| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G551 | (X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING | (X3) DATE SURVEY COMPLETED 07/19/2012 |
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| COMMUNITY ALTERNATIVES-ADEPT | 8211 CHRISTIANA LN<br>INDIANAPOLIS, IN 46256 |

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| W0000 | This visit was for the investigation of complaint #IN00111284.<br><br>Complaint #IN00111284: Substantiated, Federal and state deficiencies related to the allegation(s) are cited at W102, W104, W122, W149, W154, W156, W318 and W331.<br><br>Unrelated deficiency cited.<br><br>Dates of Survey: 7/11, 7/12, 7/13, 7/19/12<br><br>Facility Number: 001065<br>AIMS Number: 100239840<br>Provider Number: 15G551<br><br>Surveyor:<br>Paula Chika, Medical Surveyor III-Team Leader<br><br>These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 7/23/12 by Ruth Shackelford, Medical Surveyor III. | W0000 | | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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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| W0102 | 483.410<br>GOVERNING BODY AND MANAGEMENT<br>The facility must ensure that specific governing body and management requirements are met.<br><br>Based on observation, interview and record review, the facility failed to meet the Condition of Participation: Governing Body for 1 of 4 sampled clients (A). The governing body failed to ensure the facility implemented its policy and procedures to prevent neglect of a client regarding an injury of unknown origin. The governing body failed to ensure the facility conducted thorough investigations and completed investigations in a timely manner. The governing body failed to ensure the facility's nursing services met the health care needs of a client with a fractured clavicle.<br><br>Findings include:<br><br>1. The governing body failed to meet the Condition of Participation: Client Protections for 1 of 4 sampled clients (A). The governing body failed to ensure the facility implemented its written policy and procedures to ensure the facility's system for conducting investigations in regard to injuries of unknown origin was conducted thoroughly and timely in regard to a fractured clavicle. The governing body failed to ensure the | W0102 | **CORRECTION:** *The facility must ensure that specific governing body and management requirements are met.*<br>Specifically, the agency will complete its investigation into Client A's injury of unknown origin and results of the investigation into Client A's injury of unknown origin will be reported to the administrator, Indiana Adult Protective Services and the Bureau of Developmental Disability Services as required. With regard to care for Client A's fractured right clavicle, the team has taken the following steps to assure Client A's health and safety. While Client A's fractured right clavicle heals, his sling has been supplemented with a binding to assure it remains immobile. 15 minute checks have been implemented while Client A is awake to prevent him from interrupting the healing process. When Client A sleeps and is not wearing the sling, Client A will receive one to one staffing to assure he does not use his right arm. Additionally, the facility nurse is coordinating Client A's follow-up with an orthopedic specialist as well as obtaining an updated bone density scan. The nurse has provided staff with specific training toward safe lifting | 08/18/2012 |

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| | facility implemented its written policy and procedures to complete its investigation of the injury of unknown origin within 5 working days. The governing body failed to ensure the facility implemented its written policy and procedures to prevent neglect in regard to the care of the client's clavicle fracture. Please see W122.<br><br>2. The governing body failed to meet the Condition of Participation: Health Care Services for 1 of 4 sampled clients (A). The governing body failed to ensure the facility's health care services met the nursing needs of a client in regard to a clavicle fracture. Please see W318.<br><br>3. The governing body failed to exercise general policy and operating direction over the facility to ensure the facility implemented its written policy and procedures to ensure the facility's system for conducting investigations in regard to injuries of unknown origin was conducted thoroughly and timely in regard to a fractured clavicle. The governing body failed to ensure the facility implemented its written policy and procedures to conduct a thorough investigation in regard to an injury of unknown origin of a fractured clavicle. The governing body failed to exercise general policy and operating direction over the facility to | | and transferring of Client A and has developed specific protocols for assisting Client A with self-care activities while his fracture heals. **PREVENTION:** The Quality Assurance Manager will oversee and coordinate completion of investigations into the origin of all significant injuries. When the facility reports injuries of unknown origin, the team will focus on determining whether the injury occurred as a result of abuse, neglect or mistreatment. The Quality Assurance Manager has established a tracking system to assure all investigations occur for all injuries of unknown origin and that they are completed within established timelines –thus facilitating the timely reporting to the agency administrator and government entities as required. The status of all current investigation will be posted in a confidential manner to provide for follow-up with facility supervisory staff as needed. The Quality Assurance Team will audit completed investigations to all components of a thorough investigation have been completed and reported as required. With regard to the care of Client A's fractured right clavicle, the facility nurse will be retrained regarding the need to include specific care procedures as appropriate when developing comprehensive high risk and care plans. The Healthcare Services Manager will review all revisions | |

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| | ensure all investigations were conducted thoroughly, and to ensure investigations were completed within 5 business days. The governing body failed to exercise general policy and operating direction over the facility to ensure the client's health care needs in regard to a clavicle fracture were met.<br><br>The governing body failed to exercise general policy and operating direction over the facility to ensure the facility conducted thorough investigations.<br><br>The governing body failed to exercise general policy and operating direction over the facility to ensure the facility completed investigations within 5 working days. Please see W104.<br><br>4. The governing body failed to exercise general policy and operating direction over the facility to ensure the nurse developed specific protocols in regard to the care of a client's fractured clavicle. The governing body failed to exercise general policy and operating direction over the facility to ensure facility staff notified nursing services of a client's change in status and to ensure facility staff followed ordered care instructions for the fractured clavicle. The governing body failed to exercise general policy and operating direction over the facility to | | to facility nursing care plans for the next ninety days and thereafter will perform spot checks of facility nursing care plans as needed but no less than quarterly. The facility nurse will assure that all treatments and other nursing care activities entered into the Medication and Treatment Administration Records include specific times for the actions to be performed. Members of the Operations and Quality Assurance Teams will monitor active treatment sessions and review medical documentation as needed but no less than monthly to assure professional and direct support staff implement high risk and nursing care plans as written. Additionally Operations and Quality Assurance Team members will review medical documentation while auditing active treatment sessions and make recommendations to the Health Services Team as appropriate. **Responsible Parties:** QDDPD, Support Associates, Health Services Team, Operations Team, Quality Assurance Team | |

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| | ensure facility staff monitored and/or documented the client's care, and/or failed to ensure the facility's nursing services monitored and/or followed-up on client A's fractured clavicle as it was healing. Please see W331.<br><br>This federal tag relates to complaint #IN00111284.<br><br>9-3-1(a) | | | |

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| W0104 | 483.410(a)(1)<br>GOVERNING BODY<br>The governing body must exercise general policy, budget, and operating direction over the facility.<br>Based on observation, interview and record review for 1 of 4 sampled clients (A), the governing body failed to exercise general policy and operating direction over the facility to ensure the facility implemented its policy and procedures to prevent neglect of a client. The governing body failed to exercise general policy and operating direction over the facility to ensure the facility conducted thorough investigations and completed investigations in a timely manner. The governing body failed to exercise general policy and operating direction over the facility to ensure the facility's nursing services met the health care needs of a client with a fractured clavicle.<br><br>Findings include:<br><br>1. The governing body failed to exercise general policy and operating direction over the facility to ensure the facility implemented its written policy and procedures to ensure the facility's system for conducting investigations in regard to injuries of unknown origin was conducted thoroughly and timely in regard to client A's fractured clavicle. The governing body failed to ensure the facility | W0104 | **CORRECTION:** *The governing body must exercise general policy, budget, and operating direction over the facility.* Specifically, the agency will complete its investigation into Client A's injury of unknown origin and results of the investigation into Client A's injury of unknown origin will be reported to the administrator, Indiana Adult Protective Services and the Bureau of Developmental Disability Services as required. With regard to care for Client A's fractured right clavicle, the team has taken the following steps to assure Client A's health and safety. While Client A's fractured right clavicle heals, his sling has been supplemented with a binding to assure it remains immobile. 15 minute checks have been implemented while Client A is awake to prevent him from interrupting the healing process. When Client A sleeps and is not wearing the sling, Client A will receive one to one staffing to assure he does not use his right arm. Additionally, the facility nurse is coordinating Client A's follow-up with an orthopedic specialist as well as obtaining an updated bone density scan. The nurse has provided staff with specific training toward safe lifting | 08/18/2012 |

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| | implemented its written policy and procedures to conduct a thorough investigation in regard to an injury of unknown origin of a fractured clavicle. The governing body failed to exercise general policy and operating direction over the facility to ensure all investigations were conducted thoroughly, and to ensure investigations were completed within 5 business days. The governing body failed to exercise general policy and operating direction over the facility to ensure the client's health care needs in regard to a clavicle fracture were met. Please see W149.<br><br>2. The governing body failed to exercise general policy and operating direction over the facility to ensure the facility conducted thorough investigations for client A. Please see W154.<br><br>3. The governing body failed to exercise general policy and operating direction over the facility to ensure the facility completed investigations within 5 working days for client A. Please see W156.<br><br>4. The governing body failed to exercise general policy and operating direction over the facility to ensure the nurse developed specific protocols in regard to the care of a client's fractured clavicle. | | and transferring of Client A and has developed specific protocols for assisting Client A with self-care activities while his fracture heals. **PREVENTION:** The Quality Assurance Manager will oversee and coordinate completion of investigations into the origin of all significant injuries. When the facility reports injuries of unknown origin, the team will focus on determining whether the injury occurred as a result of abuse, neglect or mistreatment. The Quality Assurance Manager has established a tracking system to assure all investigations occur for all injuries of unknown origin and that they are completed within established timelines –thus facilitating the timely reporting to the agency administrator and government entities as required. The status of all current investigation will be posted in a confidential manner to provide for follow-up with facility supervisory staff as needed. The Quality Assurance Team will audit completed investigations to all components of a thorough investigation have been completed and reported as required. With regard to the care of Client A's fractured right clavicle, the facility nurse will be retrained regarding the need to include specific care procedures as appropriate when developing comprehensive high risk and care plans. The Healthcare Services Manager will review all revisions | |

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| | The governing body failed to exercise general policy and operating direction over the facility to ensure facility staff notified nursing services of a client's change in status and to ensure facility staff followed ordered care instructions for the fractured clavicle. The governing body failed to exercise general policy and operating direction over the facility to ensure facility staff monitored and/or documented the client's care, and/or failed to ensure the facility's nursing services monitored and/or followed-up on client A's fractured clavicle as it was healing. Please see W331.<br><br>This federal tag relates to complaint #IN00111284.<br><br>9-3-1(a) | | to facility nursing care plans for the next ninety days and thereafter will perform spot checks of facility nursing care plans as needed but no less than quarterly. The facility nurse will assure that all treatments and other nursing care activities entered into the Medication and Treatment Administration Records include specific times for the actions to be performed. Members of the Operations and Quality Assurance Teams will monitor active treatment sessions and review medical documentation as needed but no less than monthly to assure professional and direct support staff implement high risk and nursing care plans as written. Additionally Operations and Quality Assurance Team members will review medical documentation while auditing active treatment sessions and make recommendations to the Health Services Team as appropriate. **Responsible Parties:** QDDPD, Support Associates, Health Services Team, Operations Team, Quality Assurance Team | |

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| W0122 | 483.420<br>CLIENT PROTECTIONS<br>The facility must ensure that specific client protections requirements are met.<br>Based on observation, interview and record review, the facility failed to meet the Condition of Participation: Client Protections for 1 of 4 sampled clients (A). The facility failed to implement its policy and procedures to prevent neglect in regard to an injury of unknown origin/fractured clavicle. The facility failed to conduct a thorough investigation in regard to the client's fracture and/or failed to conduct a timely investigation.<br><br>Findings include:<br><br>1. The facility failed to implement its written policy and procedures to ensure the facility's system for conducting investigations in regard to injuries of unknown origin were conducted thoroughly in regard to a fractured clavicle. The facility failed to implement its written policy and procedures to complete its investigation of the injury of unknown origin within 5 working days. The facility failed to implement its written policy and procedures to prevent neglect in regard to the care of client A's clavicle fracture. Please see W149.<br><br>2. The facility failed to conduct a | W0122 | **CORRECTION:** *The facility must ensure that specific client protections requirements are met.* Specifically, the agency will complete its investigation into Client A's injury of unknown origin and results of the investigation into Client A's injury of unknown origin will be reported to the administrator, Indiana Adult Protective Services and the Bureau of Developmental Disability Services as required.<br>**PREVENTION:** The Quality Assurance Manager will oversee and coordinate completion of investigations into the origin of all significant injuries. When the facility reports injuries of unknown origin, the team will focus on determining whether the injury occurred as a result of abuse, neglect or mistreatment. The Quality Assurance Manager has established a tracking system to assure all investigations occur for all injuries of unknown origin and that they are completed within established timelines –thus facilitating the timely reporting to the agency administrator and government entities as required. The status of all current investigation will be posted in a confidential manner to provide for follow-up with facility supervisory staff as needed. The Quality Assurance Team will audit | 08/18/2012 |

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| | thorough investigation in regard to an injury of unknown origin for client A. Please see W154.<br><br>3. The facility failed to complete an investigation within 5 working days to report the results to the administrator and to state officials regarding client A. Please see W156.<br><br>This federal tag relates to complaint #IN00111284.<br><br>9-3-2(a) | | completed investigations to all components of a thorough investigation have been completed and reported as required. **Responsible Parties:** QDDPD, Support Associates, Health Services Team, Operations Team, Quality Assurance Team | |

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| W0149 | 483.420(d)(1)<br>STAFF TREATMENT OF CLIENTS<br>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client.<br><br>Based on observation, interview and record review for 1 of 4 sampled clients (A), the facility neglected to implement its written policy and procedures to ensure the facility's system for conducting investigations in regard to injuries of unknown origin was conducted thoroughly and timely in regard to a fractured clavicle. The facility neglected to implement its written policy and procedures to complete its investigation of the injury of unknown origin within 5 working days. The facility neglected to implement its written policy and procedures to prevent neglect in regard to the care of the client's clavicle fracture.<br><br>Findings include:<br><br>The facility's reportable incident reports and/or investigations were reviewed on 7/11/12 at 10:40 AM. The facility's 6/29/12 reportable incident report indicated "When staff woke [client A] (individual supported by ResCare), he appeared to have difficulty moving. When staff and the Home Manager began assisting [client A] they observed a bruise on his right shoulder. [Client A] has a history of fractures related to his severe | W0149 | **CORRECTION:** *The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client.* Specifically, the agency will complete its investigation into Client A's injury of unknown origin and results of the investigation into Client A's injury of unknown origin will be reported to the administrator, Indiana Adult Protective Services and the Bureau of Developmental Disability Services as required. With regard to care for Client A's fractured right clavicle, the team has taken the following steps to assure Client A's health and safety. While Client A's fractured right clavicle heals, his sling has been supplemented with a binding to assure it remains immobile. 15 minute checks have been implemented while Client A is awake to prevent him from interrupting the healing process. When Client A sleeps and is not wearing the sling, Client A will receive one to one staffing to assure he does not use his right arm. Additionally, the facility nurse is coordinating Client A's follow-up with an orthopedic specialist as well as obtaining an updated bone density scan. The nurse has provided staff with specific training toward safe lifting | 08/18/2012 |

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| | osteoporosis. Due to his limited range of motion and the bruise, the Home Manager transported him to [name of hospital] Emergency Department for evaluation and treatment. X-rays revealed a fractured right clavicle. Staff have been trained on [client A's] aftercare instructions and he is resting comfortably at home. The team has initiated an investigation to determine the origin of the injury."<br><br>The facility's attached witness statements indicated the following (not all inclusive):<br>-undated witness statement by staff #2 indicated staff #2 came in on the midnight shift on 6/27/12. The undated witness statement indicated the clients were woken up between 5 AM and 5:30 AM on 6/27/12. The undated witness statement indicated "...[Client A] was moving slowly, but he dressed himself and performed his morning hygiene with no problem...." The undated witness statement indicated on 6/28/12, "...[Client A] moved slowly, but he was able to transfer himself from the bed to the wheelchair with no problem and get dressed...After breakfast [client A] complained and we asked him what was wrong, but it was hard to understand him. I notified [staff #1] and she stated she was going to schedule him a doctor's appointment." Staff #2's undated witness | | and transferring of Client A and has developed specific protocols for assisting Client A with self-care activities while his fracture heals. **PREVENTION:** The Quality Assurance Manager will oversee and coordinate completion of investigations into the origin of all significant injuries. When the facility reports injuries of unknown origin, the team will focus on determining whether the injury occurred as a result of abuse, neglect or mistreatment. The Quality Assurance Manager has established a tracking system to assure all investigations occur for all injuries of unknown origin and that they are completed within established timelines –thus facilitating the timely reporting to the agency administrator and government entities as required. The status of all current investigation will be posted in a confidential manner to provide for follow-up with facility supervisory staff as needed. The Quality Assurance Team will audit completed investigations to all components of a thorough investigation have been completed and reported as required. With regard to the care of Client A's fractured right clavicle, the facility nurse will be retrained regarding the need to include specific care procedures as appropriate when developing comprehensive high risk and care plans. The Healthcare Services Manager will review all revisions | |

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| | statement indicated on 6/29/12, "...Between 5:30-6 a.m. I woke all clients to get dressed. After showering [client D], I noticed [client A] was still in bed and he hadn't moved. [Client A] was wet so I assisted him with removing his wet clothes, cleaned him, and assisted him with his shoes. Five minutes later I came back and noticed [client A] was in the same spot. I called [staff #1] and she came to assist me. We worked together and dressed [client A] while removing his shirt we noticed a bruise on his right shoulder. While dressing [client A] I could tell he was in pain, because he was screaming while we dressed him. [Staff #1] and I transferred [client A] to his wheel chair and gave him his meds and he ate. After eating, [staff #1] took him to the ER (emergency room)."<br><br>Staff #4's 6/29/12 witness statement indicated staff #4 worked the 4 to 12 AM shift on 6/26/12. Staff #4's witness statement indicated on 6/26/12, client A was "slow" to transfer from his wheelchair to the shower chair and from his wheelchair to the bed. The 6/29/12 witness statement indicated on 6/26/12, client A did not complain of pain and no marks were seen on client A. Staff #4's 6/29/12 witness statement indicated on 6/28/12, "...[Client A] was slow getting into shower chair from shower chair to | | to facility nursing care plans for the next ninety days and thereafter will perform spot checks of facility nursing care plans as needed but no less than quarterly. The facility nurse will assure that all treatments and other nursing care activities entered into the Medication and Treatment Administration Records include specific times for the actions to be performed. Members of the Operations and Quality Assurance Teams will monitor active treatment sessions and review medical documentation as needed but no less than monthly to assure professional and direct support staff implement high risk and nursing care plans as written. Additionally Operations and Quality Assurance Team members will review medical documentation while auditing active treatment sessions and make recommendations to the Health Services Team as appropriate. **Responsible Parties:** QDDPD, Support Associates, Health Services Team, Operations Team, Quality Assurance Team | |

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| | w.c. (wheelchair) (sic). No complain (sic) of pain until transfer w.c. to bed. tylenol (sic) given x (times) 2, no difficulties in sleeping during shift, or using urinal."<br><br>Staff #3's undated witness statement indicated on the morning of 6/28/12, "...I noticed [client A] was pouting and trying to position his self (sic) in his chair. I ask him what was wrong and he said the word 'hurt.' So I thought he (sic) stomach was hurting or something. So I gave him some milk because I thought it was acid reflux or hurt (sic) burn. So I did that and watched him for awhile and he seemed to be ok...."<br><br>Staff #1's 6/29/12 witness statement indicated on 6/28/12 staff #1 received a phone call from staff #2 indicating client A stated that "he hurt." The witness statement indicated staff #1 asked staff #2 where client A said he hurt and staff #2 "...said she could not understand what he was saying. Picked consumers up at [name of day program]. [Client E] helped push [client A] out to the van because he was moving slow (sic)...." The witness statement indicated "...Other staff said that [client A] was moving slowed (sic) and I (staff #1) observed that he was...After med pass staff said [client A] said he hurt. She gave him tylenol and I left at 7:00 pm." Staff #1's 6/29/12 | | | |

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| | witness statement indicated on 6/29/12, "Got a call from staff at 5:30 stating [client A] was not getting out of bed and she needed help. Arrived at the group home and began assisting [client A]. When I took off his shirt (sic) I noticed a bruise on his right shoulder. Staff and I assisted [client A] in getting dressed and I took him to the ER."<br><br>A typed 7/2/12 witness statement from client A's day program indicated client A did not have any incidents at the day program and/or did not have any signs of/complaints of pain. The typed day program statement indicated day program staff indicated client A was independent in transferring himself to sit on the toilet, but staff normally assisted client A to transfer himself.<br><br>The attached witness statements indicated client interviews were also conducted. The attached witness statements indicated 5 witness statements which had no dates on them, who had been interviewed and/or who conducted the interviews. The facility's investigation of the 6/29/12 injury of unknown origin neglected to indicate the facility had considered abuse of the client as no questions were asked/documented in regard to possible abuse as the facility's witness statements only indicated/included documentation of | | | |

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| | what happened on the days facility staff worked. The facility's investigation did not include any additional documentation of an investigation, conclusion, recommendations and/or corrective actions.<br><br>Interview with administrative staff #2 on 7/11/12 at 9:10 AM stated the facility's investigation was "ongoing." Administrative staff #2 stated client A's clavicle fracture was most likely due to client A's "shifting around in a chair" as the client's "bones (were) continuing to deteriorate." Administrative staff #2 indicated client A had Osteoporosis.<br><br>During the 7/11/12 observation period between 6:12 AM to 8:15 AM, at the group home, client A was in his bedroom getting ready for the day at 6:12 AM. At 6:25 AM, staff #3 asked staff #2 if she needed help with client A to get the client dressed. Staff #2 stated "[Client A] is in room getting dressed putting his own clothes on." Staff #2 went into the kitchen area and staff #3 returned to client C's bedroom. At 6:28 AM, client A could be seen through a partially opened door sitting on the side of his bed. Client A had a shirt that went on over his head on, and his pants were at his hip line trying to pull up his pants with both hands. Staff #2 entered client A's room and asked the | | | |

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| | client if he needed help and closed the door. Staff #2 then came out of the bedroom and returned to the kitchen. Client A transferred himself from the side of the bed to his wheelchair without staff assistance. Client A did not have a sling on and was using his right arm. Client A had a gait belt around his waist, but the gait belt was not used to assist the client to transfer. Client A wheeled himself using each hand/arm to turn the wheelchair wheels. Client A had his right arm extended out and up as he turned the wheel with his right hand (using full range of motion) as the right shoulder would raise and lower when turning the wheel. Facility staff did not assist client A, who had a clavicle fracture, to wheel himself into the living room area. Facility staff did not prompt and/or encourage client A not to use his right arm. Client A did not have a sling on when he came out of his bedroom. At 6:39 AM, after the client served himself independently, staff #2 stated "I'm going to cut up [client A's] food because his arm is messed up." Client A ate with his right hand/arm. The client ate with his right arm extended out and up to the client's shoulder level as he made wide scoops from his plate to his mouth. Client A elevated his right arm/elbow to shoulder level each time he took a bite of food (full range of motion). At 6:50 AM, staff #2 retrieved an arm | | | |

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| | sling and placed it on client A who had just finished his breakfast. At 6:53 AM, client A raised his right arm, which was in the sling, and placed the arm on the table. Staff reminded the client to keep his arm down. Client A moved his arm down, but the sling was now displaced. The bottom of the sling was at client A's elbow with the top part of the sling going up client A's arm to the shoulder area. The client's arm was not in the sling. Client A sat with his arm not properly placed in the sling as staff handed the client a 3 D puzzle to work on. At 7:14 AM, staff #3 prompted client A to keep his arm down and placed the client's right arm back into the sling. At 7:19 AM, client A again raised/lifted the right arm and out causing the sling to move and not be placed correctly. Client A had his right arm elevated and on the table. Staff #3 verbally prompted client A to put his arm down and placed the arm back into the sling. At 7:53 AM, client A had his right arm out of the sling, extended outward at shoulder level. The sling was at the client's elbow and extended up his arm to the shoulder area. Client A sat without staff redirecting the client and/or physically assisting the client to place the sling on his arm correctly until 7:58 AM. At 8:00 AM, staff #1 loaded client A on the van which had a wheelchair lift at the back of the van. Staff #1 then wheeled | | | |

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| | the client into the van and placed the client on the left hand side of the van facing the back of the driver's seat. Staff #1 then applied 4 tie downs to secure the wheelchair and placed a lap belt across client A's waist area.<br><br>During the 7/11/12 observation of the group home van at 4:30 PM, client wheelchairs could be sat/placed on the left side and/or the right side of the van. Lap belts were used with clients on the left side of the van and a shoulder harness was used with clients who sat on the right side of the van. The shoulder strap had a horizontal black plastic piece on the strap which was about 1 1/2 inches to 2 inches in length which laid across the width of the shoulder strap. At 5:05 PM, facility staff brought client A out to the van and loaded the client on the wheelchair to the van. Staff #1 showed the surveyor how client A would be secured if he was seated on the right side of the van. A shoulder strap went across client A's right shoulder area with the black plastic piece which would align itself across client A's right chest area (staff just laid the seat belt across the client). Client A leaned forward and attempted to hold onto the back of the passenger seat with his left hand which could have placed pressure on the client's clavicle area. Interview with staff #1 on 7/11/12 at 5:07 PM indicated | | | |

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| | client A did not sit on the right side of the van as he would hold onto the back of the passenger's seat and cause client C to get upset.<br><br>The hospital records were reviewed on 7/11/12 at 8:45 AM. The 6/29/12 OutPatient Treatment Record indicated client A had an X-ray which showed the client had a right Clavicle Fracture (collar bone). The 6/29/12 outpatient form indicated a sling was placed on the client's right arm and a "Forensic Photo Consult" was requested.<br><br>Client A's 6/29/12 Flow sheet indicated "...large band of bruising over right shoulder running from posterior to anterior in orientation. Also horizontal linear area of bruising on right anterior chest. The flow sheet indicated client A was not able to tell the hospital staff how the fracture occurred and the staff who was with client A, could not explain how the fracture occurred. The flow sheet indicated a forensic consult was requested "...due to bandlike (sic) bruising to right shoulder and pt (patient) with right clavicle fracture of unknown cause...." The flow sheet indicated "...[Staff #1] states when [client A] rides in a vehicle, he is in wheelchair and seatbelt is across lap, never across shoulders...." The 6/29/12 Forensic Photography Log | | | |

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| | indicated client A had a "6 cm (centimeter) band-like area/11 cm total bruising length" on the right anterior shoulder. The form indicated the "medical aspect" of the bruise on the right shoulder measured 16 cm in length. The form indicated the right anterior linear chest bruise was 6.5 cm in length. Client A's 6/29/12 hospital records indicated the client had 3 bruises, one on the back of the client's clavicle/shoulder area which ran to the anterior/client's chest area and then the horizontal linear bruise on the client's shoulder/chest area. A 6/29/12 Forensic Documentation Form indicated "6-29-12 1900 Review of forensic photo taken of this pt. note that dark bruising overlaying red markings on right shoulder appear as a patterned injury that could be consistent with a shoe impression."<br><br>Client A's record was reviewed on 7/11/12 at 11:55 AM. Client A's 6/29/12 After Care Instructions indicated client A had a Clavicle Fracture. The form indicated "...It is extremely rare for a clavicle fracture to need to be 'reset' or have surgery, even if the edges of the bone seem very out of place...3. The general care of a fracture includes the use of a medication to reduce pain, the use of a splint/cast to reduce movement, and resting and using ice.<br>-REST: Limit use of the injured body | | | |

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| | part.<br>-ICE: By applying ice to the affected area, swelling and pain can be reduced. Place some ice cubes in a re-sealable (Ziploc) bag and add some water. Put a thin washcloth between the bag and your skin. Apply the ice bag to the area for at least 20 minutes. Do this at least 4 times per day. Using the ice for longer times and more frequently is OK. NEVER APPLY ICE DIRECTLY TO THE SKIN...5. You have been given a sling to use. Wear the sling with all activities except bathing and sleeping. Use the sling until your follow-up appointment.<br>6. YOU SHOULD SEEK MEDICAL ATTENTION IMMEDIATELY, EITHER HERE OR AT THE NEAREST EMERGENCY DEPARTMENT, IF ANY OF THE FOLLOWING OCCURS:<br>-You experience a severe increase in pain or swelling in the affected area.<br>-You develop new numbness and tingling in your arm or hand.<br>-You develop a cold, pale hand which might mean that there is a problem with its blood supply."<br><br>Client A's 7/10/12 Record of Visit (ROV) indicated client A saw his doctor for follow-up of the fracture. The ROV indicated "Mild Abnormal appearance of Clavicle/Deformity (R) (right) Clavicle." The ROV recommended "Keep sling on. | | | |

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| | Refer to Orthopedics."<br><br>Client A's 6/12 nurse notes from 6/29/12 to the present indicated the following:<br><br>-6/29/12 Client A had a "lg (large) bruise on rt (right) shoulder & (and) collar bone (with) swelling, (decreased) ROM (range of motion) & indication of pain. X-ray reveals clavicle fracture...." The nurse note indicated client A had a blue purple bruise on his shoulder. The 6/29/12 nurse note indicated "...[Client A] cont (continues) to move arm even when encouraged to keep immobile...Will continue to monitor...."<br><br>-6/30/12 "F/U (follow-up) to fall assessment. [Client A] in bed. Awake & alert. RUE (right upper extremity) (up) on pillow." Client A's record neglected to indicate any additional documentation/monitoring by a nurse.<br><br>Client A's 7/12 Medication Administration Record (MAR)/book indicated the client had an undated Use and Application of Arm Sling Protocol in place. The undated protocol indicated "...The sling must apply gentle upward support...Apply the sling in a manner as to prevent movement of the injured site or extremity...Other Considerations: When an individual has an injury to an upper | | | |

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| | extremity, having clothing that snaps or buttons up the front or back rather than slipping over the head is recommended. This provides the least amount of movement of the injured site when getting dressed. When assisting the individual with dressing, put the sleeve of the injured extremity on first. Likewise, when getting undressed, the sleeve of the injured extremity should be removed last. Remember: Notify the nurse immediately if there are noticeable changes in color, temperature, movement of the fingers, or if the individual complains of increased pain or numbness of the injured extremity." Client A's 7/12 MAR Book indicated the client had an undated nursing protocol in place for the use of a gait belt. The undated protocol indicated the gait belt was to be used with transfers or walking when needed. Client A's 7/12 MAR indicated the following:<br>-"Use GAIT Belt For All Transfers"<br>-"Notify Nurse For Changes in Color, temperature, movement of fingers or increased pain or numbness of injured extremity"<br>-"Norco 5 mg (milligrams)/325 mg (i.e. Hydrocodone/APAP Take 1 tablet by mouth every 4-6 hours as needed for pain" The MAR indicated the pain medication was discontinued after 7/6/12.<br>-"Apply ice for 20 minutes on, then 20 minutes off. Do not apply ice directly to | | | |

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| | skin. Apply at least 4 times daily."<br>-"Right arm sling on at all times except for bathing & sleeping." Client A's 7/12 MAR indicated the above mentioned treatments/protocols documented "FYI" (For Your Information) for the hour of application and/or check. Client A's 7/12 MAR indicated the facility neglected to document the checks/monitoring of client A for changes, when right arm sling was applied and/or when ice was applied 4 times a day as no staff initialed/documented the treatment had been completed since the client returned to the group home on 6/29/12. Client A's 7/12 MAR did not indicate any listed times for the application of the ice to be done 4 times a day.<br><br>Client A's Injury Follow-Up Flow Chart indicated at the top of the form: "Procedure: Initiate with all injuries. To be completed EACH SHIFT for the first 24 hours then daily until healed. If no apparent injury noted at the time of fall or physical insult this form must still be initiated for at least 24 hours including documentation from each shift. If at the end of 24 hours there are still no apparent injuries then the follow-up is completed. If injuries are noted then continue to follow-up daily until healed...." Client A's Injury Follow-Up Flow Chart indicated the following: | | | |

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| | -7/6/12 "Still healing."<br><br>-7/7/12 "Slightly less bruising on right side. Still healing."<br><br>-7/7/12 "Light bruising on right side. Still healing."<br><br>Client A's record indicated the facility neglected to document any additional information and/or monitoring of client A's bruising/clavicle fracture.<br><br>Client A's Progress Notes indicated the following:<br><br>-6/27/12 at 7 AM, "[Client A] moved very slow (sic) while getting dressed and transferring himself to wheelchair."<br><br>-6/28/12 at 4 PM, "[Client A] transferred very slow (sic) today. It took him longer than normal to shower, get dressed, eat, and transfer from w/c (wheelchair)."<br><br>-6/28/12 "[Client A] complained of Pain Tylenol x 2 given. Moved slowly from transfer wheelchair to bed (sic)."<br><br>Client A's 6/1/12 Physician's Orders indicated client A received Fosamax 70 mg 30 minutes before food or drink with a full glass of water every week | | | |

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| NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES-ADEPT | | STREET ADDRESS, CITY, STATE, ZIP CODE 8211 CHRISTIANA LN INDIANAPOLIS, IN 46256 | |

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| | (Wednesday) and remain upright for 30 minutes for Osteoporosis. The 6/1/12 physician's order indicated client A received Calcium Antacid Chew 500 mg twice a day for calcium supplement. Client A's physician's orders indicated client A's diagnoses included, but were not limited to, Right Femoral Fracture and left lower leg fractures in 2/98 and Osteoporosis.<br><br>Client A's 12/20/11 Healthcare Supports Addendum indicated "...When staff is able to establish that [client A] is experiencing a medical problem, they should attempt to determine the nature of his distress; it may become necessary to perform a complete body check to assist with finding out what is wrong...Per doctor's orders, he is to use his wheel chair (sic) for mobility, and be non-weight bearing with lower extremities. [Client A] is independently able to do many things on his own; such as transfer in and out of his wheelchair to a regular chair...."<br><br>Client A's 2/20/12 Comprehensive High Risk Health Plan indicated the client had a risk plan for decreased mobility and history of fractures. The risk plans indicated facility staff were to notify the nurse for the following triggers (not all inclusive): | | | |

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| | "-Bruising...<br>-Pain...<br>-Guarding/Protecting a particular body part<br>-Hesitation to use arm or hand/walk on leg or foot." The facility neglected to notify nursing staff of client A's decreased mobility and/or complaints of pain on 6/26, 6/27 and/or 6/28/12.<br><br>The 10/10/11 Individual Support Plan (ISP) and/or record indicated the facility neglected to ensure safeguards were put in place to assist client A to keep his arm immobilized due to his clavicle fracture. The facility neglected to ensure the facility developed specific protocols for bathing, transfers and etc. to assist staff in the care of client A's fracture, and/or neglected to ensure facility staff followed physician's orders in regard to the care/treatment of the client's clavicle fracture.<br><br>Interview with staff #2 on 7/11/12 at 7:35 AM indicated client A had complained of pain on 6/28/12 and the client was given Tylenol. Staff #2 indicated client A would not move on 6/29/12 and she had to call for help to assist with client A. Staff #2 indicated client A's shoulder was not bruised on 6/28/12, but it was bruised on 6/29/12. Staff #2 indicated it would | | | |

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| | take more than 1 staff person to assist client A to get up off the floor if he fell. The staff indicated the client A had not fallen since she started working at the group home a year ago. Staff #2 indicated client A was independent in dressing, toileting and transferring. When asked when client A was to wear the sling, staff #2 stated "I give it him after he eats so it does not get dirty. He does not have to sleep in it." Staff #2 indicated client A's arm/shoulder was getting better as the client was using his arm more. Staff #2 stated "We (staff) are doing everything for him." Staff #2 indicated client A would sleep on his right side, the side with the fractured clavicle. When asked what protocols or measures were in place for the client's fractured clavicle, staff #2 stated "We put ice on it and keep him from laying on it." Staff #2 indicated facility staff did not have to document when ice was applied to the client's arm/shoulder. Staff #2 indicated ice was applied to client A's arm on the evening shift. Staff #2 indicated there was a plan/protocol for the client's gait belt and sling in the MAR book. Staff #2 indicated she had not witnessed and/or knew of any staff abuse in the group home. Staff #2 indicated client E would sometime hit client A, but it would not injure the client. | | | |

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| | Interview with staff #3 on 7/11/12 at 8:00 AM indicated she did not know how client A injured his shoulder. Staff #3 indicated client A had not fallen. Staff #3 stated client A would hold his arm in an "awkward angle" when eating. Staff #3 indicated client A would hold his arm up and out prior to the fracture. When asked if client A should be eating in that position with a fractured clavicle, staff #3 indicated the client was able to feed himself. When asked when the client was to wear the sling, staff #3 stated "All during the day only. He does not wear it in bed sleeping." When asked what nursing measures and/or protocols were put in place, staff #3 stated "Make sure arm is down in sling. No pressure on it and don't lay on it." Staff #3 indicated client A was no longer receiving any medication for pain. When asked when ice should be applied, staff #3 stated, "If swelling or hurting and bruise is not going away. You put it on." Staff #3 indicated she last put ice on client A's shoulder area on Monday (7/9/12). Staff #3 stated "Ice did not need to be applied that often." Staff #3 indicated staff were to monitor the client for pain. Staff #3 indicated she was not aware of any abuse with client A or any other client. Staff #3 indicated the group home did not have aggressive clients. | | | |

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| | Interview with staff #1 on 7/11/12 at 9:35 AM indicated facility staff called her on 6/28/12 and told her client A was complaining of pain, but that staff thought it was the client's stomach, and the client was sent onto the day program. Staff #1 indicated client A had been moving slower than he normally did. Staff #1 indicated client A sat on the toilet so long, she asked him if he hurt on 6/28/12. Staff #1 indicated client A did not say anything when she asked him. Staff #1 indicated client A did get Tylenol later in the evening. Staff #1 indicated client A did not have any bruising on 6/28/12 as she saw the client unclothed in the bathroom. Staff #1 indicated she took client A to the hospital on 6/29/12 as client A was not able to get up, and had bruising on his shoulder. Staff #1 indicated the hospital took pictures of client A's injury. Staff #1 stated "A lady asked me questions." Staff #1 stated the woman who questioned her "Specialized in injuries of unknown origin and injuries which were suspicious of abuse." When asked why pictures were taken, staff #1 stated "Because of fracture being unknown and functionally nonverbal. Pictures taken. In a vulnerable population." Staff #1 indicated she was still in the process of conducting an investigation in regard to client A's fracture as she did not know how client A fractured his clavicle. Staff | | | |

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| | #1 indicated she had staff who worked well with the clients. Staff #1 stated "I really have good staff at Christiana." Staff #1 indicated the hospital did not give her any indication they were concerned about client A's injury. Staff #1 indicated client A had Osteoporosis and client A was to see the orthopedic doctor on 7/17/12 at 9:00 AM. Staff #1 indicated client A was scheduled to have a bone density study done as well. When asked when client A should wear the sling, staff #1 stated client A should wear the sling "at all times except when bathing and sleeping at night." Staff #1 indicated client A should not dress himself. Staff #1 stated client A should "limit the use of arm. Don't make him do too much." Staff #1 indicated client A could feed himself and the client was to get baths sitting on the side of the bed. Staff #1 indicated facility staff were to assist the client in transfers so the client would not use and/or put weight on his arm. Staff #1 indicated client A should not be wheeling his wheelchair and staff should be redirecting the client to not use his arm and keep the sling on. When asked when ice was applied to client A's arm, staff #1 indicated the ice should be applied 4 times a day. Staff #1 indicated she would start applying the ice when she came into work and continue throughout the day. Staff #1 indicated the facility | | | |

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| | was not documenting when and/or if the ice was being applied. Staff #1 stated client E would hit client A as he "Can't get out of the way." Staff #1 indicated client A did not fall as staff would have to report the fall and call for assistance to help get client A up.<br><br>Interview with staff #4 on 7/11/12 at 10:15 AM (by phone) and at 4:22 and 4:28 PM indicated client had been moving slowly. Staff #4 indicated client A was slow in transferring from his wheelchair to the bed. Staff #4 stated client A was "cautious." Staff #4 indicated client A did not fall at the group home. Staff #4 indicated she gave client A Tylenol for pain. Staff #4 indicated when she would ask client A if he was ok, client A stated he was "all right." Staff #4 indicated she had worked at the group home for 11 years and she had not witnessed staff abuse any client. Staff #4 indicated client E would hit client A, but she did not kick others. Staff #4 indicated client A was not to be transported on the right side of the van just the left side of the van. Staff #4 indicated she was not aware of any staff transporting the client on the right side of the van. Staff #4 indicated client A would hold onto the back side of the passenger seat and client C would have behaviors as client A was holding onto the back side of the seat. | | | |

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| | When asked if client A had been transported in staffs' cars, staff #4 stated "No." When asked how often ice was applied to client A's arm/shoulder, staff #4 stated "Twice a day."<br><br>Interview with staff #7 on 7/11/12 at 10:34 AM, by phone, indicated they did not know how client A injured his shoulder. Staff #7 indicated they were not aware of any client to client aggression incidents. Staff #7 indicated they were not aware of any staff to client abuse at the group home. Staff #7 indicated client E would hit and scratch client A. Staff #7 indicated client A was to wear his gait belt during the day for staff to help with transfers if needed. Staff #7 indicated client A required 2 staff to assist with transfers. Staff #7 indicated client A could independently transfer himself from his wheelchair to the bed and would dress himself independently. Staff #7 indicated since client A fractured his shoulder, staff were to wash the client up on the side of the bed and dress the client.<br><br>Interview with staff #6 on 7/11/12 at 11:05 AM, by phone, indicated he did not know how client A fractured his clavicle. Staff #6 indicated he would assist client A to transfer even though the client could transfer himself to prevent falls. Staff #6 stated client A had "brittle bones." Staff | | | |

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| | #6 indicated he was not aware of any recent falls. When asked if staff abused clients and/or was aware of any abuse, staff #6 stated "Never. I would not allow it." When asked how often staff applied ice to client A's arm/shoulder, staff #6 indicated ice would be applied every 15 to 30 minutes. When asked what protocols/nursing measures were put in place, staff #7 indicated facility staff were to give the client medication for pain.<br><br>Interview with staff #5 on 7/11/12 at 11:20 AM, by phone, indicated she did not know how client A fractured his shoulder. Staff #5 indicated she was not aware of any falls with client A. Staff #5 indicated she was not aware of any abuse with clients in the group home. Staff #5 indicated facility staff had been trained in regard to client A's care of the clavicle fracture. Staff #5 indicated client A would not keep his arm down and would still try to use his arm. Staff #5 stated she would "prop up" client A's arm on a pillow when the client was in the wheelchair. Staff #5 indicated client E would hit client A. Staff #5 stated client E hits were more like "taps."<br><br>Interview with Program Coordinator (PC) #1 on 7/11/12 at 1:30 PM indicated staff #1 called her from the hospital and told her the hospital was asking her how client | | | |

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| | A injured himself as the client had a fractured collarbone. PC #1 indicated staff #1 told her they asked if client A had been in a car accident and/or fell. PC #1 indicated she was told the hospital took pictures of the client's injuries and were going to call Adult Protective Services. PC #1 indicated staff #1 and PC #1 were still conducting an investigation in regard to the client's fracture. When asked if PC #1 had considered the injury of unknown origin as possible abuse, PC #1 stated "We don't know how it happened if abusive nature or accident. He has bone issues. Trying to see if it occurred through a transfer or movement." PC #1 indicated she had not been asking questions in regard to possible abuse with the investigation as facility staff had only written statements. PC #1 indicated she was not aware of any instance where client A would have been riding in staff's car. PC #1 stated "if it happened we did not approve it." PC #1 indicated it would be hard for staff to get the client in and out of the car. PC #1 indicated the nurse for the group home was on vacation. PC #1 indicated she could not locate any documentation of the facility's nurse's monitoring and/or assessing client A in July 2012 as the July's nurse form was blank.<br><br>Interview with administrati | | | |

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| W0154 | 483.420(d)(3)<br>STAFF TREATMENT OF CLIENTS<br>The facility must have evidence that all alleged violations are thoroughly investigated.<br>Based on observation, interview and record review for 1 of 2 allegations of abuse, neglect and/or injuries of unknown origin reviewed, the facility failed to conduct a thorough investigation in regard to an injury of unknown origin for client A.<br><br>Findings include:<br><br>The facility's reportable incident reports and/or investigations were reviewed on 7/11/12 at 10:40 AM. The facility's 6/29/12 reportable incident report indicated "When staff woke [client A] (individual supported by ResCare), he appeared to have difficulty moving. When staff and the Home Manager began assisting [client A] they observed a bruise on his right shoulder. [Client A] has a history of fractures related to his severe osteoporosis. Due to his limited range of motion and the bruise, the Home Manager transported him to [name of hospital] Emergency Department for evaluation and treatment. X-rays revealed a fractured right clavicle...The team has initiated an investigation to determine the origin of the injury." | W0154 | **CORRECTION:** *The facility must have evidence that all alleged violations are thoroughly investigated.* Specifically, the agency will complete its investigation into Client A's injury of unknown origin.<br>**PREVENTION:** The Quality Assurance Manager will oversee and coordinate completion of investigations into the origin of all significant injuries. When the facility reports injuries of unknown origin, the team will focus on determining whether the injury occurred as a result of abuse, neglect or mistreatment. The Quality Assurance Manager has established a tracking system to assure all investigations occur for all injuries of unknown origin. The status of all current investigation will be posted in a confidential manner to provide for follow-up with facility supervisory staff as needed. The Quality Assurance Team will audit completed investigations to all components of a thorough investigation have been completed. **Responsible Parties:** QDDPD, Support Associates, Health Services Team, Operations Team, Quality Assurance Team | 08/18/2012 |

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| | The facility's attached witness statements indicated the following (not all inclusive):<br>-undated witness statement by staff #2 indicated staff #2 came in on the midnight shift on 6/27/12. The undated witness statement indicated the clients were woken up between 5 AM and 5:30 AM on 6/27/12. The undated witness statement indicated "...[Client A] was moving slowly, but he dressed himself and performed his morning hygiene with no problem...." The undated witness statement indicated on 6/28/12, "...[Client A] moved slowly, but he was able to transfer himself from the bed to the wheelchair with no problem and get dressed...After breakfast [client A] complained and we asked him what was wrong, but it was hard to understand him. I notified [staff #1] and she stated she was going to schedule him a doctor's appointment." Staff #2's undated witness statement indicated on 6/29/12, "...Between 5:30-6 a.m. I woke all clients to get dressed. After showering [client D], I noticed [client A] was still in bed and he hadn't moved. [Client A] was wet so I assisted him with removing his wet clothes, cleaned him, and assisted him with his shoes. Five minutes later I came back and noticed [client A] was in the same spot. I called [staff #1] and she came to assist me. We worked together and dressed [client A] while removing his | | | |

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| | shirt we noticed a bruise on his right shoulder. While dressing [client A] I could tell he was in pain, because he was screaming while we dressed him. [Staff #1] and I transferred [client A] to his wheel chair and gave him his meds and he ate. After eating, [staff #1] took him to the ER (emergency room)."<br><br>Staff #4's 6/29/12 witness statement indicated staff #4 worked the 4 to 12 AM shift on 6/26/12. Staff #4's witness statement indicated on 6/26/12, client A was "slow" to transfer from his wheelchair to the shower chair and from his wheelchair to the bed. The 6/29/12 witness statement indicated on 6/26/12, client A did not complain of pain and no marks were seen on client A. Staff #4's 6/29/12 witness statement indicated on 6/28/12, "...[Client A] was slow getting into shower chair from shower chair to w.c. (wheelchair) (sic). No complain (sic) of pain until transfer w.c. to bed. tylenol (sic) given x (times) 2, no difficulties in sleeping during shift, or using urinal."<br><br>Staff #3's undated witness statement indicated on the morning of 6/28/12, "...I noticed [client A] was pouting and trying to position his self (sic) in his chair. I ask him what was wrong and he said the word 'hurt.' So I thought he (sic) stomach was hurting or something. So I gave him | | | |

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| | some milk because I thought it was acid reflux or hurt (sic) burn. So I did that and watched him for awhile and he seemed to be ok...."<br><br>Staff #1's 6/29/12 witness statement indicated on 6/28/12 staff #1 received a phone call from staff #2 indicating client A stated that "he hurt." The witness statement indicated staff #1 asked staff #2 where client A said he hurt and staff #2 "...said she could not understand what he was saying. Picked consumers up at [name of day program]. [Client E] helped push [client A] out to the van because he was moving slow (sic)...." The witness statement indicated "...Other staff said that [client A] was moving slowed (sic) and I (staff #1) observed that he was...After med pass staff said [client A] said he hurt. She gave him tylenol and I left at 7:00 pm." Staff #1's 6/29/12 witness statement indicated on 6/29/12, "Got a call from staff at 5:30 stating [client A] was not getting out of bed and she needed help. Arrived at the group home and began assisting [client A]. When I took off his shirt (sic) I noticed a bruise on his right shoulder. Staff and I assisted [client A] in getting dressed and I took him to the ER."<br><br>A typed 7/2/12 witness statement from client A's day program indicated client A | | | |

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| | did not have any incidents at the day program and/or did not have any signs of/complaints of pain. The typed day program statement indicated day program staff indicated client A was independent in transferring himself to sit on the toilet, but staff normally assisted client A to transfer himself.<br><br>The attached witness statements indicated client interviews were also conducted. The attached witness statements indicated 5 witness statements which had no dates on them, who had been interviewed and/or who conducted the interviews. The facility's investigation of the 6/29/12 injury of unknown origin did not indicate the facility had considered abuse as no questions were asked/documented in regard to possible abuse as the facility's witness statements only indicated/included documentation of what happened on the days facility staff worked. The facility's investigation did not include any additional documentation of an investigation, conclusion, recommendations and/or corrective actions to prevent recurrence.<br><br>Interview with administrative staff #2 on 7/11/12 at 9:10 AM stated the facility's investigation was "ongoing." Administrative staff #2 stated client A's clavicle fracture was most likely due to | | | |

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| | client A's "shifting around in a chair" as the client's "bones (were) continuing to deteriorate." Administrative staff #2 indicated client A had Osteoporosis.<br><br>During the 7/11/12 observation period between 6:12 AM to 8:15 AM, at the group home, At 8:00 AM, staff #1 loaded client A on the van which had a wheelchair lift at the back of the van. Staff #1 then wheeled the client into the van and placed the client on the left hand side of the van facing the back of the driver's seat. Staff #1 then applied 4 tie downs to secure the wheelchair and placed a lap belt across client A's waist area.<br><br>During the 7/11/12 observation of the group home van at 4:30 PM, client wheelchairs could be sat/placed on the left side and/or the right side of the van. Lap belts were used with clients on the left side of the van and a shoulder harness was used with clients who sat on the right side of the van. The shoulder strap had a horizontal black plastic piece on the strap which was about 1 1/2 inches to 2 inches in length which laid across the width of the shoulder strap. At 5:05 PM, facility staff brought client A out to the van and loaded the client on the wheelchair to the van. Staff #1 showed the surveyor how client A would be secured if he was | | | |

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| | seated on the right side of the van. A shoulder strap went across client A's right shoulder area with the black plastic piece which would align itself across client A's right chest area (staff just laid the seat belt across the client). Client A leaned forward and attempted to hold onto the back of the passenger seat with his left hand which could have placed pressure on the client's clavicle area. Interview with staff #1 on 7/11/12 at 5:07 PM indicated client A did not sit on the right side of the van as he would hold onto the back of the passenger's seat and cause client C to get upset.<br><br>The hospital records were reviewed on 7/11/12 at 8:45 AM. The 6/29/12 OutPatient Treatment Record indicated client A had an X-ray which showed the client had a right Clavicle Fracture (collar bone). The 6/29/12 outpatient form indicated a sling was placed on the client's right arm and a "Forensic Photo Consult" was requested.<br><br>Client A's 6/29/12 Flow sheet indicated "...large band of bruising over right shoulder running from posterior to anterior in orientation. Also horizontal linear area of bruising on right anterior chest. The flow sheet indicated client A was not able to tell the hospital staff how the fracture occurred and the staff who | | | |

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| | was with client A, could not explain how the fracture occurred. The flow sheet indicated a forensic consult was requested "...due to bandlike (sic) bruising to right shoulder and pt (patient) with right clavicle fracture of unknown cause...." The flow sheet indicated "...[Staff #1] states when [client A] rides in a vehicle, he is in wheelchair and seatbelt is across lap, never across shoulders...." The 6/29/12 Forensic Photography Log indicated client A had a "6 cm (centimeter) band-like area/11 cm total bruising length" on the right anterior shoulder. The form indicated the "medical aspect" of the bruise on the right shoulder measured 16 cm in length. The form indicated the right anterior linear chest bruise was 6.5 cm in length. Client A's 6/29/12 hospital records indicated the client had 3 bruises, one on the back of the client's clavicle/shoulder area which ran to the anterior/client's chest area and then the horizontal linear bruise on the client's shoulder/chest area. A 6/29/12 Forensic Documentation Form indicated "6-29-12 1900 Review of forensic photo taken of this pt. note that dark bruising overlaying red markings on right shoulder appear as a patterned injury that could be consistent with a shoe impression."<br><br>Interview with staff #2 on 7/11/12 at 7:35 AM indicated client A had complained of | | | |

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| | pain on 6/28/12 and the client was given Tylenol. Staff #2 indicated client A would not move on 6/29/12 and she had to call for help to assist with client A. Staff #2 indicated client A's shoulder was not bruised on 6/28/12, but it was bruised on 6/29/12. Staff #2 indicated it would take more than 1 staff person to assist client A to get up off the floor if he fell. The staff indicated the client A had not fallen since she started working at the group home a year ago. Staff #2 indicated client A was independent in dressing, toileting and transferring. Staff #2 indicated she had not witnessed and/or knew of any staff abuse in the group home. Staff #2 indicated client E would sometime hit client A, but it would not injure the client.<br><br>Interview with staff #3 on 7/11/12 at 8:00 AM indicated she did not know how client A injured his shoulder. Staff #3 indicated client A had not fallen. Staff #3 indicated she was not aware of any abuse with client A or any other client. Staff #3 indicated the group home did not have aggressive clients.<br><br>Interview with staff #1 on 7/11/12 at 9:35 AM indicated facility staff called her on 6/28/12 and told her client A was complaining of pain, but that staff thought it was the client's stomach, and the client | | | |

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| | was sent onto the day program. Staff #1 indicated client A had been moving slower than he normally did. Staff #1 indicated client A sat on the toilet so long, she asked him if he hurt on 6/28/12. Staff #1 indicated client A did not say anything when she asked him. Staff #1 indicated client A did get Tylenol later in the evening. Staff #1 indicated client A did not have any bruising on 6/28/12 as she saw the client unclothed in the bathroom. Staff #1 indicated she took client A to the hospital on 6/29/12 as client A was not able to get up, and had bruising on his shoulder. Staff #1 indicated the hospital took pictures of client A's injury. Staff #1 stated "A lady asked me questions." Staff #1 stated the woman who questioned her "Specialized in injuries of unknown origin and injuries which were suspicious of abuse." When asked why pictures were taken, staff #1 stated "Because of fracture being unknown and functionally nonverbal. Pictures taken. In a vulnerable population." Staff #1 indicated she was still in the process of conducting an investigation in regard to client A's fracture as she did not know how client A fractured his clavicle. Staff #1 indicated she had staff who worked well with the clients. Staff #1 stated "I really have good staff at Christiana." Staff #1 indicated the hospital did not give her any indication they were | | | |

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| | concerned about client A's injury.<br><br>Interview with staff #4 on 7/11/12 at 10:15 AM (by phone) and at 4:22 and 4:28 PM indicated client had been moving slow (sic). Staff #4 indicated client A was slow in transferring from his wheelchair to the bed. Staff #4 stated client A was "cautious." Staff #4 indicated client A did not fall at the group home. Staff #4 indicated she gave client A Tylenol for pain. Staff #4 indicated when she would ask client A if he was ok, client A stated he was "all right." Staff #4 indicated she had worked at the group home for 11 years and she had not witnessed staff abuse any client. Staff #4 indicated client E would hit client A, but she did not kick others. Staff #4 indicated client A was not to be transported on the right side of the van just the left side of the van. Staff #4 indicated she was not aware of any staff transporting the client on the right side of the van. Staff #4 indicated client A would hold onto the back side of the passenger seat and client C would have behaviors as client A was holding onto the back side of the seat. When asked if client A had been transported in staffs' cars, staff #4 stated "No."<br><br>Interview with staff #7 on 7/11/12 at 10:34 AM, by phone, indicated they did | | | |

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| | not know how client A injured his shoulder. Staff #7 indicated they were not aware of any client to client aggression incidents. Staff #7 indicated they were not aware of any staff to client abuse at the group home. Staff #7 indicated client E would hit and scratch client A.<br><br>Interview with staff #6 on 7/11/12 at 11:05 AM, by phone, indicated he did not know how client A fractured his clavicle. Staff #6 indicated he would assist client A to transfer even though the client could transfer himself to prevent falls. Staff #6 stated client A had "brittle bones." Staff #6 indicated he was not aware of any recent falls. When asked if staff abused clients and/or was aware of any abuse, staff #6 stated "Never. I would not allow it."<br><br>Interview with staff #5 on 7/11/12 at 11:20 AM, by phone, indicated she did not know how client A fractured his shoulder. Staff #5 indicated she was not aware of any falls with client A. Staff #5 indicated she was not aware of any abuse with clients in the group home. Staff #5 indicated client E would hit client A. Staff #5 stated client E hits were more like "taps."<br><br>Interview with Program Coordinator (PC) #1 on 7/11/12 at 1:30 PM indicated staff | | | |

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| | #1 called her from the hospital and told her the hospital was asking her how client A injured himself as the client had a fractured collarbone. PC #1 indicated staff #1 told her they asked if client A had been in a car accident and/or fell. PC #1 indicated she was told the hospital took pictures of the client's injuries and were going to call Adult Protective Services. PC #1 indicated staff #1 and PC #1 were still conducting an investigation in regard to the client's fracture. When asked if PC #1 had considered the injury of unknown origin as possible abuse, PC #1 stated "We don't know how it happened if abusive nature or accident. He has bone issues. Trying to see if it occurred through a transfer or movement." PC #1 indicated she had not been asking questions in regard to possible abuse with the investigation as facility staff had only written statements. PC #1 indicated she was not aware of any instance where client A would have been riding in staff's car. PC #1 stated "if it happened we did not approve it."<br><br>Interview with administrative staff #1 and #2 on 7/11/12 at 2:00 PM indicated they knew the hospital had taken pictures of the client's injuries. Administrative staff #2 indicated the facility did not take pictures of the client's injuries prior to going to the hospital and/or after he | | | |

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| | returned. Administrative staff #2 indicated they should have taken pictures of the client's injuries. Administrative staff #1 and #2 indicated they had directed staff #1 to get more information on the witness statements. Administrative staff #1 and #2 indicated client A had Osteoporosis and a history of fractures. Administrative staff #1 and #2 indicated they did not have a problem of abuse with client A's group home. Administrative staff #1 and #2 indicated they were not aware abuse was being considered as a possible reason for client A's injury.<br><br>Interview with RN #2 on 7/11/12 at 2:35 PM indicated client A had a history of fractures and had Osteoporosis. When asked if was typical for a hospital to take pictures of an injury, RN #1 stated "No, unless they think something is suspicious."<br><br>Interview with workshop staff #1 on 7/12/12 at 12:26 PM indicated client A did not show any changes in behavior and/or movements at the day program. Workshop staff #1 indicated they were not aware of anything being wrong until the facility called to ask them questions about the client's clavicle fracture. Workshop staff #1 indicated client A did not fall at the day program and there were no reported client to client incidents. | | | |

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| | Workshop staff #1 indicated facility staff assisted the client to transfer when toileting even though the client was independent with toileting.<br><br>Interview with administrative staff #2, #3, PC #1 and staff #1 on 7/12/12 at 3:17 PM indicated the investigation was still ongoing. Administrative staff #2 indicated he normally conducted abuse and neglect investigations, but staff #1 and PC #1 were conducting the investigation of client A's injury of unknown origin/fracture. Administrative staff #2 stated "I was guiding them through the process." Administrative staff #2 indicated he had requested they obtain more information in regard to what was going on with the client. Administrative staff #1 and #2 indicated the facility had not questioned staff in regard to abuse, transporting and/or looked at the physical environment of the home/day program prior to 7/11/12. Staff #1 indicated one facility staff indicated they had transported client A in the middle of the van using the lap belt and the shoulder strap which could possibly account for the client's injury. Staff #1 indicated the staff person would have worked on 6/25, 6/27 and 6/29/12. Staff #1 stated the staff person indicated she "always" transported client A in that manner. Staff #1 indicated she was not | | | |

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| | aware staff had transported client A using a shoulder harness.<br><br>Confidential interview M stated client A presented with a "pattern injury" at the hospital. Confidential interview M stated client A had "band bruising" on his shoulder area which ran on and over the shoulder area. Confidential interview M stated client A had a "linear bruise" which ran across the client's chest area. Confidential interview M indicated no other bruises were observed on client A. Confidential interview M stated the ER nurse "originally thought bruise was from a strap." Confidential interview M stated when the photos were loaded onto the computer and examined, "dark purple marks over red seemed to be of a shoe impression. Interview with the staff at the hospital gave no other plausible reason for the injury." Confidential interview M indicated they were told the client utilized a lap belt and not a harness/shoulder belt.<br><br>This federal tag relates to complaint #IN00111284.<br><br>9-3-2(a) | | | |

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| W0156 | 483.420(d)(4)<br>STAFF TREATMENT OF CLIENTS<br>The results of all investigations must be reported to the administrator or designated representative or to other officials in accordance with State law within five working days of the incident.<br><br>Based on interview and record review for 1 of 2 allegations of abuse, neglect and/or injuries of unknown origin reviewed, the facility failed to complete their investigation within 5 working days to report the results to the administrator and/or to state officials regarding client A.<br><br>Findings include:<br><br>The facility's reportable incident reports and/or investigations were reviewed on 7/11/12 at 10:40 AM. The facility's 6/29/12 reportable incident report indicated "When staff woke [client A] (individual supported by ResCare), he appeared to have difficulty moving. When staff and the Home Manager began assisting [client A] they observed a bruise on his right shoulder. [Client A] has a history of fractures related to his severe osteoporosis. Due to his limited range of motion and the bruise, the Home Manager transported him to [name of hospital] Emergency Department for evaluation and treatment. X-rays revealed a fractured right clavicle...The team has initiated an investigation to determine the | W0156 | **CORRECTION:** *The results of all investigations must be reported to the administrator or designated representative or to other officials in accordance with State law within five working days of the incident.* Specifically, results of the investigation into Client A's injury of unknown origin will be reported to the administrator,Indiana Adult Protective Services and the Bureau of Developmental Disability Services as required.<br>**PREVENTION:** The Quality Assurance Manager has established a tracking system to assure all investigations occur and are completed within established timelines –thus facilitating the timely reporting to the agency administrator and government entities as required. The status of all current investigation will be posted in a confidential manner to provide for follow-up with facility supervisory staff as needed. The Quality Assurance Team will audit completed investigations to assure results are reported as required. **Responsible Parties:** QDDPD, Support Associates, Health Services Team, Operations Team, Quality | 08/18/2012 |

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| | origin of the injury."<br><br>Interview with administrative staff #2 on 7/11/12 at 9:10 AM stated the facility's investigation was "ongoing." Administrative staff #2 stated client A's clavicle fracture was most likely due to client A's "shifting around in a chair" as the client's "bones (were) continuing to deteriorate." Administrative staff #2 indicated client A had Osteoporosis.<br><br>Interview with staff #1 on 7/11/12 at 9:35 AM indicated she was still in the process of conducting an investigation in regard to client A's fracture as she did not know how client A fractured his clavicle.<br><br>Interview with Program Coordinator (PC) #1 on 7/11/12 at 1:30 PM indicated staff #1 and PC #1 were still conducting an investigation in regard to the client's fracture which was reported on 6/29/12.<br><br>Interview with administrative staff #2, #3, PC #1 and staff #1 on 7/12/12 at 3:17 PM indicated the investigation was still ongoing. Administrative staff #2 indicated he normally conducted abuse and neglect investigations, but staff #1 and PC #1 were conducting the investigation of client A's injury of unknown origin/fracture. Administrative staff #2 stated "I was guiding them | | Assurance Team | |

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| | through the process." Administrative staff #2 indicated he had requested they obtain more information in regard to what was going on with the client.<br><br>This federal tag relates to complaint #IN00111284.<br><br>9-3-2(a) | | | |

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| W0227 | 483.440(c)(4)<br>INDIVIDUAL PROGRAM PLAN<br>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.<br>Based on observation, interview and record review for 1 of 4 sampled clients (B), the client's Interdisciplinary Team (IDT) failed to address the client's identified behavioral need in regard to skin picking.<br><br>Findings include:<br><br>During the 7/11/12 observation period between 6:12 AM and 8:15 AM, at the group home, client B had an open area the size of a dime on the client's left upper shoulder area. The open area was wet/bloody. Client B also had a small open area on the right side of his shoulder near the top part of his shoulder. The area on client B's right shoulder was red and less than 1/2 inch long.<br><br>Interview with staff #2 on 7/11/12 at 7:35 AM stated client B demonstrated "picking behavior." Staff #2 indicated facility staff applied creams to client B's skin. Staff #2 indicated client B would pick open sores and bumps on his skin. Staff #2 indicated client B did not have a behavior plan for the picking. | W0227 | **CORRECTION:** *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.* Specifically for Client B, the interdisciplinary team has reviewed documentation and completed a functional behavioral assessment. Based on the results of the assessment, the team consensually agrees Client B would benefit from formal behavioral supports to address skin picking. The QDDP will develop appropriate behavior supports for Client B based on the assessment. **PREVENTION:** Professional staff will be retrained regarding the need to update assessments and develop supports based on each client's current needs. Members of the Operations and Quality Assurance Teams will audit and compare incident documentation and progress notes to current support documents on an ongoing basis, making recommendations for modifications as appropriate. Quality Assurance and Operations Team members will perform on-site audits at the | 08/18/2012 |

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| | Client B's record was reviewed on 7/12/12 at 9:53 AM. Client B's 2/20/12 Comprehensive High Risk Health Plan for Skin Infection indicated client B would have open areas on his skin. The risk plan indicated client B's skin infection was "Secondary to Dermatitis, eczema, and recurrent boils and to skin picking."<br><br>Client B's 8/29/11 Individual Support Plan (ISP) indicated client B did not have a program in place to address the client's identified behavior of skin picking.<br><br>Interview with staff #1 on 7/11/12 at 9:35 AM indicated the areas on client B's shoulders were from picking. Staff #1 stated client B had "dermatitis."<br><br>Interview with staff #1 and PC #1 on 7/12/12 at 3:17 PM indicated client B did not have an objective and/or plan in place to address the client's picking behavior.<br><br>9-3-4(a) | | facility as needed but no less than monthly. **Responsible Parties:** QDDPD, Support Associates, Operations Team, Quality Assurance Team | |

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| W0318 | 483.460<br>HEALTH CARE SERVICES<br>The facility must ensure that specific health care services requirements are met.<br>Based on observation, interview and record review, the facility failed to meet the Condition of Participation: Health Care Services for 1 of 4 sampled clients (A). The facility's health care services failed to meet the nursing needs of a client in regard to a clavicle fracture.<br><br>Findings include:<br><br>The facility's health care services failed to meet the nursing needs of client A. The facility's health care services failed to develop specific protocols in regard to the care of a client's fractured clavicle. The facility's health care services failed to ensure facility staff notified nursing services of a client's change in status and to ensure facility staff followed ordered care instructions for the fractured clavicle. The facility's health care services failed to ensure facility staff monitored and/or documented the client's care, and failed to ensure the facility's nursing services monitored and/or followed-up on client A's fractured clavicle as it was healing. Please see W331.<br><br>This federal tag relates to complaint #IN00111284. | W0318 | **CORRECTION:** *The facility must ensure that specific health care services requirements are met.* Specifically, the team has taken the following steps to assure Client A's health and safety.While Client A's fractured right clavicle heals, his sling has been supplemented with a binding to assure it remains immobile. 15 minute checks have been implemented while Client A is awake to prevent him from interrupting the healing process. When Client A sleeps and is not wearing the sling, Client A currently receives one to one staffing to assure he does not use his right arm. Additionally, the facility nurse is coordinating Client A's follow-up with an orthopedic specialist as well as obtaining an updated bone density scan. The nurse has provided staff with specific training toward safe lifting and transferring of Client A and has developed specific protocols for assisting Client A with self-care activities while his fracture heals. **PREVENTION:** The facility nurse will be retrained regarding the need to include specific care procedures as appropriate when developing comprehensive high risk and care plans. The Healthcare Services Manager will review all revisions to facility nursing care plans for | 08/18/2012 |

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| | 9-3-6(a) | | the next ninety days and thereafter will perform spot checks of facility nursing care plans as needed but no less than quarterly. The facility nurse will assure that all treatments and other nursing care activities entered into the Medication and Treatment Administration Records include specific times for the actions to be performed. Members of the Operations and Quality Assurance Teams will monitor active treatment sessions and review medical documentation as needed but no less than monthly to assure professional and direct support staff implement high risk and nursing care plans as written. Additionally Operations and Quality Assurance Team members will review medical documentation while auditing active treatment sessions and make recommendations to the Health Services Team as appropriate. **Responsible Parties:** QDDPD, Support Associates, Health Services Team, Operations Team, Quality Assurance Team | |

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| W0331 | 483.460(c)<br>NURSING SERVICES<br>The facility must provide clients with nursing services in accordance with their needs.<br><br>Based on observation, interview and record review for 1 of 4 sampled clients (A), the facility's nursing services failed to develop specific protocols in regard to the care of a client's fractured clavicle. The facility's nursing services failed to ensure facility staff notified nursing services of a client's change in status and to ensure facility staff followed ordered care instructions for the fractured clavicle. The facility's nursing services failed to ensure facility staff monitored and/or documented the client's care, and failed to ensure the facility's nursing services monitored and/or followed-up on client A's fractured clavicle as it was healing.<br><br>Findings include:<br><br>The facility's reportable incident reports and/or investigations were reviewed on 7/11/12 at 10:40 AM. The facility's 6/29/12 reportable incident report indicated "When staff woke [client A] (individual supported by ResCare), he appeared to have difficulty moving. When staff and the Home Manager began assisting [client A] they observed a bruise on his right shoulder. [Client A] has a history of fractures related to his severe | W0331 | **CORRECTION:** *The facility must provide clients with nursing services in accordance with their needs.* Specifically, the team has taken the following steps to assure Client A's health and safety.While Client A's fractured right clavicle heals, his sling has been supplemented with a binding to assure it remains immobile. 15 minute checks have been implemented while Client A is awake to prevent him from interrupting the healing process. When Client A sleeps and is not wearing the sling, Client A currently receives one to one staffing to assure he does not use his right arm. Additionally, the facility nurse is coordinating Client A's follow-up with an orthopedic specialist as well as obtaining an updated bone density scan. The nurse has provided staff with specific training toward safe lifting and transferring of Client A and has developed specific protocols for assisting Client A with self-care activities while his fracture heals. **PREVENTION:** The facility nurse will be retrained regarding the need to include specific care procedures as appropriate when developing comprehensive high risk and care plans. The Healthcare Services Manager will review all revisions to facility nursing care plans for | 08/18/2012 |

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| | osteoporosis. Due to his limited range of motion and the bruise, the Home Manager transported him to [name of hospital] Emergency Department for evaluation and treatment. X-rays revealed a fractured right clavicle. Staff have been trained on [client A's] aftercare instructions and he is resting comfortably at home...."<br><br>During the 7/11/12 observation period between 6:12 AM to 8:15 AM, at the group home, client A was in his bedroom getting ready for the day at 6:12 AM. At 6:25 AM, staff #3 asked staff #2 if she needed help with client A to get the client dressed. Staff #2 stated "[Client A] is in room getting dressed putting his own clothes on." Staff #2 went into the kitchen area and staff #3 returned to client C's bedroom. At 6:28 AM, client A could be seen through a partially opened door sitting on the side of his bed. Client A had a shirt that went on over his head on, and his pants were at his hip line trying to pull up his pants with both hands. Staff #2 entered client A's room and asked the client if he needed help and closed the door. Staff #2 then came out of the bedroom and returned to the kitchen. Client A transferred himself from the side of the bed to his wheelchair without staff assistance. Client A did not have a sling on and was using his right arm. Client A | | the next ninety days and thereafter will perform spot checks of facility nursing care plans as needed but no less than quarterly. The facility nurse will assure that all treatments and other nursing care activities entered into the Medication and Treatment Administration Records include specific times for the actions to be performed. Members of the Operations and Quality Assurance Teams will monitor active treatment sessions and review medical documentation as needed but no less than monthly to assure professional and direct support staff implement high risk and nursing care plans as written. Additionally Operations and Quality Assurance Team members will review medical documentation while auditing active treatment sessions and make recommendations to the Health Services Team as appropriate. **Responsible Parties:** QDDPD, Support Associates, Health Services Team, Operations Team, Quality Assurance Team | |

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| | had a gait belt around his waist, but the gait belt was not used to assist the client to transfer. Client A wheeled himself using each hand/arm to turn the wheelchair wheels. Client A had his right arm extended out and up as he turned the wheel with his right hand (using full range of motion) as the right shoulder would raise and lower when turning the wheel. Facility staff did not assist client A, who had a clavicle fracture, to wheel himself into the living room area. Facility staff did not prompt and/or encourage client A not to use his right arm. Client A did not have a sling on when he came out of his bedroom. At 6:39 AM, after the client served himself independently, staff #2 stated "I'm going to cut up [client A's] food because his arm is messed up." Client A ate with his right hand/arm. The client ate with his right arm extended out and up to the client's shoulder level as he made wide scoops from his plate to his mouth. Client A elevated his right arm/elbow to shoulder level each time he took a bite of food (full range of motion). At 6:50 AM, staff #2 retrieved an arm sling and placed it on client A who had just finished his breakfast. At 6:53 AM, client A raised his right arm, which was in the sling, and placed the arm on the table. Staff reminded the client to keep his arm down. Client A moved his arm down, but the sling was now displaced. The bottom | | | |

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| | of the sling was at client A's elbow with the top part of the sling going up client A's arm to the shoulder area. The client's arm was not in the sling. Client A sat with his arm not properly placed in the sling as staff handed the client a 3 D puzzle to work on. At 7:14 AM, staff #3 prompted client A to keep his arm down and placed the client's right arm back into the sling. At 7:19 AM, client A again raised/lifted the right arm and out causing the sling to move and not be placed correctly. Client A had his right arm elevated and on the table. Staff #3 verbally prompted client A to put his arm down and placed the arm back into the sling. At 7:53 AM, client A had his right arm out of the sling, extended outward at shoulder level. The sling was at the client's elbow and extended up his arm to the shoulder area. Client A sat without staff redirecting the client and/or physically assisting the client to place the sling on his arm correctly until 7:58 AM.<br><br>The hospital records were reviewed on 7/11/12 at 8:45 AM. The 6/29/12 OutPatient Treatment Record indicated client A had an X-ray which showed the client had a right Clavicle Fracture (collar bone).<br><br>Client A's record was reviewed on 7/11/12 at 11:55 AM. Client A's 6/29/12 | | | |

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| | After Care Instructions indicated client A had a Clavicle Fracture. The form indicated "...It is extremely rare for a clavicle fracture to need to be 'reset' or have surgery, even if the edges of the bone seem very out of place...3. The general care of a fracture includes the use of a medication to reduce pain, the use of a splint/cast to reduce movement, and resting and using ice.<br>-REST: Limit use of the injured body part.<br>-ICE: By applying ice to the affected area, swelling and pain can be reduced. Place some ice cubes in a re-sealable (Ziploc) bag and add some water. Put a thin washcloth between the bag and your skin. Apply the ice bag to the area for at least 20 minutes. Do this at least 4 times per day. Using the ice for longer times and more frequently is OK. NEVER APPLY ICE DIRECTLY TO THE SKIN...5. You have been given a sling to use. Wear the sling with all activities except bathing and sleeping. Use the sling until your follow-up appointment.<br>6. YOU SHOULD SEEK MEDICAL ATTENTION IMMEDIATELY, EITHER HERE OR AT THE NEAREST EMERGENCY DEPARTMENT, IF ANY OF THE FOLLOWING OCCURS:<br>-You experience a severe increase in pain or swelling in the affected area.<br>-You develop new numbness and tingling | | | |

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| | in your arm or hand.<br>-You develop a cold, pale hand which might mean that there is a problem with its blood supply."<br><br>Client A's 7/10/12 Record of Visit (ROV) indicated client A saw his doctor for follow-up of the fracture. The ROV indicated "Mild Abnormal appearance of Clavicle/Deformity (R) (right) Clavicle." The ROV recommended "Keep sling on. Refer to Orthopedics."<br><br>Client A's 6/12 nurse notes from 6/29/12 to the present indicated the following:<br><br>-6/29/12 Client A had a "lg (large) bruise on rt (right) shoulder & (and) collar bone (with) swelling, (decreased) ROM (range of motion) & indication of pain. X-ray reveals clavicle fracture...." The nurse note indicated client A had a blue purple bruise on his shoulder. The 6/29/12 nurse note indicated "...[Client A] cont (continues) to move arm even when encouraged to keep immobile...Will continue to monitor...."<br><br>-6/30/12 "F/U (follow-up) to fall assessment. [Client A] in bed. Awake & alert. RUE (right upper extremity) (up) on pillow." Client A's record did not indicate any additional documentation/monitoring by a nurse. | | | |

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| | Client A's 7/12 Medication Administration Record (MAR)/book indicated the client had an undated Use and Application of Arm Sling Protocol in place. The undated protocol indicated "...The sling must apply gentle upward support...Apply the sling in a manner as to prevent movement of the injured site or extremity...Other Considerations: When an individual has an injury to an upper extremity, having clothing that snaps or buttons up the front or back rather than slipping over the head is recommended. This provides the least amount of movement of the injured site when getting dressed. When assisting the individual with dressing, put the sleeve of the injured extremity on first. Likewise, when getting undressed, the sleeve of the injured extremity should be removed last. Remember: Notify the nurse immediately if there are noticeable changes in color, temperature, movement of the fingers, or if the individual complains of increased pain or numbness of the injured extremity." Client A's 7/12 MAR Book indicated the client had an undated nursing protocol in place for the use of a gait belt. The undated protocol indicated the gait belt was to be used with transfers or walking when needed. Client A's 7/12 MAR indicated the following:<br>-"Use GAIT Belt For All Transfers" | | | |

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| | -"Notify Nurse For Changes in Color, temperature, movement of fingers or increased pain or numbness of injured extremity"<br>-"Norco 5 mg (milligrams)/325 mg (i.e. Hydrocodone/APAP Take 1 tablet by mouth every 4-6 hours as needed for pain" The MAR indicated the pain medication was discontinued after 7/6/12.<br>-"Apply ice for 20 minutes on, then 20 minutes off. Do not apply ice directly to skin. Apply at least 4 times daily."<br>-"Right arm sling on at all times except for bathing & sleeping." Client A's 7/12 MAR indicated the above mentioned treatments/protocols documented "FYI" (For Your Information) for the hour of application and/or check. Client A's 7/12 MAR indicated the facility failed to document the checks/monitoring of client A for changes, when right arm sling was applied and/or when ice was applied 4 times a day as no staff initialed/documented the treatment had been completed since the client returned to the group home on 6/29/12. Client A's 7/12 MAR did not indicate any listed times for the application of the ice to be done 4 times a day.<br><br>Client A's Injury Follow-Up Flow Chart indicated at the top of the form: "Procedure: Initiate with all injuries. To be completed EACH SHIFT for the first | | | |

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| | 24 hours then daily until healed. If no apparent injury noted at the time of fall or physical insult this form must still be initiated for at least 24 hours including documentation from each shift. If at the end of 24 hours there are still no apparent injuries then the follow-up is completed. If injuries are noted then continue to follow-up daily until healed...." Client A's Injury Follow-Up Flow Chart indicated the following:<br><br>-7/6/12 "Still healing."<br><br>-7/7/12 "Slightly less bruising on right side. Still healing."<br><br>-7/7/12 "Light bruising on right side. Still healing."<br><br>Client A's record indicated the facility failed to document any additional information and/or monitoring of client A's bruising/clavicle fracture.<br><br>Client A's Progress Notes indicated the following:<br><br>-6/27/12 at 7 AM, "[Client A] moved very slow (sic) while getting dressed and transferring himself to wheelchair."<br><br>-6/28/12 at 4 PM, "[Client A] transferred very slow (sic) today. It took him longer | | | |

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| | than normal to shower, get dressed, eat, and transfer from w/c (wheelchair)."<br><br>-6/28/12 "[Client A] complained of Pain Tylenol x 2 given. Moved slowly from transfer wheelchair to bed (sic)."<br><br>Client A's 6/1/12 Physician's Orders indicated client A received Fosamax 70 mg 30 minutes before food or drink with a full glass of water every week (Wednesday) and remain upright for 30 minutes for Osteoporosis. The 6/1/12 physician's order indicated client A received Calcium Antacid Chew 500 mg twice a day for calcium supplement. Client A's physician's orders indicated client A's diagnoses included, but were not limited to, Right Femoral Fracture and left lower leg fractures in 2/98 and Osteoporosis.<br><br>Client A's 12/20/11 Healthcare Supports Addendum indicated "...When staff is able to establish that [client A] is experiencing a medical problem, they should attempt to determine the nature of his distress; it may become necessary to perform a complete body check to assist with finding out what is wrong...Per doctor's orders, he is to use his wheel chair (sic) for mobility, and be non-weight bearing with lower extremities. [Client A] is independently | | | |

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| | able to do many things on his own; such as transfer in and out of his wheelchair to a regular chair...."<br><br>Client A's 2/20/12 Comprehensive High Risk Health Plan indicated the client had a risk plan for decreased mobility and history of fractures. The risk plans indicated facility staff were to notify the nurse for the following triggers (not all inclusive):<br><br>"-Bruising...<br>-Pain...<br>-Guarding/Protecting a particular body part<br>-Hesitation to use arm or hand/walk on leg or foot." The facility staff did not notify nursing staff of client A's decreased mobility and/or complaints of pain on 6/26, 6/27 and/or 6/28/12.<br><br>The 10/10/11 Individual Support Plan (ISP) and/or record indicated the facility and/or nursing services failed to ensure safeguards were put in place to assist client A to keep his arm immobilized due to his clavicle fracture. The facility's nursing services failed to develop specific protocols for bathing, transfers and etc. to assist staff in the care of client A's fracture, and/or failed to ensure facility staff followed physician's orders in regard to the care/treatment of the client's | | | |

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| | clavicle fracture.<br><br>Interview with staff #2 on 7/11/12 at 7:35 AM indicated client A was independent in dressing, toileting and transferring. When asked when client A was to wear the sling, staff #2 stated "I give it him after he eats so it does not get dirty. He does not have to sleep in it." Staff #2 indicated client A's arm/shoulder was getting better as the client was using his arm more. Staff #2 stated "We (staff) are doing everything for him." Staff #2 indicated client A would sleep on his right side, the side with the fractured clavicle. When asked what protocols or measures were in place for the client's fractured clavicle, staff #2 stated "We put ice on it and keep him from laying on it." Staff #2 indicated facility staff did not have to document when ice was applied to the client's arm/shoulder. Staff #2 indicated ice was applied to client A's arm on the evening shift. Staff #2 indicated there was a plan/protocol for the client's gait belt and sling in the MAR book.<br><br>Interview with staff #3 on 7/11/12 at 8:00 AM stated client A would hold his arm in an "awkward angle" when eating. Staff #3 indicated client A would hold his arm up and out prior to the fracture. When asked if client A should be eating in that position with a fractured clavicle, staff #3 | | | |

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| | indicated the client was able to feed himself. When asked when the client was to wear the sling, staff #3 stated "All during the day only. He does not wear it in bed sleeping." When asked what nursing measures and/or protocols were put in place, staff #3 stated "Make sure arm is down in sling. No pressure on it and don't lay on it." Staff #3 indicated client A was no longer receiving any medication for pain. When asked when ice should be applied, staff #3 stated, "If swelling or hurting and bruise is not going away. You put it on." Staff #3 indicated she last put ice on client A's shoulder area on Monday (7/9/12). Staff #3 stated "Ice did not need to be applied that often." Staff #3 indicated staff were to monitor the client for pain.<br><br>Interview with staff #1 on 7/11/12 at 9:35 AM indicated facility staff called her on 6/28/12 and told her client A was complaining of pain, but that staff thought it was the client's stomach, and the client was sent onto the day program. Staff #1 indicated client A had been moving slower than he normally did. Staff #1 indicated client A sat on the toilet so long, she asked him if he hurt on 6/28/12. Staff #1 indicated client A did not say anything when she asked him. Staff #1 indicated client A did get Tylenol later in the evening. Staff #1 indicated client A did | | | |

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| | not have any bruising on 6/28/12 as she saw the client unclothed in the bathroom. Staff #1 indicated she took client A to the hospital on 6/29/12 as client A was not able to get up, and had bruising on his shoulder. Staff #1 indicated client A had Osteoporosis and client A was to see the orthopedic doctor on 7/17/12 at 9:00 AM. Staff #1 indicated client A was scheduled to have a bone density study done as well. When asked when client A should wear the sling, staff #1 stated client A should wear the sling "at all times except when bathing and sleeping at night." Staff #1 indicated client A should not dress himself. Staff #1 stated client A should "limit the use of arm. Don't make him do too much." Staff #1 indicated client A could feed himself and the client was to get baths sitting on the side of the bed. Staff #1 indicated facility staff were to assist the client in transfers so the client would not use and/or put weight on his arm. Staff #1 indicated client A should not be wheeling his wheelchair and staff should be redirecting the client to not use his arm and keep the sling on. When asked when ice was applied to client A's arm, staff #1 indicated the ice should be applied 4 times a day. Staff #1 indicated she would start applying the ice when she came into work and continue throughout the day. Staff #1 indicated the facility was not documenting when and/or if the | | | |

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| | ice was being applied.<br><br>Interview with staff #4 on 7/11/12 at 10:15 AM (by phone) and at 4:22 and 4:28 PM indicated client had been moving slowly. Staff #4 indicated client A was slow in transferring from his wheelchair to the bed. Staff #4 stated client A was "cautious." Staff #4 indicated client A did not fall at the group home. Staff #4 indicated she gave client A Tylenol for pain. Staff #4 indicated when she would ask client A if he was ok, client A stated he was "all right." When asked if client A had been transported in staffs' cars, staff #4 stated "No." When asked how often ice was applied to client A's arm/shoulder, staff #4 stated "Twice a day."<br><br>Interview with staff #7 on 7/11/12 at 10:34 AM, by phone, indicated client A was to wear his gait belt during the day for staff to help with transfers if needed. Staff #7 indicated client A required 2 staff to assist with transfers. Staff #7 indicated client A could independently transfer himself from his wheelchair to the bed and would dress himself independently. Staff #7 indicated since client A fractured his shoulder, staff were to wash the client up on the side of the bed and dress the client. | | | |

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| | Interview with staff #6 on 7/11/12 at 11:05 AM, by phone, indicated he would assist client A to transfer even though the client could transfer himself to prevent falls. Staff #6 stated client A had "brittle bones." Staff #6 indicated he was not aware of any recent falls. When asked how often staff applied ice to client A's arm/shoulder, staff #6 indicated ice would be applied every 15 to 30 minutes. When asked what protocols/nursing measures were put in place, staff #7 indicated facility staff were to give the client medication for pain.<br><br>Interview with staff #5 on 7/11/12 at 11:20 AM, by phone, indicated facility staff had been trained in regard to client A's care of the clavicle fracture. Staff #5 indicated client A would not keep his arm down and would still try to use his arm. Staff #5 stated she would "prop up" client A's arm on a pillow when the client was in the wheelchair.<br><br>Interview with Program Coordinator (PC) #1 on 7/11/12 at 1:30 PM indicated staff #1 called her from the hospital and told her the hospital was asking her how client A injured himself as the client had a fractured collarbone. PC #1 indicated she could not locate any documentation of the facility's nurse's monitoring and/or assessing client A in July 2012 as the | | | |

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| | July's nurse form was blank.<br><br>Interview with RN #1 on 7/11/12 at 2:35 PM indicated the nurse for the group home was on vacation. RN #1 indicated client A had a clavicle fracture. RN #1 indicated client A was to wear the sling except for sleeping and bathing. RN #1 stated client A should "limit the use of his arm." RN #1 indicated client A's ROM would be limited if the sling was on properly. RN #1 stated client A's arm should be "immobile." When asked what staff should be assisting the client to do, RN #1 indicated the group home's nurse should have clarified with staff what to do with the client. RN #1 indicated client A should not be using his arm to wheel himself. RN #1 indicated clarification was not obtained from client A's doctor in regard to what the client should do in regard to eating, dressing and/or bathing. RN #1 indicated protocols specific to client A's clavicle fracture should have been put in place. RN #1 indicated the group home's nurse did a training with facility staff, but RN #1 did not know what the training consisted of. RN #1 indicated she felt staff would need more training. RN #1 stated "It sounds like he is using full range of motion" with the client's clavicle fracture. RN #1 indicated the nursing staff were not called in regard to client A's movement/mobility | | | |

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| | decreasing and/or being slow. RN #1 indicated she would check the on-call nursing book to see if any nurse received a call in regard to client A. RN #1 indicated client A had a history of fractures and had Osteoporosis. RN #1 indicated facility staff should be documenting when the ice was applied. RN #1 indicated specific times to apply the ice should be indicated on the client's MAR. Facility staff indicated the staff should be monitoring/checking the client's arm/injury on each shift and completing an Injury Flow Chart daily until the injury/bruise was healed. When looking at the injury forms, RN #1 indicated facility staff were not documenting their monitoring of the fracture/injury. When asked if nursing staff had seen client A's injury since 6/30/12, RN #1 indicated no other documentation was found. RN #1 indicated the facility's nurse assessed client A on 6/29/12 after he returned from the hospital and on 6/30/12.<br><br>Interview with administrative staff #2 on 7/12/12 at 3:17 PM indicated more protocols needed to be put in place in regard to the care of the client's fracture. Administrative staff #2 and PC #1 indicated the facility staff were being trained on 7/12/12.<br><br>This federal tag relates to complaint | | | |

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| | #IN00111284.<br><br>9-3-6(a) | | | |