

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G362	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/15/2012
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NAME OF PROVIDER OR SUPPLIER STONE BELT ARC INC	STREET ADDRESS, CITY, STATE, ZIP CODE 713 E MILLER DR BLOOMINGTON, IN 47401
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W0000	<p>This visit was for the post certification revisit (PCR) to the fundamental recertification and state licensure survey completed on June 15, 2012.</p> <p>Survey Dates: August 14 and 15, 2012.</p> <p>Facility Number: 000876 Provider Number: 15G362 AIM Number: 100249160</p> <p>Surveyor: Steven Schwing, Medical Surveyor III</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 8/22/12 by Ruth Shackelford, Medical Surveyor III.</p>	W0000		

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

TITLE

(X6) DATE

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

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W0149	<p>483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. Based on record review and interview for 1 of 1 incident report affecting client #2, the facility neglected to implement its policies and procedures to prevent client #2 from falling, in her wheelchair, out of the back of the van while the lift was lowered.</p> <p>Findings include:</p> <p>A review of the facility's incident report was conducted on 8/14/12 at 11:06 AM. On 7/18/12 at 8:00 AM, client #2 fell out of the back of the van while staff #5 assisted client #1 off the lowered van lift. The report indicated, "[Client #2] rolled out of the van & fell on to the lowered lift. Ended up on her back with chair on top of her. Chair switch is broken." The report indicated in the injuries section, "Large bump to head." The report indicated the bump was on the back of her head. The incident report's section regarding action taken indicated, "The Coordinator spoke with [staff #5] on 7/18/12. [Staff #5] told the Coordinator that she should of (sic) not unhooked her wheelchair before she was ready to assist [client #2] off the van." The BDDS (Bureau of Developmental Disabilities</p>	W0149	<p>W 149</p> <p>GOVERNING BODY & MANAGEMENT</p> <p>Plan of Correction:</p> <p>Stone Belt will ensure that specific governing body and management requirements are met. Specifically, Stone Belt will ensure that policies and procedures that prohibit mistreatment, abuse and neglect are followed. Stone Belt Nursing Staff Protocols will be followed, in particular, that Nurses will make on-site visits and/or follow-ups with documentation of assessment in Clients file within 24 hours.</p> <p>Responsible Person:</p> <p>Miller House Coordinator & SGL Director</p> <p>Date of Completion:</p> <p>September 14, 2012</p> <p>Plan of Prevention:</p> <p>House Staff and all SGL staff will review Stone Belt's policy of prevention of abuse and neglect.</p>	09/14/2012			

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	<p>Services) incident report, dated 7/18/12, indicated client #2 was not injured. The BDDS report indicated, "The walk-in clinic found no injuries." A review of the Stone Belt Outside Services Report, dated 7/18/12, indicated, "Contusion to head." The facility did not conduct a thorough investigation of the incident. There was no investigative report, no interview with client #2, documentation of who was present at the time of the incident, corrective action (training) with client #2 regarding backing her wheelchair out of the van, or discussion of facing client #2 toward the lift. There was no documentation if staff #5 was negligent. There was no documentation staff #5 received prior training on the facility's Defensive Driving and Wheelchair Safety in the incident report.</p> <p>Staff #5 received retraining on van restraints on 7/18/12. On 8/10/12, staff #5 was given a Performance Review addressing emergency or safety procedures. The review indicated, "[Client #2] was in the van with lift down while [staff #5] was assisting [client #1]. [Client #2] backed out of van and fell. [Staff #5] ran in to try block [client #2's] fall but [client #2] still got injured. [Staff #5] was trained again on van restraints and learned she was not going to unfasten [client #2] until she was ready. [Client</p>		<p>(Attachment # 1). This training was conducted for house staff and will be reviewed at the SGL In-Service on 9/7/2012. Staff was retrained on van protocol. (Attachment # 2). Stone Belt Nursing Protocol regarding an assessment within 24 hours (Attachment # 3) will be reviewed at SGL In-Service on 9/7/2012.</p> <p>In addition, an informal goal was created for the client. The goal states, "Client will ask if its safe before backing her wheel chair when in the van." (Attachment # 4)</p> <p>Quality Assurance Monitoring:</p> <p>Training staff on Stone Belt's policy of prevention of abuse and neglect will continue as needed with current staff and covered during initial staff orientation of new hires. Stone Belt Nursing Staff and SGL Director will review all incidents to assure that a nursing assessment is conducted within 24 hours of a client visit to emergency room or advanced care.</p>				

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	<p>#2] was also told to not go until staff tells her the lift is ready."</p> <p>A review of the facility's Defensive Driving and Wheelchair Safety training, undated, was conducted on 8/14/12 at 11:28 AM. The training indicated, "When getting ready to unload 2 clients never unstrap the second chair until the first chair is completely off the lift and the lift is in the up position."</p> <p>A review of staff #5's training record, conducted on 8/14/12 at 3:14 PM, indicated she received training on Vehicle Training for New Staff on 9/9/11.</p> <p>A review of client #2's Nursing Consultation Notes, dated 7/20/12, was conducted on 8/15/12 at 10:47 AM. The note initially was not in client #2's record however the facility located and scanned the document into client #2's record. The note indicated, "Received notification from day program staff that [client #2] had fallen previously out of van while seated in wheelchair. Incident occurred 7/18. [Client #2] is awake, alert, oriented. Was seen at clinic at time of accident. PERL (pupils equal, react to light), no n/v (nausea/vomiting). Small discoloration to right temple. C/o (complaints of) soreness but otherwise no complaints. Moving all extremities and neck with no</p>						

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	<p>problems noted. No other injuries reported or noted."</p> <p>A review of the facility's abuse and neglect policy, dated 10/15/10, was conducted on 8/14/12 at 3:04 PM. The policy indicated, "Abuse and neglect are never acceptable. Abuse is defined as the willful/purposeful infliction of physical or emotional pain, injury, physical violation, revilement, malignment, exploitation and/or otherwise disregard of an individual. Neglect is the failure to provide appropriate care, food, medical care or supervision of an individual, whether purposeful or due to carelessness, inattentiveness, or omission of the responsible party which results in risk of physical harm and/or emotional trauma." The policy indicated, "Cases or suspected cases of mistreatment/neglect/abuse involving the implementation of behavioral intervention techniques or any incident involving the use of physical intervention, accident or injury to a Client shall be reported according to the Incident Reporting Procedure. The Executive Director will be notified in accordance with this procedure. A file of these Incident Reports shall be maintained by the appropriate agency personnel. This file is accessible to the Chairperson of the Human Rights Committee for review upon request. An investigation of any</p>						

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	<p>incident may be requested by a Client, parent/guardian, advocate, staff member, or other involved party."</p> <p>An interview with the Social Worker (SW) was conducted on 8/14/12 at 11:56 AM. The SW indicated she was aware of the incident but was not sure if the staff was negligent or not. She indicated she was not asked to investigate the incident but thought the Program Coordinator (PC) investigated it.</p> <p>An interview with the Director of Group Homes (DGH) was conducted on 8/14/12 at 11:02 AM. The DGH indicated the facility did not investigate the incident due to knowing what happened and the staff admitted to making a mistake of unhooking client #2 prior to being ready to assist her. The DGH stated, "We weren't going to learn anything different from what we already knew." The DGH indicated staff #5 was negligent for not having client #2 strapped down while assisting client #1 off the lift. The DGH indicated client #2 did not wait for staff #5's cue to tell her she was ready and moved her wheelchair backward. The DGH indicated staff #5 informed the PC she had unhooked both clients at the same time before and never had an issue. A follow-up interview with the DGH was conducted on 8/15/12 at 9:33 AM. The</p>				

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	<p>DGH indicated he was unsure why the BDDS report was not accurate regarding client #2's injuries.</p> <p>An interview with the Program Coordinator (PC) was conducted on 8/15/12 at 10:38 AM. The PC indicated the incident was not investigated due to staff #5 informing the DGH about the incident. The PC indicated staff #5 admitted she "screwed up." The PC indicated he would have conducted a full investigation if staff #5 denied responsibility for client #2 falling out of the van. The PC stated he "screwed up" in regard to the BDDS report indicating client #2 was not injured. He indicated he submitted the BDDS report prior to receiving the facility's internal report. The PC indicated staff #5 was negligent.</p> <p>An interview with the Director of Nursing Services (DON) was conducted on 8/15/12 at 9:56 AM. The DON indicated she was not informed about client #2 falling out of the van until 7/20/12. The DON indicated she conducted an assessment of client #2 on the date she was notified.</p> <p>An interview with client #2 was conducted on 8/14/12 at 12:11 PM. Client #2 indicated on 7/18/12 she backed up a little bit after staff #5 unstrapped her</p>						

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	<p>wheelchair. The wheelchair tilted and fell backward out of the van. Client #2 indicated the incident scared her. She indicated she had a few scratches but otherwise she was not injured. Client #2 indicated she felt safe using the lift and being assisted by staff #5. Client #5 stated, "I guess I should have stayed still." She indicated she was not aware the lift was down when she backed up. She indicated it would not happen again due to ensuring she looked every time to make sure the lift was up. She indicated since the incident, the staff had been keeping her wheelchair straps in place until the staff were ready to assist her.</p> <p>An interview with staff #5 was conducted on 8/15/12 at 8:48 AM. Staff #5 indicated she was unloading client #1 from the van and had just removed her from the lift when client #2 backed up and fell off the lift. Staff #5 indicated she had unhooked both client #1 and #2's wheelchairs at the same time and then assisted client #1 off the van. Staff #5 indicated while her back was turned assisting client #1 on the ground, she heard the van's alarm (indicating there was pressure at the top of the lift) go off. She indicated before she could turn around or prompt client #2, client #2 fell backward out of the van. Client #2 landed on her back in the wheelchair.</p>			

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	<p>Staff #5 indicated client #2 bumped her head and she was taken to the walk-in clinic. Staff #5 indicated the cause of the fall was due to her (staff #5) unhooking client #2's wheelchair prior to being ready to assist client #2. She indicated she had been unhooking client #1 and #2's chairs at the same time since November 2011 when she started without incident. Staff #5 indicated she could not recall receiving training on leaving 2nd client strapped in the van until 1st client safely out. Staff #5 indicated she should not have unstrapped client #2's chair until she was ready to assist client #2.</p> <p>This deficiency was cited on 6/15/12. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>9-3-2(a)</p>				

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W0154	<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 record review and interview for 1 of 1 incident report affecting client #2, the facility failed to conduct a thorough investigation of client #2 falling, in her wheelchair, out of the back of the van while the lift was lowered.</p> <p>Findings include:</p> <p>A review of the facility's incident report was conducted on 8/14/12 at 11:06 AM. On 7/18/12 at 8:00 AM, client #2 fell out of the back of the van while staff #5 assisted client #1 off the lowered van lift. The report indicated, "[Client #2] rolled out of the van & fell on to the lowered lift. Ended up on her back with chair on top of her. Chair switch is broken." The report indicated in the injuries section, "Large bump to head." The report indicated the bump was on the back of her head. The incident report's section regarding action taken indicated, "The Coordinator spoke with [staff #5] on 7/18/12. [Staff #5] told the Coordinator that she should of (sic) not unhooked her wheelchair before she was ready to assist [client #2] off the van." The BDDS (Bureau of Developmental Disabilities Services) incident report, dated 7/18/12,</p>	W0154	<p>W154</p> <p>STAFF TREATMENT OF CLIENTS</p> <p>Plan of Correction</p> <p>Stone Belt will ensure that all allegations are investigated thoroughly.</p> <p>Date of Completion</p> <p>September 14, 2012</p> <p>Responsible Person</p> <p>Miller Coordinator/SGL Director</p> <p>Plan of Prevention</p> <p>The Coordinator and Social Worker reviewed and completed training on Stone Belt investigation procedures. (Attachment # 5). This included how to conduct proper investigations and who should be interviewed. (Attachment # 6)</p> <p>Quality Assurance Monitoring</p> <p>The SGL Director will ensure, after reviewing the incident, that investigations will be completed</p>	09/14/2012			

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	<p>indicated client #2 was not injured. The BDDS report indicated, "The walk-in clinic found no injuries." A review of the Stone Belt Outside Services Report, dated 7/18/12, indicated, "Contusion to head." The facility did not conduct a thorough investigation of the incident. There was no investigative report, no interview with client #2, documentation of who was present at the time of the incident, corrective action (training) with client #2 regarding backing her wheelchair out of the van, or discussion of facing client #2 toward the lift. There was no documentation if staff #5 was negligent. There was no documentation staff #5 received prior training on the facility's Defensive Driving and Wheelchair Safety in the incident report.</p> <p>Staff #5 received retraining on van restraints on 7/18/12. On 8/10/12, staff #5 was given a Performance Review addressing emergency or safety procedures. The review indicated, "[Client #2] was in the van with lift down while [staff #5] was assisting [client #1]. [Client #2] backed out of van and fell. [Staff #5] ran in to try block [client #2's] fall but [client #2] still got injured. [Staff #5] was trained again on van restraints and learned she was not going to unfasten [client #2] until she was ready. [Client #2] was also told to not go until staff tells</p>		thoroughly.				

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	<p>her the lift is ready."</p> <p>A review of the facility's Defensive Driving and Wheelchair Safety training, undated, was conducted on 8/14/12 at 11:28 AM. The training indicated, "When getting ready to unload 2 clients never unstrap the second chair until the first chair is completely off the lift and the lift is in the up position."</p> <p>A review of staff #5's training record, conducted on 8/14/12 at 3:14 PM, indicated she received training on Vehicle Training for New Staff on 9/9/11.</p> <p>A review of client #2's Nursing Consultation Notes, dated 7/20/12, was conducted on 8/15/12 at 10:47 AM. The note initially was not in client #2's record however the facility located and scanned the document into client #2's record. The note indicated, "Received notification from day program staff that [client #2] had fallen previously out of van while seated in wheelchair. Incident occurred 7/18. [Client #2] is awake, alert, oriented. Was seen at clinic at time of accident. PERL (pupils equal, react to light), no n/v (nausea/vomiting). Small discoloration to right temple. C/o (complaints of) soreness but otherwise no complaints. Moving all extremities and neck with no problems noted. No other injuries</p>				

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	<p>reported or noted."</p> <p>An interview with a Social Worker (SW) was conducted on 8/14/12 at 11:56 AM. The SW indicated she was aware of the incident but was not sure if the staff was negligent or not. She indicated she was not asked to investigate the incident but thought the Program Coordinator (PC) investigated it.</p> <p>An interview with the Director of Group Homes (DGH) was conducted on 8/14/12 at 11:02 AM. The DGH indicated the facility did not investigate the incident due to knowing what happened and the staff admitted to making a mistake of unhooking client #2 prior to being ready to assist her. The DGH stated, "We weren't going to learn anything different from what we already knew." The DGH indicated staff #5 was negligent for not having client #2 strapped down while assisting client #1 off the lift. The DGH indicated client #2 did not wait for staff #5's cue to tell her she was ready and moved her wheelchair backward. The DGH indicated staff #5 informed the PC she had unhooked both clients at the same time before and never had an issue. A follow-up interview with the DGH was conducted on 8/15/12 at 9:33 AM. The DGH indicated he was unsure why the BDDS report was not accurate regarding</p>				

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	<p>client #2's injuries.</p> <p>An interview with the Program Coordinator (PC) was conducted on 8/15/12 at 10:38 AM. The PC indicated the incident was not investigated due to staff #5 informing the DGH about the incident. The PC indicated staff #5 admitted she "screwed up." The PC indicated he would have conducted a full investigation if staff #5 denied responsibility for client #2 falling out of the van. The PC stated he "screwed up" in regard to the BDDS report indicating client #2 was not injured. He indicated he submitted the BDDS report prior to receiving the facility's internal report. The PC indicated staff #5 was negligent.</p> <p>An interview with the Director of Nursing Services (DON) was conducted on 8/15/12 at 9:56 AM. The DON indicated she was not informed about client #2 falling out of the van until 7/20/12. The DON indicated she conducted an assessment on the date she was notified.</p> <p>An interview with client #2 was conducted on 8/14/12 at 12:11 PM. Client #2 indicated on 7/18/12 she backed up a little bit after staff #5 unstrapped her wheelchair. The wheelchair tilted and fell backward out of the van. Client #2 indicated the incident scared her. She</p>						

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	<p>indicated she had a few scratches but otherwise she was not injured. Client #2 indicated she felt safe using the lift and being assisted by staff #5. Client #5 stated, "I guess I should have stayed still." She indicated she was not aware the lift was down when she backed up. She indicated it would not happen again due to ensuring she looked every time to make sure the lift was up. She indicated since the incident, the staff had been keeping her wheelchair straps in place until the staff were ready to assist her.</p> <p>An interview with staff #5 was conducted on 8/15/12 at 8:48 AM. Staff #5 indicated she was unloading client #1 from the van and had just removed her from the lift when client #2 backed up and fell off the lift. Staff #5 indicated she had unhooked both client #1 and #2's wheelchairs at the same time and then assisted client #1 off the van. Staff #5 indicated while her back was turned assisting client #1 on the ground, she heard the van's alarm (indicating there was pressure at the top of the lift) go off. She indicated before she could turn around or prompt client #2, client #2 fell backward out of the van. Client #2 landed on her back in the wheelchair. Staff #5 indicated client #2 bumped her head and she was taken to the walk-in clinic. Staff #5 indicated the cause of the</p>				

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	<p>fall was due to her (staff #5) unhooking client #2's wheelchair prior to being ready to assist client #2. She indicated she had been unhooking client #1 and #2's chairs at the same time since November 2011 when she started without incident. Staff #5 indicated she could not recall receiving training on leaving 2nd client strapped in the van until 1st client safely out. Staff #5 indicated she should not have unstrapped client #2's chair until she was ready to assist client #2.</p> <p>This deficiency was cited on 6/15/12. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>9-3-2(a)</p>						

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W0331	<p>483.460(c) NURSING SERVICES</p> <p>The facility must provide clients with nursing services in accordance with their needs. Based on record review and interview for 1 of 3 clients in the sample (#2), the nurse failed to conduct a timely assessment of client #2 after client #2 fell out of the van in her wheelchair while the lift was lowered.</p> <p>Findings include:</p> <p>A review of the facility's incident report was conducted on 8/14/12 at 11:06 AM. On 7/18/12 at 8:00 AM, client #2 fell out of the back of the van while staff #5 assisted client #1 off the lowered van lift. The report indicated, "[Client #2] rolled out of the van & fell on to the lowered lift. Ended up on her back with chair on top of her. Chair switch is broken." The report indicated in the injuries section, "Large bump to head." The report indicated the bump was on the back of her head. The incident report's section regarding action taken indicated, "The Coordinator spoke with [staff #5] on 7/18/12. [Staff #5] told the Coordinator that she should of (sic) not unhooked her wheelchair before she was ready to assist [client #2] off the van." The BDDS (Bureau of Developmental Disabilities Services) incident report, dated 7/18/12, indicated client #2 was not injured. The</p>	W0331	<p>W 331</p> <p>NURSING SERVICES</p> <p>Plan of Correction</p> <p>Stone Belt will ensure that nursing services are provided in accordance to the clients needs.</p> <p>Date of Completion</p> <p>September 14, 2012</p> <p>Responsible Person</p> <p>Miller Coordinator/SGL Director/Nurse Manager</p> <p>Plan of Prevention</p> <p>Stone Belt Nursing staff will review Stone Belt Nursing Protocol and Operating Directions to ensure that client needs are met. Specifically, that a nurse will make on-site visits and/or follow-up with documentation of assessment in a client's file within 24 hours of a visit to an emergency room or advanced care facility. (Attachment # 2)</p> <p>Quality Assurance Monitoring</p> <p>Stone Belt Nursing Manager and</p>	09/14/2012			

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	<p>BDDS report indicated, "The walk-in clinic found no injuries." A review of the Stone Belt Outside Services Report, dated 7/18/12, indicated, "Contusion to head."</p> <p>A review of client #2's Nursing Consultation Notes, dated 7/20/12, was conducted on 8/15/12 at 10:47 AM. The note initially was not in client #2's record however the facility located and scanned the document into client #2's record. The note indicated, "Received notification from day program staff that [client #2] had fallen previously out of van while seated in wheelchair. Incident occurred 7/18. [Client #2] is awake, alert, oriented. Was seen at clinic at time of accident. PERL (pupils equal, react to light), no n/v (nausea/vomiting). Small discoloration to right temple. C/o (complaints of) soreness but otherwise no complaints. Moving all extremities and neck with no problems noted. No other injuries reported or noted."</p> <p>A review of an email sent from the Program Coordinator (PC) to the nurse regarding client #2's fall on 7/18/12 was conducted on 8/15/12 at 11:22 AM. The PC notified the nurse of client #2's fall on 7/18/12 at 1:43 PM.</p> <p>A review of the facility's Protocol & Operating Directions Nursing Staff, dated</p>		SGL Director will review all incidents to ensure that there is a face-to-face nursing assessment within 24 hours follow a client visit to an emergency room or advanced care facility..				

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	<p>12/2011, was conducted on 8/15/12 at 11:37 AM. The protocol indicated in the Client Records section, "d) through completion of all Nursing Comments, with documentation in the medical record of any and all assessments, impressions, or interventions, in a timely manner, within 48 hours or 2 working days of event... 9) Fortis is considered the Client's file. Nurses will insure that all Client health related records are send electronically to the Fortis in-box or copied and immediately placed in the Fortis scanning pick-up drawer for placement into the clients' individual file." The protocol indicated, "Nurses are required to make visits to each home or location for, but not limited to the following purposes: e) for the assessment and development of plan of care, when a client is home ill, misses school or work, is discharged from the hospital, is recovering from a surgical procedure, or in any situation which requires extra nursing monitoring and guidance."</p> <p>An interview with the Program Coordinator (PC) was conducted on 8/15/12 at 10:38 AM. The PC indicated he notified the nurse on the day of the incident by email.</p> <p>An interview with the Director of Nursing Services (DON) was conducted on</p>						

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	<p>8/15/12 at 9:56 AM. The DON indicated she was not informed about client #2 falling out of the van until 7/20/12. The DON indicated she conducted an assessment of client #2 on the date she was notified. The DON indicated the assessment was not conducted with 24 hours of the incident which should have been done per policy. A follow-up interview with the nurse was conducted on 8/15/12 at 11:26 AM. The DON indicated again she was not notified of the incident until 7/20/12. She stated, "I remember it well." The DON indicated she did not read the email the PC sent on 7/18/12 because she was not aware of the incident until 7/20/12.</p> <p>9-3-6(a)</p>				