured. She has seen a couple of Drs (doctors) since the time her day program has stated they told about [client A] falling and there wasn't (sic) any concerns then (sic)." The facility's 7/22/15 reportable incident report and/or attached witness statements indicated the facility failed to conduct a thorough investigation in regard to client A's fractured shoulder as there were no additional interviews, conclusion and/or recommendations attached to the reportable incident report as of 8/5/15.</p> <p>Interview with the DP (day program) Area Director (DPAD) and DPPD (Day Program Program Director) on 8/5/15 at 12:05 PM stated client A's group home stated client A had a "broken collar bone." The DPAD and the DPPD indicated the day program conducted an</p>			

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	<p>investigation in regard to the allegation of abuse by DP staff #3. The DPPD stated the allegation of abuse "could not be substantiated." DPPD indicated they could not determine if client A fractured her shoulder at the day program. DPPD stated "She (client A) fell on his body (DP staff #3)." DPPD stated client A "came out of bathroom. [DP staff #3] caught her during a fall." DPPD indicated client A had complained of her arm prior to the fall at the workshop. DPPD stated on "7/17/15 staff noted different gait walking. I mentioned it to Dungarvin staff." DPPD stated client A told her "She fell up against a dresser." DPAD and DPPD indicated the day program's investigation had just been completed and the day program staff had been retrained on client A's use of the gait belt and abuse and neglect. DPPD and DPAD indicated the facility had not received the day program's investigation results as of 8/5/15 as the day program's investigation was completed on 8/4/15.</p> <p>Interview with PD on 8/6/15 at 3:19 PM, by phone, indicated the facility just received the day program's investigation of the 7/22/15 allegation of staff to client abuse on 8/5/15. PD #1 indicated she would need to review the day program's investigation to complete the facility's investigation. PD #1 stated "They [day</p>			

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	<p>program agency] have never allowed me to interview their staff. [Name of day program/agency] policy. We can't ensure a thorough investigation."</p> <p>2. Client A's hospital records were reviewed on 8/6/15 at 10:15 AM. Client A's hospital records indicated client A went to the emergency room (ER) on 5/22/15. Client A's 5/22/15 Emergency Department Encounter indicated client A came to the ER "...with complaints of a seizure today. She wears a helmet and did not have her helmet on when she had her seizure. She fell and hit her mouth on the stove. She presents with some gingival bleeding to the right lower canine of her mouth...During this examination of this patient, other medical conditions were considered as possible causes of this patient's complaint including but not limited to 1. Mandibular fracture 2. Dental injury...."</p> <p>Client A's 5/22/15 Radiology/Procedures indicated a Cat Scan of client A's jaw was performed. The radiology report indicated "There is a fracture involving the alveolar ridge of the mandible extending below the roots of the four mandibular incisor teeth...Impression: Fracture involving the alveolar ridge of the anterior aspect of the mandible." Client A's 5/22/15 ED Note indicated</p>			

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	<p>client A was admitted to the hospital where the client was placed on a soft diet, an intravenous antibiotic (infection), and to have an oral surgery consult.</p> <p>Client A's 5/24/15 Progress Note, by the oral surgeon, indicated "Fell and hit mouth on the stove. Bleeding and mild. History of seizures. Fracture involving the alveolar ridge of the anterior aspect of the mandible. Mandible displaced. No surgery. Pt (patient) is (sic) been eating well. No pain. Soft diet 3 weeks. Follow up at the office in week." Client A was discharged back to the group home on 5/24/15.</p> <p>The facility's reportable incident reports from 5/1/15 to 8/5/15 and/or investigations were reviewed on 8/5/15 at 2:40 PM. The facility's reportable incident reports and/or investigations indicated the facility failed to conduct an investigation in regard to the 5/22/15 fall/allegation of neglect.</p> <p>Interview with PD (Program Director) on 8/6/15 at 3:19 PM, by phone, indicated the facility did not conduct an investigation in regard to neglect for the 5/22/15 incident as client A did not have her helmet on at the time of the seizure/fall.</p>			

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	<p>3. Client A's record was reviewed on 8/6/15 at 1:53 PM. Client A's 7/13/15 General Event Report (GER) indicated on 7/13/15, "staff (sic) was dressing [client A] and noticed a (sic) open scare (sic) on her right arm above her elbow... [Client A] has been having a series of seizures since Friday (sic). [Client A] must have hurt her arm and scraped the skin off during the time frame."</p> <p>The facility's reportable incident reports and/or investigations were reviewed on 8/5/15 at 2:40 PM. The facility's 7/13/15 reportable incident report indicated "[Client A] had a series of back to back seizures, which is not normal for her. Typically [client A] has one seizure and may have more later in in the day, but not repeatedly following each other. [Client A's] doctor was contacted but she could not be seen on the 13th. [Client A] was taken to [name of hospital] for an evaluation. Her seizure medication was increased and she was referred back to her neurologist..." The facility's reportable incident reports and/or investigations from 5/15 to 8/5/15 indicated the facility failed to conduct a thorough investigation in regard to client's A injury of unknown source.</p> <p>Interview with PD on 8/6/15 at 3:19 PM, by phone, indicated she was aware of</p>			

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	<p>client A's elbow injury. PD indicated she was told client A had an injury on her right elbow. PD stated "I do not know when exact elbow injury occurred. So many seizures occurred around the same time." PD #1 indicated the facility did not conduct an investigation in regard to client A's elbow injury.</p> <p>4. The facility's reportable incident reports from 5/1/15 to 8/5/15 and/or investigations were reviewed on 8/5/15 at 11:45 AM and at 2:40 PM. The facility's 7/23/15 reportable incident report indicated "Pre-Voc Program participants were finishing up lunch. [Client G] and another client came in to the Program Director's office and they were upset. Another client asked [client G] to sit by her in the workshop and she did. [Client G] stated that [day program-DP staff #8], DSP (Direct Support Professional) yelled at them and said they could not sit there. An investigation was initiated and [DP staff #8] was removed from the workshop area and access from any clients while an investigation was completed, the investigation found to be not substantiated." The facility's reportable incident reports indicated the facility did not conduct an investigation and/or have a reproducible system in regard to client G's allegation of abuse.</p>			

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W 0156 Bldg. 00	<p>Interview with the PD #1 on 8/6/15 at 3:19 PM, by phone, indicated the facility did not conduct a thorough investigation in regard to the 7/23/15 incident as no investigation was provided. The PD stated "The Day Service did investigation. We don't have a copy."</p> <p>This federal tag relates to complaint #IN00178955.</p> <p>9-3-2(a)</p> <p>483.420(d)(4) STAFF TREATMENT OF CLIENTS The results of all investigations must be reported to the administrator or designated representative or to other officials in accordance with State law within five working days of the incident.</p> <p>Based on interview and record review for 1 of 6 allegations of abuse, neglect and/or injuries of unknown source reviewed, the facility failed to complete an investigation in regard to staff to client abuse within 5 working days for client A.</p> <p>Findings include:</p> <p>The facility's reportable incident reports and/or investigations were reviewed on 8/5/15 at 2:40 PM. The facility's 7/22/15 reportable incident report indicated "When [client A] arrived home from Workshop, she came into the site and set</p>	W 0156	<p>All staff at the facility will be retrained by 09/17/15 on the Dungarvin policy and procedure pertaining to Abuse/Neglect. The QIDP will be retrained by 09/17/15 on the expectation that all allegations of abuse/neglect must be reported to state authorities within 24 hours. The QIDP will be retrained by 09/17/15 on how to conduct thorough investigations and the requirement that investigations are to be completed within 5 business days, with results sent to the administrator and state officials. The QIDP will also be retrained by 09/17/15 on how to</p>	09/17/2015

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	(sic) on the sofa next to this staff (Program Director-PD #2). [Client A] leaned her head towards staff shoulder. Staff asked her what was wrong and she began to cry and say her right arm was hurting. She said her right elbow was hurting as well. Staff calmed her down and asked her to sit straight up and left her head up. [Client A] did and stopped crying. Staff then told her to do what staff does. Staff held out her arms in front of her and asked [client A] to do the same. She did, but was favoring the right arm. Staff raised both arms straight up and asked [client A] to do the same. [Client A] raised the left arm but not the right arm. Staff asked her to do her right arm and [client A] said, 'I can't. It hurts.' Staff told her to try and she said, 'I can't.' By then the staff that transported (sic) was coming in the door and said that [client A] reported it happened at workshop. Staff noticed that she had a lump on her right shoulder. Staff said the Workshop staff denied [client A] falling at workshop. However [client A] was adamant that someone by the name of [day program staff #3] had pushed her down and hurt her arm at workshop. Staff reached for [client A's] right arm and she pulled away. Staff told her to wait and let her look at it. When staff pulled her blouse down, she had a lump about the size of a half a golf ball on her		properly store the incident reports and investigation packets in order to be readily available when requested upon for review. This will ensure that there is a reproducible system in place. Going forward, the QIDP will implement a tracking system by using the task tool in Microsoft Outlook to keep track of the timeliness of investigations and notifications to the administrator and follow-up incident report submissions to the state officials. The Area Director will monitor the QIDP with the use of a shared calendar. By 09/17/15, the QIDP and Area Director will create a new investigation summary tool to use specifically when any individual at the facility has a fall. The new investigation tool pertaining to a fall will be used to assess if the fall was related to a staff error for not following protocol or risk plan, change in medication, a change in medical status, or an environmental concern. Within 5 business days, this investigation summary will be attached to an internal incident report (pertaining to a fall) and/or the formal incident report (pertaining to a fall with injury) that is submitted to the state officials for review. By 09/17/15 the QIDP and Area Director will create a communication checklist to include questions related to incidents, falls, and injuries of an	

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	<p>shoulder about two inches from her neck. Staff advised the transport staff to call the nurse immediately because it appeared to be a dislocation. Another staff called the On-call Nurse and On-call PD. The nurse instructed staff to take [client A] to ER (emergency room). At approximately 5:3pm (sic) staff transported [client A] to [name of hospital]. [Client A] was still favoring her right arm and did not want it touched. [Client A] was called to the back around 7:30 p.m. The doctor saw [client A] and said to undress her to her waist for x-rays to be taken. The Xray showed that she had a fracture of the clavicle...Dungarvin began an investigation today (7/23/15) (sic) all 3 Dungarvin staff was (sic) interviewed that came in contact with [client A] prior to attending [name of day program]. All staff indicated that she (client A) was not in any pain and did not have any falls nor incidents. [Client A] was taken to see her hematologist [name of doctor] on July 22, 2015 before taking her to day program and her arm was not fractured or dislocated and had blood drawn in that exact same arm by the assistant. Dungarvin has requested internal incident reports from [name of day program] on 7/23/15 and has not received them yet. [Client A] will remain in Dungarvin care until a full investigation is completed by [name of day program] regarding the</p>		<p>individual that may have occurred prior to attending day program or while at the day program. The communication book for each individual will be exchanged between the residential provider and the day service provider. Going forward, all completed investigation summaries pertaining to a fall will also be reviewed by the QIDP and the facility nurse on a weekly basis at their weekly facility medical support team meeting. The agenda and minutes of the meeting are submitted by the facility nurse to the Nursing Services Director and the Area Director on a weekly basis for additional monitoring and quality assurance.</p> <p>Update:</p> <p>We have looked at the role of the QIDP as the primary investigator and if that may detract from other duties of the QIDP. When each incident is reported, there is a discussion to identify who the best person is to assign to the investigation given current duties. If the QIDP is not able to successfully investigate and manage their other duties, then we assign it to someone else to investigate. We may not have always reassigned the investigations, but it is a valid concern that we should be evaluating for each allegation.</p>	

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	<p>allegation made by [client A] against a staff member by the name of '[day program staff #3].' [Client A's] story has not changed and she is adamant regarding [day program staff #3] pushing her down and pressing on her head while down on the floor."</p> <p>The facility's 7/30/15 follow-up to the 7/22/15 reportable incident report indicated "After speaking with day program staff it was determined there was a staff named '[nick name of DP staff #3].' His real name is [DP staff #3]. At this time it is not clear if [DP staff #3] was suspended. The day program is stating that there was no incident at all regarding [client A]. They are stating that [client A] came in with the injury. However, [client A had a doctor's appointment that morning and then went to the hospital for lab work. [Client A's] injury is extensive enough that a medical professional would have noticed it. [Client A] is scheduled to have her procedure completed during the week of 8/3/2015, once her doctor schedules it... [Client A] has not returned to the day program. She is being singled staff at home to prevent any further irritation of the injury. The Program Director of residential services has reached out to the day program for an investigation summary and is awaiting a response."</p>			

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	<p>The facility's 7/23 and 7/24/15 investigation statements consisted of interviews with client A and staff at the group home. The facility's 7/23 and/or 7/24/15 investigation indicated the facility failed to conduct a thorough investigation in regard to client A's fractured shoulder within 5 business days.</p> <p>Interview with the DP Area Director (DPAD) and DPPD (Day Program Program Director) on 8/5/15 at 12:05 PM stated client A's group home stated client A had a "broken collar bone." The DPAD and the DPPD indicated the day program conducted an investigation in regard to the allegation of abuse by DP staff #3. The DPPD stated the allegation of abuse "could not be substantiated." DPPD indicated they could not determine if client A fractured her shoulder at the day program. DPPD stated "She (client A) fell on his body (DP staff #3)." DPPD stated client A "came out of bathroom. [DP staff #3] caught her during a fall." DPPD indicated client A had complained of her arm prior to the fall at the workshop. DPAD and DPPD indicated the day program's investigation had just been completed and the day program staff had been retrained on client A's use of the gait belt and abuse and neglect. DPPD</p>			

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W 0267 Bldg. 00	<p>and DPAD indicated the facility had not received the day program's investigation results as of 8/5/15 as the day program's investigation was completed on 8/4/15.</p> <p>Interview with PD on 8/6/15 at 3:19 PM, by phone, indicated the facility just received the day program's investigation of the 7/22/15 allegation of staff to client abuse on 8/5/15. PD #1 indicated she would need to review the day program's investigation to complete the facility's investigation. PD #1 stated "They [day program agency] have never allowed me to interview their staff. [Name of day program/agency] policy. We can't ensure a thorough investigation." PD #1 indicated the day program would communicate with Dungarvin via e-mail. PD #1 indicated this was the first time the day program gave Dungarvin an investigation the day program had completed.</p> <p>This federal tag relates to complaint #IN00178955.</p> <p>9-3-2(a)</p> <p>483.450(a)(1) CONDUCT TOWARD CLIENT The facility must develop and implement written policies and procedures for the management of conduct between staff and</p>			

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	<p>clients.</p> <p>Based on observation, interview and record review for 1 of 4 sampled clients (B), the facility failed to implement its written policy and procedure in regard to staff to conduct/interactions to ensure staff did not make inappropriate comments to the client.</p> <p>Findings include:</p> <p>During the 8/5/15 observation period between 4:30 PM and 6:00 PM, client B asked staff #1 for some water and then asked when they were going to eat repeatedly. Staff #1 stated "If you be quiet and good, I'll give you a piece of candy." Client B turned around and walked into the living room and sat down. Staff #1 handed the client a piece of candy. At 5:07 PM, client B was sitting on a chair in the living room. Staff #1 came into the living room and sat in a chair next to client B. Client B turned and looked at staff #1 and stated in a loud tone "Dog." Staff #1 stated in a loud tone "Don't call me no dog. You are not going to get anymore candy. I'm going to eat it right in your face." Staff #1 then stood up and handed clients C, D and E, who were in the living room, a piece of candy except for client B.</p> <p>The facility's policies and procedures</p>	W 0267	<p>Direct care staff #1 was suspended pending investigation. She was reinstated and received disciplinary action, and additional training requirements that she must complete by 09/17/15. . All staff at the facility will be retrained by 09/17/15 on the Dungarvin policy and procedure pertaining to Abuse/Neglect. All staff at the facility will be retrained by 09/17/15 on the Dungarvin policy and procedure concerning staff interactions with individuals. All staff at the facility will be retrained by 09/17/15 on the behavior support plan for Client B. All staff at the facility will be retrained by 09/25/15 on the behavior support plan for any other individual that has a behavior plan and resides at the facility. The QIDP (or designee) will observe Staff #1 during 10 of her scheduled shifts (a minimum of 2 shifts per week) to ensure that she is treating all of the individuals with dignity and respect. Immediate coaching will be provided (if needed). The observations will taper once Staff #1 has demonstrated competency in adhering to Dungarvin policy on staff interactions with individuals in the facility. The observations will be documented and the documentation will be provided to the Area Director for review and quality assurance. Going forward, the QIDP will conduct weekly visits to the home and</p>	09/17/2015

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	<p>were reviewed on 8/5/15 at 2:16 PM and on 8/6/15 at 1:57 PM. The facility's 4/25/14 policy entitled Policy and Procedures Concerning Staff Interactions With Individuals indicated "Dungarvin's goal is to support each individual in meeting his or needs for good health, safety, and a fulfilling life experience that is conducive to optimal growth, consistent with his/her optimal potential...At all times, staff will be expected to treat the individual who receives services from Dungarvin with dignity and respect...B. Employees will try to increase the individuals' self-esteem</p> <p>1. Be positive in interactions with the individuals. 2. Provide positive programming. 3. Reinforce positive behaviors. 4. Treat individuals in an age-appropriate manner, with dignity and respect...C. Employees will act as a role model for other staff and individuals. 1. Communicate with the individuals appropriately...."</p> <p>Interview with Program Director #1 on 8/6/15 at 3:19 PM, by phone, indicated facility staff should respect clients and treat them with dignity. PD #1 indicated the statements made by staff #1 on 8/5/15 were not appropriate staff to client interactions.</p> <p>9-3-5(a)</p>		<p>observe all interactions between staff and the individuals residing in the home. Immediate feedback and coaching will be provided. Disciplinary action will be administered (if needed).</p>				

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W 0318 Bldg. 00	<p>483.460 HEALTH CARE SERVICES</p> <p>The facility must ensure that specific health care services requirements are met. Based on interview and record review, the facility failed to meet the Condition of Participation: Health Care Services for 1 of 4 sampled clients (A). The facility's Health Care Services failed to ensure its nursing services met the healthcare and nursing needs of each client who resided at the facility.</p> <p>Findings include:</p> <p>The facility's health care services failed to ensure its nursing services met the health care needs of clients. The facility's health care services failed to ensure its nursing services assessed, monitored and/or documented assessments of client A. The facility's health care services failed to ensure nursing services developed a risk plan for the client's clavicle fracture to ensure staff knew how to care for the client, and/or failed to revise the client's risks plans as needed. The facility's health care services failed to ensure its nursing services obtained clarification and/or documentation of a doctor's statement in regard to the client's fracture. The facility's health care services failed to ensure its nursing</p>	W 0318	<p>The facility nurse will be retrained on the standards pertaining to health care services at the facility by 09/17/15. The training will include the expectation that nursing services should assess, monitor and document the health care needs of all individuals residing at the facility. An aspect of that documentation is ensuring that all medical records from appointments and hospitalizations are obtained and clarification on orders is sought for any discrepancies. The facility nurse will pursue online chart options (electronic medical record) that may be available through each individuals medical provider so that a high quality continuum of care of is maintained. Going forward, the facility nurse will review all discharges with the medical center nurse at the time of the discharge. In addition, the QIDP and facility nurse will review all medical discharge information within one business day. The on-call nurse or on-call QIDP will be available for immediate consultation if the discharge occurs after business hours. All follow-up directives will be completed within the designated timeframe established by the physician's orders. In addition,</p>	09/17/2015

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	<p>services obtained a physician's order in regard to the use of a gait belt for client A. Please see W331.</p> <p>This federal tag relates to complaint #IN00178955.</p> <p>9-3-6(a)</p>		<p>the facility nurse will be retrained by 09/17/15 on the expectation that risk plans are to be created and/or revised when an individual has a change in medical condition in order that the staff may be trained on how to properly provide care and treatment to the individual. An audit will be conducted by 09/17/15 by the QIDP and/or facility nurse to ensure that each individual in the facility has current risk plans in place. If any risk plans are needed, they will be created/revised and updated by 09/25/17 and all staff will be trained on the updated plans by 10/2/15 (if needed). The interdisciplinary team for each individual will meet a minimum of twice per year (quarterly if needed) to review prior incident reports, goal progression, risk plans and any other concerns. Revisions and updates will be made (as needed) and all facility staff will be retrained on any new or revised goals and risk plans within 7 days. The QIDP and the facility nurse will be retrained by 09/17/15 on the expectation that physician's orders are required for all adaptive equipment needs and uses for each individual in the facility. An audit will be conducted by 09/17/15 by the QIDP (or designee) on the adaptive equipment orders for all individuals residing in the facility. This audit will ensure that orders</p>	

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W 0331 Bldg. 00	483.460(c) NURSING SERVICES The facility must provide clients with nursing services in accordance with their needs. Based on interview and record review for 1 of 4 sampled clients (A), the facility's nursing services failed to meet the health needs of the client in regard to assessing, monitoring and/or documenting assessments of the client after falls with injuries. The facility's nursing services failed to develop a risk plan for the client's clavicle fracture to ensure staff knew how to care for the client, and/or failed to revise the client's risks plans as needed. The facility's nursing services failed to obtain clarification and/or documentation of a doctor's statement in regard to the client's fracture. The facility's nursing services also failed to obtain a physician's order in regard to the use of a gait belt.	W 0331	are on file for all adaptive equipment uses/needs for each individual in the facility. Going forward, incident reports, risk plans and physician's orders are to be reviewed weekly at the QIDP and Facility Nurse medical support team meeting. The facility nurse forwards the agenda/minutes of the meeting to the Nursing Services Director and the Area Director on a weekly basis for additional monitoring and quality assurance. The facility nurse will be retrained on the standards pertaining to health care services at the facility by 09/17/15. The training will include the expectation that nursing services should assess, monitor and document the health care needs of all individuals residing at the facility. An aspect of that documentation is ensuring that all medical records from appointments and hospitalizations are obtained and clarification on orders is sought for any discrepancies. The facility nurse will pursue online chart options (electronic medical record) that may be available through each individuals medical provider so that a high quality continuum of care of is maintained. Going forward, the facility nurse will review all discharges with the	09/17/2015

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	<p>Findings include:</p> <p>The facility's reportable incident reports and/or investigations were reviewed on 8/5/15 at 2:40 PM. The facility's reportable incident reports and/or investigations indicated the following (not all inclusive):</p> <p>-5/16/15 "[Client A] had a laceration on the back of her head due to falling off of her bed and into the dresser. [Client A] was taken to the ER (emergency room) per the nurse on call. The Doctor in the emergency room put three staples in [client A's] head. The ER doctor requested that [client A] follow-up with her doctor in one week. Staff will continue to monitor [client A] and make sure that she get the best medical care possible when needed."</p> <p>-7/13/15 "[Client A] had a series of back to back seizures, which is not normal for her. Typically [client A] has one seizure and may have more later in in the day, but not repeatedly following each other. [Client A's] doctor was contacted but she could not be seen on the 13th. [Client A] was taken to [name of hospital] for an evaluation. Her seizure medication was increased and she was referred back to her neurologist...."</p>		<p>medical center nurse at the time of the discharge. In addition, the QIDP and facility nurse will review all medical discharge information within one business day. The on-call nurse or on-call QIDP will be available for immediate consultation if the discharge occurs after business hours. All follow-up directives will be completed within the designated timeframe established by the physician's orders. In addition, the facility nurse will be retrained by 09/17/15 on the expectation that risk plans are to be created and/or revised when an individual has a change in medical condition in order that the staff may be trained on how to properly provide care and treatment to the individual. An audit will be conducted by 09/17/15 by the QIDP and/or facility nurse to ensure that each individual in the facility has current risk plans in place. If any risk plans are needed, they will be created/revised and updated by 09/25/17 and all staff will be trained on the updated plans by 10/2/15 (if needed). The interdisciplinary team for each individual will meet a minimum of twice per year (quarterly if needed) to review prior incident reports, goal progression, risk plans and any other concerns. Revisions and updates will be made (as needed) and all facility staff will be retrained on any new or revised goals and risk plans</p>		

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	<p>-7/22/15 "When [client A] arrived home from Workshop, she came into the site and set (sic) on the sofa next to this staff (Program Director-PD #2). [Client A] leaned her head towards staff shoulder. Staff asked her what was wrong and she began to cry and say her right arm was hurting. She said her right elbow was hurting as well. Staff calmed her down and asked her to sit straight up and left her head up. [Client A] did and stopped crying. Staff then told her to do what staff does. Staff held out her arms in front of her and asked [client A] to do the same. She did, but was favoring the right arm. Staff raised both arms straight up and asked [client A] to do the same. [Client A] raised the left arm but not the right arm. Staff asked her to do her right arm and [client A] said, 'I can't. It hurts.' Staff told her to try and she said, 'I can't.' By then the staff that transported (sic) was coming in the door and said that [client A] reported it happened at workshop. Staff noticed that she had a lump on her right shoulder. Staff said the Workshop staff denied [client A] falling at workshop. However [client A] was adamant that someone by the name of [day program staff #3] had pushed her down and hurt her arm at workshop. Staff reached for [client A's] right arm and she pulled away. Staff told her to wait and let her look at it. When staff</p>		<p>within 7 days. The QIDP and the facility nurse will be retrained by 09/17/15 on the expectation that physician's orders are required for all adaptive equipment needs and uses for each individual in the facility. An audit will be conducted by 09/17/15 by the QIDP (or designee) on the adaptive equipment orders for all individuals residing in the facility. This audit will ensure that orders are on file for all adaptive equipment uses/needs for each individual in the facility. Going forward, incident reports, risk plans and physician's orders are to be reviewed weekly at the QIDP and Facility Nurse medical support team meeting. The facility nurse forwards the agenda/minutes of the meeting to the Nursing Services Director and the Area Director on a weekly basis for additional monitoring and quality assurance.</p>	

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	<p>pulled her blouse down, she had a lump about the size of a half a golf ball on her shoulder about two inches from her neck. Staff advised the transport staff to call the nurse immediately because it appeared to be a dislocation. Another staff called the On-call Nurse and On-call PD. The nurse instructed staff to take [client A] to ER (emergency room). At approximately 5:3pm (sic) staff transported [client A] to [name of hospital]. [Client A] was still favoring her right arm and did not want it touched. [Client A] was called to the back around 7:30 p.m. The doctor saw [client A] and said to undress her to her waist for x-rays to be taken. The Xray showed that she had a fracture of the clavicle...."</p> <p>The day program's Immediate Investigation of Injury reports, reportable incident reports and/or investigations were reviewed on 8/5/15 at 11:45 AM. The day program's incident reports, reportable incident reports and/or investigations indicated the following:</p> <p>-7/17/15 "On 7-17-15 I (day program staff #6] assisted [client A] to the bathroom @ (at) that time while [client A] was sitting on the toilet. She complained that her right arm was hurting her. I asked her what happened, [client A] stated she fell @ home and</p>			

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	<p>broke her arm. I told her PD (Program Director at Day Program-DPPD)- and she called [PD #1]. [PD #1] stated to [DPPD] that [client A] was faking. [Client A] stated that she fell @ home previous to today on 7-16-15. No treatment provided because [DPPD] contacted [PD #1] @ Dungarvin- [PD #1] stated that [client A] was faking because another client had a broken limb in the house an (sic) [client A] wanted the same attention that staff was getting. [PD #1] states that she already filed a BDDS (Bureau of Developmental Disabilities Services) report and [client A] had been to the doctor regarding the injury she is alleging...."</p> <p>-7/20/15 "[Day program staff #5] took [client A] to bathroom and [client A] asked for privacy. [Day program staff #5] lefted (sic) out of the bathroom. [Client A] was seen walking out by herself. Staff C (day program staff #3) saw her falling and dived under her breaking...." The day program's incident report indicated client A's "Gait belt broke (C) staff (day program staff #3) dived under [client A] to break fall. [Client A] was coming from bathroom. (C) staff (day program staff #3) was coming from maintenance room by the bathroom."</p>			

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	<p>The day program's 7/28/15 investigation summary indicated "...Conclusion: Evidence could not be found to support the allegation of abuse. Evidence could not be found to determine the cause of [client A's] broken collarbone however there is evidence to support that [client A] had complained on Friday, July 17th of her right arm hurting and said that she had fallen at home and broke her arm on which was reported to her residential supervisor on July 17th (sic). Evidence supports that [client A] did ambulate from the bathroom on Monday, July 20th however witness statements support that she did not actually fall hitting any hard surface. Evidence supports that [client A's] fall risk protocol from Dungarvin does not indicate that [client A] should be assisted with ambulation unless she appears to be lethargic or weak although at Day Program they have been trained to assist her at all times with ambulation."</p> <p>Client A's hospital records were reviewed on 8/6/15 at 10:15 AM. Client A's hospital records indicated the following hospitalizations and/or ER trips (not all inclusive):</p> <p>-3/27/15 Emergency department (ED) Note indicated "Patient to ED per [name of ambulance company] for unsteady gate (sic) and altered mental status that staff</p>			

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	<p>noticed about 1100 (11:00 AM) today. Staff states that patient fell outside daycare center this morning, but are unsure who witnessed the fall or how the patient fell. Patient denies pain at this time. Staff states that patient's speech is slower than normal and that she seems not as alert as normal. Patient awake, oriented x (times) 4. respirations unlabored."</p> <p>Client A's 3/27/15 History of present Illness indicated "...She (client A) apparently had a fall outside this morning. Details of this are not clear, however. She was noted to have some gait instability which staff apparently did not think much of it initially. However, she is also demonstrating a change in her mentation. Her caregiver states that normally she is awake, very talkative and very active. She is mostly just lying in bed now. Caretaker states this is very unusual behavior for her. She does wear a helmet normally. No increased seizure activity has been noted."</p> <p>Client A's 3/27/15 Cat Scan, of the client's head, was performed with "No acute abnormality with no intracranial bleeding...." Client A's ED note indicated client A improved while in the hospital's ER and it was decided the client would be released and followed by</p>			

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	<p>the client's doctor.</p> <p>-5/16/15 Client A's 5/16/15 ED Arrival Information indicated "Patient fell at home and hit head on dresser. Chief Complaint Fall, head Injury Diagnosis: Laceration of scalp."</p> <p>Client A's 5/16/15 History indicated "...She was in bed and fell out striking the back of her head against the dresser. Staff is with patient stating there was no loss of consciousness. She's been acting at her baseline. No vomiting. She (sic) occurred just prior to arrival in the emergency department." Client A's 5/16/15 Ed Note indicated 3 staples were placed in the back of client A's head. Client A's 5/16/15 ED note indicated "...Care giver states that the fall was unwitnessed...."</p> <p>-5/22/15 Client A's 5/22/15 Emergency Department Encounter indicated client A came to the ER "...with complaints of a seizure today. She wears a helmet and did not have her helmet on when she had her seizure. She fell and hit her mouth on the stove. She presents with some gingival bleeding to the right lower canine of her mouth...During this examination of this patient, other medical conditions were considered as possible causes of this patient's complaint</p>			

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	<p>including but not limited to 1. Mandibular fracture 2. Dental injury...."</p> <p>Client A's 5/22/15 Radiology/Procedures indicated a Cat Scan of client A's jaw was performed. The radiology report indicated "There is a fracture involving the alveolar ridge of the mandible extending below the roots of the four mandibular incisor teeth...Impression: Fracture involving the alveolar ridge of the anterior aspect of the mandible." Client A's 5/22/15 ED Note indicated client A was admitted to the hospital where the client was placed on a soft diet, an intravenous antibiotic (infection), and to have an oral surgery consult.</p> <p>Client A's 5/24/15 Progress Note, by the oral surgeon, indicated "Fell and hit mouth on the stove. Bleeding and mild. History of seizures. Fracture involving the alveolar ridge of the anterior aspect of the mandible. Mandible displaced. No surgery. Pt (patient) is (sic) been eating well. No pain. Soft diet 3 weeks. Follow up at the office in week." Client A was discharged back to the group home on 5/24/15.</p> <p>-5/28/15 Client A went to the hospital to have the staples removed from the back of her head.</p>			

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	<p>-7/22/15 Client A "...is brought to the ER by caseworker after noticing patient had a deformity to right clavicle. Per caseworker. Patient states headache in adult daycare center and noticed injury when they went to pick her up. patient now complaining of right shoulder and right elbow pain...." The ED Provider Note indicated "...Right shoulder: Decreased range of motion secondary to pain. Pain with palpitation. Swelling and erythema over mid clavicle. Right elbow: Mild swelling. No erythema or obvious deformity. Decreased range of motion secondary to pain...Diagnosis management comments: Dx (diagnosis) Right clavicular fracture Rx: (prescription) Tylenol 500 mg (milligrams) (pain) Tx (treatment): Right shoulder immobilizer Patient will be referred to orthopedics, [name of doctor]...."</p> <p>Client A's 7/22/15 ED Note indicated "...Care giver states patient is 'favoring' right arm and told her she feel (sic) when leaving her adult daycare today. Patient is mentally challenged and is poor historian...." Client A's hospital X-rays indicated the doctors ordered an xray of the client's chest, right elbow and the client's right shoulder. Client A's 5/22/15 Radiology results of the client's elbow indicated "...IMPRESSION: Negative</p>			

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	<p>right elbow (no fracture/dislocation). Client A's 5/22/15 right shoulder X-ray indicated "...Impression: Fracture right clavicle..." Client A's 5/22/15 chest X-ray indicated "...IMPRESSION: 1. Interval increased displacement of right midclavicular fracture. Consideration for surgical fixation is suggested. 2. Negative for acute cardiopulmonary abnormality."</p> <p>Client A's 8/5/15 Orthopedic Surgery History And Physical (H&P) indicated "[Client A] is a 38 y.o. (year old) female admitted on 8/5/2015...with history of mental retardation and seizures presents with a right clavicle fracture approximately 2-3 weeks duration (week of 7/13/15 or 7/20/15). The fracture is displaced and therefore I (orthopedic surgeon) recommend open reduction internal fixation of the fracture." The H&P indicated client A would be admitted for observation. Client A's 8/5/15 orthopedic surgery note indicated "Patient was brought into the OR (operating room) for open reduction internal fixation of right clavicle fracture. Once patient was placed under general anesthesia by (sic) fully examine the fracture and found that the fracture was essentially stable with no crepitus (grating, cracking or popping sounds)...An x-ray was obtained and did</p>			

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	<p>not show any significant change from the initial x-ray but based on the clinical examination and the patient's general condition I've elected to not proceed with open reduction internal fixation of the clavicle because it appears to be clinically healed. Therefore this time we will continue with conservative care and allow the patient be (sic) discharged to home."</p> <p>Client A's record was reviewed on 8/6/15 at 1:53 PM. Client A's General Event Reports (GERs) indicated the following (not all inclusive):</p> <p>-6/2/15 "[Client A] left bathroom after taken (sic) medication went in [client C's] room squeeze pass (sic) [client C] while she was in the door way in wheel chair and fell on the floor staff pick her off the floor and change her clothes she had solid (sic) on her self (sic)...no visible injuries (sic)."</p> <p>-7/3/15 "[Client A] turned around to go take her bib to her room. Her housemate was preparing to put the dishes in the dishwasher. [Client A] tripped over the dishwasher hood and fell on her bottom." The GER indicated client A was not injured.</p> <p>-7/13/15 "staff (sic) was dressing [client</p>			

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	<p>A] and noticed a (sic) open scare (sic) on her right arm above her elbow...[Client A] has been having a series of seizures since Friday (sic). [Client A] must have hurt her arm and scraped the skin off during the time frame."</p> <p>-7/16/15 "[Client A] was unloading the van and she was struggling to get out. Staff was supervising and assisting [client A] but she didn't want help. Staff told [client A] that we needed to help her. [Client A] wrestled with staff and [client A] ended up on the ground coming out. Other staff came over to assist getting [client A] up. Staff looked at [client A's] knees and there were no injuries."</p> <p>-7/21/15 "[Client A] had got (sic) from sitting in a chair and went into the kitchen. About 5 p.m., she was standing in the kitchen addressing staff and was prompted to leave the kitchen and she would not. She stood over by the pantry area and about 3 minutes later went into a seizure. It lasted 15 seconds. She was not hurt. Her breathing was normal. she said she could not get up. when prompted. She appeared weakened, but it could have been her being stubborn too...."</p> <p>-7/22/15 "[Client A] was being picked up from workshop and [client A] came to</p>			

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	<p>staff and she said she hurt herself because she fell and then her day program staff walked up when they over heard her and said they didn't know what happened to her they just so happened to notice it...</p> <p>[Client A] has a big swollen knot on her right shoulder [client A] told staff she fell at workshop and that it hurts to move her arm." The GER indicated "...[Client A] will be taken to the hospital. [Client A] will be watched closely and help with walking holding he (sic) gait belt."</p> <p>-7/22/15 Another 7/22/15 entry indicated "...Staff asked the [name of workshop] staff if [client A] had fallen and hurt herself and they said she did not. [Client A] said she did fall and hurt her arm...."</p> <p>Client A's Appointment and/or consultation Forms indicated the following (not all inclusive):</p> <p>-7/13/15 Client A went to the ER. The 7/13/15 consultation form indicated "[Client A] has drop seizures and when she does she has one seizure and that is it. Today she had five seizures back to back and [client A] never has repeat seizures. She is coming in for evaluation." Client A's 7/13/15 Appointment form indicated client A's medications were increased after the hospital consulted with the client's</p>			

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	<p>Neurologist. The 7/13/15 appointment/consult form indicated a chest Xray was also completed on 7/13/15.</p> <p>-7/14/15 Client A saw her cardiologist regarding the client's pacemaker. The 7/14/15 appointment form indicated "The phlebotomist tried to take blood but was unable to get any from [client A]. The doctor waited on her and stated for her to stay on the same meds (medications) and her follow up appointment is...."</p> <p>-7/22/15 at 10:30 AM, client A went to an Oncologist appointment. Client A's 7/22/15 Appointments form indicated "[Client A] saw [name of oncologist] he gave me (staff #6) a copy of her labwork (sic) and also wanted to know if her seizures meds or does she have sleep apnea and wants her to see her primary dr (doctor)...."</p> <p>-7/22/15 at 6:00 PM, "[Client A] is being taken to the hospital because upon picking her up from Day program she said her arm hurt and when staff looked her shoulder was swollen and she couldn't move her arm without pain."</p> <p>-7/24/15 "[Client A] is seeing [name of orthopedic doctor] as a follow up from her ER visit. She was diagnosed with a</p>			

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	<p>closed right clavicular fracture...He said she needs surgery to repair her clavicular fracture and they would contact us Tuesday to let us know when."</p> <p>Client A's T-Logs (progress notes) indicated the following (not all inclusive):</p> <p>-7/13/15 at 7:00 AM, "When staff (staff #2) arrived [client A] was sitting on the couch. [Client A] greeted staff and asked to take a bath. Staff complied and helped [client A]. Staff noticed a open scrape on her right arm above her elbow. [Client A] told staff she fell but it still hurts. Staff called on call PD and completed a GER report...."</p> <p>7/14/15 at 9:36 PM, "...[Client A] stood up about 10 minutes later and when staff asked, 'Where are you going, sit down and watch TV.' [Client A] just stood in the living room. In about 40 seconds, she fell to the floor in a seizure. It was about 2:50 p.m. It lasted about 45 seconds. Staff made sure she was okay and she began to pull out of it. She was breathing heavily and had urinated on herself. Staff asked 'Are you okay?' [Client A] said, 'I can't get up.' Staff was rubbing [client A's] back and telling her to just lay there and relax. [Client A] had not taken a hard fall and there was (sic) no apparent</p>			

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	<p>injuries. [Client A] already had a sore on her right elbow. When staff asked her to try and get up, she said, 'My elbow hurt.' There was no blood coming from the sore. Staff presumed she had landed on that arm and that because there was a sore, this is why she said her elbow hurt. Staff was able to move the arm and [client A] got up with staff assistance...."</p> <p>-7/16/15 When client A came home from the day program, "...[Client A] then collapsed to the floor in a seizure. It lasted about 15 seconds. Staff asked if she was okay. [Client A] said her elbow hurt. She has a sore on her elbow and has been stating that her elbow hurts for the past two days. It is a sore that is healing...."</p> <p>-7/19/15 "[Client A] was check (sic) every 1 hour (sic) she was yelling for the staff several time (sic) about getting up and dress (sic). She woke up her roommate several times yelling. [Client A] has a scrape on her right elbo (sic) that she got during a fall several days ago...."</p> <p>-7/20/15 "...During dinner [client A's] housemate bagged (sic) up into her on accident. [Client A] fell back and had a seizure. Staff asked [client A] if she was ok. [Client A] told staff her elbow hurted</p>			

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	<p>(sic). Staff checked [client A] (sic) no visual injuries. Staff contacted the pd (PD) and nurse on call...."</p> <p>-7/22/15 at 11:08 PM, client A arrived home and was complaining of her right arm hurting. The T-Log indicated the staff who had transported client A home indicated "...[client A] said she fell at the workshop and she has a lump on her right shoulder. Staff said the Workshop staff denied [client A] fell at their site, but [client A] said she did and hurt her arm. Staff reached for [client A's] right arm and she pulled away...When staff pulled her blouse down, she had a lump about the size of a half a golf ball on her shoulder about two inches from her neck...." The T-Log indicated when the client was at the hospital, "...We finished the x-rays and returned to our booth in ER. The doctor came in about 15 minutes later and stated it was a fracture of the clavicle and asked what happened. Staff explained and [client A] said, 'I fell and hurt my arm.' The doctor stated he wanted her not to move the arm and that she ABSOLUTELY CANNOT FALL. The doctor said if she falls, she could puncture her lung. The doctor said he wanted her to have an appointment with and (sic) orthopedic surgeon, [name of doctor] ASAP (as soon as possible)...."</p>			

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	<p>-7/24/15 "[Client A] seen (sic) [name of orthopedic doctor] about her fractured clavicular (sic). [Name of orthopedic doctor] stated that when [client A] went to the hospital on July 13th and had a Xray it showed up then but no one read the Xray to let staff know so when she had that fall at day program that just pushed her shoulder to pop out. [Client A] will need surgery...." Client A's T-Logs and/or record indicated the facility's nurse failed to assess, monitor and/or document any assessments regarding client A's falls and/or fractures in the client's record. The facility's nurse failed to obtain clarification/documentation by the doctor in regard to there being a possible fracture on 7/13/15.</p> <p>Client A's 3/3/14 Annual IPP (Individual Program Plan) Health Summary (current one in record) indicated client A's diagnoses included, but were not limited to, Cerebral palsy, Grand Mal Seizures, Multiple Sclerosis and Abnormal Gait Disorder.</p> <p>Client A's 3/30/15 Seizure Management Plan (SMP) indicated client A had "Drop Seizures" which could be triggered by "...Loud noises, sun light, sudden changes in her environment and being frightened have been known to cause her to have a</p>			

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	<p>seizure...." Client A's seizure risk plan indicated client A was to wear a helmet "to help prevent possible injury during a seizure. Staff will assist [client A] with ADL's (Adult Daily Living) as needed. They will remain in the bathroom when she is taking a bath and outside the door with the door ajar when she is in shower. Staff will be ready to act quickly if she were to have a Seizure...." The risk plan indicated when client A had a seizure, facility staff were to check the client for injuries and provide first aid. The risk plan indicated once the seizure was over facility staff were to notify the nurse and/or on call nurse.</p> <p>Client A's 3/30/15 Fall Risk Plan indicated client A was to wear a gait belt at all times when out of bed. The 3/30/15 fall risk plan indicated "...During episodes of weakness or lethargy, Staff will assist [client A] with walking by walking next to her, holding on to the gait belt. Staff may have to assist [client A] with getting in or out of a car, stand by assist may be necessary at times. To decrease risk of falls, [client A] will have a bed alarm in place on her bed to remind her to ask for assistance with getting out of bed...Staff to remind [client A] to slow down when moving too quickly. Staff to remind [client A] to wear her hard shell helmet at all times to protect her head</p>			

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	<p>during a seizure/fall...Staff will assist [client A] with showers and use a shower chair...."</p> <p>Client A's IDT (interdisciplinary team) Members in Attendance at team meeting (IDT notes) indicated client A's IDT met on 1/21/15 and 4/3/15. Client A's above mentioned IDT notes and 3/4/14 Individual Support Plan (ISP), current one in the chart, indicated the facility failed to meet and review the client's increased number of falls/falls which resulted in injuries/fractures, and/or failed to meet, review/revise client A's 3/30/15 fall risk plan to ensure it met the needs of the client. The facility's nursing services failed to develop nursing measures in regard to how facility staff should assist client A to ambulate with the gait belt as client A was continuing to have falls. The facility's nursing services failed to develop a risk plan in regard to client A's fractured shoulder to ensure continuity of care when bathing and/or dressing to prevent further injury. Client A's ISP and/or record indicated the facility's nursing services failed to obtain an assessment and/or doctor's order in regard to the use of a gait belt for client A.</p> <p>Interview with DPC on 8/5/15 at 11:25 AM and at 12:12 PM indicated client A</p>			

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	<p>had attended their day program since September 2014. DPC indicated client A had not returned to the day program since the client fractured her shoulder. DPC indicated she was not at the day program the day client A fell. DPC indicated DP staff #3 was suspended when the allegation of abuse was made. DP staff #3 indicated 8/5/15 was DP staff #3's first day back as the allegation of abuse was not substantiated. DP staff #3 indicated 4 other staff were present when client A fell. DPC stated "The lump was noticed toward the end of the day." DPC indicated the lump found on client A's shoulder and client A's fall was on two different days. When asked if there was an incident with client A on the day the lump was found, DPC stated "No ma'am." DPC stated client A was to wear her gait belt "at all times." DPC indicated client A's plan did not indicate staff had to assist client A to ambulate with her gait belt at all times. DPC stated "But we (day program staff) are with clients with gait belts at all times."</p> <p>Interview with DP staff #7 on 8/5/15 at 11:38 AM indicated she did not know how client A injured her shoulder. DP staff #7 stated "She (client A) told me she fell out of bed on the 16th or 17th." DP staff #7 indicated client A had a history of falls and seizures.</p>			

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	<p>Interview with DP staff #2 on 8/5/15 at 11:38 AM indicated she did not work the day client A fell at the day program. When asked if client A had a history of falls, DP staff #2 stated "Not that I know of." DP staff #2 indicated she did not know how client A injured her shoulder.</p> <p>Interview with DP staff #6 on 8/5/15 at 11:42 AM indicated facility staff was to assist client A to ambulate with her gait belt. When asked if the staff had witnessed any abuse of clients, DP staff #6 stated "There was when I first started here. Staff is gone." DP staff #6 indicated she had worked at the day program since November 2014. DP staff #6 indicated she worked the day the lump was found on client A's shoulder. DP staff #6 she did not know how client A hurt her shoulder. DP staff #6 indicated client A had a history of falls. DP staff #6 stated "She (client A) has not had too many falls here. Transport staff (group home staff) do not hold on to her gait belt when walking in (day program)."</p> <p>Interview with DP staff #3 on 8/5/15 at 11:45 AM indicated client A had a history of falls. DP staff #3 indicated he did not know how client A fractured her shoulder. DP staff #3 indicated he was working the day client A fell at the day</p>			

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	<p>program. DP staff #3 stated "When she was getting ready to fall, I jumped in and broke the fall." DP staff #3 indicated client A was coming out of the bathroom and DP staff #3 was in the utility closet. DP staff #3 stated "I seen she was going to fall. I jumped in front of her and we fell to ground together." When asked was staff with client A when she was in the bathroom, DP staff #3 stated "The utility closet is next to the bathroom. Someone yelled [client A] is coming out and I ran to her." DP staff #3 indicated when he grabbed client A's gait belt, the belt broke. DP Staff #3 stated "It snapped." Day Program staff #3 indicated client A had complained of her arm hurting prior to her fall at the day program.</p> <p>Interview with DP staff #5 on 8/5/15 at 11:55 AM stated she worked the day client A fell coming out of the bathroom, and the day a "lump" was found on client A's shoulder. DP staff #5 indicated she was the staff who placed client A on the toilet in the bathroom. DP staff #5 indicated client A did not want her to stay in the bathroom with client A. DP staff #5 indicated she returned to her group and client A was to call when she was ready to leave the bathroom. DP staff #5 indicated they assisted client A to ambulate with the gait belt due to the</p>			

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	<p>client's seizures and falls. DP staff #5 indicated DP staff #3 was in the utility room which is next to the bathroom. DP staff #5 stated "She (client A) got up no sooner than I left. She was coming out of the bathroom. [DP staff #3] grabbed her gait belt and the gait belt broke where the plastic was at." DP staff #5 indicated DP staff #3 tried to break client A's fall. DP staff #5 stated "She has been falling a lot lately at the group home." DP staff #5 indicated client A told her she had fallen out of the bed. DP staff #5 indicated client A had complained of her arm hurting prior to her fall at the day program.</p> <p>Interview with the DP Area Director (DPAD) and DPPD on 8/5/15 at 12:05 PM stated client A's group home indicated client A had a "broken collar bone." The DPAD and the DPPD indicated the day program conducted an investigation in regard to the allegation of abuse by DP staff #3. The DPPD stated the allegation of abuse "could not be substantiated." DPPD indicated they could not determine if client A fractured her shoulder at the day program. DPPD stated "She (client A) fell on his body (DP staff #3)." DPPD stated client A "came out of bathroom. [DP staff #3] caught her during a fall." DPPD indicated client A had complained of her</p>			
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	<p>arm prior to the fall at the workshop. DPPD stated on "7/17/15 staff noted different gait walking. I mentioned it to Dungarvin staff." DPPD stated client A told her "She fell up against a dresser." DPPD indicated client A fell at the group home and received sutures to the back of her head. DPPD stated client A was brought into the day program the next day and DPPD "sent her back home."</p> <p>Interview with staff #2 on 8/5/15 at 5:32 PM indicated client A was to have surgery on her shoulder on 8/5/15. Staff #2 indicated client A was to stay at the hospital 24 hours after the surgery. Staff #2 stated client A told her her shoulder got injured because a day program staff "pushed her down." Staff #2 indicated client A had a history of seizures and falls. Staff #2 stated client A would have seizures which caused the client to "fall and hurt herself." Staff #2 indicated client A came home from the day program pointing to her shoulder. Staff #2 indicated the client saw her doctor the day before the 7/22/15 incident. Staff #2 indicated the doctor would have seen the injury. When asked if client A would fall out of her bed, staff #2 stated "Not aware of her falling out bed." Staff #2 indicated client A wore a gait belt. Staff #2 stated facility staff used the gait belt when client A was "off balance or</p>			

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	<p>after client A had a seizure."</p> <p>Interview with staff #1 on 8/5/15 at 5:40 PM stated client A wore a gait belt for an "unsteady gait. Staff #1 stated "We are supposed to hold her when walking but sometimes impossible with other ladies." Staff #1 indicated client A would have falls with her seizures. Staff #1 stated client A recently "kept having seizures and fell." When asked if client A had received injuries from the falls, staff #1 stated "She didn't, just kept having seizures." Staff #1 stated client A had a "hairline fracture then but her shoulder was not dislocated." Staff #1 stated the group home did not find out client A had a fracture until her "shoulder came out of place." Staff #1 stated the doctor/hospital "Did not say anything at the time they did the X-ray until she went to the hospital this time." When asked if client A had a history of falling out of the bed, staff #1 stated "Not that I know of. It occurred 1 time." When asked if client A received any injuries from her falling out of the bed, staff #1 stated "No she didn't." Staff #1 stated client A fell and received "a rug burn" on her elbow. Staff #1 indicated the fall occurred at the day program. Staff #1 indicated the facility's nurse came to the group home and checked client A.</p>			

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	<p>Interview with client D on 8/5/15 at 5:55 PM indicated client D was client A's roommate. Client D indicated client A would have falls in the bedroom. When asked if client A hurt herself, client D stated "Yeah. She hit her elbow. Fell out of bed."</p> <p>Interview with PD on 8/6/15 at 3:19 PM, by phone, indicated she was aware of client A's elbow injury. PD indicated she was told client A had an injury on her right elbow. PD stated "I do not know when exact elbow injury occurred. So many seizures occurred around the same time." PD #1 indicated the Orthopedic surgeon told facility staff, at the doctor's appointment on 7/24/15, client A's X-ray taken on 7/13/15 indicated a fracture. PD #1 stated "the X-ray was not read" before the client had returned home. PD #1 indicated she was not told of the 7/13/15 previous fracture on 7/13/15. PD #1 indicated the facility's nurse did not follow-up on the 7/13/15 information relayed at the doctor's office. PD #1 stated the facility did not follow up "unless they give us a print out." PD #1 indicated the labs and/or X-rays may have been ordered by the client's doctor on 7/13/15. PD #1 did not know if the facility's nurse assessed client A's elbow/rug burn. PD #1 indicated client A's gait belt broke at the day program and</p>			

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	<p>it was returned back to the group home. PD #1 indicated she spoke with the day program about them paying for the gait belt. PD #1 stated "We never discussed how it got broken." PD #1 indicated she added the gait belt to client A's risk plans. PD #1 indicated she would attempt to look for the gait belt doctor's order. PD #1 did not provide any additional information/gait belt order. PD #1 indicated client A's risk plans would need to be revised in regard to when/how staff were to use client A's gait belt.</p> <p>Interview with staff #3 on 8/6/15 at 5:40 PM indicated she was not sure if the facility had a risk plan for the care of client A's clavicle fracture. When asked how facility staff assisted client A to change/dress without injuring her arm, staff #3 stated "I assist her very slowly." Staff #3 indicated client A's orthopedic surgeon indicated surgery was not needed. Staff #3 stated "it is healing nicely without surgery."</p> <p>Interview with nurse staff #1 on 8/6/15 at 6:02 PM indicated client A had a history of falls and now had a fractured clavicle. Nurse staff #1 indicated she had assessed/seen client A since client A fractured her clavicle. When asked if nurse staff #1 documented her assessment, nurse staff #1 stated "I think</p>			

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	<p>so. They should be in the T-Logs health." Nurse staff #1 indicated she saw the client on 7/23/15 and 7/24/15. Nurse staff #1 stated "I was glad I sent her out (7/22/15)." Nurse staff #1 indicated she was told client A had a previous fracture before 7/22/15. Nurse staff #1 stated "Someone saw it on My Chart." Nurse staff #1 indicated she could not access client A's My Chart information. Nurse staff #1 indicated the previous nurse could. Nurse staff #1 indicated the facility was attempting to gain access. Nurse staff #1 indicated she did not obtain clarification in regards to what a staff reported on 7/24/15. Nurse staff #1 indicated she had not developed a risk plan for client A's acute injury/fracture of clavicle. Nurse staff #1 stated she was "She (nurse staff #1) was going to do after (client A's) surgery." Nurse staff #1 indicated facility staff were to assist the client to dress and shower. Nurse staff #1 indicated client A's ISP and/or risk plans did not specifically indicate how facility staff was to care for client A's fractured shoulder. Nurse staff #1 indicated client A had been refusing to wear the sling for her arm. Nurse staff #1 indicated client A was at the hospital for surgery on the client's shoulder, but the doctor decided not to do the surgery.</p> <p>This federal tag relates to complaint</p>			

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