

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G445	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 01/13/2016
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NAME OF PROVIDER OR SUPPLIER NEW HOPE OF INDIANA, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 12342 LANTERN RD FISHERS, IN 46038
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W 0000 Bldg. 00	<p>This visit was for an annual recertification and state licensure survey.</p> <p>Dates of Survey: January 4, 5, 6, 7 and 13, 2016.</p> <p>Facility Number: 000959 Provider Number: 15G445 AIMS Number: 100235240</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9.</p> <p>Quality review of this report completed on 1/15/16 by #09182.</p>	W 0000		
W 0104 Bldg. 00	<p>483.410(a)(1) GOVERNING BODY</p> <p>The governing body must exercise general policy, budget, and operating direction over the facility.</p> <p>Based on observation, record review and interview for 4 of 4 sampled clients (#1, #2, #3 and #4) and 4 additional clients (#5, #6, #7 and #8), the governing body failed to exercise general policy and operating direction over the facility to prevent the neglect of client #8, to ensure the facility staff reported all allegations of neglect immediately to the administrator and to the BDDS (Bureau of Developmental Disabilities Services)</p>	W 0104	<p><i>What corrective action(s) will be accomplished for these residents found to have been affected by the deficient practice? How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? Any further incidents in which the wheelchair or other equipment is not utilized correctly, neglect will be considered and investigated accordingly. New Hope of Indiana policy and</i></p>	02/05/2016

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>per IAC 9-3-1(b)(5) and APS (Adult Protective Services) per IC 12-10-3 according to state law and to ensure all allegations of neglect were investigated for client #8.</p> <p>The governing body failed to exercise general policy and operating direction over the facility to ensure health care services developed and implemented a policy/procedure to ensure clients with head injuries were monitored by health care services for clients #1, #2, #3, #4, #5, #6, #7 and #8.</p> <p>The governing body failed to exercise general policy and operating direction over the facility to ensure large amounts of money were not maintained within the home for client #3.</p> <p>Findings include:</p> <p>1. Client #3's financial records were reviewed with the Team Lead (TL) on 1/5/16 at 8:20 AM. Client #3 had \$401.93 in cash on hand at the home. Client #3's financial records indicated \$400.00 was removed from client #3's bank and placed in the home in October, 2015.</p> <p>Review of the undated facility policy Procedures for the Management of</p>		<p>procedure for Prevention of Abuse, Neglect and Exploitation was reviewed and remains appropriate. A Procedure for Head Injury has been developed and implemented effective 1/18/16. It includes directive for all head injuries to be evaluated by a physician (PCP, Immediate Care or Emergency Department). After such evaluation, the team will respond to any physician orders as well as implement and document a neurology check protocol for 72 hours post fall. New Hope of Indiana Procedure for Management of Individual Finance was reviewed and revised to limit individual's petty cash to a maximum of \$60.00. Upon need for expenditures greater than \$60.00, the money removed from the individual's bank account will be spent within 5 business days or redeposited back into their bank account. All monies remain in a safe when not being utilized. QIDP has reviewed all cash funds for all individuals. All other funds remain appropriate quantities. The funds in excess of this amount noted during survey were spent as originally intended, effective 1/26/16. New Hope of Indiana Group Home Leadership (1/18/16) and Nursing (1/20/16) teams as well as Administrator and Quality Assurance have reviewed these policies and corresponding procedures or</p>		

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	<p>Individual's Finances on 1/7/16 at 10 AM indicated the maximum amount of cash that was to be maintained within the home was "approximately" \$40.00.</p> <p>The Group Home Director (GHD) and the TL were interviewed on 1/7/16 at 10 AM.</p> <p>__The TL indicated she had taken the \$400.00 out of client #3's bank account in October with the intentions of taking client #3 shopping. The TL indicated she had decided to wait and see what client #3 received for Christmas to see what client #3 still needed. When asked why she did not return the money to client #3's bank until after Christmas and then take it out again, the TL stated, "I should have."</p> <p>__The GHD indicated large amounts of money were not to be maintained within the home and the financial policy/procedure was to be followed.</p> <p>2. The governing body failed to exercise general policy and operating direction over the facility to prevent the neglect of client #8, to ensure the facility staff reported all allegations of neglect immediately to the administrator and to the BDDS (Bureau of Developmental Disabilities Services) per IAC 9-3-1(b)(5) and APS (Adult Protective Services) per IC 12-10-3 according to state law and to</p>		<p>protocols. Group Home staff will be trained by 2/12/16 completion date. All parties fully understand the deficiencies as well as New Hope of Indiana Policy and Procedure expectations. <i>What measures will be put into place or what systematic changes you will make to ensure that the deficient practice does not recur? How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?</i> NHI Director of Quality Assurance and Director of Group Homes review all internal and external incident reports and investigations. An Executive Quality Assurance Committee also reviews all falls, medication errors, sentinel events and allegations of abuse, neglect and exploitation monthly. This Executive Committee consists of NHI Administrator, Directors of Group Homes, Waiver Services and Quality Assurance. The purpose of this committee is to further ensure policy and procedures are consistently implemented across programs as well as address trends or indications that policy enhancements are needed. Director will prepare reports for this meeting, including any allegations and results of those investigations, sentinel events, med errors and falls. Additionally, Director will report on number of incident reports, timeliness of</p>	

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W 0149 Bldg. 00	<p>ensure all allegations of neglect were investigated. The governing body failed to exercise general policy and operating direction over the facility to ensure health care services developed and implemented a policy/procedure to ensure clients with head injuries were monitored by health care services for clients #1, #2, #3, #4, #5, #6, #7 and #8. Please see W149.</p> <p>3. The governing body failed to exercise general policy and operating direction over the facility to ensure all allegations of neglect were reported immediately to the administrator and to the BDDS and APS according to state law. Please see W153.</p> <p>4. The governing body failed to exercise general policy and operating direction over the facility to ensure all allegations of neglect were thoroughly investigated for client #8. Please see W154.</p> <p>9-3-1(a)</p> <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 4 of 4 sampled clients (#1, #2, #3 and #4)</p>	W 0149	<p>reporting. This Executive QA Committee in turn reports to the Board of Directors Quality Assurance subcommittee quarterly. All findings of this facility survey, in addition to current trend of all facilities, were reviewed with Board of Directors QA subcommittee on 1/14/2016. Facility will continue to follow NHI Procedure for Managing Individual's finances. QIDP will review all other individuals' funds to ensure amounts are within acceptable range. QIDP will continue to audit individuals' funds amounts monthly to ensure acceptable ranges remain.</p> <p><i>What corrective action(s) will be accomplished for these residents found to have been affected by</i></p>	02/02/2016			

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	<p>and 4 additional clients (#5, #6, #7 and #8), the facility failed to implement its policy and procedures to prevent the neglect of client #8, to ensure the facility staff reported all allegations of neglect immediately to the administrator and to the BDDS (Bureau of Developmental Disabilities Services) per IAC 9-3-1(b)(5) and APS (Adult Protective Services) per IC 12-10-3 according to state law and to ensure all allegations of neglect were investigated.</p> <p>The facility failed to ensure health care services developed and implemented a policy/procedure to ensure clients with head injuries were monitored by health care services for all clients living in the home (clients #1, #2, #3, #4, #5, #6, #7 and #8.)</p> <p>Findings include:</p> <p>1. The facility's BDDS reports and General Event Reports (GERs) were reviewed on 1/5/16 at 1 PM.</p> <p>The 10/14/15 GER indicated on 10/14/15 at 9:05 PM client #2 got up from his bed, took one step and fell face first onto the floor. The GER indicated "[Client #2's] knees are red, staff asked if they hurt he said no. Staff asked if anything hurt he said only his nose [(which bled a little)].</p>		<p><i>the deficient practice? How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? Any further incidents in which the wheelchair or other equipment is not utilized correctly, neglect will be considered and investigated accordingly. New Hope of Indiana policy and procedure for Prevention of Abuse, Neglect and Exploitation was reviewed and remains appropriate. A Procedure for Head Injury has been developed and implemented effective 1/18/16. It includes directive for all head injuries to be evaluated by a physician (PCP, Immediate Care or Emergency Department). After such evaluation, the team will respond to any physician orders as well as implement and document a neurology check protocol for 72 hours post fall. A Procedure for Gait Belt was developed and implemented effective 1/18/16. Procedure indicates that all individuals who require use of a gait belt for ambulation or transfer assistance will have such direction in their High Risk Plans. All staff will be trained on the proper use of gait belts and transfers upon hire, annually or upon new implementation. <i>What measures will be put into place or what systematic changes you will make to ensure that the deficient practice does not recur? How the</i></i></p>				

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	<p>Staff checked his chest, arms and face and did not see anything. Staff got a cold washcloth and he (client #2) held it on his nose." The report did not indicate the facility nurse was notified of the client's fall.</p> <p>The 10/17/15 BDDS report indicated on 10/17/15 at 11:15 PM client #7 had been in bed for an hour when the staff heard a noise coming from the client's bedroom. The staff checked client #7's bedroom and found client #7 on the floor. "Staff said she attempted to get out of bed on her own and fell. In process of falling she hit her head on her bedroom door. Staff stated she did not loose (sic) consciousness and they continued to talk to her while the other staff called 911." The report indicated the facility nurse was notified.</p> <p>__The 10/19/15 follow up BDDS report indicated client #7 obtained a "laceration that was 1 inch long" that required four stitches. Client #7 was treated at a local hospital emergency room and released at 2 AM on 10/18/15.</p> <p>During interview with the facility's LPN on 1/7/16 at 10 AM, the LPN: __Indicated no protocol in place to monitor clients after a head injury for all clients in the home (clients #1, #2, #3, #4, #5, #6, #7 and #8).</p>		<p><i>corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?</i> New Hope of Indiana Group Home Leadership (1/18/16) and Nursing (1/20/16) teams reviewed these policies and corresponding procedures or protocols. All parties fully understand the deficiencies as well as New Hope of Indiana Policy and Procedure expectations. Group Home and Day Service staff will be trained on all adaptive equipment needs, reviewing purposes and schedules for each by 2/12/16 deadline. Written reference for each will be maintained at the Group Home for reference. Group Home Team Leader will observe that proper use of gait belt, as well as all other adaptive equipment, is occurring daily for 5 business days and then upon visits to the home thereafter, averaging 2 to 3 visits per week. Observations will be documented on Adaptive Equipment observation form.</p>	

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	<p>__ Stated the facility nurse would "usually" tell the staff what to monitor and for how long when they called to report the fall.</p> <p>__ Indicated no neurological assessments were conducted for clients #2 and #7 after the clients fell and hit their head.</p> <p>__ Indicated the staff was given no specific instructions in monitoring clients #2 and #7 after the clients' falls involving their heads.</p> <p>During interview with the Group Home Director (GHD) on 1/7/16 at 10 AM, the GHD indicated there was no facility protocol/procedure in place to monitor clients after injuries involving the head for clients #1, #2, #3, #4, #5, #6, #7 and #8. The GHD indicated the facility nurse was consulted and a protocol would be developed.</p> <p>2. The facility failed to implement its policy and procedures to ensure the staff immediately reported all allegations of abuse/neglect immediately to the administrator and to the BDDS and APS according to state law for client #8. Please see W153.</p> <p>3. The facility failed to implement its policy and procedures to ensure all allegations of abuse/neglect were thoroughly investigated for client #8.</p>			

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W 0153 Bldg. 00	<p>Please see W154.</p> <p>Review of the revised 10/2015 Prevention of Abuse, Neglect and Exploitation policy and the revised 2/2015 Incident Management and Reporting policies on 1/6/16 at 9 AM indicated:</p> <p>__ "Neglect includes, but is not limited to, the following acts: Failure of a caregiver to provide supervision and appropriate care.... Failure to implement safeguards that compromise an individual's safety, health or well- being."</p> <p>__ Incidents to be reported will include any event or occurrence characterized by risk or uncertainty resulting in or having the potential to result in significant harm or injury to an individual.</p> <p>__ All allegations of abuse/neglect were to be reported immediately to the administrator and to BDDS and APS within 24 hours.</p> <p>__ All allegations of abuse/neglect were to be investigated.</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</p>			
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	<p>immediately to the administrator or to other officials in accordance with State law through established procedures.</p> <p>Based on interview and record review for 1 of 2 allegations of abuse, neglect and mistreatment reviewed, the facility failed to ensure all allegations of neglect were reported immediately to the administrator and to the BDDS (Bureau of Developmental Disabilities Services) per IAC 9-3-1(b)(5) and APS (Adult Protective Services) per IC 12-10-3 according to state law.</p> <p>Findings include:</p> <p>The facility reportable records and General Event Reports (GERs) were reviewed on 1/5/16 at 1 PM. The 11/10/15 GER indicated on 11/10/15 at 12:30 PM while at the facility owned day program, the day program staff was assisting client #8 with a transfer in the bathroom when client #8 began to slip and was lowered to the floor.</p> <p>The GER indicated the Qualified Intellectual Disabilities Professional (QIDP) reviewed the GER on 11/13/15 and commented "TL (Team Lead) received phone call from [name of staff at day program] stating day program staff was assisting [client #8] with a transfer in the bathroom and staff did not have brakes locked on the wheelchair. [Client</p>	W 0153	<p><i>What corrective action(s) will be accomplished for these residents found to have been affected by the deficient practice? How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? Any further incidents in which the wheelchair or other equipment is not utilized correctly, neglect will be considered and investigated accordingly. New Hope of Indiana policy and procedure for Prevention of Abuse, Neglect and Exploitation was reviewed and remains appropriate. The review date/time stamp on NHI internal reporting system is not indicative of initial reporting to administrator. Director will identify initial notifications in the internal reporting system review to clarify. What measures will be put into place or what systematic changes you will make to ensure that the deficient practice does not recur? How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? New Hope of Indiana Group Home Leadership (1/18/16) and Nursing (1/20/16) teams as well as Administrator and Quality Assurance have reviewed these policies and</i></p>	02/12/2016
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	<p>#8] then started to slip and staff lowered [client #8] to the ground. No injuries." __The GER indicated the Group Home Director reviewed the GER on 11/18/15.</p> <p>During interview with the Group Home Director (GHD) on 1/7/16 at 10 AM, the GHD: __ Indicated all allegations of abuse, neglect and mistreatment were to be reported immediately to the administrator and to BDDS and APS within 24 hours of the time of knowledge of the abuse, neglect and mistreatment. __ Indicated the allegation of staff neglect to lock the wheelchair prior to transferring client #8 resulting in client #8 ending up on the floor was not reported. __ Indicated the day program staff failed to lock the brakes on the wheelchair and stated, "We didn't look at it as neglect."</p> <p>9-3-2(a)</p>		<p>corresponding procedures or protocols. All parties fully understand the deficiencies as well as New Hope of Indiana Policy and Procedure expectations. NHI Director of Quality Assurance and Director of Group Homes review all internal and external incident reports and investigations. An Executive Quality Assurance Committee also reviews all falls, medication errors, sentinel events and allegations of abuse, neglect and exploitation monthly. This Executive Committee consists of NHI Administrator, Directors of Group Homes, Waiver Services and Quality Assurance. The purpose of this committee is to further ensure policy and procedures are consistently implemented across programs as well as address trends or indications that policy enhancements are needed. Director will prepare reports for this meeting, including any allegations and results of those investigations, sentinel events, med errors and falls. Additionally, Director will report on number of incident reports, timeliness of reporting. This Executive QA Committee in turn reports to the Board of Directors Quality Assurance subcommittee quarterly. All findings of this facility survey, in addition to current trend of all facilities, were reviewed with Board of Directors QA subcommittee on 1/14/2016.</p>		

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W 0154 Bldg. 00	<p>483.420(d)(3) STAFF TREATMENT OF CLIENTS</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated.</p> <p>Based on interview and record review for 1 of 2 allegations of abuse, neglect and mistreatment reviewed, the facility failed to ensure all allegations of neglect were thoroughly investigated for client #8.</p> <p>Findings include:</p> <p>The facility reportable records and General Event Reports (GERs) were reviewed on 1/5/16 at 1 PM. The 11/10/15 GER indicated on 11/10/15 at 12:30 PM while at the facility owned day program, the day program staff was assisting client #8 with a transfer in the bathroom when client #8 began to slip and was lowered to the floor.</p> <p>__The GER indicated the Qualified Intellectual Disabilities Professional (QIDP) reviewed the GER on 11/13/15 and commented "TL (Team Lead) received phone call from [name of staff at day program] stating day program staff was assisting [client #8] with a transfer in the bathroom and staff did not have brakes locked on the wheelchair. [Client #8] then started to slip and staff lowered [client #8] to the ground. No injuries."</p> <p>During interview with the Group Home</p>	W 0154	<p><i>What corrective action(s) will be accomplished for these residents found to have been affected by the deficient practice? How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? Any further incidents in which the wheelchair or other equipment is not utilized correctly will be identified as neglect and investigated accordingly. New Hope of Indiana policy and procedure for Prevention of Abuse, Neglect and Exploitation was reviewed and remains appropriate. What measures will be put into place or what systematic changes you will make to ensure that the deficient practice does not recur? How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? New Hope of Indiana Group Home Leadership (1/18/16) and Nursing (1/20/16) teams as well as Administrator and Quality Assurance have reviewed these policies and corresponding procedures or protocols. Group Home Staff will be trained by 2/12/16 completion date. All parties fully understand the deficiencies as well as New</i></p>	02/12/2016			

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W 0189 Bldg. 00	<p>Director (GHD) on 1/7/16 at 10 AM, the GHD:</p> <p>__ Indicated all allegations of abuse, neglect and mistreatment were to be investigated.</p> <p>__ Indicated no investigation was conducted in regard to the staff neglect to lock the wheelchair prior to transferring client #8 resulting in client #8 ending up on the floor.</p> <p>__ Indicated the day program failed to lock the brakes on the wheelchair and stated, "We didn't look at it as neglect."</p> <p>9-3-2(a)</p> <p>483.430(e)(1) STAFF TRAINING PROGRAM The facility must provide each employee</p>		<p>Hope of Indiana Policy and Procedure expectations. NHI Director of Quality Assurance and Director of Group Homes review all internal and external incident reports and investigations. An Executive Quality Assurance Committee also reviews all falls, medication errors, sentinel events and allegations of abuse, neglect and exploitation monthly. This Executive Committee consists of NHI Administrator, Directors of Group Homes, Waiver Services and Quality Assurance. The purpose of this committee is to further ensure policy and procedures are consistently implemented across programs as well as address trends or indications that policy enhancements are needed. Director will prepare reports for this meeting, including any allegations and results of those investigations, sentinel events, med errors and falls. Additionally, Director will report on number of incident reports, timeliness of reporting. This Executive QA Committee in turn reports to the Board of Directors Quality Assurance subcommittee quarterly. All findings of this facility survey, in addition to current trend of all facilities, were reviewed with Board of Directors QA subcommittee on 1/14/2016.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G445	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 01/13/2016
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	<p>with initial and continuing training that enables the employee to perform his or her duties effectively, efficiently, and competently.</p> <p>Based on observation, interview and record review for 1 of 4 sampled clients (#2) and 2 additional clients (#7 and #8), the facility failed to ensure the staff were retrained on the use of a gait belt for client #2 and the transferring of clients #7 and #8 in or out of wheelchairs.</p> <p>Findings include:</p> <p>Observations were conducted at the group home on 1/4/16 between 3:30 PM and 6:30 PM and on 1/5/16 between 6 AM and 8 AM. During both observation periods client #2 wore a leg brace and a gait belt and walked with an unsteady gait. The staff did not utilize the gait belt each time they assisted client #2 with ambulation. The staff would place their arm under client #2's arm or hold onto client #2's arm to assist client #2.</p> <p>At 4:24 PM staff #1 assisted client #8 out of the wheelchair into a lounge chair. As staff #1 lifted client #8 to transfer her into the chair, the wheelchair rolled backward. Staff #1 failed to lock client #8's wheelchair prior to transferring client #8.</p> <p>The facility Bureau of Developmental Disabilities Services (BDDS) reports</p>	W 0189	<p><i>What corrective action(s) will be accomplished for these residents found to have been affected by the deficient practice? How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? A Procedure for Gait Belt was developed and implemented effective 1/18/16. Procedure indicates that all individuals who require use of a gait belt for ambulation or transfer assistance will have such direction in their High Risk Plans. All staff will be trained on the proper use of gait belts and transfers upon hire, annually or upon new implementation. New Hope of Indiana Group Home Leadership (1/18/16) and Nursing (1/20/16) teams as well as Administrator and Quality Assurance have reviewed these policies and corresponding procedures or protocols. Group Home and Day Service Staff will be trained by 2/12/16 completion date. All parties fully understand the deficiencies as well as New Hope of Indiana Policy and Procedure expectations. <i>What measures will be put into place or what systematic changes you will make to ensure that the deficient practice does not recur? How the corrective action(s) will be</i></i></p>	02/12/2016	

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	<p>were reviewed on 1/5/16 at 1 PM. The 7/8/15 BDDS report indicated on 7/8/15 at 11:30 AM "Staff was assisting [client #2] to the restroom. Staff had her right hand under [client #2's] left armpit to help him walk. [Client #2's] foot got tangled with staff's feet and the two of them rolled to the floor together. [Client #2] told staff he hit his right knee on the floor. Staff looked at the knee and it visually appeared to be fine. Staff and [client #2] had gently rolled to the floor. Plan to resolve: Staff will be careful when walking with [client #2], as he tends to cross his feet when walking. [Client #2] has a diagnosis of Cerebral Palsy and wears leg braces. He walks with an uneven gait and is in danger of falling if walking alone. Staff always walk with [client #2]."</p> <p>The 8/12/15 GER indicated on 8/12/15 at 10 PM client #7 got up from her chair, lost her balance, stumbled back against the wall and slid down to her bottom. The staff reached down to assist client #7 and client #7 walked away from the staff and fell again. The report indicated client #7's gait belt had fallen down around client #7's ankles. The staff noticed "a long scratch/welt on her (client #7's) upper left side of her neck."</p> <p>The 11/10/15 GER indicated on 11/10/15</p>		<p><i>monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? All fall investigations continue to be reviewed by Director of Group Homes and Quality Assurance. Any variation in use of equipment will be investigated to see that appropriate risk plan information and references are in place. Director of Group Homes maintains an annual training plan and this specific topic is within that annual plan.</i></p>	

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	<p>at 12:30 PM while at the facility owned day program, the day program staff was assisting client #8 with a transfer in the bathroom. The staff failed to lock the wheelchair brakes prior to transferring client #8. Client #8 began to slip and was lowered to the floor.</p> <p>Client #2's record was reviewed on 1/5/16 at 1 PM. Client #2's 9/29/15 HRP (High Risk Plan) for falls prevention indicated client #2 was at risk of falling due to an unsteady gait. The HRP indicated client #2 was to wear a gait belt with staff assistance while ambulating.</p> <p>The facility's training records were reviewed on 1/5/16 at 1 PM. The facility's 10/21/15 Training Roster sign in sheet indicated a training facilitated by the Qualified Intellectual Disabilities Professional (QIDP) and the Team Lead. The roster indicated staff training in regard to the correct use of the gait belt and client transfers from a wheelchair to the toilet or bed.</p> <p>During interview with the Group Home Director (GHD) on 1/7/16 at 10 AM, the GHD: ___ Indicated no documentation was available for review in regard to the retraining of the staff at the facility owned day program after client #8's fall</p>			

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W 0249 Bldg. 00	<p>on 11/10/15 at the day program in regard to transferring clients in and out of a wheelchair.</p> <p>__ The GHD indicated the staff was told to make sure the wheelchair was locked when transferring clients and stated, "There was not a formal training."</p> <p>__ Indicated no specific protocol or procedure was available for review in regard to the use of a gait belt.</p> <p>During interview with the QIDP on 1/7/16 at 10 AM, the QIDP:</p> <p>__ Indicated the staff were to hold onto the back of client #2's gait belt whenever assisting client #2 with ambulation.</p> <p>__ Indicated no specific protocol or procedure was available for review in regard to the specific training provided for the use of a gait belt.</p> <p>__ Indicated the staff were to lock the wheelchair prior to any transfer in and out of the wheelchair.</p> <p>__ Indicated the staff will need to be retrained on the use of a gait belt and transferring clients in and out of the wheelchair.</p> <p>9-3-3(a)</p> <p>483.440(d)(1) PROGRAM IMPLEMENTATION As soon as the interdisciplinary team has</p>				

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	<p>formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan.</p> <p>Based on observation, record review and interview for 2 of 4 sampled clients (#2 and #4), the facility failed to ensure the staff followed client #2's High Risk Plan (HRP) for falls and client #4's HRP for choking/dining.</p> <p>Findings include:</p> <p>1. Observations were conducted at the group home on 1/5/16 between 6 AM and 8 AM. During this observation period client #2 wore a leg brace and a gait belt and walked with an unsteady gait. At 6:52 AM client #2 stood up from the dining room table and walked to the kitchen sink. After placing his dish in the sink client #2 bent over to pick something up from the floor. He then stood up and returned to the dining room table. The staff did not assist client #2 while ambulating back and forth to the dining room table.</p> <p>The facility Bureau of Developmental Disabilities Services (BDDS) reports were reviewed on 1/5/16 at 1 PM. The 7/8/15 BDDS report indicated on 7/8/15</p>	W 0249	<p><i>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? QIDP and Team Leader reviewed all High Risk Plans, including, but not limited to those directives for falls and dining. Necessary revisions were completed and all staff will be retrained on complete High Risk Plans for all individuals in home. Reference Dining Plans were reviewed and reprinted to ensure quality resources for staff reference were available. What measures will be put into place or what systematic changes you will make to ensure that the deficient practice does not recur? How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? Team Leader and/or QIDP will observe that proper implementation of High Risk Plans, including all directives for fall prevention and dining safety, as well as any other risk protocols, are followed properly. Observations will occur daily for 5 business days and then occur at regular home visits, on average 2-3 per week. Observations will</i></p>	02/12/2016

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	<p>at 11:30 AM "Staff was assisting [client #2] to the restroom. Staff had her right hand under [client #2's] left armpit to help him walk. [Client #2's] foot got tangled with staff's feet and the two of them rolled to the floor together. [Client #2] told staff he hit his right knee on the floor. Staff looked at the knee and it visually appeared to be fine. Staff and [client #2] had gently rolled to the floor. Plan to resolve: Staff will be careful when walking with [client #2], as he tends to cross his feet when walking. [Client #2] has a diagnosis of Cerebral Palsy and wears leg braces. He walks with an uneven gait and is in danger of falling if walking alone. Staff always walk with [client #2]."</p> <p>Client #2's record was reviewed on 1/5/16 at 1 PM. Client #2's 9/29/15 HRP for falls prevention indicated client #2 was at risk of falling due to an unsteady gait. The HRP indicated client #2 was to wear a gait belt with staff assistance while ambulating.</p> <p>During interview with the Qualified Intellectual Disabilities Professional (QIDP) on 1/7/16 at 10 AM, the QIDP: ___ Indicated client #2 had a history of falls. ___ Indicated the staff were to follow client #2's HRP for falls.</p>		be documented on the meal observation form.				

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	<p>__ Indicated the staff were to provide client #2 with assistance while ambulating by use of the gait belt.</p> <p>2. Observations were conducted at the group home on 1/4/16 between 3:30 PM and 6:30 PM and on 1/5/16 between 6 AM and 8 AM. During both observation periods:</p> <p>__ Client #4 was observed eating a meal.</p> <p>__ Client #4 did not dry swallow one time after each bite of food.</p> <p>__ The staff did not prompt client #4 to dry swallow one time after each bite of food.</p> <p>__ The staff did not provide client #4 with constant supervision while eating her meals.</p> <p>Client #4's record was reviewed on 1/5/16 at 5 PM. Client #4's High Risk Plan (HRP) dated 6/11/15 indicated:</p> <p>__ Client #4 was at risk of choking.</p> <p>__ Client #4 was to dry swallow one time after each bite of food.</p> <p>__ The staff were to provide client #4 constant supervision with meals.</p> <p>During interview with the QIDP on 1/7/16 at 10 AM, the QIDP indicated the staff were to follow client #4's HRP for choking/dining and stated constant supervision meant "someone should be watching her (client #4) at all times</p>			

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W 0331 Bldg. 00	<p>whenever she was eating."</p> <p>9-3-4(a)</p> <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 4 of 4 sampled clients (#1, #2, #3 and #4) and 4 additional clients (#5, #6, #7 and #8), the facility's nursing services failed to ensure a protocol/procedure was developed and implemented to monitor clients after injury to the head for all clients in the home (clients #1, #2, #3, #4, #5, #6, #7 and #8) and to ensure the staff notified nursing services of client falls for clients #2, #5, #7 and #8.</p> <p>Findings include:</p> <p>The facility's Bureau of Developmental Disabilities Services (BDDS) reports and General Event Reports (GERs) were reviewed on 1/5/16 at 1 PM.</p> <p>The 7/8/15 BDDS report indicated on 7/8/15 at 11:30 AM "Staff was assisting [client #2] to the restroom. Staff had her right hand under [client #2's] left armpit to help him walk. [Client #2's] foot got tangled with staff's feet and the two of</p>	W 0331	<p><i>What corrective action(s) will be accomplished for these residents found to have been affected by the deficient practice? How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? A Procedure for Head Injury has been developed and implemented effective 1/18/16. It includes directive for all head injuries to be evaluated by a physician (PCP, Immediate Care or Emergency Department). After such evaluation, the team will respond to any physician orders as well as implement and document a neurology check protocol for 72 hours post fall. Procedure for Head Injury also identifies documentation requirements for nursing staff. All falls will be reported to nursing staff. All nursing staff will document notification and follow up in their nursing notes.</i></p> <p><i>What measures will be put into place or what systematic changes you will make to ensure that the deficient practice does not recur?</i></p>	02/12/2016	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G445	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 01/13/2016
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	<p>them rolled to the floor together. [Client #2] told staff he hit his right knee on the floor. Staff looked at the knee and it visually appeared to be fine. Staff and [client #2] had gently rolled to the floor. Plan to resolve: Staff will be careful when walking with [client #2], as he tends to cross his feet when walking. [Client #2] has a diagnosis of Cerebral Palsy and wears leg braces. He walks with an uneven gait and is in danger of falling if walking alone. Staff always walk with [client #2]."</p> <p>__The BDDS report did not indicate nursing services was notified of client #2's fall.</p> <p>The 8/12/15 GER indicated on 8/12/15 at 10 PM client #7 got up from her chair, lost her balance, stumbled back against the wall and slid down to her bottom. The staff reached down to assist client #7 and client #7 walked away from the staff and fell again. The report indicated client #7's gait belt had fallen down around her ankles. The staff noticed "a long scratch/welt on her upper left side of her neck." The staff attempted to assess for further injury and the client went to her bedroom and pulled the covers up and closed her eyes.</p> <p>__The GER did not indicate nursing services was notified of client #7's fall.</p> <p>__The GER indicated nursing services</p>		<p><i>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?</i></p> <p>New Hope of Indiana Group Home Leadership (1/18/16) and Nursing (1/20/16) teams as well as Administrator and Quality Assurance have reviewed these policies and corresponding procedures or protocols. Group Home and Day Services Staff will be trained prior to 2/12/16 completion date. All parties fully understand the deficiencies as well as New Hope of Indiana Policy and Procedure expectations.</p>	

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	<p>reviewed the GER on 8/18/15.</p> <p>The 9/8/15 GER indicated on 9/8/15 at 9 AM client #5 lost her balance when getting out of the van and fell. The report indicated the staff assessed client #5 for injury and found none. __The GER did not indicate nursing services was notified of client #5's fall.</p> <p>The 10/14/15 GER indicated on 10/14/15 at 9:05 PM client #2 got up from his bed, took one step and fell face first onto the floor. The GER indicated "[Client #2's] knees are red, staff asked if they hurt he said no. Staff asked if anything hurt he said only his nose [(which bled a little)]. Staff checked his chest, arms and face and did not see anything. Staff got a cold washcloth and he (client #2) held it on his nose." __The GER did not indicate nursing services was notified of client #2's fall. __The GER indicated nursing services reviewed the GER on 11/2/15.</p> <p>The 10/17/15 BDDS report indicated on 10/17/15 at 11:15 PM client #7 had been in bed for an hour when the staff heard a noise coming from the client's bedroom. The staff checked client #7's bedroom and found client #7 on the floor. "Staff said she attempted to get out of bed on her own and fell. In process of falling she</p>			

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	<p>hit her head on her bedroom door. Staff stated she did not loose (sic) consciousness and they continued to talk to her while the other staff called 911." The report indicated the facility nurse was notified.</p> <p>__The 10/19/15 follow up BDDS report indicated client #7 obtained a "laceration that was 1 inch long" that required four stitches. Client #7 was treated at a local hospital emergency room and released at 2 AM on 10/18/15.</p> <p>The 11/10/15 GER indicated on 11/10/15 at 12:30 PM the day program staff was assisting client #8 with a transfer in the bathroom. The staff failed to lock the wheelchair brakes prior to transferring client #8. Client #8 began to slip and was lowered to the floor.</p> <p>__The GER did not indicate nursing services was notified of client #8's fall.</p> <p>__The GER indicated no review of the GER by nursing services.</p> <p>During interview with the facility's LPN on 1/7/16 at 10 AM, the LPN:</p> <p>__ Indicated the staff were to notify nursing services of all falls.</p> <p>__ Indicated no documentation for review to indicate the staff had notified nursing services of the falls on 7/8/15, 8/12/15, 9/8/15, 10/14/15 or 11/10/15.</p> <p>__ Indicated she did not assess all clients</p>			

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W 0436 Bldg. 00	<p>post falls.</p> <p>__ Indicated no protocol in place for clients with head injury in the home of clients #1, #2, #3, #4, #5, #6, #7 and #8.</p> <p>__ Stated the facility nurse would "usually" tell the staff what to monitor and for how long when they called to report the fall.</p> <p>__ Indicated no neurological assessments were conducted for clients #2 and #7 after the clients fell and hit their heads.</p> <p>__ Indicated the staff was given no specific instructions in monitoring clients #2 and #7 after the clients' falls involving their heads.</p> <p>During interview with the Group Home Director (GHD) on 1/7/16 at 10 AM, the GHD indicated there was no facility protocol/procedure in place to monitor clients after injuries involving the head for clients #1, #2, #3, #4, #5, #6, #7 and #8. The GHD indicated the facility nurse was consulted and a protocol would be developed.</p> <p>9-3-6(a)</p> <p>483.470(g)(2) SPACE AND EQUIPMENT</p> <p>The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures,</p>				

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	<p>eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client.</p> <p>Based on observation, interview and record review for 3 of 4 sampled clients (#1, #2 and #3) with adaptive equipment, the facility failed:</p> <p>__ To address the recommendations of the Audiologist for hearing aids for client #1.</p> <p>__ To ensure clients #1, #2 and #3 were provided training and encouraged to wear their prescribed eye glasses.</p> <p>__ To ensure client #2 was provided training in the use of a rocker knife.</p> <p>Findings include:</p> <p>1. Observations were conducted at the group home on 1/4/16 between 3:30 PM and 6:30 PM and on 1/5/16 between 6 AM and 8 AM. During both observation periods:</p> <p>__ Client #1 did not wear hearing aids or eyeglasses.</p> <p>__ Clients #2 and #3 did not wear eyeglasses.</p> <p>Client #1's record was reviewed on 1/5/16 at 12 PM. Client #1's hearing evaluation dated 10/16/14 indicated "Results: Normal hearing 250 - 2000 HZ (Hertz, the frequency of pitch heard). Sloping to moderate sensorineural hearing loss bilaterally. Consider binaural</p>	W 0436	<p><i>What corrective action(s) will be accomplished for these residents found to have been affected by the deficient practice? How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? New Audiology appointment for Client will be scheduled prior to 2/12/16 to update and clarify recommendations. Any recommendations resulting from this visit will then be addressed by the team and implemented appropriately. All other adaptive equipment use and schedule were reviewed by QIDP. QIDP also reviewed all other hearing evaluations, as well as other routine consultations, for any other recommendations that may need addressed. This evaluation was misinterpreted, not overlooked. All other evaluations and consultation recommendations have been addressed. Group Home and Day Services staff will be retrained by 2/12/16. <i>What measures will be put into place or what systematic changes you will make to ensure that the deficient practice does not recur? How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what</i></i></p>	02/12/2016

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	<p>amplification (sic) (hearing aids for both ears)."</p> <p>Client #1's Individualized Support Plan (ISP) dated 3/11/15 indicated client #1 was to wear eyeglasses. The ISP indicated "Staff will prompt [client #1] to wear her eye glasses full time as prescribed by her doctor."</p> <p>Client #2's record was reviewed on 1/5/16 at 1 PM. Client #2's ISP dated 3/11/15 indicated client #2 was to wear prescription eyeglasses.</p> <p>Client #3's record was reviewed on 1/5/16 at 3 PM. Client #3's ISP dated 4/21/15 indicated client #3 was to wear prescription eyeglasses during waking hours.</p> <p>During interview with the Qualified Intellectual Disabilities Professional (QIDP) on 1/7/16 at 10 AM, the QIDP: ___ Indicated client #1 did not wear hearing aids and the recommendation for the hearing aids had not been addressed. ___ Indicated the staff were to prompt clients #1, #2 and #3 throughout the day to wear their prescription eyeglasses.</p> <p>2. Observations were conducted at the group home on 1/5/16 between 6 AM and 8 AM. At 6:45 AM staff #5 used a rocker</p>		<p><i>quality assurance program will be put into place?</i> Team Leader and/or QIDP will observe that proper implementation of High Risk Plans, including use and schedule for all adaptive equipment, as well as any other risk protocols, are followed properly. Observations will occur daily for 5 business days and then occur at regular home visits, on average 2-3 per week, documented on the adaptive equipment review form.</p>	

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W 0488 Bldg. 00	<p>knife to cut client #2's breakfast sandwich. The staff did not provide client #2 with training on the use of a rocker knife.</p> <p>Client #2's record was reviewed on 1/5/16 at 1 PM. Client #2's dining plan dated October 2015 indicated client #2 required a rocker knife for cutting his food.</p> <p>During interview with the QIDP on 1/7/16 at 10 AM, the QIDP indicated the staff were to provide client #2 hand over hand assistance to use the rocker knife to cut his own food.</p> <p>9-3-7(a)</p> <p>483.480(d)(4) DINING AREAS AND SERVICE The facility must assure that each client eats in a manner consistent with his or her developmental level.</p> <p>Based on observation and interview for 4 of 4 sampled clients (#1, #2, #3 and #4) and 4 additional clients (#5, #6, #7 and #8), the facility failed to provide the clients with training in food/meal preparation and to encourage clients to independently serve themselves and/or provide hand over hand assistance.</p>	W 0488	<p><i>What corrective action(s) will be accomplished for these residents found to have been affected by the deficient practice? How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? Group Home Team Leader and QIDP will retrain staff on strategies to engage and</i></p>	02/12/2016
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	<p>Findings include:</p> <p>Observations were conducted at the group home on 1/4/16 between 3:30 PM and 6:30 PM.</p> <p>__ Clients #1, #2, #3, #4, #5, #6, #7 and #8 were served tuna casserole, coleslaw, canned mandarin oranges and bread with butter for their evening meal of 1/4/16.</p> <p>__ At 4:30 PM staff #1 began the preparation of the evening meal while client #4 began setting the table.</p> <p>__ Clients #1 and #4 were in and out of the kitchen and watching staff #1 while preparing the evening meal.</p> <p>__ Staff #1 did not prompt the clients to assist with the preparation of the food.</p> <p>__ The evening meal was prepared and brought to the table by the staff.</p> <p>__ At 5:07 PM all clients were seated at the dining room table.</p> <p>__ At 5:15 PM staff #2 placed a serving of tuna casserole onto client #3's and #8's plates and then added thickener to client #4's drink.</p> <p>__ At 5:18 PM staff #1 poured milk onto client #8's bread.</p> <p>__ At 5:22 PM staff #1 placed one serving of coleslaw onto client #3's, #4's and #7's plates.</p> <p>__ At 5:28 PM staff #1 placed a serving of fruit onto client #2's plate.</p> <p>__ At 5:45 PM staff #2 placed butter on client #5's bread.</p>		<p>assist all individuals in participation in meal preparation and dining. QIDP will review all Dining Plans and ISPs to ensure independence and participation goals remain appropriate. IDT notes were created to review and address all changes to previous dining plans. <i>What measures will be put into place or what systematic changes you will make to ensure that the deficient practice does not recur? How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?</i> Team Leader and/or QIDP will observe that proper implementation of meal preparation and participation goals are followed properly. Observations will occur daily for 5 business days and then occur at regular home visits, on average 2-3 per week, documented on the meal observation form.</p>		

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W 9999 Bldg. 00	<p>During this observation period clients #1, #2, #3, #4, #5, #6, #7 and #8 did not actively participate in the food preparation for the evening meal and were not verbally prompted and/or provided hand over hand assistance to serve themselves at every available opportunity.</p> <p>During interview with the Qualified Intellectual Disabilities Professional (QIDP) on 1/7/16 at 10 AM, the QIDP: ___ Indicated the clients were to assist with the food preparation. ___ Indicated the staff were to assist the clients in preparing their meals and to serve themselves with verbal and hand over hand assistance. ___ Indicated the staff were to supervise the clients while eating their meals.</p> <p>9-3-8(a)</p> <p>State Findings</p> <p>The following Community Residential Facilities for Persons with</p>	W 9999	<p><i>What corrective action(s) will be accomplished for these residents found to have been affected by the deficient practice? How will you identify other residents having the potential to be affected</i></p>	02/12/2016

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	<p>Developmental Disabilities rule was not met.</p> <p>460 IAC 9-3-1(a) Governing Body</p> <p>(b) The residential provider shall report the following circumstances to the division by telephone no later than the first business day followed by written summaries as requested by the division: 15) A fall resulting in injury, regardless of the severity of the injury.</p> <p>This state rule was not met as evidenced by:</p> <p>Based on record review and interview for 1 of 4 sampled clients (#2) and 1 additional client (#7), the facility failed to ensure all incidents of falls resulting in injury were reported to the Bureau of Developmental Disabilities Services (BDDS) no later than the first business day following the date of the incident.</p> <p>Findings include:</p> <p>The facility reportable records and General Events Reports (GER) were reviewed on 1/5/16 at 1 PM.</p> <p>The 8/12/15 GER indicated on 8/12/15 at 10 PM client #7 got up from her chair, lost her balance and stumbled back</p>		<p><i>by the same deficient practice and what corrective action will be taken?</i> All falls will be reported and investigated. These instances had such minimal injury, the Team Leader had not considered them reportable. All Group Home staff have been retrained on this and will continue to report all falls, particularly those with injury. <i>What measures will be put into place or what systematic changes you will make to ensure that the deficient practice does not recur? How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?</i> NHI Director of Quality Assurance and Director of Group Homes review all internal and external incident reports and investigations. An Executive Quality Assurance Committee also reviews all falls, medication errors, sentinel events and allegations of abuse, neglect and exploitation monthly. This Executive Committee consists of NHI Administrator, Directors of Group Homes, Waiver Services and Quality Assurance. The purpose of this committee is to further ensure policy and procedures are consistently implemented across programs as well as address trends or indications that policy enhancements are needed. Director will prepare reports for this meeting, including any</p>		

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	<p>against the wall and sliding down to her bottom. Staff reached down to assist her and she walked away from the staff and fell again. The report indicated client #7's gait belt had fallen down around her ankles. The staff noticed "a long scratch/welt on her upper left side of her neck." The staff attempted to assess for further injury and the client went to her bedroom and pulled the covers up and closed her eyes.</p> <p>__The facility records did not indicate client #7's fall with injury was reported to BDDS.</p> <p>The 10/14/15 GER indicated on 10/14/15 at 9:05 PM client #2 got up from his bed, took one step and fell face first onto the floor. The GER indicated "[Client #2's] knees are red, staff asked if they hurt he said no. Staff asked if anything hurt he said only his nose [(which bled a little)]. Staff checked his chest, arms and face and did not see anything. Staff got a cold washcloth and he (client #2) held it on his nose."</p> <p>__The facility records did not indicate client #2's fall with injury was reported to BDDS.</p> <p>During interview with the Group Home Director (GHD) on 1/7/16 at 10 AM, the GHD: __Indicated the facility followed the</p>		<p>allegations and results of those investigations, sentinel events, med errors and falls. Additionally, Director will report on number of incident reports, timeliness of reporting. This Executive QA Committee in turn reports to the Board of Directors Quality Assurance subcommittee quarterly. Any further variance from NHI policy and procedure for reporting and investigating will be addressed via performance standards.</p>	

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	<p>BDDS policy.</p> <p>__ Indicated all falls with injury were to be reported to BDDS within 24 hours from the date of knowledge of the fall.</p> <p>__ Indicated client #2's fall on 10/14/15 and client #7's fall on 8/12/15 were not reported to BDDS.</p> <p>9-3-1(b)</p>				