

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  09/13/2013
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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 a post certification revisit (PCR) to the extended annual recertification and state licensure survey of 08-07-13.</p> <p>Dates of Survey: September 11, 12 and 13, 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 10/1/13 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 client #2 from repeated falls with injuries.</p> <p>__ To ensure the staff were adequately trained on the use of client #2's medical equipment.</p> <p>__ To ensure expired food was 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 general policy and operating direction over the facility to ensure client #2's safety in regard to injuries due to falls and to ensure the staff were adequately trained on the use of client #2's medical equipment. Please see W149.</p> <p>2. The governing body failed to exercise general policy and operating direction</p>	W000104	<p>Corrective action for resident(s) found to have been affected Client #2 has a gait belt, walker, bed alarm, and room monitor in place to reduce the number of falls and increase staff responsiveness to consumer's safety. These were put in place on 8/17/13 with verbal training for staff by LPN. A complete and comprehensive training was conducted on 8/26/13. Group home management have been retrained to ensure staff's complete and comprehensive training are put in place before changes are made. A weekly team leader checklist has been implemented that require team leaders to conduct medication audits, financial audits, and ensure 3rd shift cleaning checklists are done weekly. These 3rd shift cleaning lists include checking for expired food. The team leaders will fill out the weekly checklist and these will be signed off by the Group Home Manager and QDDP. 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. Measures or systemic changes facility put in place to ensure no</p>	10/12/2013			

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	<p>over the facility to ensure staff were adequately trained on client #2's medical equipment. Please see W331.</p> <p>3. Observations were conducted at the group home of clients #1, #2, #3, #4, #5, #6 and #7 on 9/12/13 between 5:30 AM and 7:30 AM. A bottle of salad dressing with an expiration date of 9/5/13 was sitting inside the refrigerator on a shelf.</p> <p>Review of the facility's group home cleaning list for 2013 on 9/12/13 at 11 AM indicated the staff were to check all food and to "pull outdated" food. A cleaning list for September 2013 was not provided for review.</p> <p>Interview with staff #1 on 9/12/13 at 7:30 AM indicated all expired food was to be discarded.</p> <p>Interview with the QIDP (Qualified Intellectual Disabilities Professional) on 9/12/13 at 11:30 AM indicated the staff had informed him the morning of 9/12/13 the September cleaning list had not been provided to the group home staff from the TL (Team Leader) and no cleaning duties had been documented from 9/1/13 to present. The QIDP indicated one of the duties of the cleaning list was to check for and discard outdated food. The QIDP stated the staff "should have requested the</p>		<p>recurrenceRegional Director trained group home management to ensure staff training occurs before any consumer changes are made. A new QDDP starts in this facility on 10-14-13. This QDDP will receive documented training from experienced QDDPs within AWS to ensure compliance with ISDH regulations. How corrective actions will be monitored to ensure no recurrenceTeam Leaders will complete the weekly TL checklist and turn in to GHM. GHM will review and sign and turn into QDDP to sign. Also a member of GH management will conduct a monthly environmental check to ensure expired food is removed. This monthly environmental check is turned into the Regional Director for review and a report is sent to AWS corporate compliance. Regional Director will ensure new QDDP receives training on ISDH regulations.</p>				

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	<p>list from the TL" and completed the duties as indicated on the list. The QIDP indicated all outdated food was to be discarded.</p> <p>This deficiency was cited on 8/7/13. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>9-3-1(a)</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 failed to implement its policy and procedures to ensure client #2's safety in regard to repeated head injuries due to falls and to ensure the staff were adequately trained on client #2's medical equipment.</p> <p>Findings include:</p> <p>Observations were conducted at the group home on 9/12/13 between 5:30 AM and 7:30 AM. Client #2 ambulated at a fast pace, using a rolling walker, wearing a gait belt and assisted by staff while walking.</p> <p>The facility's records were reviewed on 9/11/13 at 2 PM. The facility BDDS (Bureau of Developmental Disabilities Services) reports indicated:          ___ 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...."          ___ On 12/1/12 at 11:45 AM while at the bowling alley, client #2 "lost her balance</p>	W000149	<p>Corrective action for resident(s) found to have been affected Client #2 has a gait belt, walker, bed alarm, and room monitor in place to reduce the number of falls and increase staff responsiveness to consumer's safety. These were put in place on 8/17/13 with verbal training for staff. A complete and documented training was conducted on 8/26/13. Group home management have been retrained by the Regional Director to ensure staff's complete and comprehensive training are put in place before consumers changes are made. 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. Measures or systemic changes facility put in place to ensure no recurrence Regional Director trained group home management to ensure staff training occurs before any consumer changes are made. A new QDDP starts in this facility on 10-14-13. This QDDP will receive documented training from experienced QDDPs within AWS to ensure compliance with state regulations. How corrective actions will be</p>	10/12/2013	

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	<p>while attempting to bowl and fell to the ground."            ___ 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.... [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.... 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.... [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...."            ___ 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."</p>		<p>monitored to ensure no recurrenceStaff 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.The Regional Director will ensure QDDP receives training from experienced AWS QDDPs to ensure compliance with ISDH regulations.</p>				

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	<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...."</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> <p>__ On 8/15/13 at 5:45 AM one of client #2's "housemates disclosed to staff that she heard a loud 'thud' in [client #2's] room. When staff went to check on her they saw [client #2] bending over supporting herself on her bed. [Client #2] disclosed to staff that when she got out of bed she lost her balance, fell hitting her</p>						

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	<p>head on her wardrobe, then falling backwards into the frame of her bed. [Client #2] suffered a small laceration on her left side of her forehead approx (approximately) 1" (inch) and a scrape on her right shoulder blade from falling backwards into the frame of her bed. Staff took [client #2] into the medication room and began first aide (sic) to the injury.... [Client #2] has a risk summary regarding falls which states that staff are to prompt [client #2] anytime she is seen not using her walker, be within arms reach when ambulating, and to ensure that [client #2's] area is free from any trip hazards.... At the request of the team her physician ordered the use of a gait belt anytime she is up and moving. Due to a number of her falls occurring in her room right after getting up the team is also going to get HRC (Human Rights Committee) approval for the use of an in room monitor...."</p> <p>__On 8/16/13 at 4:10 AM the staff went to wake client #2 to complete a neuro assessment following her fall of 8/15/13. Client #2 refused to get up for the assessment. The staff left client #2's room to go to another room to document her refusal when the staff heard client #2 fall in her bedroom. When staff entered client #2's room, client #2 had gotten to her feet. Client #2 had "suffered a linear abrasion to her right jaw/cheek area approx 3 1/2"</p>						

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	<p>(inches) long and a quarter sized bruise to her left forearm. [Client #2] disclosed to staff that she had gotten up to use the bathroom when the fall occurred. She (client #2) stated that she felt dizzy at the time of the fall. [Client #2] is unable to recollect what she fell into causing the injury or any other details regarding the fall." The plan to resolve indicated client #2's risk summary had been updated on 8/15/13 to include the use of gait belt anytime client #2 was up and out of bed. "At the time of the addition of the gait belt [client #2] was counseled on the importance of telling staff when she is ready to get out of bed so that staff can assist her. [Client #2] did not follow this request at the time of the fall. [Client #2] was taken to the emergency room where a head and chest CT were completed. The results were negative.... The team met and decided that to ensure safety a bed alarm and room monitor would be needed so that staff could be aware if [client #2] were to get out of bed.... Those devices are now in place."</p> <p>__On 8/20/13 at 4 PM (incorrect time - 8:15 AM) "While on the way to day services staff were pushing [client #2] on her seated walked (sic) when the wheel caught the curb near a sidewalk. This resulted in [client #2] falling forward to the ground lightly. [Client #2] stated that she had hit her head during the fall. When</p>			
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	<p>this writer (the QIDP) was contacted and informed of the fall he was told there was no injury as a result of the fall.... Even though it appeared that [client #2] had no lasting effects it was decided by the team that [client #2] would be seen in the ER (Emergency Room) as a precaution to rule out any hidden injuries. [Client #2's] primary care physician was involved in this decision. Once in the ER [client #2] was examined and observed to have no injuries...." The Plan to Resolve indicated the staff involved were to be counseled on the correct use of a seated walker and were to receive formal training "regarding this issue. Staff will continue to follow [client #2's] risk summary concerning falls...." The Follow Up BDDS report of 8/26/13 indicated "Staff were retrained because at the time of the fall they were not having [client #2] use the seated walker for its intended use. Instead they were using it more like a walker. Staff were formerly trained on the proper use of a seated walker on 8/26/13."</p> <p>The facility staff training records for August and September 2013 were reviewed on 9/12/13 at 1 PM. The training records indicated the facility staff were trained on the use of client #2's bed alarm and rolling seated walker on 8/26/13. The facility staff training records indicated no staff training on client #2's</p>			

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	<p>changes in the falls risk summary, the use of the monitor and the use of the gait belt. Interview with administrative assistant #1 on 9/12/13 at 3 PM indicated all training records from 8/1/13 to present had been provided for review.</p> <p>Client #2's record was reviewed on 9/12/13 at 12 PM. Client #2's PFAs (Post Fall Assessments) indicated:            ___ On 8/15/13 at 5:50 AM client #2 got out of bed and fell. The PFA indicated client #2 obtained a 1 inch triangular "gash" to her left forehead, a 2 by 2 inch scrape to the middle of her back, a 1 inch bruise to her right jaw and a 2 inch bruise to her left forearm.            ___ On 8/16/13 at 4:10 AM client #2 got out of bed and fell. The PFA indicated client #2 had a 1 inch gash on her forehead from the fall from the previous day and redness to her right cheek. The PFA indicated "Appears to have hit her face during fall, redness and light bruising to right of jaw and also a 2 by 1 1/2 inch bruise on her left forearm.</p> <p>Client #2's 8/15/13 IDT (Interdisciplinary Team) meeting note indicated "Due to [client #2's] recent increase in falls and [client #2's ] continued documented cases of refusals to use her walker despite staff prompting the team is meeting to discuss further steps to be taken in order to</p>						

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	<p>guarantee health and safety. At this time the team believes that [client #2] now will require the use of a gait belt and hands on assistance anytime that she is up and ambulating. The group home nurse will make this request to her primary care physician. This measure will remain in place and be revisited on a monthly basis. Also due to the fact that many of [client #2's] recent falls have taken place while in her room after getting out of bed or while getting dressed the team will request that a monitor be added to her room so that staff can be more aware of when [client #2] is up and moving...."</p> <p>Client #2's updated Risk Summary of 8/23/13 indicated client #2 was at risk for falls. The risk plan indicated client #2 was to use a seated walker whenever ambulating and the client could sit and rest until she felt she could continue ambulating. The plan indicated on 8/15/13 client #2 was evaluated by her physician and was to wear a gait belt and have hands on assist from the staff whenever ambulating. The plan indicated on 8/22/13 a new order was received for a PRN (as needed) wheelchair for client #2 to use for long distances. The plan indicated client #2 was to use a bed alarm and a room monitor to alert the staff whenever client #2 was getting out of bed.</p>			

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	<p>Review of client #2's undated Owner's Operator Maintenance Manual for the rolling seated walker on 9/12/13 at 1:30 PM indicated "Do not use the seat to transport people or objects. Do not use the seat to carry or move anything."</p> <p>Telephone interview with the facility LPN (Licensed Practical Nurse) on 9/13/13 at 3 PM indicated after client #2's recent falls the team decided to use a bed alarm for client #2's safety. The LPN indicated the bed alarm, gait belt and the room monitor were implemented on 8/16/13. The LPN indicated the staff were trained at a formal training on 8/26/13 which included the use of the bed alarm and client #2's rolling walker. The LPN indicated she could not remember if the training also included the use of the gait belt and/or the monitor. The LPN indicated on 8/20/13 staff #1 was told by staff #2 to push client #2 to the day program in her seated rolling walker. The LPN stated client #2 has used a rolling seated walker for a long time and staff #1 and staff #2 "should have known" client #2's walker was not to be used to transport client #2 "like a wheel chair."</p> <p>This deficiency was cited on 8/7/13. The facility failed to implement a systemic plan of correction to prevent recurrence.</p>			

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NAME OF PROVIDER OR SUPPLIER  AWS				STREET ADDRESS, CITY, STATE, ZIP CODE 817 MENDLESON DR RICHMOND, IN 47374			
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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 9/12/13 between 5:30 AM and 7:30 AM. Client #1 was a young, short individual who 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.</p> <p>Client #1's record was reviewed on 9/12/13 at 11 AM. Client #1's record indicated a diagnosis of, but not limited to, bilateral hip dysplasia with recurrent subluxation (incomplete or partial dislocation). 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 indicated client #1 was to have a 1200 calorie diet with</p>	W000227	<p>Corrective action for resident(s) found to have been affected An ISP objective has been added for portion control for Client #1. The ISP has been updated to reflect this new goal and the need for staff to offer reminders. Staff were trained on the new ISP and new objectives prior to its implementation. 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. 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. How corrective actions will be monitored to ensure no recurrence IDT team will meet quarterly to discuss all aspects of client programming including needed objectives. The IDT will fill out the quarterly meeting checklist and submit to director</p>	10/12/2013			

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	<p>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 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, weight loss and/or to make healthy choices.</p> <p>Interview with staff #1 on 9/12/13 at 7:30 AM stated client #1 did not have any objectives "to my knowledge" in regard to portion control and/or weight loss. Staff</p>		<p>for review and signature. The Regional Director will ensure the new QDDP that starts 10-14-2013 will receive comprehensive training from experienced AWS QDDPs to ensure compliance with ISDH regulations.</p>				

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	<p>#1 stated, "We give her a smaller plate now to eat from. I think that is to help her to eat less."</p> <p>Interview with the QIDP (Qualified Intellectual Disabilities Professional) on 9/12/13 at 11:30 AM indicated client #1 did not have any objectives to assist client #1 with portion control, weight loss and/or to make healthy choices. The QIDP indicated he had spoken with the dietician but was unsure on how to develop specific goals for client #1's identified needs. The QIDP stated client #1 was given a smaller plate to eat from "in hopes she would take smaller portions."</p> <p>This deficiency was cited on 8/7/13. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>9-3-4(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 ensure the staff were adequately trained on client #2's medical equipment.</p> <p>Findings include:</p> <p>Observations were conducted at the group home on 9/12/13 between 5:30 AM and 7:30 AM. Client #2 ambulated at a fast pace, using a rolling walker, wearing a gait belt and assisted by staff while walking.</p> <p>The facility's records were reviewed on 8/11/13 at 2 PM. The facility BDDS (Bureau of Developmental Disabilities Services) reports indicated:          ___ 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...."          ___ 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."          ___ On 12/7/12 at 11:15 PM "while moving from the living room couch to the kitchen</p>	W000331	<p>Corrective action for resident(s) found to have been affected Client #2 has a gait belt, walker, bed alarm, and room monitor in place to reduce the number of falls and increase staff responsiveness to consumer's safety. HRC approval has been obtained and a complete and comprehensive training was given in person by the LPN to all staff. Regional Director attended this training to ensure proper and complete training. Group home management were retrained by the Regional Director to ensure staff's complete and comprehensive training are put in place before consumers changes are made. 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. Measures or systemic changes facility put in place to ensure no recurrence Regional Director trained group home management to ensure staff training occurs before any consumer changes are made. A new QDDP starts in this facility on 10-14-13. This QDDP will receive documented training from experienced QDDPs within AWS to ensure compliance with state regulations. How</p>	10/12/2013			

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	<p>area without the use of her prescribed walker [client #2] fell hitting her face on the counter and knee on the ground.... [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.... 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.... [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...."</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."</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.</p>		<p>corrective actions will be monitored to ensure no recurrenceStaff 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.The Regional Director will ensure QDDP receives training from experienced AWS QDDPs to ensure compliance with ISDH regulations.</p>				

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	<p>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...."</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> <p>__ On 8/15/13 at 5:45 AM one of client #2's "housemates disclosed to staff that she heard a loud 'thud' in [client #2's] room. When staff went to check on her they saw [client #2] bending over supporting herself on her bed. [Client #2] disclosed to staff that when she got out of bed she lost her balance, fell hitting her head on her wardrobe, then falling backwards into the frame of her bed. [Client #2] suffered a small laceration on her left side of her forehead approx</p>						

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	<p>(approximately) 1" (inch) and a scrape on her right shoulder blade from falling backwards into the frame of her bed. Staff took [client #2] into the medication room and began first aide (sic) to the injury.... [Client #2] has a risk summary regarding falls which states that staff are to prompt [client #2] anytime she is seen not using her walker, be within arms reach when ambulating, and to ensure that [client #2's] area is free from any trip hazards.... At the request of the team her physician ordered the use of a gait belt anytime she is up and moving. Due to a number of her falls occurring in her room right after getting up the team is also going to get HRC (Human Rights Committee) approval for the use of an in room monitor...."</p> <p>__ On 8/16/13 at 4:10 AM the staff went to wake client #2 to complete a neuro assessment following her fall of 8/15/13. Client #2 refused to get up for the assessment. The staff left client #2's room to go to another room to document her refusal when the staff heard client #2 fall in her bedroom. When staff entered client #2's room, client #2 had gotten to her feet. Client #2 had "suffered a linear abrasion to her right jaw/cheek area approx 3 1/2" (inches) long and a quarter sized bruise to her left forearm. [Client #2] disclosed to staff that she had gotten up to use the bathroom when the fall occurred. She</p>						

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	<p>(client #2) stated that she felt dizzy at the time of the fall. [Client #2] is unable to recollect what she fell into causing the injury or any other details regarding the fall." The plan to resolve indicated client #2's risk summary had been updated on 8/15/13 to include the use of gait belt anytime client #2 was up and out of bed. "At the time of the addition of the gait belt [client #2] was counseled on the importance of telling staff when she is ready to get out of bed so that staff can assist her. [Client #2] did not follow this request at the time of the fall. [Client #2] was taken to the emergency room where a head and chest CT were completed. The results were negative.... The team met and decided that to ensure safety a bed alarm and room monitor would be needed so that staff could be aware if [client #2] were to get out of bed.... Those devices are now in place."</p> <p>__ On 8/20/13 at 4 PM (incorrect time - 8:15 AM) "While on the way to day services staff were pushing [client #2] on her seated walked (sic) when the wheel caught the curb near a sidewalk. This resulted in [client #2] falling forward to the ground lightly. [Client #2] stated that she had hit her head during the fall. When this writer (the QIDP) was contacted and informed of the fall he was told there was no injury as a result of the fall.... Even though it appeared that [client #2] had no</p>				

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	<p>lasting effects it was decided by the team that [client #2] would be seen in the ER (Emergency Room) as a precaution to rule out any hidden injuries. [Client #2's] primary care physician was involved in this decision. Once in the ER [client #2] was examined and observed to have no injuries...." The Plan to Resolve indicated the staff involved were to be counseled on the correct use of a seated walker and were to receive formal training "regarding this issue. Staff will continue to follow [client #2's] risk summary concerning falls...." The Follow Up BDDS report of 8/26/13 indicated "Staff were retrained because at the time of the fall they were not having [client #2] use the seated walker for its intended use. Instead they were using it more like a walker. Staff were formerly trained on the proper use of a seated walker on 8/26/13."</p> <p>The facility staff training records for August and September 2013 were reviewed on 9/12/13 at 1 PM. The training records indicated the facility staff were trained on the use of client #2's bed alarm and rolling seated walker on 8/26/13. The facility staff training records indicated no staff training on client #2's changes in the falls risk summary, the use of the monitor and the use of the gait belt. Interview with administrative assistant #1 on 9/12/13 at 3 PM indicated all training</p>			

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	<p>records from 8/1/13 to present had been provided for review.</p> <p>Client #2's record was reviewed on 9/12/13 at 12 PM. Client #2's PFAs (Post Fall Assessments) indicated:            ___ On 8/15/13 at 5:50 AM client #2 got out of bed and fell. The PFA indicated client #2 obtained a 1 inch triangular "gash" to her left forehead, a 2 by 2 inch scrape to the middle of her back, a 1 inch bruise to her right jaw and a 2 inch bruise to her left forearm.            ___ On 8/16/13 at 4:10 AM client #2 got out of bed and fell. The PFA indicated client #2 had a 1 inch gash on her forehead from the fall from the previous day and redness to her right cheek. The PFA indicated "Appears to have hit her face during fall, redness and light bruising to right of jaw and also a 2 by 1 1/2 inch bruise on her left forearm.</p> <p>Client #2's 8/15/13 IDT (Interdisciplinary Team) meeting note indicated "Due to [client #2's] recent increase in falls and [client #2's ] continued documented cases of refusals to use her walker despite staff prompting the team is meeting to discuss further steps to be taken in order to guarantee health and safety. At this time the team believes that [client #2] now will require the use of a gait belt and hands on assistance anytime that she is up and</p>				

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	<p>ambulating. The group home nurse will make this request to her primary care physician. This measure will remain in place and be revisited on a monthly basis. Also due to the fact that many of [client #2's] recent falls have taken place while in her room after getting out of bed or while getting dressed the team will request that a monitor be added to her room so that staff can be more aware of when [client #2] is up and moving...."</p> <p>Client #2's updated Risk Summary of 8/23/13 indicated client #2 was at risk for falls. The risk plan indicated client #2 was to use a seated walker whenever ambulating and the client could sit and rest until she felt she could continue ambulating. The plan indicated on 8/15/13 client #2 was evaluated by her physician and was to wear a gait belt and have hands on assist from the staff whenever ambulating. The plan indicated on 8/22/13 a new order was received for a PRN (as needed) wheelchair for client #2 to use for long distances. The plan indicated client #2 was to use a bed alarm and a room monitor to alert the staff whenever client #2 was getting out of bed.</p> <p>Review of client #2's undated Owner's Operator Maintenance Manual for the rolling seated walker on 9/12/13 at 1:30</p>						

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	<p>PM indicated "Do not use the seat to transport people or objects. Do not use the seat to carry or move anything."</p> <p>Telephone interview with the facility LPN (Licensed Practical Nurse) on 9/13/13 at 3 PM indicated after client #2's recent falls the team decided to use a bed alarm for client #2's safety. The LPN indicated the bed alarm, gait belt and the room monitor were implemented on 8/16/13. The LPN indicated the staff were trained at a formal training on 8/26/13 which included the use of the bed alarm and client #2's rolling walker. The LPN indicated she could not remember if the training also included the use of the gait belt and/or the monitor. The LPN indicated on 8/20/13 staff #1 was told by staff #2 to push client #2 to the day program in her seated rolling walker. The LPN stated client #2 has used a rolling seated walker for a long time and staff #1 and staff #2 "should have known" client #2's walker was not to be used to transport client #2 "like a wheel chair."</p> <p>This deficiency was cited on 8/7/13. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>9-3-6(a)</p>						

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

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W009999		W009999	No deficiency listed	10/12/2013	