

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G107	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 09/18/2012
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NAME OF PROVIDER OR SUPPLIER CAREY SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 615 E NORTH ST HARTFORD CITY, IN 47348
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W0000	<p>This visit was for a post certification revisit to the investigation of complaint #IN00111553 completed on August 8, 2012.</p> <p>Complaint #IN00111553 - Not corrected.</p> <p>Dates of Survey: September 10, 11, 18, 2012.</p> <p>Facility Number: 000644 Provider Number: 15G107 AIMS Number: 100234170</p> <p>Surveyors: Susan Reichert, Medical Surveyor III-Team Leader Susan Eakright, Medical Surveyor III</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 9/25/12 by Ruth Shackelford, Medical Surveyor III.</p>	W0000	W0000 is labeled as "Initial Comments"	

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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W0318	<p>483.460 HEALTH CARE SERVICES The facility must ensure that specific health care services requirements are met.</p> <p>Based on record review and interview, the Condition of Participation: Health Care Services is not met for 2 of 3 sampled clients (clients A, B). The facility failed to provide adequate health care monitoring and nursing services to clients A and B.</p> <p>Findings include:</p> <p>1. Please refer to W331. The facility failed for 2 of 3 sampled clients (clients A and B) to ensure nursing services provided medical care as prescribed to prevent/treat pressure wounds, failed to assess and monitor pressure wounds, failed to ensure hospital discharge orders were followed, failed to ensure physician's orders were followed, and failed to ensure physician orders were reflected in the medication administration record.</p> <p>2. Please refer to W368. The facility failed for 2 of 3 sampled clients (clients A and B) to administer medications per physician's orders.</p> <p>3. Please refer to W436. The facility failed to ensure adaptive equipment met the client's identified needs for 1 of 3</p>	W0318	<p>W318 Condition– Health Care Services The facility must ensure that specific health care service requirements are met. The facility failed to meet this condition of participation by failing to provide adequate health care monitoring and nursing services to client A and client B. W331 the facility failed to ensure nursing services for client A and B as prescribed to prevent/treat pressure wounds, failed to assess and monitor pressure wounds, failed to ensure hospital discharge orders were followed, failed to ensure physician orders were reflected in the medication administration record. W368 the facility failed for clients A and B to administer medications per physician's orders. W436 the facility failed to ensure adaptive equipment met the identified needs for client B. Specific corrections, preventative measures, and monitoring protocols will be addressed in tags W331, W368 and W436.</p>	10/04/2012			

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	sampled clients (client B). 9-3-6(a)			

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W0331	483.460(c) NURSING SERVICES The facility must provide clients with nursing services in accordance with their needs.	W0331	W331 CareyServices must provide client with nursing services in accordance with theirneeds. The facility failed to ensurenursing services for client A and B as prescribed to prevent/treat pressurewounds, failed to assess and monitor pressure wounds, failed to ensure hospitaldischarge orders were followed, failed to ensure physician orders werereflected in the medication administration record. Correction: Staff will betrained to complete daily skin assessments on all consumers. Staff will be trained on the agency procedurefor Consumer Discharge from Hospital or ER back to residential setting. Completedon 10/4/12. Prevention: TheResidential staff will complete a daily skin assessment for all consumers andsend copies to the Residential Manager and Residential Nurse for review. If any areas of concern are noticed on theskin when completing the Skin assessment the NOD will be notified if afterhours. Medical personnel will asses the identifiedarea of concern within 48 hours. TheResidential staff will follow medical personnel	10/04/2012	

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	<p>Based on record review and interview, the facility failed for 2 of 3 sampled clients (clients A and B) by not ensuring clients received nursing services as prescribed to prevent/treat pressure wounds, failed to assess and monitor pressure wounds, failed to ensure hospital discharge orders were followed, failed to ensure physician's orders were followed, and failed to ensure physician orders were reflected in the medication administration record.</p> <p>Findings include:</p> <p>The facility's reports to BDDS (Bureau of Developmental Disabilities Services) were reviewed on 9/10/12 at 3:30 PM and included the following reports:</p>		<p>recommendation and/or follow the agency procedure for Consumer Discharge from Hospital or ER back to residential setting.</p> <p>Monitoring: The Residential Manager and Residential Nurse will review the daily skin assessments daily for any changes in skin integrity. See agency procedures for Consumer Discharge from Hospital or ER back to residential setting. Staff training was completed on 10/4/12. See attached copies of staff training verification sheets.</p>		

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	<p>1. A report dated 8/10/12 indicated client B had sustained a 1/2 inch superficial cut on the back of his head requiring first aid. The report indicated the injury was unknown in origin.</p> <p>-A report dated 8/28/12 indicated client B had an abdominal evaluation and was found with a suspected ileus (intestinal bowel obstruction) and admitted to the hospital. There was no additional information in the report regarding the status of client B.</p> <p>-A report dated 9/2/12 indicated client B was taken to the ER (emergency room) to be evaluated for a low grade temperature, elevated respiration and blood pressure, and excessive sleeping. The report indicated client B was diagnosed with pneumonia. There was no additional information in the report regarding the status of client B.</p> <p>The group home nurse was interviewed on 9/10/12 at 3:30 PM. She indicated client B had a gastric tube placed while in the hospital stay beginning on 9/2/12, and had been discharged from the hospital on 9/9/12. She stated client B had developed a pressure wound to his buttocks "about 2 weeks ago," and indicated it may have resulted from a poorly fitting wheelchair.</p>						

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	<p>Client B's records were reviewed at the office on 9/10/12 at 4:00 PM. Hospital discharge orders dated 8/30/12 indicated a new medication of Senna 8.6 mg (milligrams) twice daily was prescribed and indicated client B was to go to the hospital or call his doctor if his temperature was over 100 degrees. A hospital discharge summary dated 9/9/12 indicated client B underwent PEG tube placement and had a decubitus ulcer upon admission (site of ulcer not specified). Discharge instructions dated 9/9/12 indicated client B was to go to the ER or call the doctor if his temperature was elevated over 100 and "physician to see patient in one week." Wound care instructions included vasolex to sacrum (large triangular bone at the base of the spine) 4 times daily and as needed after toileting. Discharge home medications included loratadine 10 mg (milligrams) for allergies, Amitiza 24 mcg (micrograms) daily for constipation, omeprazole 20 mg daily for stomach acid, and pentoxifylline 400 mg three times daily (circulation).</p> <p>Client B's records in the group home were reviewed on 9/10/12 at 6:31 PM. A physician's order dated 8/31/12 indicated client B's primary care physician had discontinued Senna 8.6 mg. The</p>						

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	<p>Medication Administration Record (MAR) for September 2012 indicated client B had been given Senna on 9/1/12 and on 9/2/12. The MAR records indicated client B did not receive loratadine, Amitiza, omeprazole, pentoxifylline or vasolex since he returned from the hospital on 9/9/12. There was no evidence in the record to indicate client B's temperature had been taken or monitored since discharge from the hospital on 9/9/12. Client B's MAR included the use of A and D ointment every 2 hours "apply to affected area." The MAR did not include the use of vasolex to treat client B's sacrum as indicated in the hospital discharge orders dated 9/9/12.</p> <p>The House Manager was interviewed on 9/10/12 at 6:31 PM. He indicated client B's temperature was taken weekly and had not been taken since his discharge from the hospital on 9/9/12. When asked if client B's temperature should be taken more often to assess for elevated temperature, he stated, "We probably should." He indicated some of client B's medications could not be crushed and had to be ordered from the pharmacy in liquid form and had not yet been filled.</p> <p>Client B's records were reviewed again at the facility office on 9/11/12 at 12:45 PM.</p>						

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	<p>An August, 2012 MAR failed to indicate client B's temperature was taken after his discharge from the hospital. An August, 2012 Monthly Vitals Sheet indicated client B's temperature had been taken weekly on August 12 and August 19 with normal readings. Physician's orders for September, 2012 indicated Amitiza cap 24 mcg twice daily, loratidine 10 mg daily, omeprazole 20 mg daily, pentoxifylline 400 mg, and vitamin A and D ointment apply thin layer to affected area every 2 hours. The orders indicated staff were to reposition client B every 2 hours. An 8/13/12 Nursing Assessment indicated a "Stage 1 ulcer to buttocks. Will continue to monitor." A skin assessment completed by group home staff dated 8/22/12 indicated a checkmark next to buttocks without comment. A nursing note on the bottom of the form dated 8/23/12 indicated, "ulcer to buttocks. Apply A and D ointment and reposition every 2 hours...1/2 " (inch) x 1 in (inch) pink around edges." The assessment indicated there were no signs or symptoms of pain or drainage.</p> <p>Additional BDDS reports and follow up reports were reviewed on 9/11/12 at 3:11 PM and included the following: -A BDDS report dated 7/22/12 indicated client B "doubled forward hitting just above right eye on the bed." The report</p>						

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	<p>indicated client B was taken to the ER and received 4 stitches.</p> <p>-A BDDS follow up report dated 9/11/12 for the incident involving a wound to client B's head on 8/10/12 indicated the cause of the wound remained unknown. "Due to the cause of being unknown no measures have been implemented to prevent a reoccurrence."</p> <p>-A BDDS follow up report dated 9/10/12 to the incident on 8/28/12 regarding client B's hospitalization regarding a possible ileus. The report indicated client B was released to the group home on 8/30/12 after a hospital evaluation "revealed patterns consistent with ileus as well as moderate fecal load" and client B was scheduled for a G tube to address decreased appetite.</p> <p>-A BDDS follow up dated 9/10/12 regarding the hospitalization on 9/2/12 for client B indicated client B had been admitted to the hospital due to not eating properly, loss of weight, and development of cough and fever. Client B was treated for health care associated pneumonia, developed hypoxia (low oxygen) and was in critical care. Mucous plugs were removed from his lungs and client B underwent a PEG tube placement while on the ventilator and was released to the group home on 9/9/12. The report indicated client B had an appointment scheduled with his primary health care</p>						

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	<p>provider on 9/21/12.</p> <p>The group home nurse was interviewed on 9/11/12 at 2:35 PM and indicated she had asked the staff person why the staff had not documented the ulcer on client B on the skin assessment form dated 8/22/12 and the staff had stated, "It was hard to tell." The nurse indicated she had retrained staff on assessing skin on 9/10/12.</p> <p>The group home nurse was interviewed on 9/11/12 at 3:11 PM. She indicated the medications loratadine, Amitiza, omeprazole, pentoxifylline had not been given to client B as they were unable to be crushed, and were on order in liquid form from the pharmacy, and vasolex was in the process of being ordered to treat the pressure wound to client B's sacrum. She indicated client B's Senna should not have been given after being discontinued on 8/31/12. She indicated client B's temperature was taken weekly and when asked if client B's temperature should have been monitored for elevation, she indicated his temperature should have been taken at least every 8 hours after his discharge from the hospital. She indicated it was group home staff's assignment to ensure discharge orders were included on the MAR and to ensure medications were ordered upon discharge</p>						

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	<p>from the hospital. She indicated there was not a written policy and procedure developed to address hospital discharge orders to ensure physician's orders were followed. She indicated she had not assessed client B's pressure wound prior to his admission to the hospital, had assessed it on 9/9/12 after his discharge, but had not documented the assessment.</p> <p>2. A report dated 8/26/12 indicated client A had not had a BM (bowel movement) since being discharged from the hospital (date of discharge not specified), and was evaluated at the ER. There was no further information available to review in the reports regarding the status of client A after his visit to the ER on 8/26/12 or in regards to his hospitalization prior to the visit to the ER.</p> <p>Additional BDDS reports and follow up reports were reviewed on 9/11/12 at 3:11 PM and included the following: -a BDDS report dated 8/16/12 indicated client A was sent to the hospital after vomiting and failure to have a BM after 2 days for evaluation and treatment of bowel obstruction. The report indicated client A had a history of bowel obstruction. A follow up report indicated client A had a small bowel obstruction and was treated with IV fluids. -a follow up BDDS report dated 8/26/12</p>			

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	<p>indicated client A was released from the hospital on 8/30/12 and received an order for Amitiza 24 mcg from his primary care provider.</p> <p>Client A's records in the agency office were reviewed on 9/10/12 at 4:00 PM. Hospital discharge orders dated 8/30/12 included silver sulfadiazine topical; apply to the skin three times daily.</p> <p>The group home nurse was interviewed on 9/10/12 at 3:30 PM. She indicated client A had a healing wound on his toes.</p> <p>Client A's records were reviewed at the group home on 9/10/12 at 5:50 PM. The MAR for September, 2012 did not include the use of betadine to client A's toes, leave open to air and indicated Silvasorb had not been given for the month of September. There was no evidence of silver sulfadiazine topical in the MAR.</p> <p>The group home manager was interviewed on 9/10/12 at 6:40 PM. He indicated the September MAR did not document client A had been given Silvasorb to treat his toes.</p> <p>Client A's records were reviewed in the office again on 9/11/12 at 2:45 PM. A wound clinic assessment dated 7/11/12</p>						

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	<p>indicated client A was being treated for a wound to his left and right 2nd toes and was to receive betadine daily and leave open to air. A nursing assessment dated 8/13/12 indicated client A had stage 2 ulcers to bilateral 2nd toes. An impaired skin integrity protocol dated 7/12 indicated "no treatment is required at this time." There was no evidence of an updated protocol for client A's skin. An August, 2012 MAR included documentation client A had been given Silvasorb gel left 2nd toes twice daily; cover with Band-Aid each day except while client A was in the hospital. There was no evidence client A received betadine to his toes and the wound left open to air as was recommended by the wound clinic on 7/11/12. Physician's orders provided for August, 2012 did not include the use of Silvasorb gel. Physician's orders for September, 2012 included the use of Silvasorb gel; apply to bilateral toes twice daily.</p> <p>The group home nurse was interviewed on 9/11/12 at 11:30 AM. She indicated client A was to receive Silvasorb, and it was a medication error when he did not receive the medication in September. She indicated there was not an updated protocol for client A's skin integrity and it should have been updated when he was diagnosed with an ulcer in 6/12. She was</p>						

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	<p>unaware of the orders to treat client A's foot with betadine and leave open to air from the wound clinic in 7/12. She indicated the failure to give client A's medications was a med error. She indicated it was group home staff's assignment to ensure discharge orders were included on the MAR and to ensure medications were ordered upon discharge from the hospital. She indicated it was the nurse's role to go over the discharge order to ensure accuracy, and indicated she had not reviewed client A and B's discharge orders of 8/30/12 and 9/9/12. She indicated there was not a written policy and procedure developed to address hospital discharge orders to ensure physician's orders were followed.</p> <p>The group home manager and nurse were interviewed on 9/18/12 at 11:30 AM and indicated hospital discharge orders dated 8/30/12 for the use of silver sulfadiazine were overlooked until pointed out by the surveyor on 9/10/12.</p> <p>This federal tag relates to complaint #IN00111553.</p> <p>This deficiency was cited on August 8, 2012. The facility failed to implement a systemic plan of correction to prevent reoccurrence.</p>						

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NAME OF PROVIDER OR SUPPLIER CAREY SERVICES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 615 E NORTH ST HARTFORD CITY, IN 47348			
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W0368	<p>483.460(k)(1) DRUG ADMINISTRATION</p> <p>The system for drug administration must assure that all drugs are administered in compliance with the physician's orders. Based on record review and interview, the facility failed for 2 of 3 sampled clients (clients A and B) to administer medications per physician's orders.</p> <p>Findings include:</p> <p>1. Client B's records were reviewed at the office on 9/10/12 at 4:00 PM. Hospital discharge orders dated 8/30/12 indicated a new medication of Senna 8.6 mg twice daily. Wound care instructions included vasolex to sacrum (triangular shaped bone at the base of the spine) 4 times daily and as needed after toileting. Discharge home medications included loratadine 10 mg (milligrams) for allergies, Amitiza 24 mcg (micrograms) daily for constipation, omeprazole 20 mg daily for stomach acid, and pentoxifylline 400 mg three times daily (circulation).</p> <p>Client B's records in the group home were reviewed on 9/10/12 at 6:31 PM. A physician's order dated 8/31/12 indicated client B's primary care physician had discontinued Senna 8.6 mg. The Medication Administration Record (MAR) for September 2012 indicated client B had been given Senna on 9/1/12</p>	W0368	<p>W368 Carey Services system for drug administration must assure that all medications/drugs are administered in compliance with the physician's orders. The facility failed for clients A and B to administer medications per physician's orders. Correction: The Residential staff will administer all medications/drugs in compliance with the physician's orders. Completed on 10/4/12. Prevention: Upon completion of administering medications a second staff person that did not administer medications will review (buddy check) on all medications/drugs to ensure that all medications/drugs were administered per physician's orders. See copy of buddy check form. Monitoring: The Residential Manager and Residential Nurse will review all buddy check documentation weekly. The Residential Manager will complete weekly reviews of all medication administration records to ensure that all medications are administered in compliance with the physician's orders and submit a copy of the Group Home Observation Summary to the Residential. The Residential Manager and Residential Nurse will meet weekly to review all</p>	10/04/2012			

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	<p>and on 9/2/12. The MAR records indicated client B did not receive loratadine, Amitiza, omeprazole, pentoxifylline or vasoalex since he returned from the hospital. The MAR did not include the use of vasoalex to treat client B's sacrum as indicated in the hospital discharge orders dated 9/9/12.</p> <p>The House Manager was interviewed on 9/10/12 at 6:31 PM. He indicated some of client B's medications could not be crushed and had to be ordered from the pharmacy in liquid form and had not yet been filled.</p> <p>Client B's records were reviewed again at the facility office on 9/11/12 at 12:45 PM. Physician's orders for September, 2012 indicated Amitiza cap 24 mcg twice daily, loratidine 10 mg daily, omeprazole 20 mg daily, pentoxifylline 400 mg, and vitamin A and D ointment apply thin layer to affected area every 2 hours.</p> <p>The group home nurse was interviewed on 9/11/12 at 3:11 PM. She indicated the medications loratadine, Amitiza, omeprazole, and pentoxifylline had not been given to client B as they were unable to be crushed, and were on order in liquid form from the pharmacy, and vasoalex was in the process of being ordered to treat the pressure wound to client B's sacrum. She</p>		<p>medications/drugs are administered in compliance with the physicians orders. Staff training was completed on 10/4/12. See attached copies of staff training verification sheets. See attached copy of the Group Home Observation Summary</p>		

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	<p>indicated client B's Senna should not have been given after being discontinued on 8/31/12.</p> <p>2. Client A's records in the agency office were reviewed on 9/10/12 at 4:00 PM. Hospital discharge orders dated 8/30/12 included silver sulfadiazine topical; apply to the skin three times daily.</p> <p>Client A's records were reviewed at the group home on 9/10/12 at 5:50 PM. The MAR for September, 2012 did not include the use of betadine to client A's toes, leave open to air and indicated Silvasorb had not been given for the month of September. There was no evidence of silver sulfadazine topical in the MAR.</p> <p>The group home manager was interviewed on 9/10/12 at 6:40 PM. He indicated the MAR did not document client A had been given Silvasorb to treat his toes.</p> <p>Client A's records were reviewed in the office again on 9/11/12 at 2:45 PM. A wound clinic assessment dated 7/11/12 indicated client A was being treated for a wound to his left and right 2nd toes and was to receive betadine daily and leave open to air. A nursing assessment dated 8/13/12 indicated client A had stage 2</p>						

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	<p>ulcers to bilateral 2nd toes. A impaired skin integrity protocol dated 7/12 indicated "no treatment is required at this time." There was no evidence of an updated protocol for client A's skin. An August, 2012 MAR included documentation client A had been given Sulvasorb gel left 2nd toes twice daily; cover with bandaid each day except while client A was in the hospital. There was no evidence client A received betadine to his toes and the wound left open to air as was recommended by the wound clinic on 7/11/12. Physician's orders provided for August, 2012 did not include the use of Silvasorb gel. Physician's orders for September, 2012 included the use of Silvasorb gel; apply to bilateral toes twice daily.</p> <p>The group home nurse was interviewed on 9/11/12 at 11:30 AM. She indicated client A was to receive Silvasorb, and it was a medication error when he did not receive the medication in September.</p> <p>The group home manager and nurse were interviewed on 9/18/12 at 11:30 AM and indicated hospital discharge orders dated 8/30/12 for the use of silver sulfadiazine were overlooked until pointed out by the surveyor on 9/10/12.</p> <p>9-3-6(a)</p>						

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W0436	<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, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client.</p> <p>Based upon observation, record review and interview for 1 of 3 sampled clients (client B), the facility failed to ensure adaptive equipment met the client's identified needs.</p> <p>Findings include:</p> <p>The group home nurse was interviewed on 9/10/12 at 3:30 PM. She stated client B had developed a pressure wound "about 2 weeks ago", and indicated it may have resulted from a poorly fitting wheelchair.</p> <p>Observations were completed at the group home on 9/10/12 from 5:30 PM until 7:00 PM. Client B was either lying in bed or seated in a recliner during the observation.</p> <p>Client B's records were reviewed again at the facility office on 9/11/12 at 12:45 PM. A wheelchair evaluation dated 8/23/12 indicated client B had 2 falls forward out of his current manual wheelchair despite a pelvic positioning belt secured requiring ER visits to close wounds with sutures.</p>	W0436	<p>W436 the facility failed to ensure adaptive equipment meet the identified needs for client B.</p> <p>Correction: The Residential Manager and Residential Nurse will ensure that adaptive equipment meets the identified needs for all consumers. Specifically for client B a wheelchair assessment was completed by HomeHealth Depot on 9/10/12. The Residential Nurse has been in contact with Home Health Depot see attached copy of equipment repair communication log in regards to the expected date of arrival for the modified wheelchair for client B. Completed on 10/4/12.</p> <p>Prevention: Residential staff will complete the Adaptive equipment repair form for any repairs needed to adaptive equipment and turn in a copy to the Residential Manager and Residential Nurse.</p> <p>Monitoring: Weekly the Residential Manager and Residential Nursing will meet</p>	10/04/2012			

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	<p>"Poor condition of wheelchair seat with slung upholstery at seat and back contributing to progressive deformities and poor positioning to engage with feeding...pt (patient) does not have a wheelchair cushion...Due to poor head and trunk control, pt's head hit one of the wheelchair canes which resulted in laceration but did not require sutures...Pt is total assist with for feeding by caregivers...Caregiver having to sit with forearm on armrest of wheelchair due to pt's movements increasing when upright in wheelchair...Pt total assist for all self care and dependent for wheelchair mobility. Pt is nonverbal and does not express needs for toileting, positioning, Staff member present is not aware of pressure ulcer history." An 8/13/12 Nursing Assessment indicated a "Stage 1 ulcer to buttocks."</p> <p>The group home nurse and house manager were interviewed on 9/18/12 at 11:30 AM. The group home nurse indicated client B had been evaluated for a wheelchair in the past prior to admission to the group home and paperwork had not been completed to obtain the chair, but a new wheelchair was now on order. She indicated the wheelchair client B was using did not meet client B's needs and did not have a cushion.</p>		<p>to review if any repairs are needed to adaptive equipment and will keep a log of where or when the adaptive equipment is expected to be repaired or replaced. This information will be maintained by the Residential Nurse.</p> <p>See copy of log for equipment repair communication log.</p>				

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	<p>Client B's wheelchair evaluation records were reviewed on 9/18/12 at 12:30 PM. The evaluation dated 5/9/11 indicated it was for replacement of client B's chair.</p> <p>9-3-7(a)</p>			