

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G800	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  05/17/2013
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NAME OF PROVIDER OR SUPPLIER  ADEC INC	STREET ADDRESS, CITY, STATE, ZIP CODE 6803 LUTZ DR SOUTH BEND, IN 46614
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W000000	<p>This visit was for the investigation of Complaint #IN00127043.</p> <p>COMPLAINT #IN00127043: Substantiated, federal/state deficiencies related to the allegation(s) are cited at W149, W154, W331, and W436.</p> <p>Dates of Survey: May 2, 3, and 17, 2013.</p> <p>Facility number: 012598 Provider number: 15G800 AIM number: 201023280</p> <p>Surveyor: Amber Bloss, QIDP</p> <p>The following deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 5/31/13 by Dotty Walton, QIDP and Ruth Shackelford, 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.</p> <p>Based on interview and record review, the facility failed to develop and implement written policies in regards to immediate notification to the administrator of injuries of unknown origin. The facility failed to thoroughly investigate injuries of unknown origin for 1 of 1 report reviewed for injuries of unknown origin affecting 1 of 3 sampled clients (Client #1).</p> <p>Findings include:</p> <p>1. The facility's reportable incidents to the Bureau of Developmental Disabilities Services (BDDS) and reports of injury were reviewed on 5/2/13 at 2:09 PM. A BDDS report dated 4/2/13 indicated staff "helped [Client #1] to his bed at 9pm. Approximately one hour later, staff heard a commotion coming from his bedroom and found [Client #1] sitting on the ground." The report indicated staff asked Client #1 if he was okay and he stated "It hurts." The report indicated Client #1 was unable to bear weight on his left leg and staff called 911. The report indicated Client #1 was admitted to a local hospital with a hip fracture and was awaiting surgery.</p> <p>On 5/02/13 at 2:24 PM, the Director of Residential Operations indicated Client #1's fractured hip on 4/2/13 was not investigated as an injury of unknown origin because staff heard Client #1. The Director indicated the staff working with Client #1 on that shift wrote statements.</p> <p>During an interview on 5/03/13 at 3:34 PM, the</p>	W000149	All client injuries known or unknown will result in an investigation of the cause. Staff have been trained to notify the manager of any injuries that happen during a shift. The manager will be responsible for notifying the QIDP and implementing the investigative process. If staff are suspected of abuse they will immediately be remove from the home. The investigation will be completed by the QIDP and Human Rights Representative. The investigation will include statements from the individual served as well as staff. If there are concerns that come about from the statements, the individual will be further interviewed to determine facts of the investigation. Upon notification of an incident of suspected abuse neglect or exploitation, the CEO will be immediately notified, and this information will be documented in the individuals investigation file. Per agency policy dated 12/21/11, "In all cases (A/N/E) incident reports will sent immediately to the BIS, the BDDS service coordinator, APS, CPS, the ADEC CEO, the clients legal representative, the case manager and any other person identified in the individuals ISP. A training will be held for all facility managers on	06/11/2013	

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	<p>Director indicated injuries are reported to the facility's medical staff (nurses). The Director indicated it is the medical staff's responsibility to determine whether an injury should be investigated as an injury of unknown origin.</p> <p>During the interview on 5/3/13 at 3:34 PM, the QIDP (Qualified Intellectual Disabilities Professional) indicated she did not consider Client #1's injury an "injury of unknown origin" because Client #1 was found on the floor by staff and went to the hospital with a fractured hip.</p> <p>On 5/3/13 at 11:00 AM, the Human Rights Officer (HRO) was interviewed and indicated he has been the staff notified of allegations of abuse, neglect, and exploitation. The HRO indicated he has been the staff to investigate allegations of abuse, neglect, and exploitation. The HRO indicated if a client had an injury of unknown origin, he would not be reported to first. The HRO indicated the facility's nursing staff has been the first staff to receive reports of injury. The HRO indicated he has received copies of all incident reports. The HRO indicated he would be involved with the investigation of an injury of unknown origin if it is classified as such by the nursing staff or team. The HRO indicated if a client sustains a major injury but is unable to report what happened and there are no other witnesses, it is not necessarily an injury of unknown origin. The HRO indicated he reviewed the BDDS report for Client #1 dated 4/3/13 and indicated the team discussed it and no abuse, neglect, exploitation or injury of unknown origin was indicated. The HRO indicated the facility deemed the fractured hip as an injury only.</p> <p>During the interview on 5/3/13 at 11:00 AM, the Director of Residential Operations indicated the facility policy was developed according to State recommendations. The Director indicated she</p>		6/20/12 by the IDOH at ADEC to provide further guidance to staff on proper investigation. Person Responsible: QIDP, Human Rights Rep.				

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	<p>understood allegations or incidents of abuse, neglect, exploitation, and injuries of unknown origin should be reported immediately to the facility Administrator and indicated she believed the facility Abuse and Neglect policy sufficiently stated as such.</p> <p>On 5/2/13 at 3:08 AM, the facility's Abuse and Neglect Policy (Policy Number 5.5.1, revised 12/21/11) was received from the Director as current. The policy indicated "It is the policy of ADEC to...not tolerate abuse, neglect or exploitation of clients by staff members, clients or persons in the community." The policy indicated "incidents involving Abuse, Neglect, Exploitation, peer-to-peer aggression, criminal activity, medication errors, aversive techniques and use of mechanical restraints...are to be referred to the Human Rights Officer of ADEC immediately. The Human Rights Officer will file timely reports on all allegations received. All other incidents as defined above are the responsibility of the client's Qualified Development Disability Professional (QDDP) [QIDP] or Program Manager." Included in the policy as reportable incident #12 was "any injury to an individual when the cause of the injury is unknown and the injury could be indicative of abuse, neglect or exploitation." The facility's policy failed to indicate injuries of unknown origin (reportable incident #12) were to be reported to the administrator immediately and investigated thoroughly.</p> <p>In regards to "ADEC reporting process for suspected abuse, neglect, exploitation, suspected criminal activity, peer-to-peer aggression, medication errors, aversive techniques and use of mechanical restraints...", the policy indicated the HRO would immediately file an incident report and "the Human Rights Officer will send an electronic copy of the filed incident report to the</p>				

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	<p>President/CEO [designated in policy as Administrator]." The BDDS report was submitted by LPN #2 on 4/3/13 at 4:18 PM for Client #1's fractured hip which occurred at bedtime on 4/2/13. The facility's policy failed to indicate the Administrator would be notified immediately an injury of unknown origin.</p> <p>2) The facility's reportable incidents to the Bureau of Developmental Disabilities Services (BDDS) and reports of injury were reviewed on 5/2/13 at 2:09 PM. A BDDS report dated 4/2/13 indicated staff "helped [Client #1] to his bed at 9pm. Approximately one hour later, staff heard a commotion coming from his bedroom and found [Client #1] sitting on the ground." The report indicated staff asked Client #1 if he was okay and he stated "It hurts." The report indicated Client #1 was unable to bear weight on his left leg and staff called 911. The report indicated Client #1 was admitted with a hip fracture and was awaiting surgery.</p> <p>On 5/02/13 at 2:24 PM, the Director of Residential Operations indicated Client #1's fractured hip on 4/2/13 was not investigated as an injury of unknown origin because staff "heard [Client #1] fall." The Director indicated the staff working with Client #1 on that shift wrote statements.</p> <p>On 5/2/13 at 2:45 PM, the statements from staff members working with Client #1 on 4/2/13 were reviewed. In an undated written statement, DSP #1 (Direct Support Staff) stated Client #1 was "throwing a fit about paper." DSP #1 indicated staff had already given him paper earlier and staff told Client #1 to go to bed but he "refused." DSP #1 indicated Client #1 went to bed after he realized he wasn't getting any more paper. DSP</p>						

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	<p>#1 indicated staff went to check on Client #1 "around" 9 PM and he was on the floor complaining. DSP #1 indicated staff helped Client #1 to his bed and noticed his hip was swollen. DSP #1 stated, "I did not see [Client #1] or when [Client #1] fell."</p> <p>In a written statement dated 4/3/13, DSP #2 stated on 4/2/13, "[Client #1] was upset because he wanted more paper, that's all I know. I did not see or hear anything because I was putting [Client #2] to bed."</p> <p>In an undated written statement, DSP #3 indicated Client #1 was upset about paper. DSP #3 indicated she was in the kitchen putting away dishes and "didn't hear [Client #1] fall or him yell." DSP #3 indicated, "I went into [Client #1]'s room once I heard a staff say he was on the floor, that's all I no [sic]."</p> <p>In an undated written statement, DSP #4 indicated Client #1 got upset with staff because he wanted more paper. DSP #4 indicated Client #1 was yelling in the face of "new staff." DSP #4 indicated, "[DSP #1] came up to him and told him to stop and tried to move him away, but instead he pushed her back!" DSP #4 indicated she walked Client #1 to his room and he sat on the bed and DSP #4 closed the door. DSP #4 indicated in 5 minutes, "we didn't hear or see nothing [sic] the time he fell or whatever he did to him-self [sic] in his room." DSP #4 indicated as she was helping Client #3 to bed, she heard "ow, that hurts" from Client #1's room. DSP #4 indicated she went into Client #1's room and found him lying on the floor. DSP #4 indicated she "called staff in to witness" and they assisted Client #1 off the floor and onto his bed. DSP #4 indicated they took Client #1's vitals and called Residential Manager. DSP #4 indicated Client #1 was sitting in a chair when she</p>						

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	<p>left for another shift. DSP #4 indicated she "didn't see or hear nothing [sic]" of what occurred in Client #1's room.</p> <p>Record review done on 5/02/13 at 2:30 PM indicated Client #1's diagnoses included, but were not limited to, moderate intellectual disabilities, pervasive development disorder, psychosis, Obsessive Compulsive Disorder, Schizoaffective disorder, and "possible" bipolar disorder. Client #1's record review indicated a 3/13/13 Fall Risk plan. An addendum was made to the Fall Risk plan on 4/18/13 to include use of side rails in bed and bed alarm, two person assist while ambulating and transferring, seat belt use while using wheelchair for long distance transfers, and use of gait belt and walker when ambulating.</p> <p>During an interview on 5/03/13 at 3:34 PM, the Director indicated Client #1 returned from the hospital using a walker with his hip healing from surgery. The Director indicated DSP #4's statement of Client #1 pushing staff the evening of his injury on 4/2/13 was not reported by the other staff working. The Director indicated the Human Rights Officer investigates allegations of abuse, neglect, and exploitation. The Director indicated injuries are reported to the facility's medical staff (nurses). The Director indicated it is the medical staff's responsibility to determine whether an injury should be investigated as an injury of unknown origin. The Director indicated Client #1's fractured hip was not identified as an injury of unknown origin because they thought he fell in his room. The Director indicated Client #1 is not using the bed alarm as indicated in his updated Fall Risk plan because he moves too much throughout the night. The Director indicated they switched Client #1's bed to a lower bed as they thought Client #1's injury was due to the height of his bed.</p>			

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	<p>During the interview on 5/3/13 at 3:34 PM, the QIDP (Qualified Intellectual Disabilities Professional) indicated Client #1 was not interviewed regarding his injury on 4/2/13 due to Client #1's history of falsifying stories. QIDP indicated on 4/2/13, staff called the Residential Manager because they were worried about the swelling of Client #1's hip. QIDP indicated the Residential Manager went to the group home and called the the Medical Director (LPN #1). QIDP indicated she did not consider Client #1's injury an "injury of unknown origin" because Client #1 was found on the floor by staff and went to the hospital with a fractured hip. QIDP indicated she was not aware of the time differences between DSP #4's statement that 5 minutes had elapsed between Client #1 going to his room and being found with an injury as compared to the BDDS reported dated 4/3/13 which stated "approximately one hour later" he was found on the floor. QIDP indicated LPN #2 wrote the BDDS report and she doesn't recall telling her an exact time frame. QIDP indicated she did not know the timeline of events that evening nor what time the ambulance was called.</p> <p>On 5/3/13 at 10:27 AM, Client #1's hospital discharge paperwork was reviewed. The hospital discharge paperwork indicated Client #1 was admitted to the hospital on 4/3/13 and discharged on 4/08/13. The physician indicated in the hospital paperwork on 4/5/13, Client #1 "was ambulating in the group home when he fell causing fracture of hip." The hospital paperwork indicated Client #1 left hip sustained a "comminuted, reverse obliquity subtrochanteric fracture. There are small butterfly fracture fragments medially and laterally." The hospital discharge indicated Client #1 had "operative treatment for his left hip fracture with the use of a</p>			
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	<p>cephalomedullary device [hip screws]."</p> <p>On 5/3/13 at 11:00 AM, the Human Rights Officer (HRO) was interviewed and indicated he investigated abuse, neglect, and exploitation. The HRO indicated if there was an injury of origin he might not be contacted first, he indicated the facility's nurse would probably be the first staff to receive a report of injury. The HRO indicated he does receive copies of all incident reports. The HRO indicated he would be involved in investigating an injury of unknown origin if it is reported as such. The HRO indicated if a client sustains a major injury but is unable to report what happened and there are no other witnesses, it is not "necessarily an injury of unknown origin." The HRO indicated he reviewed the BDDS report for Client #1 dated 4/3/13 and stated the team discussed it and no abuse, neglect, exploitation occurred and they deemed the fractured hip as "an injury not as an injury of unknown origin." The HRO indicated no further investigation was completed.</p> <p>During the interview on 5/3/13 at 11:00 AM, the Director of Residential Operations indicated there should have been no discrepancies between the BDDS report, staff statements, and the hospital discharge paperwork. The Director stated the facility staff should have been "on the same page."</p> <p>On 5/2/13 at 3:08 AM, the facility's Abuse and Neglect Policy (Policy Number 5.5.1, revised 12/21/11) was received from the Director as current. The policy indicated "incidents to be reported... 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." Included in the policy as reportable incidents was "any injury to an individual when the cause is unknown and the</p>						

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	<p>injury could be indicative of abuse, neglect or exploitation." The policy indicated "when actions by an ADEC employee or client are alleged to be abuse, neglectful or exploitative or to involve criminal activity the Human Rights Officer...will conduct an investigation and complete a written investigation report. The policy indicated the investigation would include interviews with reporting staff, other witnesses including clients. The policy indicated the investigative report would include a statement of the incident, statement regarding information gained from interviews, findings of substantiation or unsubstantiated of allegations and intent, and recommendations.</p> <p>No investigation was available for review to address the findings.</p> <p>This federal tag relates to complaint #IN00127043.</p> <p>9-3-2(a)</p>				

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W000154	<p>483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated.</p> <p>Based on record review and interview, the facility failed to investigate injuries of unknown origin for 1 of 1 report reviewed for injuries of unknown origin affecting 1 of 3 sampled clients (Client #1).</p> <p>Findings include:</p> <p>The facility's reportable incidents to the Bureau of Developmental Disabilities Services (BDDS) and reports of injury were reviewed on 5/2/13 at 2:09 PM. A BDDS report dated 4/2/13 indicated staff "helped [Client #1] to his bed at 9pm. Approximately one hour later, staff heard a commotion coming from his bedroom and found [Client #1] sitting on the ground." The report indicated staff asked Client #1 if he was okay and he stated "it hurts." The report indicated Client #1 was unable to bear weight on his left leg and staff called 911. The report indicated Client #1 was admitted to a local hospital with a hip fracture and was awaiting surgery.</p> <p>On 5/02/13 at 2:24 PM, the Director indicated Client #1's fractured hip on 4/2/13 was not investigated as an injury of unknown origin because staff heard Client</p>	W000154	All client injuries known or unknown will result in an investigation of the cause. Staff have been trained to notify the manager of any injuries that happen during a shift. The manager will be responsible for notifying the QIDP and implementing the investigative process. If staff are suspected of abuse they will immediately be remove from the home. The investigation will be completed by the QIDP and Human Rights Representative. The investigation will include statements from the individual served as well as staff. If there are concerns that come about from the statements, the individual will be further interviewed to determine facts of the investigation. Upon notification of an incident of suspected abuse neglect or exploitation, the CEO will be immediately notified, and this information will be documented in the individuals investigation file. Per agency policy dated 12/21/11, "In all cases (A/N/E) incident reports will sent immediately to the BIS, the BDDS service coordinator, APS, CPS, the ADEC CEO, the clients legal representative, the case manager and any other person identified in the individuals ISP. A training will be held for all facility managers on	06/11/2013	

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	<p>#1. The Director indicated the staff working with Client #1 on that shift wrote statements.</p> <p>On 5/2/13 at 2:45 PM, the statements from staff members working with Client #1 on 4/2/13 were reviewed. In an undated written statement, DSP #1 (Direct Support Staff) indicated Client #1 was "throwing a fit about paper." DSP #1 indicated staff had already given him paper earlier and staff told Client #1 to go to bed but he "refused." DSP #1 indicated Client #1 went to bed after he realized he wasn't getting any more paper. DSP #1 indicated staff went to check on Client #1 "around" 9 PM and he was on the floor complaining. DSP #1 indicated staff helped Client #1 to his bed and noticed his hip was swollen. DSP #1 stated, "I did not see [Client #1] or when [Client #1] fell."</p> <p>In a written statement dated 4/3/13, DSP #2 indicated on 4/2/13, "[Client #1] was upset because he wanted more paper, that's all I know. I did not see or hear anything because I was putting [Client #2] to bed."</p> <p>In an undated written statement, DSP #3 indicated Client #1 was upset about paper. DSP #3 indicated she was in the kitchen putting away dishes and "didn't</p>		6/20/12 by the IDOH at ADEC to provide further guidance to staff on proper investigation. Person Responsible: QIDP, Human Rights Rep.		

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	<p>hear [Client #1] fall or him yell." DSP #3 indicated, "I went into [Client #1]'s room once I heard a staff say he was on the floor, that's all I no [sic]."</p> <p>In an undated written statement, DSP #4 indicated Client #1 got upset with staff because he wanted more paper. DSP #4 indicated Client #1 was yelling in the face of "new staff." DSP #4 indicated, "[DSP #1] came up to him and told him to stop and tried to move him away, but instead he pushed her back!" DSP #4 indicated she walked Client #1 to his room and he sat on the bed and DSP #4 closed the door. DSP #4 indicated in 5 minutes, "we didn't hear or see nothing [sic] the time he fell or whatever he did to him-self [sic] in his room". DSP #4 indicated as she was helping Client #3 to bed, she heard "ow, that hurts" from Client #1's room. DSP #4 indicated she went into Client #1's and found him lying on the floor. DSP #4 indicated she "called staff in to witness" and they assisted Client #1 off the floor and onto his bed. DSP #4 indicated they took Client #1's vitals and called the Residential Manager. DSP #4 indicated Client #1 was sitting in a chair when she left for another shift. DSP #4 indicated she "didn't see or hear nothing [sic]" of what occurred in Client #1's room.</p> <p>Record review done on 5/02/13 at 2:30</p>				

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	<p>PM indicated Client #1's diagnoses included, but were not limited to, moderate intellectual disabilities, pervasive development disorder, psychosis, Obsessive Compulsive Disorder, Schizoaffective disorder, and "possible" bipolar disorder. Client #1's record review indicated a 3/13/13 Fall Risk plan. An addendum was made to the Fall Risk plan on 4/18/13 to include use of side rails in bed and bed alarm, two person assist while ambulating and transferring, seat belt use while using wheelchair for long distance transfers, and use of gait belt and walker when ambulating.</p> <p>During an interview on 5/03/13 at 3:34 PM, the Director indicated Client #1 returned from the hospital using a walker with his hip healing from surgery. The Director indicated DSP #4's statement of Client #1's pushing staff the evening of his injury on 4/2/13 was not reported by the other staff working. The Director indicated the Human Rights Officer investigated allegations of abuse, neglect, and exploitation. The Director indicated injuries are reported to the facility's medical staff (nurses). The Director indicated it is the medical staff's responsibility to determine whether an injury should be investigated as an injury of unknown origin. The Director</p>				

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	<p>indicated Client #1's fractured hip was not identified as an injury of unknown origin because they thought he fell in his room. The Director indicated Client #1 was not using the bed alarm indicated in his updated Fall Risk plan because he moves too much throughout the night. The Director indicated they switched Client #1's bed to a lower bed as they thought Client #1's injury was due to the height of his bed. The Director indicated she did not know whether Client #1 was still upset when DSP #4 left him in his room the evening of 4/2/13 because it wasn't in her statement but she assumed he was not upset.</p> <p>During the interview on 5/3/13 at 3:34 PM, the QIDP (Qualified Intellectual Disabilities Professional) indicated Client #1 was not interviewed regarding his injury on 4/2/13 due to Client #1's history of falsifying stories. The QIDP indicated on 4/2/13, staff called the Residential Manager because they were worried about the swelling of Client #1's hip. The QIDP indicated the Residential Manager went to the group home and called the Medical Director (LPN #1). The QIDP indicated she did not consider Client #1's injury an "injury of unknown origin" because Client #1 was found on the floor by staff and went to the hospital with a fractured hip. The QIDP indicated she was not aware of</p>				

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	<p>the time differences between DSP #4's statement that 5 minutes had elapsed between Client #1 going to his room and being found with an injury as compared to the BDDS reported dated 4/3/13 which stated "approximately one hour later" he was found on the floor. The QIDP indicated LPN #2 wrote the BDDS report and she doesn't recall telling her an exact time frame. The QIDP indicated she did not know the timeline of events that evening nor what time the ambulance was called.</p> <p>On 5/3/13 at 10:27 AM, Client #1's hospital discharge paperwork was reviewed. The hospital discharge paperwork indicated Client #1 was admitted to the hospital on 4/3/13 and discharged on 4/08/13. The physician indicated in the hospital paperwork on 4/5/13, Client #1 "was ambulating in the group home when he fell causing fracture of hip." The hospital paperwork indicated Client #1 left hip sustained a "comminuted, reverse obliquity subtrochanteric fracture. There are small butterfly fracture fragments medially and laterally." The hospital discharge indicated Client #1 had "operative treatment for his left hip fracture with the use of a cephalomedullary device [hip screws]."</p>				

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	<p>On 5/3/13 at 11:00 AM, the Human Rights Officer (HRO) was interviewed and indicated he investigated abuse, neglect, and exploitation. The HRO indicated if there was an injury of origin he might not be contacted first, he indicated the facility's nurse would probably be the first staff to receive a report of injury. The HRO indicated he does receive copies of all incident reports. The HRO indicated he would be involved in investigating an injury of unknown origin if it is reported as such. The HRO indicated if a client sustains a major injury but is unable to report what happened and there are no other witnesses, it is not necessarily an injury of unknown origin. The HRO indicated he reviewed the BDDS report for Client #1 dated 4/3/13 and said the team discussed it and no abuse, neglect, exploitation occurred and they deemed the fractured hip as an injury not as an injury of unknown origin. The HRO indicated no further investigation was completed.</p> <p>During the interview on 5/3/13 at 11:00 AM, the Director of Residential Operations indicated there should have been no discrepancies between the BDDS report, staff statements, and the hospital discharge paperwork. The Director stated the facility staff should have been "on the same page."</p>						

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	<p>No investigation was available for review to address the findings.</p> <p>This federal tag relates to complaint #IN00127043.</p> <p>9-3-2(a)</p>						

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W000331	<p><b>483.460(c)</b> <b>NURSING SERVICES</b> The facility must provide clients with nursing services in accordance with their needs.</p> <p>Based on interview, observation, and record review, the facility failed to provide nursing services in accordance with client needs in regards to obtaining physician's orders for bed side rails for 2 of 3 sampled clients (Client #1, Client #3) and failed to develop a care plan which included use of side rails for 2 of 3 sampled clients (Client #3).</p> <p>Findings include:</p> <p>1) During group home observations on 5/2/13 between 4:58 PM and 6:20 PM, Client #1's bed was observed with a full side rail in the down position on the left side of his bed.</p> <p>Record review done on 5/02/13 at 2:30 PM and indicated Client #1's diagnoses included, but were not limited to, moderate intellectual disability, pervasive development disorder, psychosis, Obsessive Compulsive Disorder, Schizoaffective disorder, and "possible" bipolar disorder. Client #1's record review indicated a 3/13/13 Fall Risk plan. An addendum was made to the Fall Risk plan on 4/18/13 to include use of side rails in bed and bed alarm, two person assist while ambulating and transferring, seat belt use while using wheelchair for long distance transfers, and use of gait belt and walker when ambulating.</p> <p>During an interview on 5/02/13 at 3:34 PM, the Director of Residential Operations indicated Client #1 returned from the hospital using a walker with his hip healing from surgery. The Director indicated Client #1 was not using the bed alarm indicated in his updated Fall Risk plan because he</p>	W000331	After review of client needs and safety, the bed rails were removed from the beds of client #1 and #3. Staff have been trained on when bed rails can be implemented, and the HRC process that must be implemented for the restriction. All individuals who have bed rails have been reviewed to make sure that there are physician orders and HRC approval. In addition they were observed to be in proper operation. Many of the facility bed rails were removed after further review. In order to prevent this in the future, the process for implementing bed rails had been updated. The bed rails will not be ordered until a PO is in the hand of the nurse who will implement a safety plan. The QIDP will complete the bed rail assessment for appropriateness. Once in place, staff will do a daily inspection of the rails that will be documented on the individuals TAR.	06/11/2013			

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	<p>moves too much throughout the night. The Director indicated they switched Client #1's bed to a lower bed as they thought Client #1's hip fracture sustained on date 4/2/13 was due to a fall occurring as a result of the height of his bed.</p> <p>During an interview on 5/3/13 at 3:34 PM, the QIDP (Qualified Individual Disability Professional) indicated she could not locate the physician's order for Client #1's side rail use and had called the hospital for the order.</p> <p>On 5/3/13 at 10:27 AM, a physician's order for Client #1's side rail was received from the QIDP. The physician order for Client #1's side rail indicated he was aware of the side rail use on Client #1's bed but the physician's order was dated 5/3/13.</p> <p>2) During group home observations on 5/2/13 between 4:58 PM and 6:20 PM, Client #3's bed was observed with a half side rail on the right side of his bed.</p> <p>On 5/3/13 at 1:07 PM, record review for Client #3 indicated he had risk plans dated 3/13/13 which included Seizure Management, Choking Management, Diet plan, Constipation plan, Dry/Itching Skin, Hypokalemia (low potassium), venous insufficiency, medication side effects, and a Fall Risk plan. None of Client #3's plans included use of side rails.</p> <p>During an interview on 5/3/13 at 1:18 PM, the QIDP indicated Client #3's use of side rails is not care planned in his high risk plans. The QIDP also indicated Client #3's physician's order for use of side rails on his bed could not be located and she was waiting for the physician to call the facility back. No further documentation was available for review.</p>			

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	This federal tag relates to complaint #IN00127043.  9-3-6(a)				

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W000436	<p>483.470(g)(2) SPACE AND EQUIPMENT 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 on observation, interview and record review, the facility failed to repair and attach a bed siderail in safe working condition for 1 of 2 clients reviewed for adaptive equipment (Client #1).</p> <p>Findings include:</p> <p>The facility's reportable incidents to the Bureau of Developmental Disabilities Services (BDDS) and reports of injury were reviewed on 5/2/13 at 2:09 PM. A BDDS report dated 4/2/13 indicated staff "helped [Client #1] to his bed at 9 PM. Approximately one hour later, staff heard a commotion coming from his bedroom and found [Client #1] sitting on the ground." The report indicated staff asked Client #1 if he was okay and he stated "it hurts." The report indicated Client #1 was unable to bear weight on his left leg and staff called 911. The report indicated Client #1 was admitted with a hip fracture and was awaiting surgery.</p> <p>Record review done on 5/02/13 at 2:30</p>	W000436	<p>The bed rails were removed from client #1's bed during the course of the survey. Staff have been trained on when bed rails can be implemented, and the HRC process that must be implemented for the restriction. All individuals who have bed rails have been reviewed to make sure that there are physician orders and HRC approval. In addition they were observed to be in proper operation. Many of the facility bed rails were removed after further review. In order to prevent this in the future, the process for implementing bed rails had been updated. The bed rails will not be ordered until a PO is in the hand of the nurse who will implement a safety plan. The QIDP will complete the bed rail assessment for appropriateness. Once in place, staff will do a daily inspection of the rails that will be documented on the individuals TAR. Person Responsible: Nurse, QIDP</p>	06/12/2013			

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	<p>PM of Client #1's record indicated a 3/13/13 Fall Risk plan. An addendum was made to the Fall Risk plan on 4/18/13 to include use of side rails in bed and bed alarm, two person assist while ambulating and transferring, seat belt use while using wheelchair for long distance transfers, and use of gait belt and walker when ambulating.</p> <p>On 5/3/13 at 10:27 AM, Client #1's hospital discharge paperwork was reviewed. The hospital paperwork indicated Client #1's left hip sustained a "comminuted, reverse obliquity subtrochanteric fracture. There are small butterfly fracture fragments medially and laterally." The hospital discharge indicated Client #1 had "operative treatment for his left hip fracture with the use of a cephalomedullary device [hip screws]."</p> <p>During group home observation on 5/2/13 from 4:58 PM to 6:20 PM, Client #1's bed was observed at 5:59 PM with a full side rail in the down position on the left side of his bed and the right side of the bed against a wall. The side rail was observed loose with a gap of approximately 4" (inches) between the safety rail and the bed. The bed safety rail was composed of two horizontal bars with approximately 14" gap between the two bars. A zippered</p>						

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	<p>netting was observed to have covered the side rail but the zipper was broken which exposed a gap the size of about 10" by 14" between the bars of the safety rail at the left foot of Client #1's bed.</p> <p>During an interview at the group home on 5/2/13 at 5:59 PM, the QIDP (Qualified Intellectual Disability Professional) indicated Client #1's side rail must have come unanchored when they were changing bed linens. The QIDP was observed to lift the top mattress and reattach the strap attaching Client #1's side rail to the box mattress. The QIDP indicated the zipper was also broken exposing a gap in Client #1's side rail at the left foot of his bed. The QIDP indicated staff would monitor Client #1 for overnight safety and repair the netting for the side rail in the morning.</p> <p>During an interview on 5/3/13 at 10:27 AM, the Director of Residential Operations indicated she was unaware of safety requirements for side rails used in group homes. During a subsequent interview at 11:50 AM, the Director indicated she would agree Client #1's side rail was in disrepair.</p> <p>This federal tag relates to complaint #IN00127043.</p>						

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