

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G013	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/07/2013
NAME OF PROVIDER OR SUPPLIER AWS			STREET ADDRESS, CITY, STATE, ZIP CODE 817 MENDLESON DR RICHMOND, IN 47374		
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W000000	<p>This visit was for an extended annual recertification and state licensure survey.</p> <p>Dates of Survey: July 23, 24, 25 and August 7, 2013</p> <p>Facility Number: 000588 Provider Number: 15G013 AIMS Number: 100233310</p> <p>Surveyor: Vickie Kolb, RN</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 8/12/13 by 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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W000104	<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, interview and record review for 4 of 4 sampled clients (#1, #2, #3 and #4) and 3 additional clients (#5, #6 and #7), the facility's governing body failed to exercise general policy and operating direction over the facility:</p> <p>__ To ensure the facility implemented its written policy and procedures to prevent neglect in regard to client #2's repeated falls with injuries and to ensure the facility identified and/or prevented neglect of client #2 in regard to implementing safeguards to address the client's reoccurring falls and to prevent further and/or future injury as a result of the falls.</p> <p>__ To ensure the facility provided clients #2, #3, #4, #5, #6 and #7 nourishment during a facility power outage.</p> <p>__ To ensure the facility prevented clients #1, #3 and #7 from accumulating late fees from overdue library items.</p> <p>__ To ensure expired foods were removed from use for clients #1, #2, #3, #4, #5, #6 and #7.</p> <p>Findings include:</p> <p>1. The governing body failed to exercise</p>	W000104	<p>Corrective action for resident(s) found to have been affected</p> <p>Client #2 who had repeated falls was assessed by PT on 7/31/13. PT has been ordered 2 times per week for 5 weeks with a reassessment at that time. Client #2 also received a physicians order for a gait belt, and received HRC approval for use of a bed alarm and monitor. The gait belt, bed alarm, and monitor have been implemented and staff have been trained. All clients were reimbursed by AWS for dinner purchased during power outage. These reimbursements were deposited into each individual's checking account on 8/9/13. All clients who received library late fees were reimbursed by AWS for the late fees. These reimbursements were deposited into each individual's checking account on 8/9/13. Expired food was removed from the house and discarded. Staff are responsible for checking for expired food nightly.</p> <p>How facility will identify other residents potentially affected and what measures taken</p> <p>All residents could potentially be affected and corrective action will</p>	09/06/2013			

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	<p>general policy and operating direction over the facility to ensure the facility implemented its policy and procedures to ensure safeguards were implemented to prevent recurring falls and/or injuries due to falls and to ensure client #2 was assessed/reassessed by PT (Physical Therapy) in regard to recurring falls. Please see W149.</p> <p>2. Review of client #2's, #3's, #4's, #5's, #6's and #7's financial records on 7/24/13 at 8:45 AM indicated on 7/10/13 clients #2, #3, #4, #5, #6 and #7 went out to eat at a local restaurant. The record indicated clients #2 and #4 spent \$9.75 each on their meals and clients #3, #5, #6 and #7 spent \$10.97 each on their meals.</p> <p>Interview with the TL (Team Leader) on 7/24/13 at 8:45 AM indicated there was a total power outage at the facility group home on 7/10/13. The TL indicated the power was off when clients #2, #3, #4, #5, #6 and #7 got home from the day program on 7/10/13 at 3 PM and the facility was unable to prepare an evening meal because there was no electricity in the home. The TL indicated clients #2, #3, #4, #5, #6 and #7 went to a local restaurant for their evening meal and clients #2, #3, #4, #5, #6 and #7 paid for their own meals.</p>		<p>address the needs of all clients.</p> <p>Measures or systemic changes facility put in place to ensure no recurrence Staff retraining will occur on 8/26/13. Retraining will include: Direct care staff discarding expired food nightly. This is and will continue to be documented on the nightly cleaning list. AWS financial accountability policy including the need for AWS to pay for all consumer needs including dinner out during a power outage and library late fees. Monthly finances are monitored by team leaders, reviewed by group home manger, reviewed by director, and sent to corporate compliance each month. The need for PT/ST/OT assessments will be discussed at the annual meetings or as changes warrant by the individual clients IDT.</p> <p>How corrective actions will be monitored to ensure no recurrence Team Leaders will review consumer finances weekly during finance audit. Team Leaders will review for expired food and the completion of nightly cleaning list weekly during home inspection. Group home manager will review these audits weekly to ensure completion. Quarterly meetings will continue to occur where changes or</p>				

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	<p>3. Review of client #1's, #3's and #7's financial records on 7/24/13 at 8:45 AM indicated:</p> <p>___ On 2/15/13 client #1 paid \$3.25 for late fees for overdue library material.</p> <p>___ On 2/06/13 client #3 paid \$7.50 for late fees for overdue library material.</p> <p>___ On 2/07/13 client #7 paid \$7.50 for late fees for overdue library material.</p> <p>Interview with the RM (Residential Manager) on 7/25/13 at 1 PM indicated clients #1, #3 and #7 had gotten items from the library and accumulated late fees when the items were not returned in a timely manner. The RM indicated client #1 had hid the items in her room, not wanting to return them; client #3 refused to return the items and cursed at the staff when he was asked about the items and client #7 thought the items were his to keep. The RM indicated there was no documentation of staff attempts/prompts to return the items to the library or of the clients' refusals to comply with staff requests. The RM stated client #1's and #3's guardians "could have gone in their (the clients') rooms and gotten them (the overdue library items) I guess, I didn't think about it." The RM indicated the clients' guardians were not consulted or asked to assist the clients in returning their overdue items. The RM indicated clients #1, #3 and #7 required staff to</p>		<p>concerns will be discussed and the meeting checklist filled out by the IDT will be sent to the director for review and signature. Director will sign off on staff retraining.</p>				

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	<p>assist them to meet their obligation of returning the library items in a timely manner. The RM indicated client #3 originally owed \$46.46 and the library discounted his fees to \$7.50. The RM indicated the money was taken from each client's personal money to pay the overdue late fees.</p> <p>4. Observations were conducted at the group home of clients #1, #2, #3, #4, #5, #6 and #7 on 7/23/13 between 4 PM and 6:30 PM. There were 2 packages of expired hotdogs on the refrigerator shelf. The 2 packages of expired hot dogs had a use by date of 7/16/13.</p> <p>Interview with staff #1 on 7/23/13 at 6:20 PM indicated all expired food was to be discarded.</p> <p>9-3-1(a)</p>				

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W000122	<p>483.420 CLIENT PROTECTIONS The facility must ensure that specific client protections requirements are met. Based on observation, interview and record review, the facility failed to meet the Condition of Participation: Client Protections for 1 of 4 sampled clients (#2). The facility failed to implement written policy and procedures to prevent neglect of client #2 in regard to reoccurring falls and to implement safeguards to prevent client #2 from further injury due to falls.</p> <p>Findings include:</p> <p>1. The facility failed to implement written policies and procedures to prevent neglect of client #2 in regard to reoccurring falls and injuries due to falls. The facility failed to implement safeguards to prevent client #2 from further injury due to falls. Please see W149.</p> <p>2. The facility failed to ensure the IDT (Interdisciplinary Team) had client #2 re-assessed by PT (Physical Therapy) due to reoccurring falls and injuries due to falls. Please see W210.</p> <p>9-3-2(a)</p>	W000122	<p>Corrective action for resident(s) found to have been affected Client #2 received a PT evaluation on 7/31/13. PT has been ordered 2 times per week for 5 weeks at which time a reassessment will occur. A gait belt was ordered by a physician and implemented on 8/15/13 and the risk plan was revised on 8/15/13. Staff were trained. A bed alarm and bedroom monitor was approved by Human Rights Committee on 8/17/13 and implemented on 8/17/13. Staff have been trained on the use of the new adaptive equipment. Client #2's Risk Plan and ISP will be updated no later than 9/6/13.</p> <p>How facility will identify other residents potentially affected and what measures taken The physician of the one other consumer with a hx of falls and walker usage will receive a request for a PT evaluation.</p> <p>Measures or systemic changes facility put in place to ensure no recurrence Staff will be retrained to document every occurrence of non compliance in relation to use of the walker or the gait belt. LPN was reminded by Manager</p>	09/06/2013			

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			<p>of Health Services of the need to request PT anytime there is a hx of falls. Staff will be trained to document daily skin integrity on all consumers to ensure all bruises are identified and reported.</p> <p>How corrective actions will be monitored to ensure no recurrence Staff will document every occurrence of non compliance in relation to use of the walker or the gait belt. Staff will document daily skin integrity on all consumers to ensure all bruises are identified and reported. Team Leader, LPN, and QDDP will monitor these tracking mechanisms to ensure compliance and identify trends. Director will sign off on retraining.</p>	

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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 observation, record review and interview for 1 of 4 sample clients (#2), the facility neglected to implement its policy and procedures to ensure safeguards were implemented to prevent recurring falls and/or injuries due to falls, to ensure the staff prompted client #2 to use her walker whenever ambulating and to ensure client #2 was assessed/reassessed by PT (Physical Therapy) in regard to recurring falls.</p> <p>Findings include:</p> <p>Observations were conducted at the group home on 7/23/13 between 4 PM and 6:30 PM. At 4:30 PM client #2 walked to a nearby group home to attend a peer's birthday party. Client #2 ambulated at a fast pace, using a walker and was escorted by staff while walking to the nearby group home.</p> <p>Observations were conducted at the group home on 7/24/13 between 6 AM and 8:30 AM. __At 6 AM client #2 was in her bed, lying down. Client #2's walker was in the corner of the room and out of reach for client #2 to retrieve without getting up</p>	W000149	<p>Correctiveactionforresident(s)foundtohavebeenaffected Client #2 received a PT evaluation on 7/31/13. PT has been ordered 2 times per week for 5 weeks at which time a reassessment will occur. A gait belt was ordered by a physician and implemented on 8/15/13 and the risk plan was revised on 8/15/13. A bed alarm and bedroom monitor was approved by Human Rights Committee on 8/17/13 and implemented on 8/17/13. Staff have been trained on the use of the new adaptive equipment. Client #2's Risk Plan and ISP will be updated no later than 9/6/13 and staff will be trained on new documentation. The physician's prescription dated 2/26/13 was included in Client #2's medical chart. This order has been added to the physicians orders.</p> <p>Howfacilitywillidentifyotherresidentspotentiallyaffectedandwh atmeasurestaken The physician of the one other consumer with a hx of falls and walker usage will receive a request for a PT evaluation.</p> <p>Measuresorsystemicchangesfacilityputinplacetoensurenorecu</p>	09/06/2013	

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	<p>and walking to the walker.</p> <p>__At 6:40 AM staff #2 woke client #2 and stated, "Come on, it's time to get up." Client #2 got up, got dressed and made her bed. While making her bed, client #2 used her bed to support herself. After making her bed, client #2 stretched, while holding onto her bed, to reach for her walker. Client #2 did not use her walker while in her bedroom and was not directly supervised by the staff.</p> <p>__At 7:10 AM client #2 walked from her bedroom to the med (medication) room, using her walker. Client #2 left her walker in front of the filing cabinet in the med room and walked to the bathroom in the med room to wash her hands. Client #2 washed her hands and returned to the med area, sitting down in a straight chair near one of the desks.</p> <p>At 7:25 AM after taking her AM meds, client #2 stood up, walked to her walker and proceeded to the living room off of the dining room. Client #2 left her walker in the living room and walked to the kitchen. From 7:25 AM through 8:12 AM client #2 ambulated in the living room, kitchen, dining room and garage, carried her lunch box from the garage into the kitchen, got up and down from the dining room table and carried her plate/dishes back and forth from the kitchen to the dining room without the use of her walker. There were 4 staff in the home</p>		<p>rence</p> <p>Staff will be retrained to document every occurrence of non compliance in relation to use of the walker or the gait belt. LPN was reminded by Manager of Health Services of the need to request a PT assessment anytime there is a hx of falls. Staff will be trained to document daily skin integrity on all consumers to ensure all bruises are identified and reported. IDT discusses the need for all therapies annually at the annual meeting. The Annual Physical form asks the physician to identify any need for therapies annually.</p> <p>Howcorrectiveactionswillbemonitoredtoensurenorecurrence</p> <p>Staff will document every occurrence of non compliance in relation to use of the walker or the gait belt. Staff will document daily skin integrity on all consumers to ensure all bruises are identified and reported. Team Leader, LPN, and QDDP will monitor these tracking mechanisms to ensure compliance and identify trends. Director will sign off on retraining.</p>				

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	<p>and the QIDP (Qualified Intellectual Disabilities Professional). The staff did not prompt client #2 to use her walker while in her bedroom and/or while in the kitchen/dining room/living room. The QIDP indicated he had prompted client #2 to use her walker once while she was in the back of the home near her bedroom and the main bathroom.</p> <p>Observations were conducted at the day program on 7/24/13 between 10 AM and 11 AM. Client #2 sat at a table, her walker sitting nearby but out of her reach. Client #2 stood up and walked to her walker. Client #2 walked unassisted by staff to the bathroom, used the bathroom and returned to the main area of the day program and sat down in a chair. During this time client #2 ambulated with her walker. Staff did not assist client #2 while ambulating and/or give client #2 direct supervision.</p> <p>The facility's records were reviewed on 7/23/13 at 1 PM.</p> <p>The facility BDDS (Bureau of Developmental Disabilities Services) reports indicated: ___ On 7/29/12 at 2:45 PM client #2 was putting groceries away in the pantry of the group home when she began backing out of the pantry and lost her footing. Client #2 fell backward into the island in the</p>			

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	<p>kitchen. The report indicated client #2 was using her walker at the time of the fall. Client #2 had a "red mark about 4 inches in length on the middle part of her back. She also complained that she had bumped her head during the fall. Staff observed no injuries to her head. The nurse completed an exam on [client #2] on 7/30 and observed that [client #2] now has a bruise approx (approximately) 3 inches around on her right thigh, deep purple in color, as a result of the fall." The report indicated "This writer [the QIDP (Qualified Intellectual Disabilities Professional)] notes once again that [client #2] was using her walker as needed." The Follow Up BDDS report of 8/3/12 indicated an education piece was added to client #2's fall risk plan for the nurse to educate client #2 about falls, prevention, long term risks, and complications that could arise from a serious fall. These meetings in the beginning will be weekly and continue as needed.</p> <p>__On 11/27/12 at 12 PM the nurse was notified client #2 had a "large bruise" on her right knee. Client #2 "disclosed that sometime on Sunday she was in the kitchen and fell after tripping on her walker. She [client #2] was unable to provide any further details regarding the fall. She [client #2] stated that the fall was</p>			

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	<p>not witnessed by anyone and that she did not tell anyone about the fall of (sic) injury until now. This injury was discovered on 11/26 at approx (approximately) 5 pm.... Falls are addressed in [client #2's] risk summary which states that anytime [client #2] is ambulating she is to use her walker which she was using when the injury occurred. Staff will continue to prompt [client #2] to use her walker at all times while ambulating."</p> <p>__ On 12/1/12 at 11:45 AM while at the bowling alley, client #2 "lost her balance while attempting to bowl and fell to the ground." The report indicated client #2 initially complained of pain in her left ankle "but was checked out by medical staff and had full range of motion. She [client #2] no longer complains of pain in her ankle and has no problems ambulating. She now complains of pain in her left buttock but at this time there is no bruising. She was using her walker at the time of the fall. Falls are addressed in [client #2's] risk summary which states that anytime [client #2] is ambulating she is to use her walker which she was using when the injury occurred. Staff will continue to prompt [client #2] to use her walker at all times while ambulating." The Follow Up BDDS report of 12/7/12 indicated "the group home nurse will</p>			

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	<p>update her [client #2's] risk summary to state that staff are to be within arms reach whenever [client #2] is ambulating on unfamiliar or uneven surfaces, such as the step down from the bowling lane."</p> <p>__ On 12/7/12 at 11:15 PM "while moving from the living room couch to the kitchen area without the use of her prescribed walker [client #2] fell hitting her face on the counter and knee on the ground. Staff were following [client #2's] risk summary by prompting [client #2] to use her walker when the fall occurred. [Client #2] suffered injuries under her right eye and bruising to her right knee." The Follow Up BDDS report of 12/16/12 indicated "when staff see that [client #2] is not using her prescribed walker they are to prompt [client #2] to use her walker and revisit the issue every 5 minutes moving forward. Also per her risk summary staff are to be within arms reach when ambulating on uneven and changing terrain. [Client #2] is also educated by the nurse on a weekly basis the dangers of falls and the importance of using her prescribed walker to prevent falls. Staff were not within eyesight, having their back turned, when the fall occurred only hearing the fall and coming to the scene to see [client #2] on the ground, thus could not provide the prompt to [client #2] to use her walker. It should be noted</p>				

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	<p>that this fall was split second and the distance between the couch where [client #2] got up and the kitchen area is approx 5 ft (feet). [Client #2's] injury to her eye included slight bruising under the eye and a superficial scratch approx 2 inches under her eye.... Staff will be retrained on [client #2's] risk plan regarding the use of her walker to ensure that they are prompting [client #2] to use her walker when they see her walking without. This writer (the QIDP) has witnessed countless incidents of [client #2] walking without her walker and have witnessed staff prompting her to use her walker but [client #2] often refuses. After her most recent fall she was seen by her primary care physician who referred her to an ENT (Ears, Nose and Throat) Dr. (doctor) to rule out Meniere's Disease (a disorder of the inner ear that can affect hearing and balance)...."</p> <p>__On 5/27/13 at 7:30 PM client #2 tripped on an end table leg and fell backwards into the table, hitting her right knee and the right side of her head. "[Client #2] suffered a knot to her knee and the right side of head." The report indicated client #2 was using her walker at the time of the fall and client #2 "will be counseled on the importance of being more careful while ambulating near and around furniture." The Follow Up BDDS</p>			

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	<p>report of 6/3/13 indicated client #2 was to see an Ophthalmologist (eye doctor) to rule out any vision or depth perception issues that might be causing her recent falls.</p> <p>__ On 5/28/13 at 1:30 PM client #2 was getting a snack from the vending machine at the day program when the client saw a staff person she had not seen for awhile. Client #2 "attempted to rush over and hug that person. In the process, she tripped over her feet and her walker and fell. She landed on her bottom and hit the back of her head on a table that was behind her." The report indicated client #2 had a bruise on her "tailbone" 1/2 inch in diameter and she complained of pain in her left hip and bottom "when it happened." The report indicated client #2 was using her walker at the time of the fall and her risk plan was followed.</p> <p>__ On 6/20/13 at 3 PM client #2 informed the staff that she had fallen earlier in the day while in her bedroom. Client #2 "stated that she had pulled out her clothes drawer and tripped and landed on that drawer. [Client #2] suffered a large bruise from her knee to her thigh." The report indicated client #2 was using her walker while she was in her room but was not using it at the time of the fall because she was attempting to get dressed for the day.</p>				

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	<p>The report indicated client #2 "is counseled weekly regarding the dangers of falls and the importance of keeping her area clear of tripping hazards and using her walker by the group home nurse." The report indicated client #2 "was also counseled on the importance of informing staff when she falls immediately so that the staff are aware of the fall and can take necessary steps. Staff will continue to follow [client #2's] risk summary regarding falls which states that staff are to prompt [client #2] anytime she is seen not using her walker and to ensure [client #2's] area is free from any trip hazards." The BDDS Follow Up report of 6/28/13 indicated "[Client #2] enjoys her independence while getting dressed and the team does not feel like an isolated fall while getting dressed should constitute taking that independence away from [client #2] at this time. The team will continue to assess and address these issues moving forward and make necessary changes to ensure her [client #2's] health and safety as needed." Staff will continue to follow client #2's risk plan regarding falls.</p> <p>Client #2's record was reviewed on 7/24/13 at 11 AM.</p> <p>Client #2's Post Fall Assessments indicated:</p>			

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	<p>__4/6/13 at 2:30 PM indicated client #2 "was bringing her clothes into the living room, she let go of her walker and leaned her weight on her laundry basket which caused it and her to topple over. The fall scared her more than anything though." The assessment indicated client #2 had a possible injury to her left wrist and left side. The assessment indicated "immediate actions to prevent future falls: Hold onto your walker, don't put weight on laundry basket. Ask for help if needed."</p> <p>__5/27/13 "immediate actions to prevent future falls: scooted table to left."</p> <p>__5/28/13 "immediate actions to prevent future falls: remind [client #2] to be careful."</p> <p>__6/20/13 "immediate actions to prevent future falls: Make sure room well lit, drawer is shut after clothes picked out, all objects (trip hazards) removed from area and staff assist if needed."</p> <p>Client #2's IDT (Interdisciplinary Team) meeting notes for 2012/2013 indicated: __10/16/12 "Reviewed clients plan and will possibly look into Velcro shoes in the future due to fall risk. Spoke about noncompliance." __1/8/13 "Team discussed use of walker to prevent injuries - she [client #2] states she will try, doesn't want to get hurt." __4/9/13 "No falls thru quarter - use of</p>						

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	<p>walker, have walker replaced at [name of medical supply company]." ___7/9/13 "Spoke at length about importance to cont [continue] use of walker.... Spoke of dizziness when up and ambulating. Informed her of importance of informing staff when dizzy.... Once again spoke with [client #2] about the risk of falls and fall prevention - informed her of the possible consequences of a serious injury after a fall - including rehab (rehabilitation) stay. She stated she will make better efforts."</p> <p>Client #2's Risk Summary of 11/1/12 indicated client #2 was at risk for falls. The risk plan indicated: ___ "[Client #2] should use a seated walker anytime she ambulates." ___ "[Client #2] should increase her endurance and may walk to the [name of day services] when weather permits while using walker with staff within arms reach." ___ "Environment will be kept clean and free from clutter." ___ "No rugs will be in the home." ___ "When ambulating on ramps staff will provide assistance d/t (due/to) unsteady gait." ___ "During night hours there will be a night light plugged in an outlet in [client #2's] room, so that when she ambulates at night she can see where she is going."</p>			

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	<p>__ "When [client #2] is ambulating in the kitchen, the dishwasher door will be closed prior to [client #2] ambulating that walker can fit easily through doorway."</p> <p>__ "[Client #2] will be within staff eye sight anytime she is ambulating."</p> <p>__ "Any fall will be reported to nurse, an injury report and a fall assessment sheet will be completed and turned into nurse the next business day."</p> <p>__ "Any time [client #2] refuses to use her walker, staff will provide verbal prompts every 5 minutes."</p> <p>__ "Remind [client #2] of the consequences of refusing to use her walker and how the walker is used to steady her gait and provided assistance."</p> <p>__ "The nurse meets with [client #2] to discuss fall prevention. The nurse will monitor and update fall risk plan as needed."</p> <p>Client #2's medical appointment forms indicated client #2 saw a doctor on: __ 9/6/12 due to "Increase in falls, c/o (complaining of) dizziness and tinnitus (ringing of the ears). B/P (blood pressure) WNL (within normal limits) ortho status B/P completed 8/12 WNL. Dizziness - refer for ENT evaluation - r/o (rule out) Meniere's Disease (a disorder of the inner ear that can affect hearing and balance)." __ 9/20/12 client #2 saw an ENT doctor with no findings.</p>			

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	<p>__12/11/12 client #2 saw her doctor for a follow up appointment due to injury to both knees, left ankle and left hip due to falls. The form indicated client #2's Clonazepam was increased due to increased "agitation."</p> <p>Client #2's 2013 physician's orders indicated no order for the use of a walker.</p> <p>Client #2's record indicated nursing services failed/neglected to: __ Revise/update client #2's fall risk plan to include sufficient safeguards to protect client #2 from falls and/or injury from falls. __ To ensure client #2 was assessed/reassessed by a PT. __ To ensure the IDT addressed client #2's continued falls and/or falls with injury and implemented sufficient safeguards to prevent recurring falls and/or injuries due to recurring falls. __ To ensure client #2's physician's orders included the use of a walker.</p> <p>Interview with the QIDP (Qualified Intellectual Disabilities Professional) on 7/24/13 at 1 PM indicated client #2 was at risk for falls. The QIDP indicated the IDT (Interdisciplinary Team) had looked at client #2's falls and the team felt client #2's plan did not need revision. The QIDP indicated the facility nurse counseled</p>						

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	<p>client #2 on the risk of falls, the use of her walker and the consequences of falling. The QIDP indicated the staff were to prompt client #2 to use her walker whenever client #2 was ambulating without it. The QIDP indicated client #2 did not use her walker on a regular basis and had to be reminded to use it. The QIDP stated client #2 did not require direct staff supervision but the staff "should keep her [client #2] in their line of sight" whenever client #2 was ambulating. When asked how the staff were to ensure client #2's protection while she was in her bedroom, the QIDP indicated the IDT did not want to reduce client #2's freedom and privacy so the staff did not have to have client #2 in line of sight while in her bedroom and/or the bathroom. The QIDP indicated the IDT had not discussed client #2 having a PT evaluation.</p> <p>Interview with the facility LPN (Licensed Practical Nurse) on 7/24/13 at 1:30 PM indicated client #2 walked at a fast pace and used a walker while ambulating. The LPN indicated client #2 was at risk for falls and had a history of falling. The LPN stated she had counseled client #2 on "numerous occasions" on the safety of using her walker. The LPN indicated the staff were to prompt client #2 to use her walker every time client #2 was observed</p>				

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	<p>ambulating without it. The LPN stated "I'm not the one that took her to the doctor or I would have said something to the doctor about her having one (a PT evaluation)." The LPN indicated she was not sure when and/or if client #2 had been assessed by PT as client #2's PT results were not on the client's record. The LPN indicated she would have to call the hospital to see when client #2 was last assessed by PT and to get the results. The LPN indicated client #2's PCP referred client #2 to an ENT (Ears, Nose and Throat specialist). The LPN indicated client #2's Fall Risk Summary/Plan was last updated 11/1/12. The LPN stated client #2's physician's orders "should" include the client's use of a walker.</p> <p>Interview with the facility LPN on 7/25/13 at 1:30 PM indicated the hospital had faxed client #2's most recent PT evaluation dated 2009 to the facility. The facility nurse indicated client #2 had not been evaluated by PT since 2009.</p> <p>Review of client #2's PT (Physical Therapy) evaluation of 9/16/09 on 7/25/13 at 2 PM indicated when client #2 arrived for her assessment client #2 had "multiple bruises present on her legs." The evaluation indicated a "primary diagnosis is frequent falls, difficulty walking, generalize DJD (Degenerative</p>				

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	<p>Joint Disease)." The evaluation indicated "Pt/Pt's (patient/patient's) caregiver (from Achieva [AWS] report hx (history) of falls, however are not sure of situations or how many times (notes are at Achieva). Pt's caregiver note she has become unstable walking, however is independent with ADL's (Adult Daily Living Skills) at group home." The evaluation indicated client #2 would benefit from skilled PT.</p> <p>Review of the 2/18/11 facility policy "Group Home Abuse and Neglect" on 7/23/13 at 1 PM indicated "Neglect includes failure to provide appropriate care, food, medical care or supervision."</p> <p>9-3-2(a)</p>						

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W000210	<p>483.440(c)(3) INDIVIDUAL PROGRAM PLAN Within 30 days after admission, the interdisciplinary team must perform accurate assessments or reassessments as needed to supplement the preliminary evaluation conducted prior to admission.</p> <p>Based on observation, record review and interview for 1 of 4 sampled clients (#2), the facility failed to ensure the IDT (Interdisciplinary Team) had client #2 re-assessed by PT (Physical Therapy) due to reoccurring falls and falls with injury.</p> <p>Findings include:</p> <p>Observations were conducted at the group home on 7/23/13 between 4 PM and 6:30 PM. At 4:30 PM client #2 walked to a nearby group home to attend a peer's birthday party. Client #2 ambulated at a fast pace, using a walker and was escorted by staff while walking to the nearby group home.</p> <p>Observations were conducted at the group home on 7/24/13 between 6 AM and 8:30 AM.</p> <p>__At 6 AM client #2 was in her bed, lying down. Client #2's walker was in the corner of the room and out of reach for client #2 to retrieve without getting up and walking to the walker.</p> <p>__At 6:40 AM staff #2 woke client #2 and stated, "Come on, it's time to get up."</p>	W000210	<p>Correctiveactionforresident(s) oundtohavebeenaffected Client #2 received a PT evaluation on 7/31/13. PT has been ordered 2 times per week for 5 weeks at which time a reassessment will occur.</p> <p>Howfacilitywillidentifyotherresidentspotentiallyaffectedandwh atmeasurestaken The physician of the one other consumer with a hx of falls and walker usage will receive a request for a PT evaluation.</p> <p>Measuresorsystemicchangesfa cilityputinplacetoensurenorecu rrence LPN was reminded by Manager of Health Services of the need to request PT anytime there is a hx of falls. IDT discusses the need for all therapies annually at the annual meeting or more frequently as needed for changes or concerns.</p> <p>The Annual Physical form asks the physician to identify any need for therapies annually.</p> <p>Howcorrectiveactionswillbemo nitoredtoensurenorecurrence AWS Compliance Trends Review</p>	09/06/2013
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	<p>Client #2 got up, got dressed and made her bed. While making her bed, client #2 used her bed to support herself. After making her bed, client #2 stretched, while holding onto her bed, to reach for her walker. Client #2 did not use her walker while in her bedroom and was not directly supervised by the staff.</p> <p>__At 7:10 AM client #2 walked from her bedroom to the med (medication) room, using her walker. Client #2 left her walker in front of the filing cabinet in the med room and walked to the bathroom in the med room to wash her hands. Client #2 washed her hands and returned to the med area, sitting down in a straight chair near one of the desks.</p> <p>At 7:25 AM after taking her AM meds, client #2 stood up, walked to her walker and proceeded to the living room off of the dining room. Client #2 left her walker in the living room and walked to the kitchen. From 7:25 AM through 8:12 AM client #2 ambulated in the living room, kitchen, dining room and garage, carried her lunch box from the garage into the kitchen, got up and down from the dining room table and carried her plate/dishes back and forth from the kitchen to the dining room without the use of her walker. There were 4 staff in the home and the QIDP (Qualified Intellectual Disabilities Professional). The staff did not prompt client #2 to use her walker</p>		<p>committee and well as Manager of Health Services will continue to review all incident reports and monitor for trends and provide suggestions to IDT.</p> <p>IDT team will meet quarterly to discuss all aspects of client programming including health services. The IDT will fill out the quarterly meeting checklist and submit to director for review and signature.</p>				

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	<p>while in her bedroom and/or while in the kitchen/dining room/living room. The QIDP indicated he had prompted client #2 to use her walker once while she was in the back of the home near her bedroom and the main bathroom.</p> <p>Observations were conducted at the day program on 7/24/13 between 10 AM and 11 AM. Client #2 sat at a table, her walker sitting nearby but out of her reach. Client #2 stood up and walked to her walker. Client #2 walked unassisted by staff to the bathroom, used the bathroom and returned to the main area of the day program and sat down in a chair. During this time client #2 ambulated with her walker. Staff did not assist client #2 while ambulating and/or give client #2 direct supervision.</p> <p>During all 3 observations, client #2 ambulated at a fast pace with and without her walker and at times, determined to get to her destination without paying attention to her surrounding and/or what was going on around her.</p> <p>The facility's records were reviewed on 7/23/13 at 1 PM. The facility BDDS (Bureau of Developmental Disabilities Services) reports indicated: __ On 7/29/12 at 2:45 PM client #2 was</p>						

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	<p>putting groceries away in the pantry of the group home when she began backing out of the pantry and lost her footing. Client #2 fell backward into the island in the kitchen. The report indicated client #2 was using her walker at the time of the fall. Client #2 had a "red mark about 4 inches in length on the middle part of her back. She also complained that she had bumped her head during the fall. Staff observed no injuries to her head. The nurse completed an exam on [client #2] on 7/30 and observed that [client #2] now has a bruise approx (approximately) 3 inches around on her right thigh, deep purple in color, as a result of the fall." The report indicated "This writer [the QIDP] notes once again that [client #2] was using her walker as needed." The Follow Up BDDS report of 8/3/12 indicated an education piece was added to client #2's fall risk plan for the nurse to educate client #2 about falls, prevention, long term risks, and complications that could arise from a serious fall. These meetings in the beginning will be weekly and continue as needed.</p> <p>__ On 11/27/12 at 12 PM the nurse was notified client #2 had a "large bruise" on her right knee. Client #2 "disclosed that sometime on Sunday she was in the kitchen and fell after tripping on her walker. She [client #2] was unable to</p>			

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	<p>provide any further details regarding the fall. She [client #2] stated that the fall was not witnessed by anyone and that she did not tell anyone about the fall of (sic) injury until now. This injury was discovered on 11/26 at approx (approximately) 5 pm.... Falls are addressed in [client #2's] risk summary which states that anytime [client #2] is ambulating she is to use her walker which she was using when the injury occurred. Staff will continue to prompt [client #2] to use her walker at all times while ambulating."</p> <p>__On 12/1/12 at 11:45 AM while at the bowling alley, client #2 "lost her balance while attempting to bowl and fell to the ground." The report indicated client #2 initially complained of pain in her left ankle "but was checked out by medical staff and had full range of motion. She [client #2] no longer complains of pain in her ankle and has no problems ambulating. She now complains of pain in her left buttock but at this time there is no bruising. She was using her walker at the time of the fall. Falls are addressed in [client #2's] risk summary which states that anytime [client #2] is ambulating she is to use her walker which she was using when the injury occurred. Staff will continue to prompt [client #2] to use her walker at all times while ambulating."</p>			

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	<p>The Follow Up BDDS report of 12/7/12 indicated "The group home nurse will update her [client #2's] risk summary to state that staff are to be within arms reach whenever [client #2] is ambulating on unfamiliar or uneven surfaces, such as the step down from the bowling lane."</p> <p>__ On 12/7/12 at 11:15 PM "while moving from the living room couch to the kitchen area without the use of her prescribed walker [client #2] fell hitting her face on the counter and knee on the ground. Staff were following [client #2's] risk summary by prompting [client #2] to use her walker when the fall occurred. [Client #2] suffered injuries under her right eye and bruising to her right knee." The Follow Up BDDS report of 12/16/12 indicated "when staff see that [client #2] is not using her prescribed walker they are to prompt [client #2] to use her walker and revisit the issue every 5 minutes moving forward. Also per her risk summary staff are to be within arms reach when ambulating on uneven and changing terrain. [Client #2] is also educated by the nurse on a weekly basis the dangers of falls and the importance of using her prescribed walker to prevent falls. Staff were not within eyesight, having their back turned, when the fall occurred only hearing the fall and coming to the scene to see [client #2] on the ground, thus</p>			

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	<p>could not provide the prompt to [client #2] to use her walker. It should be noted that this fall was split second and the distance between the couch where [client #2] got up and the kitchen area is approx 5 ft (feet). [Client #2's] injury to her eye included slight bruising under the eye and a superficial scratch approx 2 inches under her eye.... Staff will be retrained on [client #2's] risk plan regarding the use of her walker to ensure that they are prompting [client #2] to use her walker when they see her walking without. This writer (the QIDP) has witnessed countless incidents of [client #2] walking without her walker and have witnessed staff prompting her to use her walker but [client #2] often refuses. After her most recent fall she was seen by her primary care physician who referred her to an ENT (Ears, Nose and Throat) Dr. (doctor) to rule out Meniere's Disease (a disorder of the inner ear that can affect hearing and balance)...."</p> <p>__ On 5/27/13 at 7:30 PM client #2 tripped on an end table leg and fell backwards into the table, hitting her right knee and the right side of her head. "[Client #2] suffered a knot to her knee and the right side of head." The report indicated client #2 was using her walker at the time of the fall and client #2 "will be counseled on the importance of being</p>			

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	<p>more careful while ambulating near and around furniture." The Follow Up BDDS report of 6/3/13 indicated client #2 was to see an Ophthalmologist (eye doctor) to rule out any vision or depth perception issues that might be causing her recent falls.</p> <p>__ On 5/28/13 at 1:30 PM client #2 was getting a snack from the vending machine at the day program when the client saw a staff person she had not seen for awhile. Client #2 "attempted to rush over and hug that person. In the process, she tripped over her feet and her walker and fell. She landed on her bottom and hit the back of her head on a table that was behind her." The report indicated client #2 had a bruise on her "tailbone" 1/2 inch in diameter and she complained of pain in her left hip and bottom "when it happened." The report indicated client #2 was using her walker at the time of the fall and her risk plan was followed.</p> <p>__ On 6/20/13 at 3 PM client #2 informed the staff that she had fallen earlier in the day while in her bedroom. Client #2 "stated that she had pulled out her clothes drawer and tripped and landed on that drawer. [Client #2] suffered a large bruise from her knee to her thigh." The report indicated client #2 was using her walker while she was in her room but was not</p>			

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	<p>using it at the time of the fall because she was attempting to get dressed for the day. The report indicated client #2 "is counseled weekly regarding the dangers of falls and the importance of keeping her area clear of tripping hazards and using her walker by the group home nurse." The report indicated client #2 "was also counseled on the importance of informing staff when she falls immediately so that the staff are aware of the fall and can take necessary steps. Staff will continue to follow [client #2's] risk summary regarding falls which states that staff are to prompt [client #2] anytime she is seen not using her walker and to ensure [client #2's] area is free from any trip hazards." The BDDS Follow Up report of 6/28/13 indicated "[Client #2] enjoys her independence while getting dressed and the team does not feel like an isolated fall while getting dressed should constitute taking that independence away from [client #2] at this time. The team will continue to assess and address these issues moving forward and make necessary changes to ensure her [client #2's] health and safety as needed." Staff will continue to follow client #2's risk plan regarding falls.</p> <p>Client #2's record was reviewed on 7/24/13 at 11 AM.</p>			

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	<p>Client #2's Post Fall Assessments indicated:</p> <p>__4/6/13 at 2:30 PM indicated client #2 "was bringing her clothes into the living room, she let go of her walker and leaned her weight on her laundry basket which caused it and her to topple over. The fall scared her more than anything though." The assessment indicated client #2 had a possible injury to her left wrist and left side. The assessment indicated "immediate actions to prevent future falls: Hold onto your walker, don't put weight on laundry basket. Ask for help if needed."</p> <p>__5/27/13 "immediate actions to prevent future falls: scooted table to left."</p> <p>__5/28/13 "immediate actions to prevent future falls: remind [client #2] to be careful."</p> <p>__6/20/13 "immediate actions to prevent future falls: Make sure room well lit, drawer is shut after clothes picked out, all objects (trip hazards) removed from area and staff assist if needed."</p> <p>Client #2's IDT meeting notes for 2012/2013 indicated:</p> <p>__10/16/12 "reviewed client's plan and will possibly look into Velcro shoes in the future due to fall risk. Spoke about noncompliance."</p> <p>__1/8/13 "Team discussed use of walker to prevent injuries - she [client #2] states</p>						

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	<p>she will try, doesn't want to get hurt." __4/9/13 "No falls thru quarter - use of walker, have walker replaced at [name of medical supply company]." __7/9/13 "Spoke at length about importance to cont [continue] use of walker.... Spoke of dizziness when up and ambulating. Informed her of importance of informing staff when dizzy.... Once again spoke with [client #2] about the risk of falls and fall prevention - informed her of the possible consequences of a serious injury after a fall - including rehab (rehabilitation) stay. She stated she will make better efforts." Client #2's IDT meeting notes indicated no recommendations for an assessment/reassessment by a PT.</p> <p>Client #2's medical appointment forms indicated client #2 saw a doctor on: __9/6/12 due to "Increase in falls, c/o (complaining of) dizziness and tinnitus (ringing of the ears). B/P (blood pressure) WNL (within normal limits) ortho status B/P completed 8/12 WNL. Dizziness - refer for ENT evaluation - r/o (rule out) Meniere's Disease (a disorder of the inner ear that can affect hearing and balance)." __9/20/12 client #2 saw an ENT doctor with no findings. __12/11/12 client #2 saw her doctor for a follow up appointment due to injury to both knees, left ankle and left hip due to</p>			

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	<p>falls. The form indicated client #2's Clonazepam was increased due to increased "agitation."</p> <p>Interview with the QIDP on 7/24/13 at 1 PM indicated client #2 was at risk for falls. The QIDP indicated the IDT had looked at client #2's falls and the team felt client #2's plan did not need revision. The QIDP indicated the facility nurse counseled client #2 on the risk of falls, the use of her walker and the consequences of falling. The QIDP indicated the staff were to prompt client #2 to use her walker whenever client #2 was ambulating without it. The QIDP indicated client #2 did not use her walker on a regular basis and had to be reminded to use it. The QIDP stated client #2 did not require direct staff supervision but the staff "should keep her [client #2] in their line of sight" whenever client #2 was ambulating. When asked how the staff were to ensure client #2's protection while she was in her bedroom, the QIDP indicated the IDT did not want to reduce client #2's freedom and privacy so the staff did not have to have client #2 in line of sight while in her bedroom and/or the bathroom. The QIDP indicated the IDT had not discussed client #2 having a PT evaluation.</p> <p>Interview with the facility LPN (Licensed</p>			

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	<p>Practical Nurse) on 7/24/13 at 1:30 PM indicated client #2 walked at a fast pace and used a walker while ambulating. The LPN indicated client #2 was at risk for falls and had a history of falling. The LPN stated "I'm not the one that took her to the doctor or I would have said something to the doctor about her having a PT eval." The LPN indicated client #2's PCP referred client #2 to an ENT (Ears, Nose and Throat specialist). The LPN indicated she was not sure when and/or if client #2 had been assessed by PT as the results were not available on the client's record. The LPN indicated she would have to call the hospital to get the results and to see when client #2 was last assessed by PT.</p> <p>Interview with the facility LPN on 7/25/13 at 1:30 PM indicated the hospital had faxed client #2's most recent PT evaluation dated 2009 to the facility. The facility nurse indicated client #2 had not been evaluated by PT since 2009.</p> <p>Review of client #2's PT evaluation of 9/16/09 on 7/25/13 at 2 PM indicated when client #2 arrived for her assessment client #2 had "multiple bruises present on her legs." The evaluation indicated a "primary diagnosis is frequent falls, difficulty walking, generalize DJD (Degenerative Joint Disease)." The evaluation indicated "Pt/Pt's</p>						

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	(patient/patient's) caregiver (from Achieva [AWS] report hx (history) of falls, however are not sure of situations or how many times (notes are at Achieva). Pt's caregiver note she has become unstable walking, however is independent with ADL's (Adult Daily Living Skills) at group home." The evaluation indicated client #2 would benefit from skilled PT. 9-3-4(a)				

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W000227	<p>483.440(c)(4) INDIVIDUAL PROGRAM PLAN The individual program plan states the specific objectives necessary to meet the client's needs, as identified by the comprehensive assessment required by paragraph (c)(3) of this section. Based on observation, record review and interview for 1 of 4 sampled clients (#1), the ISP (Individual Support Plan) failed to address the client's identified training need for portion control.</p> <p>Findings include:</p> <p>Observations were conducted at the group home on 7/23/13 between 4 PM and 6:15 PM. Client #1 was a young, short individual that walked with a side to side gait, throwing her legs out and around from one side to the other while using a walker each time she ambulated. At 5:15 PM client #1 sat down at the dining room table for her evening meal. Client #1 placed double portions of lettuce, meat, shredded cheese, tortilla chips and sour cream on a large dining plate. Client #1's food covered her plate and was piled at minimum 4 inches tall with food. Client #1 also served herself a portion of strawberries with a double portion of yogurt on top of the strawberries. While client #1 filled her plate and/or ate her evening meal, the staff did not prompt client #1 in portion</p>	W000227	<p>Corrective action for resident(s) found to have been affected A goal will be added for portion control for Client #1. The ISP will be updated to reflect this new goal and the need for staff to offer reminders. Staff will be trained on the new ISP.</p> <p>How facility will identify other residents potentially affected and what measures taken All consumers could potentially be affected. The IDT discusses the need for additional objectives at each quarterly meeting.</p> <p>Measures or systemic changes facility put in place to ensure no recurrence The IDT will meet quarterly to discuss concerns or changes for each client. At these meetings the need for new objectives will be discussed and then implemented by the QDDP. The QDDP is responsible for implementing new objectives and revising the ISP.</p> <p>How corrective actions will be monitored to ensure no recurrence IDT team will meet quarterly to</p>	09/06/2013	

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	<p>control.</p> <p>Review of the facility Spring/Summer 1500 calorie menu of 3/29/09 on 7/23/13 at 5 PM indicated on the evening of 7/23/13 the clients were to have: 2 cups of lettuce and tomato mix 1/4 cup of seasoned taco meat 1/4 cup of shredded cheese 2 tablespoons of fat free dressing 1 1/2 ounce of baked tortilla chips 1/2 cup of unsweetened strawberries with 1 tablespoon of light whipped topping.</p> <p>Client #1's record was reviewed on 7/24/13 at 2 PM. Client 1's record indicated a diagnosis of, but not limited to, bilateral hip dysplasia with recurrent subluxation (incomplete or partial dislocation).</p> <p>Client #1's physician's orders of 7/13 indicated client #1 required a walker for ambulation and was to be provided resting periods for long distances along with a wheelchair. Client #1's physician's orders of July 2013 indicated client #1 was to have a 1200 calorie diet with single servings.</p> <p>Client #1's nutritional review from the facility dietician on 10/9/12 indicated client #1 was 54 1/2 inches tall and weighed 146 pounds. The review</p>		<p>discuss all aspects of client programming including needed objectives. The IDT will fill out the quarterly meeting checklist and submit to director for review and signature.</p>				

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	<p>indicated client #1's nutritional concern was "obesity" and need for weight loss "but was limited in her activity." The dietician indicated client #1's calories could not be lowered to less than 1200 calories and encouraged diet compliance with no additional snacking other than the menu items. The review indicated client #1's IBW (ideal body weight) was 100 pounds to 120 pounds.</p> <p>Client #1's nutritional review from the facility dietician on 3/14/13 indicated client #1 weighed 148 pounds and weight loss was encouraged as client #1 was above her ideal body weight and the increased weight "only exacerbates hip pain and problems."</p> <p>Client #1's ISP of 10/9/12 did not indicate any objectives to assist client #1 in portion control and/or weight loss.</p> <p>Interview with staff #1 on 7/23/13 at 6 PM indicated client #1 would take double portions of foods she liked and would get upset if the staff would say anything to her.</p> <p>Interview with the QIDP (Qualified Intellectual Disabilities Professional) on 7/25/13 at 2 PM indicated client #1 did not have any objectives to assist client #1 with portion control and/or weight loss.</p>						

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W000312	<p>483.450(e)(2) DRUG USAGE Drugs used for control of inappropriate behavior must be used only as an integral part of the client's individual program plan that is directed specifically towards the reduction of and eventual elimination of the behaviors for which the drugs are employed. Based on record review and interview for 2 of 4 sampled clients receiving medications to control behaviors (#2 and #4), the facility failed to ensure a specific plan of reduction was in place to reduce and eventually eliminate the behaviors for which each psychoactive medication was to target.</p> <p>Findings include:</p> <p>Client #2's record was reviewed on 7/24/13 at 11 AM. Client #2's 2012/2013 physician's orders indicated client #2 took Abilify 2 mg (milligrams) a day for mood disorders, Wellbutrin 450 mg a day and Lexapro 20 mg every day for depression and Clonazepam 0.5 mg three times a day. Client #2's BSP (Behavior Support Plan) of 4/9/13 indicated client #2 had targeted behaviors of verbal aggression, physical aggression, depressive symptoms, noncompliance, resistance, exaggeration and instigation of conflicts. Client #2's BSP indicated a medication reduction plan for the Lexapro and the Wellbutrin to be "If [client #2] continues</p>	W000312	<p>Correctiveactionforresident(s) oundtohavebeenaffected The Behavior Clinician that was previously working at this home is no longer contracted with AWS. A temporary BC has been contracted from corporate office who will be revising BSPs to include consumer specific titration plans. AWS is currently recruiting for a permanent behavior specialist to monitor the behavior plans of this home.</p> <p>Howfacilitywillidentifyotherresi dentspotentiallyaffectedandwh atmeasurestaken All residents receiving psychotropic medications are affected and corrective action will address the needs of all clients.</p> <p>Measuresorsystemicchangesfa cilityputinplacetoensurenorecu rrence The temporary BC is supervised by Dr. Jim Wiltz of AWS. The new behavior specialist will be mentored by Dr. Wiltz who will provide oversight and will sign off on all BSPs.</p> <p>Howcorrectiveactionswillbemo</p>	09/06/2013
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	to show progress in her replacement behavior objective and if there is a reduction in the symptoms of depression, the team will consider a reduction in psychotropic medication at least annually. The overall plan would be to have [client #2] on the least amount of psychotropic medication while allowing her the greatest level of participation in her life. This should always be balanced with a risk versus benefit assessment of her overall med regimen. The pros and cons of a medication reduction should be discussed at [client #2's] semiannual and annual meeting with thorough review of behavioral data and observation/input from the team. This information will then be made on whether a reduction is appropriate." Client #2's BSP indicated a medication reduction plan for the Clonazepam to be "If [client #2] continues to show progress in her replacement behavior objective and if there is a reduction in the symptoms of agitation, the team will consider a reduction in psychotropic medication at least annually. The overall plan would be to have [client #2] on the least amount of psychotropic medication while allowing her the greatest level of participation in her life. This should always be balanced with a risk versus benefit assessment of her overall med regimen. The pros and cons of a medication reduction should be		nitoredtoensurenorecurrence BSPs will be written and revised by a BC employed by AWS. Dr. Wiltz will provide mentoring and sign off on all BSPs. The QDDP will continue to use the Quarterly Meeting Checklist which encourages the team to discuss behavior support plans, dates and titration plans. The IDT will sign off on this checklist and it will be forwarded to the Director for review and signature.	

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	<p>discussed at [client #2's] semiannual and annual meeting with thorough review of behavioral data and observation/input from the team. This information will then be made on whether a reduction is appropriate." Client #2's BSP did not indicate the use of Abilify and/or a plan of reduction for the Abilify. Client #2's BSP indicated no specific plan of reduction to reduce and eventually eliminate the behaviors for which each psychoactive medication was to target.</p> <p>Client #4's record was reviewed on 7/24/13 at 3 PM. Client #4's 2012/2013 physician's orders indicated client #4 took Abilify 10 mg a day and Paxil 30 mg a day for mood disorders, Cogentin 1 mg every day, Saphris (an antipsychotic medication) 20 mg a day and Risperidone 0.5 mg. Client #4's BSP (Behavior Support Plan) of 3/22/13 indicated client #4 had targeted behaviors of verbal aggression, persevering/obsessive thoughts, psychotic symptoms, exaggerating and/or instigating conflicts, inappropriate toileting, suicidal ideation and threats of self harm. Client #4's BSP indicated a medication reduction plan for the Risperdal, Abilify, Paxil and Saphris to be "If [client #4] continues to show progress in her replacement behavior objective and if there is a reduction in her psychiatric symptoms, the team will</p>						

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	consider a reduction in psychotropic medication at least annually. The overall plan would be to have [client #4] on the least amount of psychotropic medication while allowing her the greatest level of participation in her life. This should always be balanced with a risk versus benefit assessment of her overall med regimen. The pros and cons of a medication reduction should be discussed at [client #4's] semiannual and annual meeting with thorough review of behavioral data and observation/input from the team. This information will then be made on whether a reduction is appropriate." Client #4's BSP indicated a medication reduction plan for the Clonazepam to be "If [client #4] continues to show progress in her replacement behavior objective and if there is a reduction in the symptoms of agitation, the team will consider a reduction in psychotropic medication at least annually. The overall plan would be to have [client #4] on the least amount of psychotropic medication while allowing her the greatest level of participation in her life. This should always be balanced with a risk versus benefit assessment of her overall med regimen. The pros and cons of a medication reduction should be discussed at [client #4's] semiannual and annual meeting with thorough review of behavioral data and observation/input			

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	<p>from the team. This information will then be made on whether a reduction is appropriate." Client 4's BSP did not indicate the use of Cogentin and/or a plan of reduction for the Cogentin. Client #4's BSP indicated no specific plan of reduction to reduce and eventually eliminate the behaviors for which each psychoactive medication was to target.</p> <p>Interview with the QIDP (Qualified Intellectual Disabilities Professional) on 7/25/13 at 2 PM indicated client #2's and #4's BSPs included the same titration criteria and were not specific to the clients' behaviors for which each psychoactive medication was to target.</p> <p>9-3-5(a)</p>				

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W000331	<p>483.460(c) NURSING SERVICES</p> <p>The facility must provide clients with nursing services in accordance with their needs. Based on observation, record review and interview for 1 of 4 sample clients (#2), nursing services failed to review/revise clients #2's fall risk plan to ensure safeguards were implemented to prevent recurring falls and/or injury due to falls, to ensure the staff prompted client #2 to use her walker whenever ambulating, to ensure client #2 was reassessed by PT (Physical Therapy) in regard to recurring falls and to ensure client #2's physician's orders included client #2's use of a walker.</p> <p>Findings include:</p> <p>Observations were conducted at the group home on 7/23/13 between 4 PM and 6:30 PM. At 4:30 PM client #2 walked to a nearby group home to attend a peer's birthday party. Client #2 ambulated at a fast pace, using a walker and was escorted by staff while walking to the nearby group home.</p> <p>Observations were conducted at the group home on 7/24/13 between 6 AM and 8:30 AM.</p> <p>__At 6 AM client #2 was in her bed, lying down. Client #2's walker was in the corner of the room and out of reach for</p>	W000331	<p>Corrective action for resident(s) found to have been affected</p> <p>Client #2 received a PT evaluation on 7/31/13. PT has been ordered 2 times per week for 5 weeks at which time a reassessment will occur. A gait belt was ordered by a physician and implemented on 8/15/13 and the risk plan was revised on 8/15/13. A bed alarm and bedroom monitor was approved by Human Rights Committee on 8/17/13 and implemented on 8/17/13. Staff have been trained on the use of the new adaptive equipment. Client #2's Risk Plan and ISP will be updated no later than 9/6/13. The physician's prescription dated 2/26/13 was included in Client #2's medical chart. This order has been added to the physicians orders.</p> <p>How facility will identify other residents potentially affected and what measures taken</p> <p>The physician of the one other consumer with a hx of falls and walker usage will receive a request for a PT evaluation.</p> <p>Measures or systemic changes facility put in place to ensure no recurrence</p> <p>Staff will be retrained to</p>	09/06/2013

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	<p>client #2 to retrieve without getting up and walking to the walker.</p> <p>__At 6:40 AM staff #2 woke client #2 and stated, "Come on, it's time to get up." Client #2 got up, got dressed and made her bed. While making her bed, client #2 used her bed to support herself. After making her bed, client #2 stretched, while holding onto her bed, to reach for her walker. Client #2 did not use her walker while in her bedroom and was not directly supervised by the staff.</p> <p>__At 7:10 AM client #2 walked from her bedroom to the med (medication) room, using her walker. Client #2 left her walker in front of the filing cabinet in the med room and walked to the bathroom in the med room to wash her hands. Client #2 washed her hands and returned to the med area, sitting down in a straight chair near one of the desks.</p> <p>At 7:25 AM after taking her AM meds, client #2 stood up, walked to her walker and proceeded to the living room off of the dining room. Client #2 left her walker in the living room and walked to the kitchen. From 7:25 AM through 8:12 AM client #2 ambulated in the living room, kitchen, dining room and garage, carried her lunch box from the garage into the kitchen, got up and down from the dining room table and carried her plate/dishes back and forth from the kitchen to the dining room without the use of her</p>		<p>document every occurrence of non compliance in relation to use of the walker or the gait belt. Staff will be retrained to prompt Client #2 to use walker and document noncompliance. LPN will follow up to ensure all managers in other department than group home are trained on revised risk plans. LPN was reminded by Manager of Health Services of the need to request PT anytime there is a hx of falls.</p> <p>How corrective actions will be monitored to ensure no recurrence Staff will document every occurrence of non compliance in relation to use of the walker or the gait belt. Team Leader, LPN, and QDDP will monitor these tracking mechanisms to ensure compliance and identify trends. Director will sign off on retraining.</p>		

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	<p>walker. There were 4 staff in the home and the QIDP (Qualified Intellectual Disabilities Professional). The staff did not prompt client #2 to use her walker while in her bedroom and/or while in the kitchen/dining room/living room. The QIDP indicated he had prompted client #2 to use her walker once while she was in the back of the home near her bedroom and the main bathroom.</p> <p>Observations were conducted at the day program on 7/24/13 between 10 AM and 11 AM. Client #2 sat at a table, her walker sitting nearby but out of her reach. Client #2 stood up and walked to her walker. Client #2 walked unassisted by staff to the bathroom, used the bathroom and returned to the main area of the day program and sat down in a chair. During this time client #2 ambulated with her walker. Staff did not assist client #2 while ambulating and/or give client #2 direct supervision.</p> <p>The facility's records were reviewed on 7/23/13 at 1 PM. The facility BDDS (Bureau of Developmental Disabilities Services) reports indicated: _ On 7/29/12 at 2:45 PM client #2 was putting groceries away in the pantry of the group home when she began backing out of the pantry and lost her footing. Client</p>						

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	<p>#2 fell backward into the island in the kitchen. The report indicated client #2 was using her walker at the time of the fall. Client #2 had a "red mark about 4 inches in length on the middle part of her back. She also complained that she had bumped her head during the fall. Staff observed no injuries to her head. The nurse completed an exam on [client #2] on 7/30 and observed that [client #2] now has a bruise approx (approximately) 3 inches around on her right thigh, deep purple in color, as a result of the fall." The report indicated "This writer [the QIDP (Qualified Intellectual Disabilities Professional)] notes once again that [client #2] was using her walker as needed." The Follow Up BDDS report of 8/3/12 indicated an education piece was added to client #2's fall risk plan for the nurse to educate client #2 about falls, prevention, long term risks, and complications that could arise from a serious fall. These meetings in the beginning will be weekly and continue as needed.</p> <p>__ On 11/27/12 at 12 PM the nurse was notified client #2 had a "large bruise" on her right knee. Client #2 "disclosed that sometime on Sunday she was in the kitchen and fell after tripping on her walker. She [client #2] was unable to provide any further details regarding the</p>						

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	<p>fall. She [client #2] stated that the fall was not witnessed by anyone and that she did not tell anyone about the fall of (sic) injury until now. This injury was discovered on 11/26 at approx (approximately) 5 pm.... Falls are addressed in [client #2's] risk summary which states that anytime [client #2] is ambulating she is to use her walker which she was using when the injury occurred. Staff will continue to prompt [client #2] to use her walker at all times while ambulating."</p> <p>__On 12/1/12 at 11:45 AM while at the bowling alley, client #2 "lost her balance while attempting to bowl and fell to the ground." The report indicated client #2 initially complained of pain in her left ankle "but was checked out by medical staff and had full range of motion. She [client #2] no longer complains of pain in her ankle and has no problems ambulating. She now complains of pain in her left buttock but at this time there is no bruising. She was using her walker at the time of the fall. Falls are addressed in [client #2's] risk summary which states that anytime [client #2] is ambulating she is to use her walker which she was using when the injury occurred. Staff will continue to prompt [client #2] to use her walker at all times while ambulating." The Follow Up BDDS report of 12/7/12</p>						

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	<p>indicated "the group home nurse will update her [client #2's] risk summary to state that staff are to be within arms reach whenever [client #2] is ambulating on unfamiliar or uneven surfaces, such as the step down from the bowling lane."</p> <p>__On 12/7/12 at 11:15 PM "while moving from the living room couch to the kitchen area without the use of her prescribed walker [client #2] fell hitting her face on the counter and knee on the ground. Staff were following [client #2's] risk summary by prompting [client #2] to use her walker when the fall occurred. [Client #2] suffered injuries under her right eye and bruising to her right knee." The Follow Up BDDS report of 12/16/12 indicated "when staff see that [client #2] is not using her prescribed walker they are to prompt [client #2] to use her walker and revisit the issue every 5 minutes moving forward. Also per her risk summary staff are to be within arms reach when ambulating on uneven and changing terrain. [Client #2] is also educated by the nurse on a weekly basis the dangers of falls and the importance of using her prescribed walker to prevent falls. Staff were not within eyesight, having their back turned, when the fall occurred only hearing the fall and coming to the scene to see [client #2] on the ground, thus could not provide the prompt to [client</p>						

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	<p>#2] to use her walker. It should be noted that this fall was split second and the distance between the couch where [client #2] got up and the kitchen area is approx 5 ft (feet). [Client #2's] injury to her eye included slight bruising under the eye and a superficial scratch approx 2 inches under her eye.... Staff will be retrained on [client #2's] risk plan regarding the use of her walker to ensure that they are prompting [client #2] to use her walker when they see her walking without. This writer (the QIDP) has witnessed countless incidents of [client #2] walking without her walker and have witnessed staff prompting her to use her walker but [client #2] often refuses. After her most recent fall she was seen by her primary care physician who referred her to an ENT (Ears, Nose and Throat) Dr. (doctor) to rule out Meniere's Disease (a disorder of the inner ear that can affect hearing and balance)...."</p> <p>__ On 5/27/13 at 7:30 PM client #2 tripped on an end table leg and fell backwards into the table, hitting her right knee and the right side of her head. "[Client #2] suffered a knot to her knee and the right side of head." The report indicated client #2 was using her walker at the time of the fall and client #2 "will be counseled on the importance of being more careful while ambulating near and</p>						

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	<p>around furniture." The Follow Up BDDS report of 6/3/13 indicated client #2 was to see an Ophthalmologist (eye doctor) to rule out any vision or depth perception issues that might be causing her recent falls.</p> <p>__ On 5/28/13 at 1:30 PM client #2 was getting a snack from the vending machine at the day program when the client saw a staff person she had not seen for awhile. Client #2 "attempted to rush over and hug that person. In the process, she tripped over her feet and her walker and fell. She landed on her bottom and hit the back of her head on a table that was behind her." The report indicated client #2 had a bruise on her "tailbone" 1/2 inch in diameter and she complained of pain in her left hip and bottom "when it happened." The report indicated client #2 was using her walker at the time of the fall and her risk plan was followed.</p> <p>__ On 6/20/13 at 3 PM client #2 informed the staff that she had fallen earlier in the day while in her bedroom. Client #2 "stated that she had pulled out her clothes drawer and tripped and landed on that drawer. [Client #2] suffered a large bruise from her knee to her thigh." The report indicated client #2 was using her walker while she was in her room but was not using it at the time of the fall because she</p>			

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	<p>was attempting to get dressed for the day. The report indicated client #2 "is counseled weekly regarding the dangers of falls and the importance of keeping her area clear of tripping hazards and using her walker by the group home nurse." The report indicated client #2 "was also counseled on the importance of informing staff when she falls immediately so that the staff are aware of the fall and can take necessary steps. Staff will continue to follow [client #2's] risk summary regarding falls which states that staff are to prompt [client #2] anytime she is seen not using her walker and to ensure [client #2's] area is free from any trip hazards." The BDDS Follow Up report of 6/28/13 indicated "[Client #2] enjoys her independence while getting dressed and the team does not feel like an isolated fall while getting dressed should constitute taking that independence away from [client #2] at this time. The team will continue to assess and address these issues moving forward and make necessary changes to ensure her [client #2's] health and safety as needed." Staff will continue to follow client #2's risk plan regarding falls.</p> <p>Client #2's record was reviewed on 7/24/13 at 11 AM.</p> <p>Client #2's Post Fall Assessments</p>						

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	<p>indicated:</p> <p>__4/6/13 at 2:30 PM indicated client #2 "was bringing her clothes into the living room, she let go of her walker and leaned her weight on her laundry basket which caused it and her to topple over. The fall scared her more than anything though." The assessment indicated client #2 had a possible injury to her left wrist and left side. The assessment indicated "immediate actions to prevent future falls: Hold onto your walker, don't put weight on laundry basket. Ask for help if needed."</p> <p>__5/27/13 "immediate actions to prevent future falls: scooted table to left."</p> <p>__5/28/13 "immediate actions to prevent future falls: remind [client #2] to be careful."</p> <p>__6/20/13 "immediate actions to prevent future falls: Make sure room well lit, drawer is shut after clothes picked out, all objects (trip hazards) removed from area and staff assist if needed."</p> <p>Client #2's IDT (Interdisciplinary Team) meeting notes for 2012/2013 indicated:</p> <p>__10/16/12 "reviewed client's plan and will possibly look into Velcro shoes in the future due to fall risk. Spoke about noncompliance."</p> <p>__1/8/13 "Team discussed use of walker to prevent injuries - she [client #2] states she will try, doesn't want to get hurt."</p>			

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	<p>__ 4/9/13 "No falls thru quarter - use of walker, have walker replaced at [name of medical supply company]."</p> <p>__ 7/9/13 "Spoke at length about importance to cont [continue] use of walker.... Spoke of dizziness when up and ambulating. Informed her of importance of informing staff when dizzy.... Once again spoke with [client #2] about the risk of falls and fall prevention - informed her of the possible consequences of a serious injury after a fall - including rehab (rehabilitation) stay. She stated she will make better efforts."</p> <p>Client #2's Risk Summary of 11/1/12 indicated client #2 was at risk for falls. The risk plan indicated:</p> <p>__ "[Client #2] should use a seated walker anytime she ambulates."</p> <p>__ "[Client #2] should increase her endurance and may walk to the [name of day services] when weather permits while using walker with staff within arms reach."</p> <p>__ "Environment will be kept clean and free from clutter."</p> <p>__ "No rugs will be in the home."</p> <p>__ "When ambulating on ramps staff will provide assistance d/t (due/to) unsteady gait."</p> <p>__ "During night hours there will be a night light plugged in an outlet in [client #2's] room, so that when she ambulates at</p>			

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	<p>night she can see where she is going." ___ "When [client #2] is ambulating in the kitchen, the dishwasher door will be closed prior to [client #2] ambulating that walker can fit easily through doorway." ___ "[Client #2] will be within staff eye sight anytime she is ambulating." ___ "Any fall will be reported to nurse, an injury report and a fall assessment sheet will be completed and turned into nurse the next business day." ___ "Any time [client #2] refuses to use her walker, staff will provide verbal prompts every 5 minutes." ___ "Remind [client #2] of the consequences of refusing to use her walker and how the walker is used to steady her gait and provided assistance." ___ "The nurse meets with [client #2] to discuss fall prevention. The nurse will monitor and update fall risk plan as needed."</p> <p>Client #2's medical appointment forms indicated client #2 saw a doctor on: ___ 9/6/12 due to "Increase in falls, c/o (complaining of) dizziness and tinnitus (ringing of the ears). B/P (blood pressure) WNL (within normal limits) ortho status B/P completed 8/12 WNL. Dizziness - refer for ENT evaluation - r/o (rule out) Meniere's Disease (a disorder of the inner ear that can affect hearing and balance)." ___ 9/20/12 client #2 saw an ENT doctor</p>			

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	<p>with no findings.</p> <p>__ 12/11/12 client #2 saw her doctor for a follow up appointment due to injury to both knees, left ankle and left hip due to falls. The form indicated client #2's Clonazepam was increased due to increased "agitation."</p> <p>Client #2's 2013 physician's orders indicated no order for the use of a walker.</p> <p>Client #2's record indicated nursing services failed to:</p> <p>__ Revise/update client #2's fall risk plan to include sufficient safeguards to protect client #2 from falls and/or injury from falls.</p> <p>__ To ensure client #2 was reassessed by a PT.</p> <p>__ To ensure the IDT addressed client #2's continued falls and/or falls with injury and implemented sufficient safeguards to prevent recurring falls and/or injuries due to recurring falls.</p> <p>__ To ensure client #2's physician's orders included client #2's use of a walker.</p> <p>Interview with the facility LPN (Licensed Practical Nurse) on 7/24/13 at 1:30 PM indicated client #2 walked at a fast pace and used a walker while ambulating. The LPN indicated client #2 was at risk for falls and had a history of falling. The LPN stated she had counseled client #2 on</p>				

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	<p>"numerous occasions" on the safety of using her walker. The LPN indicated the staff were to prompt client #2 to use her walker every time client #2 was observed ambulating without it. The LPN stated "I'm not the one that took her to the doctor or I would have said something to the doctor about her having one (a PT evaluation)." The LPN indicated she was not sure when and/or if client #2 had been assessed by PT as client #2's PT results were not on the client's record. The LPN indicated she would have to call the hospital to see when client #2 was last assessed by PT and to get the results. The LPN indicated client #2's PCP referred client #2 to an ENT (Ears, Nose and Throat specialist). The LPN indicated client #2's Fall Risk Summary/Plan was last updated 11/1/12. The LPN stated client #2's physician's orders "should" include the client's use of a walker.</p> <p>Interview with the facility LPN on 7/25/13 at 1:30 PM indicated the hospital had faxed client #2's most recent PT evaluation dated 2009 to the facility. The facility nurse indicated client #2 had not been evaluated by PT since 2009. Review of client #2's PT (Physical Therapy) evaluation of 9/16/09 on 7/25/13 at 2 PM indicated when client #2 arrived for her assessment client #2 had "multiple bruises present on her legs." The evaluation</p>						

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	<p>indicated a "primary diagnosis is frequent falls, difficulty walking, generalize DJD (Degenerative Joint Disease)." The evaluation indicated "Pt/Pt's (patient/patient's) caregiver (from Achieva [AWS] report hx (history) of falls, however are not sure of situations or how many times (notes are at Achieva). Pt's caregiver note she has become unstable walking, however is independent with ADL's (Adult Daily Living Skills) at group home." The evaluation indicated client #2 would benefit from skilled PT.</p> <p>9-3-6(a)</p>			

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W000368	<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.</p> <p>Based on record review and interview for 4 of 4 sampled clients (#1, #2, #3 and #4) and 2 additional clients (#5 and #7), the facility nurse failed to ensure all drugs were administered in compliance with the physician's orders.</p> <p>Findings include:</p> <p>The facility's reportable records were reviewed on 7/23/13 at 1 PM.</p> <p>__ BDDS (Bureau of Developmental Disabilities Services) report dated 8/5/12 indicated during the 7 AM medication pass on 8/5/12 the staff discovered that client #2 had not received her Clonazepam 0.5 mg for seizures "the entire day" of 8/4/12.</p> <p>__ BDDS report dated 8/21/12 indicated client #4 did not receive her Cortisporin (an antibiotic ointment/cream) on 8/20/12 at 4 PM and 8 PM and 8/21/12 at 7 AM. The report indicated this occurred due to only 1 bottle of Cortisporin being sent from the pharmacy.</p> <p>__ BDDS report dated 9/6/12 indicated on 9/5/12 at 9 PM client #5 did not receive</p>	W000368	<p>Corrective action for resident(s) found to have been affected</p> <p>Staff have been retrained on medication administration. Also staff have been trained on "Preventing Medication Errors," a handout written by the AWS Manager of Health Services and reminded to only pass medications as prescribed on the MAR. All staff will be trained again on the Preventing Medication Errors handout and on the updated Medication Error Disciplinary Procedure. The team leader will observe one medication pass for each staff monthly. The nurse or manager will observe one medication pass for the team leader monthly.</p> <p>How facility will identify other residents potentially affected and what measures taken</p> <p>All residents are affected and corrective action will address the needs of all clients.</p> <p>Measures or systemic changes facility put in place to ensure no recurrence</p> <p>The East Central Indiana Medication Error Disciplinary Procedure has been updated to have staff suspended from passing medications after the</p>	09/06/2013			

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	<p>his 9 PM breathing treatment of Albuterol for shortness of breath because there was a missing piece to his nebulizer. The report indicated the staff used a mask from the day services to be able to administer client #6's next scheduled treatment of Albuterol.</p> <p>__BDDS report dated 10/4/12 indicated on 10/1/12 client #2 did not get her Clonazepam 0.5 mg on 10/1/12 at 4 PM and 8 PM and on 10/2/12 at 7 AM and 4 PM. The report indicated the group home nurse attempted to have the script filled for "several days, leaving messages to have it filled before the prescribing doctor finally ordered the script."</p> <p>__BDDS report dated 10/4/12 indicated on 10/1/12 and 10/2/12 client #5 did not receive his Chlorhexidine 12% mouthwash because it could not be found in his medication supply. The medication was found on 10/3/12. "The location of the mouthwash for those two days is still unknown."</p> <p>__BDDS report dated 12/5/12 indicated during the 12/5/12 7 AM medication pass the staff discovered client #2 was not given her Ibandronate 150 mg for Osteoporosis on 12/3/12 as scheduled. The medication was prescribed to be given every month of the 3rd day of the</p>		<p>second medication error, mandated to repeat Core A after the third medication error, and recommended for termination after the fourth medication error. This stricter procedure has been passed out to staff along with the handout written by the Manager of Health Services titled Preventing Medication Errors. Staff has been retrained on the importance of taking their time and passing medications accurately. The Team Leader will observe one medication pass for each staff monthly and the nurse or manager will observe one medication pass for the team leader. This will ensure staff are continually passing medications as trained in Core A. The Manager of Health Services at AWS as well as a task force of AWS nurses are currently working on revising the internal Core A curriculum to ensure staff are being appropriately and comprehensively trained in Medication Administration.</p> <p>How corrective actions will be monitored to ensure no recurrence The Team Leaders will sign off on a medication observation sheet and turn it into the LPN and Group Home Manager monthly to ensure they are doing all required medication observations. The Regional Director will ensure staff receive this retraining and</p>				

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	<p>month.</p> <p>__BDDS report dated 12/26/12 indicated when client #7's brother returned client #7 to the group home from his home visit at 6 PM on 12/25/12, the brother informed the staff that client #7 did not receive his 8 PM Lovaza for cholesterol, Ranitidine for acid reflux and Melexitam for arthritis on 12/25/12. The report indicated the brother did not give a reason why the medications were not given.</p> <p>__BDDS report dated 1/4/13 indicated during the 7 AM medication pass of 1/4/13 a pill was discovered on the floor. The report indicated "After some investigation it was determined that the pill was Pravastatin 20 mg which client #2 took at 7 AM for her high cholesterol. "Review of the MAR (Medication Administration Record) didn't not (sic) show any documented cases of the medication not being given. At this time it is impossible to determine who and when the pill was not given."</p> <p>__BDDS report dated 1/9/13 indicated during a medication audit on 1/9/13 a pill was discovered in the drawer of the medication cart. "It was later determined that the pill was prescribed to [client #2]. The pill was client #2's Oxybutynin 5 mg which she gets both in the AM and PM</p>		will sign off on all Record of Trainings.				

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	<p>for urinary incontinence.</p> <p>__BDDS report dated 1/10/13 indicated during a medication audit on 1/9/13 the staff discovered client #1 not receive her 7 AM dose of Vitamin D on 1/5/13.</p> <p>__BDDS report dated 1/28/13 indicated on 1/27/13 when the staff picked up client #5 from a home visit, the staff failed to pick up client #5's Chlorhexidine prescribed mouthwash. Client #5 did not get his prescribed Chlorhexidine mouthwash at 8 PM 1/27/13.</p> <p>__BDDS report dated 2/13/13 indicated on 2/12/13 at 7:45 PM while the staff were searching under the couch cushions for the missing television remote control, the staff discovered a Clonazepam which was taken by client #2 at 7 AM, 4 PM and 8 PM. "It can not be determined how the pill ended up in the couch at this time or which dose was not given."</p> <p>__BDDS report dated 3/12/13 indicated on 3/11/13 client #5 was "accidentally given" his Proair rescue inhaler instead of his Symbicort inhaler for shortness of breath.</p> <p>__BDDS report dated 3/16/13 indicated on 3/15/13 client #3 was not given his Polyethylene Glycol (a stool softener) at 8</p>			

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	<p>AM because he had run out of the medication. The medication is a powder and is prescribed to last 30 days but staff failed to measure out the right amount of powder each day resulting in client #3 running out before the 30th day.</p> <p>__BDDS report dated 4/3/13 indicated on 4/2/13 client #7 was not given his 7 AM dose of Namenda 5 mg for dementia.</p> <p>__BDDS report dated 4/10/13 indicated on 4/9/13 client #2 was given her 8 PM dose of Gabapentin 600 mg (milligrams) for seizures and Oxybutynin 5 mg. at 4 PM.</p> <p>__BDDS report dated 1/11/13 indicated on 4/10/13 client #1 was not given her 8 PM dose of Clindamycin 1% face solution.</p> <p>__BDDS report dated 5/13/13 indicated while client #1 was on a home visit, her family failed to give her Tylenol with Codeine prescribed to be given at 3 PM for menstrual related pain and her 4 PM Glucosamine for "hip issues."</p> <p>Client #1's record was reviewed 7/18/13 at 9 AM. Client #1's PO (physician's orders) dated 7/1/13 indicated client #1 had an order for Tylenol with Codeine #3</p>				

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	<p>2 tablets every 4 hours as needed for pain, Glucosamine capsules 3 times a day, Vitamin D3 1000 units once a day and Clindamycin lotion to affected areas twice a day.</p> <p>Client #2's record was reviewed on 7/24/13 at 11 AM. Client #2's PO (physician's orders) dated 7/1/13 indicated client #2 had an order for Clonazepam 0.5 mg 3 times a day, Gabapentin 600 mg 2 times a day, ibandronate 150 mg once a month on the 3rd of each month, Oxybutynin 5 mg 2 times a day and Pravastatin Sodium 20 mg once a day.</p> <p>Client #3's record was reviewed on 7/24/13 at 12 PM. Client #3's PO (physician's orders) dated 7/1/13 indicated client #3 had an order for Polyethylene Glycol powder 17 grams once a day.</p> <p>Client #4's record was reviewed on 7/24/13 at 3 PM. Client #4's PO (physician's orders) dated 7/1/13 indicated client #4 had an order for Triple Antibiotic Ointment as needed for skin breaks.</p> <p>Client #5's PO dated 7/1/13 was reviewed on 7/25/13 at 1 PM. Client #5's PO indicated client #5 had an order for Albuterol via the nebulizer inhaler 3 times</p>			

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	<p>a day as needed, Proair inhaler every 4 - 6 hours as needed, Symbicort inhaler twice a day and Chlorhexidine mouth rinse twice a day.</p> <p>Client #7's PO dated 7/1/13 was reviewed on 7/25/13 at 1 PM. Client #7's PO indicated client #7 had an order for Lovaza 1 gm 2 times a day and Namenda 10 mg 2 times a day. Client #7's PO indicated no current order for Ranitidine and Meloxicam for client #7.</p> <p>Interview with the LPN (licensed practical nurse) on 7/25/13 at 2 PM indicated clients should receive medications as ordered by their physician. The LPN indicated even though the staff were retrained and disciplinary actions were taken as needed, the facility continued to have an ongoing issue of medication errors in the group home.</p> <p>9-3-6(a)</p>						

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W000369	<p>483.460(k)(2) DRUG ADMINISTRATION</p> <p>The system for drug administration must assure that all drugs, including those that are self-administered, are administered without error.</p> <p>Based on observation, interview and record review, the facility failed to ensure all medications were administered without error for 1 of 26 doses administered for client #1.</p> <p>Findings include:</p> <p>During observations of the medication pass at the group home on 7/24/13 between 6:35 AM and 7:20 AM, staff #4 gave client #1 Chlorhexidine 0.12% mouth rinse at 7:05 AM. After rinsing with the Chlorhexidine, client #1 went to the kitchen, prepared her breakfast and sat down at the dining room table and ate her breakfast.</p> <p>Review of client #1's 7/2013 MAR (Medication Administration Record) on 7/24/13 at 8:30 AM indicated client #1 was to have Chlorhexidine rinse twice daily after breakfast and before bedtime.</p> <p>Client #1's record was reviewed on 7/24/13 at 2 PM. Client #1's physician's orders for July 2013 indicated client #1 was to have Chlorhexidine rinse twice daily after breakfast and before bedtime.</p>	W000369	<p>Corrective action for resident(s) found to have been affected</p> <p>Staff have been retrained on medication administration. Also staff have been trained on "Preventing Medication Errors," a handout written by the AWS Manager of Health Services and reminded to only pass medications as prescribed on the MAR. All staff will be retrained on the Preventing Medication Errors handout and updated Medication Error Disciplinary Procedure. The team leader will observe one medication pass for each staff monthly. The nurse or manager will observe one medication pass for the team leader monthly.</p> <p>How facility will identify other residents potentially affected and what measures taken</p> <p>All residents are affected and corrective action will address the needs of all clients.</p> <p>Measures or systemic changes facility put in place to ensure no recurrence</p> <p>The East Central Indiana Medication Error Disciplinary Procedure has been updated to have staff suspended from</p>	09/06/2013			

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	<p>Interview with the facility LPN on 7/25/13 at 1 PM indicated the staff were to give the medications as ordered by the physician, as indicated on the MAR and as instructed by the pharmacist on the client's individual medicine bottles.</p> <p>9-3-6(a)</p>		<p>passing medications after the second medication error, mandated to repeat Core A after the third medication error, and recommended for termination after the fourth medication error. This stricter procedure has been passed out to staff along with the handout written by the Manager of Health Services titled Preventing Medication Errors. Staff has been retrained on the importance of taking their time and passing medications accurately.</p> <p>The Team Leader will observe one medication pass for each staff monthly and the nurse or manager will observe one medication pass for the team leader. This will ensure staff are continually passing medications as trained in Core A.</p> <p>The Manager of Health Services at AWS as well as a task force of AWS nurses are currently working on revising the internal Core A curriculum to ensure staff are being appropriately and comprehensively trained in Medication Administration.</p> <p>How corrective actions will be monitored to ensure no recurrence</p> <p>The Team Leaders will sign off on a medication observation sheet and turn it into the LPN and Group Home Manager monthly to ensure they are doing all required medication observations. The Regional Director will ensure</p>		

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			staff receive this retraining and will sign off on all Record of Trainings.	

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W000436	<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 on observation, interview and record review for 1 of 4 sample clients (#2), the facility failed to ensure client #2 was provided with the recommended adaptive dining equipment.</p> <p>Findings include:</p> <p>Observations were conducted at the group home on 7/24/13 between 6 AM and 8:30 AM. Client #2 did not use adaptive equipment to eat her morning meal. Client #2 was not provided built up silverware to eat her morning meal.</p> <p>Client #2's record was reviewed on 7/24/13 at 11 AM. Client #2's 2013 physician's orders indicated client #2 was to use weighted silverware while eating.</p> <p>Interview with staff #1 on 7/24/13 at 8:15 AM indicated client #2 was to have weighted silverware while eating. Staff #1 stated client #2's weighted silverware had been broken "for a while" and the facility was "trying to get it replaced."</p>	W000436	<p>Corrective action for resident(s) found to have been affected</p> <p>Broken weighted silverware has been replaced. Additional sets of adaptive utensils have been purchased in case of the need for immediate replacement.</p> <p>How facility will identify other residents potentially affected and what measures taken</p> <p>All residents could potentially be affected and corrective action will address the needs of all clients.</p> <p>Measures or systemic changes facility put in place to ensure no recurrence</p> <p>Staff will be retrained to notify LPN or other member of management immediately in the case of any broken equipment. Staff will receive retraining. Additional pieces of adaptive equipment will be kept in storage for immediate replacement as needed.</p> <p>How corrective actions will be monitored to ensure no recurrence</p>	09/06/2013

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	Interview with the RM (Residential Manager) on 7/25/13 at 1 PM indicated client #2's weighted silverware was being replaced. 9-3-7(a)		Staff will be retrained on the need to report immediately any cases of adaptive equipment in disrepair. Director will sign off on retraining.				

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W000440	<p>483.470(i)(1) EVACUATION DRILLS The facility must hold evacuation drills at least quarterly for each shift of personnel. Based on record review and interview, the facility failed for 4 of 4 sampled clients (#1, #2, #3 and #4) and 3 additional clients (#5, #6 and #7) who resided in the group home, to ensure evacuation drills were conducted at least quarterly for the day shift (7 AM to 3 PM) for the third quarter (July, August, September) of 2012/2013.</p> <p>Findings include:</p> <p>The facility's evacuation drills were reviewed on 7/23/13 at 11 AM. The review indicated the facility had failed to conduct an evacuation drill for clients #1, #2, #3, #4, #5, #6 and #7 for the third quarter of 2012/2013 for the day shift.</p> <p>Interview with the QIDP (Qualified Intellectual Disabilities Professional) on 7/25/13 at 11 AM indicated he had located an evacuation drill for clients #1, #2, #3, #4, #5, #6 and #7 for the third quarter of 2012 dated 7/1/12 that was conducted at 4:30 PM. The QIDP did not provide an evacuation drill for the third quarter of 2012/2013 for the day shift.</p> <p>9-3-7(a)</p>	W000440	<p>Corrective action for resident(s) found to have been affected An annual emergency drill calendar has been designed and will be implemented which includes drills on each shift quarterly. Team Leaders will post this annual calendar and mark on the monthly calendar the dates and times drills are due to be completed.</p> <p>How facility will identify other residents potentially affected and what measures taken All residents could potentially be affected and corrective action will address the needs of all clients.</p> <p>Measures or systemic changes facility put in place to ensure no recurrence An annual emergency drill calendar has been designed and implemented. This annual schedule will include drills to be conducted on each shift quarterly. Team Leaders will post this calendar and mark on the monthly calendar the dates and times drills are to be conducted.</p> <p>How corrective actions will be monitored to ensure no recurrence Staff will be trained to follow</p>	09/06/2013			

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			emergency drill calendar. Team Leaders will check weekly to ensure drills are being completed as scheduled. Management will check monthly during the environmental quality assessment to ensure drills are being completed as scheduled. Director will sign off on retraining.		

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W009999	<p>1. State Findings</p> <p>The following Community Residential Facilities for Persons with Developmental Disabilities rules were 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:</p> <p>(1) An emergency rendering the residential facility temporarily uninhabitable.</p> <p>(6) Illness of any resident which requires hospitalization or which renders the resident bedfast for more than seven (7) days.</p> <p>(15). A fall resulting in injury, regardless of the severity 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 4 of 4 sample clients (#1, #2, #3 and #4) and 3 additional clients (#5, #6 and #7), the facility failed to report to BDDS (Bureau of Developmental Disabilities</p>	W009999	<p>Correctiveactionforresident(s)foundtohavebeenaffected</p> <p>Training will be provided for all staff on reporting reportable incidents. This training will include training on what is reportable and reporting immediately to the QDDP or the LPN. The QDDP will notify the Regional Director and BDDS within 24 hours.</p> <p>Howfacilitywillidentifyotherresidentspotentiallyaffectedandwh atmeasurestaken</p> <p>All residents are affected and corrective action will address the needs of all clients.</p> <p>Measuresorsystemicchangesfa cilityputinplacetoensurenorecu rrence</p> <p>All staff will be trained on what incidents are reportable and the need for reporting reportable incidents to the QDDP or LPN immediately. The QDDP will notify the Regional Director and BDDS within 24 hours.</p> <p>Howcorrectiveactionswillbemo nitoredtoensurenorecurrence</p> <p>The QDDP is responsible for ensuring the Regional Director and BDDS are notified of reportable incidents within 24 hours. The QDDP is supervised by the Regional Director. The Regional Director will sign off on all records of training ensuring</p>	09/06/2013			

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	<p>Services):</p> <p>__A total power outage at the facility group home for clients #1, #2, #3, #4, #5, #6 and #7.</p> <p>__A Colonoscopy for client #4 due to reported rectal bleeding.</p> <p>__A fall with injury for client #2.</p> <p>Findings include:</p> <p>1a. The facility's reportable records were reviewed on 7/23/13 at 1 PM. The records indicated no incidents of power outage at the group home for clients #1, #2, #3, #4, #5, #6 and #7.</p> <p>Interview with the TL (Team Leader) on 7/24/13 at 8:45 AM indicated a total power outage at the facility group home on 7/10/13. The TL indicated the power was off when clients #1, #2, #3, #4, #5, #6 and #7 got home from the day program at 3 PM and did not come on again until later in the evening. The TL indicated the clients went out to a local restaurant for their evening meal. The TL stated "I think" the power was returned around 6 PM.</p> <p>Interview with the QIDP (Qualified Intellectual Disabilities Professional) on 7/25/13 at 11:30 AM indicated BDDS was not notified of the power outage in the group home.</p>		<p>all staff are trained.</p> <p>Corrective action for resident(s) found to have been affected</p> <p>All new hires will receive three complete reference checks. This has been relayed by HR to the staff responsible for reference checks. If a reference refuses to release full information that reference will not be used and another reference will be contacted.</p> <p>How facility will identify other residents potentially affected and what measures taken</p> <p>All consumers could potentially be affected and the corrective action will address the need to protect all consumers.</p> <p>Measures or systemic changes facility put in place to ensure no recurrence</p> <p>HR has been instructed to receive 3 complete reference checks for all new hires.</p> <p>How corrective actions will be monitored to ensure no recurrence</p> <p>The Richmond HR coordinator will review all new hires to ensure there are 3 complete reference checks present before calling them for new hire screenings. If a new hire does not have 3 complete reference checks that person will not be called until AWS has received other references to contact.</p>				

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	<p>1b. The facility's reportable records were reviewed on 7/23/13 at 1 PM. The records indicated no report in regard to client #4 having a Colonoscopy due to rectal bleeding.</p> <p>Client #4's record was reviewed on 7/24/13 at 3 PM. Client #4's record indicated client #4 had a Colonoscopy on 4/26/13 due to rectal bleeding.</p> <p>Interview with the QIDP on 7/25/13 at 1 PM indicated he had not reported client #4's need for a Colonoscopy due to rectal bleeding to BDDS.</p> <p>1c. The facility's reportable records were reviewed on 7/23/13 at 1 PM. The facility BDDS report of 5/29/13 indicated on 5/27/13 at 7:30 PM client #2 tripped on an end table leg and fell backwards into the table, hitting her right knee and the right side of her head. "[Client #2] suffered a knot to her knee and the right side of head." The report indicated "The staff failed to notify this writer [the QIDP (Qualified Intellectual Disabilities Professional)] of the fall so that it could be reported within the 24 hour window will be retrained on company policy regarding incident reporting policy."</p> <p>Interview with the QIDP on 7/25/13 at</p>						

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	<p>11:30 AM indicated BDDS was to be notified of all reportable incidents within 24 hours of the time of the incident.</p> <p>9-3-1(a)</p> <p>2. State Findings</p> <p>The following Community Residential Facilities for Persons with Developmental Disabilities rules were not met:</p> <p>460 IAC 9-3-2(a) Resident Protections</p> <p>"The provider shall obtain, as a minimum, a bureau of motor vehicles record, a criminal history check as authorized in IC 5-2-5-5 [IC 5-2-5 was repealed by P.L.2-2003, SECTION 102, effective July 1, 2003. See IC 10-13-3-27.], and three (3) references. Mere verification of employment dates by previous employers shall not constitute a reference in compliance with this section."</p> <p>This State Rule is not met as evidenced by:</p> <p>Based on record review and interview, for 2 of 4 personnel files reviewed (staff #2 and #5), the facility failed to ensure three references were obtained prior to employment.</p>				

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	<p>Findings include:</p> <p>The facility personnel records were reviewed on 7/23/13 at 3 PM. Staff #2's and #5's employee files indicated 1 of 3 references verifying only employment dates by previous employers.</p> <p>Interview with administrative assistant #1 on 7/23/13 at 3:15 PM indicated 1 of the 3 references for staff #2 and #5 provided only verification of previous employment dates. The administrative assistant #1 indicated staff #2 and #5 had not provided any further references for review.</p> <p>9-3-2(a)</p>				