

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G528	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 06/13/2013
NAME OF PROVIDER OR SUPPLIER HOUSTON GROUP HOMES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 1275 MID JAMESTOWN RD LEBANON, IN 46052		
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W000000	<p>This visit was for a fundamental annual recertification and state licensure survey.</p> <p>Dates of survey: June 10, 11, 12 and 13, 2013.</p> <p>Facility Number: 001042 Provider Number: 15G528 AIMS Number: 100245270</p> <p>Surveyor: Claudia Ramirez, RN</p> <p>The following federal deficiencies also reflect state findings in accordance with 460 IAC 9.</p> <p>Quality review completed June 20, 2013 by Dotty Walton, QIDP.</p>	W000000			

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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W000149	<p>483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. Based on record review and interview for 3 of 5 BDDS (Bureau of Developmental Disabilities Services) reports, the facility neglected to implement the facility's written policy and procedure to prevent neglect by failing to ensure client #2's safety and to protect client #2 from falls resulting in injury.</p> <p>Findings include:</p> <p>The facility's BDDS (Bureau of Developmental Disabilities Services) reports and investigations were reviewed on 06/10/13 at 11:53 AM. The BDDS reports indicated the following:</p> <p>10/10/12: A BDDS ((Bureau of Developmental Disabilities Services) report indicated, "Staff reported that [client #2] had several small bruises on her face. Initial investigation revealed that she had recently been unsteady and fallen earlier in the week. Complete investigation to follow...."</p> <p>A BDDS Follow-up Report dated 10/16/12 to the initial report dated 10/10/12 indicated, "Through our investigation and review of internal incident reports it was discovered that</p>	W000149	<p>The facility Director met with the Director of Nursing and the Residential Supervisor regarding notifying Supervisor when falls occur. The current Fall Prevention Plan dated August 2, 2012 (See Attachment A) stated that the Residential supervisor should be notified of any falls. a memo was posted on 10/10/12 for all staff that instructed them to report all falls to the Residential Supervisor or the person on call for the Residential Supervisor. (See Attachment B) The Residential Supervisor scheduled a staff training for July 1, 2013 to go over the most recent Fall Prevention Plan dated 11/5/12 when to report falls to the Residential Supervisor (See Attachment C) and Reporting Allegations of Mistreatment of an Individual Policy (See Attachment D). The Executive Director, Director of Nursing and the residential Supervisor will ensure that all staff understand and follow all aspects of the Fall Prevention Plan and the Reporting Allegations of Mistreatment of an Individual policy to ensure the safety of the Clients.</p>	07/01/2013	

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	<p>[client #2] fell on 10/3/12, 10/4/12, and 10/5/12. An internal incident report was completed at the time of each fall and then updated later when injury (bruising) was noted. However, staff did not report these injuries to supervisor until several days later. Once the supervisor/RN were made aware of the bruising the internal incident reports were reviewed and staff were interviewed. It is evident that the bruises ARE consistent with the falls described in the incident reports. The falls occurred at night when [client #2] awoke to use the restroom and did not call for staff assistance, making it difficult for staff to follow the plan that is in place. Immediately a visual reminder was placed to help remind [client #2] to call for help and staff were instructed to use her gait belt for assistance at all times. Prior to the falls it was known that [client #2] was becoming more unsteady. An appointment was scheduled with her neurologist for 10/22/12. Following the falls the neurologist was notified to see if there were any recommendations prior to the appointment. He ordered labs (blood tests) to check medication levels (all were within normal limits) and a CT (Computed Tomography) scan of her head (pending results). Conclusion of the investigation revealed: The falls described on the incident reports directly correspond to the injuries noted.</p>				

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	<p>A fall plan was in place and being utilized at the time of the falls. [Client #2] is not always compliant with requests to ask for assistance making it difficult for staff to follow the plan...Houston Group Homes Inc. failed to report a fall with injury in a timely manner...."</p> <p>10/10/12: An internal memo to staff indicated: "When a client falls (with or without injury) the supervisor has to be called immediately. If there is no injury at the time of the fall we will fill out an injury report...."</p> <p>10/12/12: A BDDS report indicated, "[Client #2] fell at approximately 12:15 am, she did not complain of any pain discomfort at that time. When she awoke for the day at approximately 6:30 am staff noted that her left hand was swollen and discolored. Her primary care physician was notified and he ordered x-rays and saw her later in the day. The x-rays revealed multiple fractures so she was sent to the hospital to see the orthopedist...Immediate corrective action put into place includes 15 minute bed checks throughout the night (since she sometimes is getting up without calling for assistance) and a doorbell has also been placed next to her bed that will ring into the common area of the house to alert staff that she would like assistance getting</p>						

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	<p>up...[client #2] has a fall plan in place... [client #2] has been unsteady for the past week...."</p> <p>11/25/12: A BDDS report indicated, "[Client #2] was in her room getting dressed at approximately 9:25 AM Sunday morning. She apparently fell while standing to pull her pants up. She fell and hit the left side of her face on the floor causing a 1 1/2" (inch) x (by) 1/2" swollen area and bruise on her left cheek. The residential supervisor and nurse were notified. The nurse recommended that staff on duty apply ice and administer acetaminophen and report any further concerns...Fall prevention plan updated to include: 'Staff will ensure that [client #2] is supervised at all times while getting dressed.' All staff were informed of the change...[Client #2] has recently been approved for physical therapy to address gait training and balance. She has been doing exercises at home but will begin formal therapy sessions on 11/27/12."</p> <p>Client #2's records were reviewed on 06/11/13 at 9:29 AM. Client #2's ISP (Individual Support Plan) dated 01/29/13 contained a Fall Risk Plan which indicated client #2 was at risk for falls. The ISP indicated client #2's gait had become increasingly unsteady in the past year. Client #2's record contained Fall</p>						

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	<p>Risk Plans dated 08/02/12, 10/12/12 and 05/23/13. Client #2's record contained the following dated documents:</p> <p>08/02/12: Fall Risk Plan indicated, "[Client #2] has a fall risk due to existing chronic or acute medical conditions: 1. dizziness/vertigo; 2. seizures; 3. medication side effects; 4. polypharmacy and; 5. osteoporosis. Functional Limitations: 1. impaired gait; 2. decreased judgment or safety awareness; 3. memory deficit and; 4. no attempt to prevent fall....1. Staff will notify Residential Supervisor should a fall occur...."</p> <p>10/12/12: Fall Risk Plan contained the information of the 08/02/12 plan with two additional steps which included, "...Staff will encourage [client #2] to use 'doorbell' to call for assistance before getting up. 9. Staff will perform 15 minute bed checks throughout the night to reduce the chance of [client #2] getting up without assistance...."</p> <p>05/23/13: Fall Risk Plan contained the information of the 10/12/12 plan with one additional step which included, "...Staff will assist and/or supervise [client #2] while dressing-giving reminders/instructions to complete the task before attempting to get up or</p>						

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	<p>walk...."</p> <p>On 06/10/13 at 11:48 AM, a review of the facility's undated Policy on Reporting Allegations of Mistreatment of an Individual indicated, "...Allegations of mistreatment to an individual will be investigated by the interdisciplinary team (IDT). The IDT may consist of the individual client, the Residential Supervisor, the Registered Nurse, the QMRP (Qualified Mental Retardation Professional), and the Executive Director...."</p> <p>An interview was conducted on 06/12/13 at 11:30 AM with the Residential Supervisor (RS). The RS indicated staff failed to contact the RS several times when client #2 fell. She further indicated client #2 had a known history of unsteady gait and required supervision. The RS indicated the agency's policy/procedure on abuse/neglect was not followed as client #2 had repeated falls with injury.</p> <p>9-3-2(a)</p>				

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W000157	<p>483.420(d)(4) STAFF TREATMENT OF CLIENTS If the alleged violation is verified, appropriate corrective action must be taken.</p> <p>Based on record review and interview for 3 of 5 BDDS (Bureau of Developmental Disabilities Services) reports regarding allegations of abuse, neglect and/or injuries of unknown source reviewed, the facility neglected to initiate and document effective corrective action to prevent neglect of client #2, by failing to supervise the client to prevent her from receiving additional injuries.</p> <p>Findings include:</p> <p>The facility's BDDS (Bureau of Developmental Disabilities Services) reports and investigations were reviewed on 06/10/13 at 11:53 AM. The BDDS reports indicated the following:</p> <p>10/10/12: A BDDS ((Bureau of Developmental Disabilities Services) report indicated, "Staff reported that [client #2] had several small bruises on her face. Initial investigation revealed that she had recently been unsteady and fallen earlier in the week. Complete investigation to follow...."</p> <p>A BDDS Follow-up Report dated 10/16/12 to the initial report dated 10/10/12 indicated, "Through our investigation and review of internal</p>	W000157	The Executive Director met with the Director of Nursing and the Residential Supervisor in regards to updating Fall Prevention Plans. The Executive Director instructed the Director of Nursing to update the Fall Prevention Plan when the fall happens. In this incident the Director o Nursing and the Residential supervisor on call did give verbal instruction to the Residential Train to write a memo to all staff on how to ensure the safety of the client until a formal Fall Prevention Plan could be updated. On 10/10/12 a memo was left for all staff. (See Attachment A) We were unable to produce this documentation on the day of the survey. During an interview with the Residential Supervisor on call and the Director of Nursing it was discovered that the Residential Supervisor on call called the Residential trainer with instruction to write the memo. The call to the Residential was made on the same day that the Director of Nursing and the Residential supervisor were made aware of the falls 10/10/12. On 10/12/12 a new Fall Prevention was written and implemented. (See Attachment B)	07/01/2013			

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	<p>incident reports it was discovered that [client #2] fell on 10/3/12, 10/4/12, and 10/5/12. An internal incident report was completed at the time of each fall and then updated later when injury (bruising) was noted. However, staff did not report these injuries to supervisor until several days later. Once the supervisor/RN were made aware of the bruising the internal incident reports were reviewed and staff were interviewed. It is evident that the bruises ARE consistent with the falls described in the incident reports. The falls occurred at night when [client #2] awoke to use the restroom and did not call for staff assistance, making it difficult for staff to follow the plan that is in place. Immediately a visual reminder was placed to help remind [client #2] to call for help and staff were instructed to use her gait belt for assistance at all times. Prior to the falls it was known that [client #2] was becoming more unsteady. An appointment was scheduled with her neurologist for 10/22/12. Following the falls the neurologist was notified to see if there were any recommendations prior to the appointment. He ordered labs (blood tests) to check medication levels (all were within normal limits) and a CT (Computed Tomography) scan of her head (pending results). Conclusion of the investigation revealed: The falls described on the incident reports</p>				

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	<p>directly correspond to the injuries noted. A fall plan was in place and being utilized at the time of the falls. [Client #2] is not always compliant with requests to ask for assistance making it difficult for staff to follow the plan...Houston Group Homes Inc. failed to report a fall with injury in a timely manner...."</p> <p>10/10/12: An internal memo to staff indicated: "When a client falls (with or without injury) the supervisor has to be called immediately. If there is no injury at the time of the fall we will fill out an injury report...." The memo failed to indicate how staff were to keep client #2 safe and monitor her.</p> <p>10/12/12: A BDDS report indicated, "[Client #2] fell at approximately 12:15 am, she did not complain of any pain discomfort at that time. When she awoke for the day at approximately 6:30 am staff noted that her left hand was swollen and discolored. Her primary care physician was notified and he ordered x-rays and saw her later in the day. The x-rays revealed multiple fractures so she was sent to the hospital to see the orthopedist...Immediate corrective action put into place includes 15 minute bed checks throughout the night (since she sometimes is getting up without calling for assistance) and a doorbell has also</p>						

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	<p>been placed next to her bed that will ring into the common area of the house to alert staff that she would like assistance getting up...[client #2] has a fall plan in place... [client #2] has been unsteady for the past week...."</p> <p>11/25/12: A BDDS report indicated, "[Client #2] was in her room getting dressed at approximately 9:25 AM Sunday morning. She apparently fell while standing to pull her pants up. She fell and hit the left side of her face on the floor causing a 1 1/2" (inch) x (by) 1/2" swollen area and bruise on her left cheek. The residential supervisor and nurse were notified. The nurse recommended that staff on duty apply ice and administer acetaminophen and report any further concerns...Fall prevention plan updated to include: 'Staff will ensure that [client #2] is supervised at all times while getting dressed.' All staff were informed of the change...[Client #2] has recently been approved for physical therapy to address gait training and balance. She has been doing exercises at home but will begin formal therapy sessions on 11/27/12."</p> <p>Client #2's records were reviewed on 06/11/13 at 9:29 AM. Client #2's ISP (Individual Support Plan) dated 01/29/13 contained a Fall Risk Plan which indicated client #2 was at risk for falls.</p>				

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	<p>The ISP indicated client #2's gait had become increasingly unsteady in the past year. Client #2's record contained Fall Risk Plans dated 08/02/12, 10/12/12 and 05/23/13. Client #2's record contained the following dated documents:</p> <p>08/02/12: Fall Risk Plan indicated, "[Client #2] has a fall risk due to existing chronic or acute medical conditions: 1. dizziness/vertigo; 2. seizures; 3. medication side effects; 4. polypharmacy and 5. osteoporosis. Functional Limitations: 1. impaired gait; 2. decreased judgment or safety awareness; 3. memory deficit and 4. no attempt to prevent fall...1. Staff will notify Residential Supervisor should a fall occur...." The risk plan failed to indicate how staff were to monitor client #2 at night or assist her in dressing.</p> <p>10/12/12: Fall Risk Plan contained the information of the 08/02/12 plan with two additional steps which included, "...Staff will encourage [client #2] to use 'doorbell' to call for assistance before getting up. 9. Staff will perform 15 minute bed checks throughout the night to reduce the chance of [client #2] getting up without assistance...." The risk plan failed to indicate how staff were to monitor client #2 to assist her in dressing.</p>				

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	<p>05/23/13: Fall Risk Plan contained the information of the 10/12/12 plan with one additional step which included, "...Staff will assist and/or supervise [client #2] while dressing-giving reminders/instructions to complete the task before attempting to get up or walk...."</p> <p>An interview was conducted on 06/12/13 at 11:30 AM with the Residential Supervisor (RS). The RS indicated staff failed to contact the RS several times when client #2 fell. She further indicated client #2 had a known history of unsteady gait and required supervision. The RS indicated additional measures had been put into place on 10/10/12 but failed to be documented in the plan and client #2 continued to fall after that time.</p> <p>9-3-2(a)</p>				