STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G282	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 12/29/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REM-INDIANA INC	2715 ROCKFORD LN KOKOMO, IN 46902

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W000000	This visit was for the investigation of complaint #IN00157666. Complaint #IN00157666: Substantiated, Federal and state deficiencies related to the allegations are cited at W149, W210, W240 and W331. Dates of Survey: 12/16, 12/17, 12/18 and 12/29/14. Facility number: 000802 Provider number: 15G282 AIM number: 100243610 Surveyor: Paula Eastmond, QIDP These federal deficiencies also reflect state findings in accordance with 460 IAC 9. Quality review completed January 6, 2015 by Dotty Walton, QIDP.	W000000		
W000149	483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. Based on observation, interview and record review for 1 of 3 sampled clients (C) and for 1 additional client (G), the	W000149	Indiana Mentor has policies and procedures in place in regards to the health and safety of clients. Included in this are risk plans	01/27/2015

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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	facility failed to implement its written policy and procedures to prevent neglect of clients in regard to falls. Findings include: 1. The facility's reportable incident reports and/or investigations were reviewed on 12/16/14 at 1:49 PM. The facility's reportable incident reports and/or investigations indicated the following (not all inclusive): -9/23/14 "[Client G] was exiting the building for a fire drill at 9:30am on 9/23/14. [Client G] was not using her walker appropriately and fell down. Staff assisted her to sit on her walker. She was initially checked by staff, but they did not notice any bleeding or bruising at the time. Once she returned inside, nursing staff did a thorough check and found bruising and swelling of her right elbow. She was able to complete a passive range of motion. Nursing staff applied ice...." The facility's 8/23/14 Investigation Summary indicated day program staff "...tried to get to [client G] before she fell but could not get her...[Client G] had fallen outside of [name of day program] coming in from a fire drill due to not using her walker appropriately...." The facility's investigation indicated in a		developed by trained nurses in conjunction with the QMRP. Staff are trained on all clients risk plans prior to working with them. For clients C and G the nurse and QMRP reviewed their current plans as well as reviewing the fall plans for all other individuals in the house. The House Manager and QMRP did a training with the staff on these plans as well to ensure proper implementation and comprehension was met. On going falls are being reviewed by the complete IDT and will include a discussion on adaptative equipment, staffing, and ensuring the fall protocol still mets the individuals needs. These reports will be sent to the Area Director for review. In addition for the next 6 months the nurse, qmrp, and othe members of management will review all IRs with Area Director on a monthly basis. For monitoring the management will do at least 3 monthly observations on staff to ensure staff are following all protocols and procedures. Management will keep documentation of these observations. After the 6 months the Area Director will continue to review all IRs and meet with the nursing staff at least monthly to ensure protocols are up to date. The nurse will continue to do a monthly nursing review which will be reviewed by management. Responsible Party: QMRP, NurseComplete Date: 1/28/15	

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	section entitled "Recommendations/Corrective Measures to Prevent Likelihood of Future Occurrences: Staff will continue to follow her fall protocol and remind her to use her walker appropriately." -9/23/14 at 7:15 PM, "[Client G] was in the kitchen and fell hitting her left ear on her walker. Staff assisted her up and checked her for injuries. Her left ear was bleeding a little so minor first aid was applied and the bleeding stopped. Staff will continue to monitor [client G] and notify the nurse of any changes. THey (sic) will also continue to follow her fall protocol." The facility's 9/24/14 Investigation Summary indicated facility staff was in the kitchen with client G when the client fell. The facility's investigation indicated "...and seen (sic) her lose her balance...." The facility's investigation did not indicate if facility staff was close enough to try and stop the client's fall/ where the facility staff was located in the kitchen. The facility's investigation recommendation/corrective action section indicated "Staff will continue to follow her fall protocol and remind her to use her walker appropriately. Due to multiple falls in short span an appointment has been made with PCP			

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	(Primary care Physician) for 9/27/14. Staff to continue sight supervision and use the adaptive equipment to aid [client G]. Staff to also checked (sic) environment to ensure no fall hazards were in [client G's] way at time of the incident and ongoing, none were noted." -9/26/14 at 4:30 PM, "[Name of day program] staff called Indiana Mentor house manager to report [client G] had fallen at day program and her arm did not seem normal. Residential staff took [client G] (sic) the hospital where she was diagnosed with a fracture in her right arm and a broken left thumb from the fall. Hospital put a splint on her (sic) thumb and sling for her arm. She will be following up with her primary care. Staff were trained on the discharge instructions and she has PRN (as needed) pain medication. Her fall plan has been reviewed and currently she has a gait belt, walker, and wheelchair as available aids in walking. Staff are continuing to utilize these with [client G]." The facility's 9/28/14 Investigation Summary indicated "...[Name of day program] staff stated the (sic) [client G] was walking by the entryway in the room and got her feet tangled in her walker and fell on her arm. [Name of day program] staff stated there were no trip hazards			

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	present at the time of the fall...." The facility's investigation also indicated "...Staff were trained on the discharge orders and procedures. [Client G] has a number of assistive equipment to aid in her mobility including her walker, PRN wheelchair, and belt. She had an appointment set with PCP in regards to falls on date of incident but is being rescheduled due to her being in ER (emergency room) at time of appointment." The facility's investigation indicated the facility failed to review the group home's staffing pattern to ensure client G would be adequately supervised due to the client's fractured thumb and arm. -9/27/14 at 12:20 AM, "[Client G] was in the living room and had gotten up to transfer to her wheelchair, staff prompted her to wait for assistance, [client G] refused to wait and got up and fell. [Client G] complained of pain in her arm and head. Staff called EMTs (emergency medical technicians) and she was transferred to the local hospital where she was assessed and admitted for observation and evaluation...." The facility's 10/8/14 Summary of Internal Investigation Report indicated client G got up and tried to sit herself in her wheelchair when she fell and hit her			

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	arm and her head. The facility's investigation indicated client G was placed in the hospital's Intensive Care Unit (ICU) due to a fall at the group home. The facility's investigation indicated the hospital was concerned client G may have a "...possible brain injury from the fall that night...." The facility's investigation indicated the hospital did a scan on 9/29 and 10/1/14, at the hospital, and did not find "...no evidence of any bleeding in the brain or head trauma...[Staff #1] stated on 10/8/2014 the hospital informed her that [client G] never broke her arm either but instead had just a muscle tear by her shoulder...." The facility's 10/8/14 investigation indicated "...[staff #3] stated that at around 12:30 am on 9/27/2014 she was getting ready to do bed checks. [Staff #3] stated [client G] was still sitting on chair in living room and had refused to go to her bed. [Staff #3] stated as she was conducting her checks that another client [client A] was having a seizure and she went and swiped the VNS (Vagal Nerve Stimulator) on her. [Staff #3] stated as she was exiting [client A's] room she saw [client G] standing up and transferring herself to the wheelchair. [Staff #3] stated she told [client G] to wait so she could help her. [Staff #3] stated [client G] would not wait and immediately tried to move to the			

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	wheelchair but slipped off the end of it. [Staff #3] stated the wheels were not locked on the chair. [Staff #3] stated as [client G] fell she hit injured arm on the ground and then knocked her head back into the wooden chair...." The facility's investigation indicated staff #3 was the only staff working at the time of the incident. The facility's 10/8/14 investigation indicated "...Conclusion: Evidence shows [client G] had a proper fall plan in place and had follow up set up for the balance issues. Evidence shows [client G] tried to self transfer during the overnight resulting in the fall." -10/7/14 "[Client G] was discharged from [name of hospital] and sent to [name of nursing home] for Rehab (rehabilitation) on her arm...." Client G's record was reviewed on 12/17/14 at 3:24 PM. Client G's 9/26/14 Medical Appointment Form indicated "She (client G) altered, fell at work, 5 falls last two days. not (sic) really herself. has (sic) not (sic). fracture (sic) R (right) humeral head (shoulder/upper arm area) - sling. Left thumb fracture - Splint. Call [name of orthopedic doctor] - see discharge instructions for follow up call - Monday." Client G's 9/26/14 Patient Discharge			

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	Disposition Form indicated "Diagnosis Humeral (arm) fracture, Fracture of phalanx of thumb." The discharge form also indicated the hospital had completed labs and x-rays while client G was at the hospital. Client G's discharge form indicated client G was given pain medication for the client's pain and was to call/follow-up with an orthopedic surgeon the following Monday. Client G's discharge instructions indicated "...extra assistance with walking due to not able to walk with her walker with fractures of R arm and L thumb. Try to keep affected area elevated above level of the heart when possible. Apply ice pack for 2-30 minutes every few hours. Use Ibuprofen for pain if not allergic or any other anti-inflammatory medication." The discharge instructions indicated client G was to wear a sling for the client's arm and a splint for the client's thumb. Client G's September 2014 Health care Coordination/Monthly Health Review indicated the following (not all inclusive): -9/23/14 "[Client G] fell today. Staff noted a cut on Left ear. Staff started fall observation sheet. Staff will use gait belt with [client G] starting today for frequent falls."			

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	-9/27/14 "[Client G] fell backwards hitting her head on chair. She was taken by ambulance to [name of hospital] ER. X-rays and labs done. Head ct (cat scan) showed Brain bleed??? X-ray showed broken right radius??? Broken right thumb. She was admitted to ICU at this time." -9/29/14 "CT head scan redone. Shows no brain bleed. New x-ray of right arm shows no broken right radius. Left thumb is broken. Remains in ICU at this time." -9/30/14 "[Client G] moved from ICU at [name of hospital] to room 246 today. She has a sling on her right arm and her left thumb is bandaged. Her family is present at this time." Client G's 5/21/14 Quarterly Nursing Assessment indicated client G "...Uses walker when walking for help with balance without difficulty...." Client G's 8/21/14 Quarterly Nursing Assessment indicated "...Continues to use walker for balance and frequent falls without difficulty...." Client G's 8/8/14 Fall Observation Flowsheet and fall Assessment sheet			

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	indicated client G fell walking to the restroom in the bathroom. The fall assessment indicated client G was using her walker at the time of the fall. Client G's 11/21/14 Quarterly Nursing Assessment indicated "11-21-14 [Client G] placed in rehab [name of nursing home] rehab from fall back on September 27th, 2014 in the living room at the home. [Client G] was released from our services October 10th, 2014." Client G's 3/7/14 Physical examination indicated "Recommended Therapies: PT (Physical Therapy): NO, OT (Occupational Therapy): No...." Client G's 4/21/13 Annual Health Care Assessment (current one in record) indicated client G was evaluated by PT. The annual assessment indicated "PT for frequent falls this year." The assessment indicated client G was prescribed a walker to "help with balance" as client G had been falling since 2012. Client G's record and/or 4/2/14 Individual Support Plan (ISP) did not indicate any documentation of a PT evaluation prior to and/or after 4/12/13. Client G's record and/or 4/2/14 ISP did not indicate any additional documented falls for client G. Client G's 11/1/13 Fall Protocol (current			

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	one in record) indicated "[Client G] has unexplainable falls in the past year; currently uses a walker." The fall assessment indicated client G used a 4 wheeled walker with a seat to help prevent falls. The fall protocol sheet indicated specific guidelines facility staff were to follow if client G had a fall, and included who facility staff were to notify. Client G's 11/1/13 fall protocol failed to indicate how facility staff were to monitor/supervise the client to prevent falls/injuries. Client G's 9/23/14 Gait Belt Protocol indicated "Unsteady balance even with walker. Staff use gait belt when [client G] is up ambulating with walker for safety. Encourage remind client that gait belt and assistance is needed. Always use gait belt when walking with, or transferring client...PT evaluation as needed...." Client G's 11/1/13 fall protocol and/or 9/23/14 gait belt protocol did not indicate/include specifically how facility staff were to assist client G to ambulate with a fractured right arm and a broken left thumb to prevent falls/injuries. The above mentioned protocols did not indicate/include the use of a wheelchair. The facility's inservice training records were reviewed on 12/17/14 at 4:10 PM			

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	and on 12/8/14 at 1:35 PM. The facility's 9/26/14 Inservice Training Report indicated a training was conducted at 8:00 PM on 9/26/14 with the 3 staff who were on duty. The inservice training record indicated the 3 staff were trained on "[Client G's[Fractured (R) arm & (and) (L) thumb due to fall. To know and understand attached discharge instructions. Per nurse, use wheelchair and gait belt when transferring/walking." Interview with the Qualified Intellectual Disabilities Professional (QIDP) on 12/16/14 at 4:30 PM indicated client G had a history of falls. The QIDP stated client G would fall "one to two times a month but is a lot better since she uses walker." The QIDP indicated one staff worked at night and one staff was on duty at the time client G fell and had to be sent out to the hospital. The QIDP indicated client G would at times refuse to use her walker. Interview with staff #2 on 12/16/14 at 4:32 PM indicated client G had fallen in the past but had stopped when the client started utilizing a walker. Staff #2 indicated client G had used a walker for a year and half. Interview with staff #4 on 12/16/14 at 4:40 PM indicated client G had a history			

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	of falls. When asked how often client G fell, staff #4 stated client G "fell a few times at [name of day program]. Maybe one time a month at the group home." Staff #4 indicated client G had a fall protocol in place. Interview with staff #1 on 12/16/14 at 4:45 PM indicated client G was in a nursing home due to injuries the client had received from a fall and was no longer able to use her walker when ambulating. Staff #1 stated client G's falls had "severely decreased" and now occurred about "once every other month." Staff #1 stated client G had a "slight increase in falling" prior to client G's going to the nursing home. Staff #1 indicated client G would refuse to use her walker when ambulating at times. Staff #1 indicated client G would be returned to the group home once she finished her rehabilitation therapy at the nursing home. Interview with LPN #1 and administrative staff #1 on 12/17/14 at 3:55 PM indicated client G had a history of falls. LPN #1 indicated client G did not have a history of fractures with falls. LPN #1 indicated client G fell on 8/8/14 and had not fallen until 9/23/14 when the client had several falls. LPN #1 indicated facility staff were to use a wheelchair			

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	with client G as client G was not able to use her walker due to her fractured arm and thumb. LPN #1 indicated the hospital stated client G did not have a fractured arm but had a tear in the client's "rotator cuff." LPN #1 indicated facility staff had been trained in regard to gait belt training. LPN #1 indicated LPN #1 had not put any nursing measures/guidelines in place after the 9/26/14 fall resulting in the fracture. LPN #1 indicated she did not update the client's risk plan. LPN #1 indicated client G's risk plan did not specifically indicate how facility staff was to ambulate with client G with a fractured arm/thumb and/or indicate how facility staff were to assist the client with dressing and/or bathing/showering. LPN #1 indicated client G fell again on 9/27/14 and was sent out to the hospital and had not returned to the group home. LPN #1 indicated client last had a PT evaluation in September of 2012. LPN #1 indicated she was not able to locate the PT evaluation. LPN #1 indicated client G had not been re-assessed. Administrative staff #1 indicated the facility had completed investigation in regard to client G's falls. Administrative staff #1 indicated client G's IDT (interdisciplinary team) had not met since client G fell on 9/23/14. Administrative staff #1 indicated client G's IDT and/or the			

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	facility did not look at increasing staffing at the group home to ensure facility staff monitored/supervised the client to prevent falls. Administrative staff #1 indicated client G did not have anything in her plan to encourage her to use her walker. 2. The facility's reportable incident reports and/or investigations were reviewed on 12/16/14 at 1:49 PM. The facility's reportable incident reports and/or investigations indicated the following (not all inclusive): -10/5/14 "On 10/5/14, [client C] tripped over her own feet and bruised her left forearm leaving about a half dollar sized bruise. [Client C] had no further injuries at the time of the report. [Client C] has a fall protocol that was completed. Staff will continue to assist [client C] when necessary and HM (home manager) and PD (Program Director) will continue to monitor." The facility's 10/7/14 Investigation Summary indicated facility staff was walking by client C when she tripped and fell over her own feet. The facility's investigation did not indicate and/or address if facility staff was near the client to prevent and/or stop the client's fall. The facility's			

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	recommendations/corrective measures indicated "Continue to follow fall plan prompt [client C] to watch where she is going. To keep at appropriate pace." -12/14/14 "[Client C] went to sit down for dinner and missed the chair and fell onto her rear end and slightly grazing her head on the wall as she went down. Staff helped her up and checked for injuries. No injuries were noted...Staff will continue to monitor her and follow her fall protocol.." The facility's 12/15/14 Investigation Summary indicated "Staff was by the table when [client C] started to sit down. Staff stated as [client C] began to sit she misjudged where the seat was at (sic) missed it causing her to fall to the floor. Staff did a fall assessment and noted no injuries and monitored her for any signs or complaints of pain which none were noted." The facility's investigation indicated "Staff checked environment to ensure no hazards, will prompt her to check and ensure seat is in place when sitting." During the 12/16/14 observation period between 3:19 PM and 5:00 PM, at the group home, client C did not ambulate independently. Facility staff held the client's arm and walked with the client			

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	and/or walked in front of client C as staff walked backwards to assist the client when ambulating. Client C's record was reviewed on 12/17/14 at 12:50 PM. Client C's 11/6/14 physician's orders indicated client C's diagnoses included, but were not limited to, Osteoporosis, Lower Extremity Edema and Osteoarthritis. Client C's 5/2/14 Fall Assessment indicated client C fell walking out of the bathroom without assistance. The 5/2/14 assessment indicated client C had her shoes on at the time of the fall. Client C's 10/21/14 Fall Assessment indicated client C fell standing up from the table. The assessment indicated facility staff was present at time of the fall. Client C's July 2014 Health care Coordination/Monthly Health Review indicated client C had Osteopenia and Osteoporosis and had "Multiple contractures of hands." The July 2014 monthly review indicated client C went to a medical facility to be checked due to "balance issues." Client C's September 2014 Monthly Health Review indicated on 9/24/14			

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	"Staff noticed [client C] leaning more to the right today. She fell in the living room when getting up from the chair. She was seen at [name of hospital] ER. Labs (laboratory tests) drawn in ER. Labs within normal limits. No injuries noted." Client C's record indicated client C's last PT and/or OT assessments were completed on 1/29/02. Client C's record and/or 7/2/14 ISP did not indicate client C's gait and/or ambulation had been re-assessed. Client C's 11/3/14 Fall Protocol indicated "[Client C] has contractures of hands and feet from osteoarthritis. She has lower extremity edema and leans to slightly to right side because of osteoporosis. She susceptibility of falls due to diagnosis (sic)." The fall assessment indicated client C walked independently. The assessment indicated "Non-skid shoes on at all times while up and walking during the day. Prompts from staff to slow down while walking. Needs assistance when going to bathroom; showering and getting up and down to bed. Client C's 11/13/14 fall protocol indicated what facility staff were to do when the client fell and indicated who facility staff were to contact. Client C's 11/3/14 fall protocol and/or 7/2/14 ISP did not			

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	indicate how facility staff were to monitor/supervise the client when she ambulated to ensure the client did not fall. Client C's 7/2/14 ISP indicated "...She (client C) was seen at the ER on 4-29-13 for a fall which resulted in a dislocation to her shoulder...Ct (cat scan) of head on 1-4-12 was also negative. She had a hairline fracture in mid spine caused by osteoporosis...." Client C's 7/2/14 ISP and/or risk plans/protocols indicated client C did not have a risk plan/protocol for the client's Osteoporosis/Osteopenia diagnoses in regard to potential fractures/injuries from falls. Client C's record and/or ISP indicated the client's interdisciplinary team (IDT) did not meet and/or review the above mentioned falls to ensure the client's risk plans were appropriate and/or needed to be revised. Interview with the QIDP on 12/16/14 at 4:30 PM indicated client C had a history of falls. The QIDP stated client C would fall "an average of 1 to 2 times a month." Interview with staff #2 on 12/16/14 at 4:32 PM indicated client C could ambulate without facility staff. Staff #2 indicated client C would take staff's hand			

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	if client C felt she needed assistance. Staff #2 stated client C fell this past Sunday 12/14/14 and "one week ago Friday." Staff #2 indicated client C did not have any injuries at the time of her 12/14/14 fall, but did have bruises later. Staff #2 indicated facility staff monitored client C as the client had hit her head when she fell to the floor on her side. Interview with staff #4 on 12/16/14 at 4:40 PM indicated client C was a fall risk and had a fall protocol in place. Staff #4 indicated client C did not require assistance when walking but would "grab your arm and hand if assistance needed." Interview with staff #1 on 12/16/14 at 4:45 PM indicated client C had a history of falls. Staff #1 stated client C would fall one time a month and "May go awhile without falling." Staff #1 indicated facility staff assisted client C during the 12/16/14 observation as client C was not used to walking on the new wooden floor that was put in the group home as the group home had carpet in the past. Interview with LPN #1 and administrative staff #1 on 12/17/14 at 3:55 PM indicated client C was at risk for falls. LPN #1 indicated client C did not have a risk plan in place for the client's			

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	Osteoporosis diagnosis. LPN #1 indicated client C had not been re-assessed in regard to her recent falls as the client's last PT assessment, was completed in 9/11/11 (not in chart). Administrative staff #1 and LPN #1 indicated client C were to wear her shoes to help prevent the client from falling. LPN #1 stated "It is effective when you can get her to wear her shoes." Administrative staff #1 and LPN #1 indicated client C's ISP and/or risk plans did not indicate how facility staff were to monitor/supervise the client to prevent falls/injuries. The facility's policy and procedures were reviewed on 12/16/14 at 12:16 PM. The facility's April 2011 policy entitled Quality Risk Management indicated "Indiana Mentor promotes a high quality service and seeks to protect individuals receiving Indiana Mentor services through oversight of management procedures and company operations, close monitoring of service delivery and through a process of identifying, evaluating and reducing risks to which individuals are exposed...Indiana Mentor is committed to ensuring the individuals we serve are provided with a safe and quality living environment...." This federal tag relates to complaint			

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	#IN00157666. 9-3-2(a)			
W000210	483.440(c)(3) INDIVIDUAL PROGRAM PLAN Within 30 days after admission, the interdisciplinary team must perform accurate assessments or reassessments as needed to supplement the preliminary evaluation conducted prior to admission. Based on observation, interview and record review for 1 of 3 sampled clients (C) and for 1 additional client (G), the clients' interdisciplinary teams (IDTs) failed to re-assess the clients' gait/mobility skills when needed. Findings include: 1. The facility's reportable incident reports and/or investigations were reviewed on 12/16/14 at 1:49 PM. The facility's reportable incident reports and/or investigations indicated the following (not all inclusive): -9/23/14 "[Client G] was exiting the building for a fire drill at 9:30am on 9/23/14. [Client G] was not using her walker appropriately and fell down. Staff assisted her to sit on her walker. She was initially checked by staff, but they did not notice and bleeding or bruising at the time. Once she returned inside, nursing	W000210	Indiana Mentor has policies and procedures in place to ensure the health and safety of all consumers in services. As part of these services the nurse develops, implements, and aids in training staff with assessments and re-assessments as needed. The IDT met with the nurse and reviewed the fall plans for clients C and G and additionally the other consumers in the house. The team has put in place a new guidelines for assessments. On going after falls the nurse is notified and a fall assessment is to be completed. Once the assessment is done the IDT will conduct an investigation for the falls which will include a reivew on the current fall plans, and a determination will be made on if the plans needs to remain or revised. If revisions are needed the nurse will make required changes and training with staff will be completed. These investigations will be sent to the area director as long with any	01/27/2015

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	staff did a thorough check any found bruising and swelling of her right elbow. She was able to complete a passive range of motion. Nursing staff applied ice...." The facility's 8/23/14 Investigation Summary indicated day program staff "...tried to get to [client G] before she fell but could not get her...[Client G] had fallen outside of [name of day program] coming in from a fire drill due to not using her walker appropriately...." -9/23/14 at 7:15 PM, "[Client G] was in the kitchen and fell hitting her left ear on her walker. Staff assisted her up and checked her for injuries. Her left ear was bleeding a little so minor first aid was applied and the bleeding stopped. Staff will continue to monitor [client G] and notify the nurse of any changes. THey (sic) will also continue to follow her fall protocol." The facility's 9/24/14 Investigation Summary indicated facility staff was in the kitchen with client G when the client fell. The facility's investigation recommendation/corrective action section indicated "Staff will continue to follow her fall protocol and remind her to use her walker appropriately. Due to multiple falls in short span an appointment has been made with PCP		revisions to the plans.Additionally the IDT will meet monthly to review clients plans and the nurse will complete a monthly nursing report for reveiw by the IDTResponsible Party: QMRP, NurseComplete Date: 1/28/15	

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	(Primary care Physician) for 9/27/14. Staff to continue sight supervision and use the adaptive equipment to aid [client G]. Staff to also checked (sic) environment to ensure no fall hazards were in [client G's] way at time of the incident and ongoing, none were noted." -9/26/14 at 4:30 PM, "[Name of day program] staff called Indiana Mentor house manager to report [client G] had fallen at day program and her arm did not seem normal. Residential staff took [client G] (sic) the hospital where she was diagnosed with a fracture in her right arm and a broken left thumb from the fall. Hospital put a splint on her (sic) thumb and sling for her arm. She will be following up with her primary care. Staff were trained on the discharge instructions and she has PRN (as needed) pain medication. Her fall plan has been reviewed and currently she has a gait belt, walker, and wheelchair as available aids in walking. Staff are continuing to utilize these with [client G]." The facility's 9/28/14 Investigation Summary indicated "...[Name of day program] staff stated the (sic) [client G] was walking by the entryway in the room and got her feet tangled in her walker and fell on her arm. [Name of day program] staff stated there were no trip hazards			

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	present at the time of the fall...." The facility's investigation also indicated "...Staff were trained on the discharge orders and procedures. [Client G] has a number of assistive equipment to aid in her mobility including her walker, PRN wheelchair, and belt. She had an appointment set with PCP in regards to falls on date of incident but is being rescheduled due to her being in ER (emergency room) at time of appointment." -9/27/14 at 12:20 AM, "[Client G] was in the living room and had gotten up to transfer to her wheelchair, staff prompted her to wait for assistance, [client G] refused to wait and got up and fell. [Client G] complained of pain in her arm and head. Staff called EMTs (emergency medical technicians) and she was transferred to the local hospital where she was assessed and admitted for observation and evaluation...." -10/7/14 "[Client G] was discharged from [name of hospital] and sent to [name of nursing home] for Rehab (rehabilitation) on her arm...." Client G's record was reviewed on 12/17/14 at 3:24 PM. Client G's 9/26/14 Medical Appointment Form indicated "She (client G) altered, fell at work, 5			

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	falls last two days. not (sic) really herself. has (sic) not (sic). fracture (sic) R (right) humeral head (shoulder/upper arm area) - sling. Left thumb fracture - Splint. Call [name of orthopedic doctor] - see discharge instructions for follow up call - Monday." Client G's 9/26/14 Patient Discharge Disposition Form indicated "Diagnosis Humeral (arm) fracture, Fracture of phalanx of thumb." The discharge form also indicated the hospital had completed labs and x-rays while client G was at the hospital. Client G's discharge form indicated client G was given pain medication for the client's pain and was to call/follow-up with an orthopedic surgeon the following Monday. Client G's discharge instructions indicated "...extra assistance with walking due to not able to walk with her walker with fractures of R arm and L thumb...." Client G's September 2014 Health care Coordination/Monthly Health Review indicated the following (not all inclusive): -9/23/14 "[Client G] fell today. Staff noted a cut on Left ear. Staff started fall observation sheet. Staff will use gait belt with [client G] starting today for frequent falls."			

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	-9/27/14 "[Client G] fell backwards hitting her head on chair. She was taken by ambulance to [name of hospital] ER. X-rays and labs done. Head ct (cat scan) showed Brain bleed??? X-ray showed broken right radius??? Broken right thumb. She was admitted to ICU at this time." -9/29/14 "CT head scan redone. Shows no brain bleed. New x-ray of right arm shows no broken right radius. Left thumb is broken. Remains in ICU at this time." -9/30/14 "[Client G] moved from ICU at [name of hospital] to room 246 today. She has a sling on her right arm and her left thumb is bandaged. Her family is present at this time." Client G's 5/21/14 Quarterly Nursing Assessment indicated client G "...Uses walker when walking for help with balance without difficulty...." Client G's 8/21/14 Quarterly Nursing Assessment indicated "...Continues to use walker for balance and frequent falls without difficulty...." Client G's 8/8/14 Fall Observation Flowsheet and fall Assessment sheet			

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	indicated client G fell walking to the restroom in the bathroom. The fall assessment indicated client G was using her walker at the time of the fall. Client G's 3/7/14 Physical examination indicated "Recommended Therapies: PT (Physical Therapy): NO, OT (Occupational Therapy): No...." Client G's 4/21/13 Annual Health Care Assessment (current one in record) indicated client G was evaluated by PT. The annual assessment indicated "PT for frequent falls this year." The assessment indicated client G was prescribed a walker to "help with balance" as client G had been falling since 2012. Client G's record and/or 4/2/14 Individual Support Plan (ISP) did not indicate any documentation of a PT evaluation prior to and/or after 4/12/13. Client G's 9/23/14 Gait Belt Protocol indicated "Unsteady balance even with walker. Staff use gait belt when [client G] is up ambulating with walker for safety. Encourage remind client that gait belt and assistance is needed. Always use gait belt when walking with, or transferring client...PT evaluation as needed...." Interview with the Qualified Intellectual			

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	Disabilities Professional (QIDP) on 12/16/14 at 4:30 PM indicated client G had a history of falls. The QIDP stated client G would fall "one to two times a month but is a lot better since she uses walker." The QIDP indicated client G would at times refuse to use her walker. Interview with staff #2 on 12/16/14 at 4:32 PM indicated client G had fallen in the past but had stopped when the client started utilizing a walker. Staff #2 indicated client G had used a walker for a year and half. Interview with staff #4 on 12/16/14 at 4:40 PM indicated client G had a history of falls. When asked how often client G fell, staff #4 stated client G "fell a few times at [name of day program]. Maybe one time a month at the group home." Interview with staff #1 on 12/16/14 at 4:45 PM indicated client G was in a nursing home due to injuries the client had received from a fall and was no longer able to use her walker when ambulating. Staff #1 stated client G's falls had "severely decreased" and now occurred about "once every other month." Staff #1 stated client G had a "slight increase in falling" prior to client G's going to the nursing home. Staff #1 indicated client G would refuse to use her			

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	walker when ambulating at times. Interview with LPN #1 and administrative staff #1 on 12/17/14 at 3:55 PM indicated client G had a history of falls. LPN #1 indicated client G did not have a history of fractures with falls. LPN #1 indicated client G fell on 8/8/14 and had not fallen until 9/23/14 when the client had several falls. LPN #1 indicated facility staff were to use a wheelchair with client G as client G was not able to use her walker due to her fractured arm and thumb. LPN #1 indicated client G last had a PT evaluation in September of 2012. LPN #1 indicated she was not able to locate the PT evaluation. LPN #1 indicated client G had not been re-assessed. 2. The facility's reportable incident reports and/or investigations were reviewed on 12/16/14 at 1:49 PM. The facility's reportable incident reports and/or investigations indicated the following (not all inclusive): -10/5/14 "On 10/5/14, [client C] tripped over her own feet and bruised her left forearm leaving about a half dollar sized bruise. [Client C] had no further injuries at the time of the report. [Client C] has a fall protocol that was completed. Staff will continue to assist [client C] when			

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	15G282		12/29/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REM-INDIANA INC	2715 ROCKFORD LN KOKOMO, IN 46902

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	necessary and HM (home manager) and PD (Program Director) will continue to monitor." -12/14/14 "[Client C] went to sit down for dinner and missed the chair and fell onto her rear end and slightly grazing her head on the wall as she went down. Staff helped her up and checked for injuries. No injuries were noted...Staff will continue to monitor her and follow her fall protocol.." During the 12/16/14 observation period between 3:19 PM and 5:00 PM, at the group home, client C did not ambulate independently. Facility staff held the client's arm and walked with the client and/or walked in front of client C as staff walked backwards to assist the client when ambulating. Client C's record was reviewed on 12/17/14 at 12:50 PM. Client C's 11/6/14 physician's orders indicated client C's diagnoses included, but were not limited to, Osteoporosis, Lower Extremity Edema and Osteoarthritis. Client C's 5/2/14 Fall Assessment indicated client C fell walking out of the bathroom without assistance. The 5/2/14 assessment indicated client C had her shoes on at the time of the fall.			

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	Client C's 10/21/14 Fall Assessment indicated client C fell standing up from the table. The assessment indicated facility staff was present at time of the fall. Client C's July 2014 Health care Coordination/Monthly Health Review indicated client C had Osteopenia and Osteoporosis and had "Multiple contractures of hands." The July 2014 monthly review indicated client C went to a medical facility to be checked due to "balance issues." Client C's September 2014 Monthly Health Review indicated on 9/24/14 "Staff noticed [client C] leaning more to the right today. She fell in the living room when getting up from the chair. She was seen at [name of hospital] ER. Labs (laboratory tests) drawn in ER. Labs within normal limits. No injuries noted." Client C's record indicated client C's last PT and/or OT assessments were completed on 1/29/02. Client C's record and/or 7/2/14 ISP did not indicate client C's gait and/or ambulation had been re-assessed. Interview with the QIDP on 12/16/14 at			

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	4:30 PM indicated client C had a history of falls. The QIDP stated client C would fall "an average of 1 to 2 times a month." Interview with staff #2 on 12/16/14 at 4:32 PM indicated client C could ambulate without facility staff. Staff #2 indicated client C would take staff's hand if client C felt she needed assistance. Staff #2 stated client C fell this past Sunday 12/14/14 and "one week ago Friday." Staff #2 indicated client C did not have any injuries at the time of her 12/14/14 fall, but did have bruises later. Interview with staff #4 on 12/16/14 at 4:40 PM indicated client C was a fall risk and had a fall protocol in place. Staff #4 indicated client C did not require assistance when walking but would "grab your arm and hand if assistance needed." Interview with staff #1 on 12/16/14 at 4:45 PM indicated client C had a history of falls. Staff #1 stated client C would fall one time a month and "May go awhile without falling." Staff #1 indicated facility staff assisted client C during the 12/16/14 observation as client C was not used to walking on the new wooden floor that was put in the group home as the group home had carpet in the past.			

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	Interview with LPN #1 and administrative staff #1 on 12/17/14 at 3:55 PM indicated client C was at risk for falls. LPN #1 indicated client C had not been re-assessed in regard to her recent falls as the client's last PT assessment, was completed in 9/11/11 (not in chart). This federal tag relates to complaint #IN00157666. 9-3-4(a)			
W000240	483.440(c)(6)(i) INDIVIDUAL PROGRAM PLAN The individual program plan must describe relevant interventions to support the individual toward independence. Based on observation, interview and record review for 1 of 3 sampled clients (C) and for 1 additional client (G), the clients' Individual Support Plans (ISPs) failed to indicate how the clients were to be monitored/supervised to prevent falls/injuries, and/or indicate how facility staff was to assist a client to ambulate. Findings include: 1. The facility's reportable incident reports and/or investigations were reviewed on 12/16/14 at 1:49 PM. The facility's reportable incident reports and/or investigations indicated the	W000240	Indiana Mentor has policies and procedures in place in regards to the health and safety of clients. Included in this are risk plans developed by trained nurses in conjunction with the QMRP. The QMRP is also trained on how to properly relay this information accurately in the individuals ISP. Staff are trained on all clients risk plans and the ISP prior to working with them. For clients C and G the nurse and QMRP reviewed their current plans as revised the ISPs to ensure it more accurately described the procedure and assistance level for the clients. The QMRP reviewed ISP for other individuals in the home as well to ensure they accurately	01/27/2015

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	following (not all inclusive): -9/23/14 "[Client G] was exiting the building for a fire drill at 9:30am on 9/23/14. [Client G] was not using her walker appropriately and fell down. Staff assisted her to sit on her walker. She was initially checked by staff, but they did not notice any bleeding or bruising at the time. Once she returned inside, nursing staff did a thorough check and found bruising and swelling of her right elbow. She was able to complete a passive range of motion. Nursing staff applied ice...." The facility's 8/23/14 Investigation Summary indicated day program staff "...tried to get to [client G] before she fell but could not get her...[Client G] had fallen outside of [name of day program] coming in from a fire drill due to not using her walker appropriately...." The facility's investigation indicated in a section entitled "Recommendations/Corrective Measures to Prevent Likelihood of Future Occurrences: Staff will continue to follow her fall protocol and remind her to use her walker appropriately." -9/23/14 at 7:15 PM, "[Client G] was in the kitchen and fell hitting her left ear on her walker. Staff assisted her up and checked her for injuries. Her left ear was		individuals risks and assistance levels. The reivisions were sent to the Area Director for approval. The QMRP along with the IDT will continue to develop the ISP and be sent to management for review prior to implementation.Responsible Party: QMRP, NurseComplete Date: 1/27/15	

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	bleeding a little so minor first aid was applied and the bleeding stopped. Staff will continue to monitor [client G] and notify the nurse of any changes. THey (sic) will also continue to follow her fall protocol." The facility's 9/24/14 Investigation Summary indicated facility staff was in the kitchen with client G when the client fell. The facility's investigation indicated "...and seen (sic) her lose her balance...." The facility's investigation did not indicate if facility staff was close enough to try and stop the client's fall/ where the facility staff was located in the kitchen. The facility's investigation recommendation/corrective action section indicated "Staff will continue to follow her fall protocol and remind her to use her walker appropriately. Due to multiple falls in short span an appointment has been made with PCP (Primary care Physician) for 9/27/14. Staff to continue sight supervision...." -9/26/14 at 4:30 PM, "[Name of day program] staff called Indiana Mentor house manager to report [client G] had fallen at day program and her arm did not seem normal. Residential staff took [client G] (sic) the hospital where she was diagnosed with a fracture in her right arm and a broken left thumb from the			

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	fall. Hospital put a splint on her (sic) thumb and sling for her arm. She will be following up with her primary care. Staff were trained on the discharge instructions and she has PRN (as needed) pain medication. Her fall plan has been reviewed and currently she has a gait belt, walker, and wheelchair as available aids in walking. Staff are continuing to utilize these with [client G]." The facility's 9/28/14 Investigation Summary indicated "...[Name of day program] staff stated the (sic) [client G] was walking by the entryway in the room and got her feet tangled in her walker and fell on her arm. [Name of day program] staff stated there were no trip hazards present at the time of the fall...." The facility's investigation also indicated "...Staff were trained on the discharge orders and procedures. [Client G] has a number of assistive equipment to aid in her mobility including her walker, PRN wheelchair, and belt. She had an appointment set with PCP in regards to falls on date of incident but is being rescheduled due to her being in ER (emergency room) at time of appointment." The facility's investigation indicated the facility failed to review the group home's staffing pattern to ensure client G would be adequately supervised/monitored due to the client's			

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	fractured thumb and arm. -9/27/14 at 12:20 AM, "[Client G] was in the living room and had gotten up to transfer to her wheelchair, staff prompted her to wait for assistance, [client G] refused to wait and got up and fell. [Client G] complained of pain in her arm and head. Staff called EMTs (emergency medical technicians) and she was transferred to the local hospital where she was assessed and admitted for observation and evaluation...." The facility's 10/8/14 Summary of Internal Investigation Report indicated client G got up and tried to sit herself in her wheelchair when she fell and hit her arm and her head. The facility's investigation indicated client G was placed in the hospital's Intensive Care Unit (ICU) due to a fall at the group home. The facility's investigation indicated the hospital was concerned client G may have a "...possible brain injury from the fall that night...." The facility's 10/8/14 investigation indicated "...[staff #3] stated that at around 12:30 am on 9/27/2014 she was getting ready to do bed checks. [Staff #3] stated [client G] was still sitting on chair in living room and had refused to go to her bed. [Staff #3] stated as she was conducting her checks that another client [client A]			

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	was having a seizure and she went and swiped the VNS (Vagal Nerve Stimulator) on her. [Staff #3] stated as she was exiting [client A's] room she saw [client G] standing up and transferring herself to the wheelchair. [Staff #3] stated she told [client G] to wait so she could help her. [Staff #3] stated [client G] would not wait and immediately tried to move to the wheelchair but slipped off the end of it. [Staff #3] stated the wheels were not locked on the chair. [Staff #3] stated as [client G] fell she hit injured arm on the ground and then knocked her head back into the wooden chair...." The facility's investigation indicated staff #3 was the only staff working at the time of the incident. -10/7/14 "[Client G] was discharged from [name of hospital] and sent to [name of nursing home] for Rehab (rehabilitation) on her arm...." Client G's record was reviewed on 12/17/14 at 3:24 PM. Client G's 9/26/14 Medical Appointment Form indicated "She (client G) altered, fell at work, 5 falls last two days. not (sic) really herself. has (sic) not (sic). fracture (sic) R (right) humeral head (shoulder/upper arm area) - sling. Left thumb fracture - Splint. Call [name of orthopedic doctor] - see discharge instructions for follow up			

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	call - Monday." Client G's 9/26/14 Patient Discharge Disposition Form indicated "Diagnosis Humeral (arm) fracture, Fracture of phalanx of thumb." The discharge form also indicated the hospital had completed labs and x-rays while client G was at the hospital. Client G's discharge form indicated client G was given pain medication for the client's pain and was to call/follow-up with an orthopedic surgeon the following Monday. Client G's discharge instructions indicated "...extra assistance with walking due to not able to walk with her walker with fractures of R arm and L thumb...." Client G's 5/21/14 Quarterly Nursing Assessment indicated client G "...Uses walker when walking for help with balance without difficulty...." Client G's 8/21/14 Quarterly Nursing Assessment indicated "...Continues to use walker for balance and frequent falls without difficulty...." Client G's 8/8/14 Fall Observation Flowsheet and fall Assessment sheet indicated client G fell walking to the restroom in the bathroom. The fall assessment indicated client G was using her walker at the time of the fall.			

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	Client G's 11/1/13 Fall Protocol (current one in record) indicated "[Client G] has unexplainable falls in the past year; currently uses a walker." The fall assessment indicated client G used a 4 wheeled walker with a seat to help prevent falls. The fall protocol sheet indicated specific guidelines facility staff were to follow if client G had a fall, and included who facility staff were to notify. Client G's 11/1/13 fall protocol failed to indicate how facility staff were to monitor/supervise the client to prevent falls/injuries. Client G's 9/23/14 Gait Belt Protocol indicated "Unsteady balance even with walker. Staff use gait belt when [client G] is up ambulating with walker for safety. Encourage remind client that gait belt and assistance is needed. Always use gait belt when walking with, or transferring client...PT evaluation as needed...." Client G's 11/1/13 fall protocol and/or 9/23/14 gait belt protocol did not indicate/include specifically how facility staff were to assist client G to ambulate with a fractured right arm and a broken left thumb to prevent falls/injuries. Interview with the Qualified Intellectual Disabilities Professional (QIDP) on			

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	12/16/14 at 4:30 PM indicated client G had a history of falls. The QIDP stated client G would fall "one to two times a month but is a lot better since she uses walker." The QIDP indicated one staff worked at night and one staff was on duty at the time client G fell and had to be sent out to the hospital. The QIDP indicated client G would at times refuse to use her walker. Interview with staff #2 on 12/16/14 at 4:32 PM indicated client G had fallen in the past but had stopped when the client started utilizing a walker. Staff #2 indicated client G had used a walker for a year and half. Interview with staff #4 on 12/16/14 at 4:40 PM indicated client G had a history of falls. When asked how often client G fell, staff #4 stated client G "fell a few times at [name of day program]. Maybe one time a month at the group home." Interview with staff #1 on 12/16/14 at 4:45 PM indicated client G was in a nursing home due to injuries the client had received from a fall and was no longer able to use her walker when ambulating. Staff #1 stated client G's falls had "severely decreased" and now occurred about "once every other month." Staff #1 stated client G had a "slight			

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	increase in falling" prior to client G's going to the nursing home. Staff #1 indicated client G would refuse to use her walker when ambulating at times. Interview with LPN #1 and administrative staff #1 on 12/17/14 at 3:55 PM indicated client G had a history of falls. LPN #1 indicated client G did not have a history of fractures with falls. LPN #1 indicated client G's risk plan did not specifically indicate how facility staff was to ambulate with client G with a fractured arm/thumb and/or indicate how facility staff were to assist the client with dressing and/or bathing/showering. Administrative staff #1 and LPN #1 indicated client G's risk plans did not indicate how facility staff were to monitor/supervise client G to prevent the client from falling. 2. The facility's reportable incident reports and/or investigations were reviewed on 12/16/14 at 1:49 PM. The facility's reportable incident reports and/or investigations indicated the following (not all inclusive): -10/5/14 "On 10/5/14, [client C] tripped over her own feet and bruised her left forearm leaving about a half dollar sized bruise. [Client C] had no further injuries at the time of the report. [Client C] has a			

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	fall protocol that was completed. Staff will continue to assist [client C] when necessary and HM (home manager) and PD (Program Director) will continue to monitor." The facility's 10/7/14 Investigation Summary indicated facility staff was walking by client C when she tripped and fell over her own feet. The facility's investigation did not indicate and/or address if facility staff was near the client to prevent and/or stop the client's fall. The facility's recommendations/corrective measures indicated "Continue to follow fall plan prompt [client C] to watch where she is going. To keep at appropriate pace." -12/14/14 "[Client C] went to sit down for dinner and missed the chair and fell onto her rear end and slightly grazing her head on the wall as she went down. Staff helped her up and checked for injuries. No injuries were noted...Staff will continue to monitor her and follow her fall protocol.." The facility's 12/15/14 Investigation Summary indicated "Staff was by the table when [client C] started to sit down. Staff stated as [client C] began to sit she misjudged where the seat was at (sic) missed it causing her to fall to the			

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	floor...." During the 12/16/14 observation period between 3:19 PM and 5:00 PM, at the group home, client C did not ambulate independently. Facility staff held the client's arm and walked with the client and/or walked in front of client C as staff walked backwards to assist the client when ambulating. Client C's record was reviewed on 12/17/14 at 12:50 PM. Client C's 5/2/14 Fall Assessment indicated client C fell walking out of the bathroom without assistance. The 5/2/14 assessment indicated client C had her shoes on at the time of the fall. Client C's 10/21/14 Fall Assessment indicated client C fell standing up from the table. The assessment indicated facility staff was present at time of the fall. Client C's July 2014 Health care Coordination/Monthly Health Review indicated client C had Osteopenia and Osteoporosis and had "Multiple contractures of hands." The July 2014 monthly review indicated client C went to a medical facility to be checked due to "balance issues."			

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	Client C's September 2014 Monthly Health Review indicated on 9/24/14 "Staff noticed [client C] leaning more to the right today. She fell in the living room when getting up from the chair. She was seen at [name of hospital] ER. Labs (laboratory tests) drawn in ER. Labs within normal limits. No injuries noted." Client C's record indicated client C's last PT and/or OT assessments were completed on 1/29/02. Client C's record and/or 7/2/14 ISP did not indicate client C's gait and/or ambulation had been re-assessed. Client C's 11/3/14 Fall Protocol indicated "[Client C] has contractures of hands and feet from osteoarthritis. She has lower extremity edema and leans to slightly to right side because of osteoporosis. She susceptibility of falls due to diagnosis (sic)." The fall assessment indicated client C walked independently. The assessment indicated "Non-skid shoes on at all times while up and walking during the day. Prompts from staff to slow down while walking. needs assistance when going to bathroom; showering and getting up and down to bed. Client C's 11/13/14 fall protocol indicated what facility staff were to do when the client fell and indicated who facility staff were			

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	to contact. Client C's 11/3/14 fall protocol and/or 7/2/14 ISP did not indicate how facility staff were to monitor/supervise the client when she ambulated to ensure the client did not fall. Interview with the QIDP on 12/16/14 at 4:30 PM indicated client C had a history of falls. The QIDP stated client C would fall "an average of 1 to 2 times a month." Interview with staff #2 on 12/16/14 at 4:32 PM indicated client C could ambulate without facility staff. Staff #2 indicated client C would take staff's hand if client C felt she needed assistance. Staff #2 stated client C fell this past Sunday 12/14/14 and "one week ago Friday." Staff #2 indicated client C did not have any injuries at the time of her 12/14/14 fall, but did have bruises later. Staff #2 indicated facility staff monitored client C as the client had hit her head when she fell to the floor on her side. Interview with staff #4 on 12/16/14 at 4:40 PM indicated client C was a fall risk and had a fall protocol in place. Staff #4 indicated client C did not require assistance when walking but would "grab your arm and hand if assistance needed." Interview with staff #1 on 12/16/14 at			

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	4:45 PM indicated client C had a history of falls. Staff #1 stated client C would fall one time a month and "May go awhile without falling." Staff #1 indicated facility staff assisted client C during the 12/16/14 observation as client C was not used to walking on the new wooden floor that was put in the group home as the group home had carpet in the past. Interview with LPN #1 and administrative staff #1 on 12/17/14 at 3:55 PM indicated client C was at risk for falls. Administrative staff #1 and LPN #1 indicated client C were to wear her shoes to help prevent the client from falling. LPN #1 stated "It is effective when you can get her to wear her shoes." Administrative staff #1 and LPN #1 indicated client C's ISP and/or risk plans did not indicate how facility staff were to monitor/supervise the client to prevent falls/injuries. This federal tag relates to complaint #IN00157666. 9-3-4(a)			
W000331	483.460(c) NURSING SERVICES The facility must provide clients with nursing services in accordance with their needs.			

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	Based on observation, interview and record review for 1 of 3 sampled clients (C) and for 1 additional client (G), the facility's nursing services failed to meet the nursing needs of the clients in regard to revising/updating risk plans and/or developing risk plans. Findings include: 1. The facility's reportable incident reports and/or investigations were reviewed on 12/16/14 at 1:49 PM. The facility's reportable incident reports and/or investigations indicated the following (not all inclusive): -9/23/14 "[Client G] was exiting the building for a fire drill at 9:30am on 9/23/14. [Client G] was not using her walker appropriately and fell down. Staff assisted her to sit on her walker. She was initially checked by staff, but they did not notice any bleeding or bruising at the time. Once she returned inside, nursing staff did a thorough check and found bruising and swelling of her right elbow. She was able to complete a passive range of motion. Nursing staff applied ice...." -9/23/14 at 7:15 PM, "[Client G] was in the kitchen and fell hitting her left ear on her walker. Staff assisted her up and checked her for injuries. Her left ear was	W000331	Indiana Mentor has policies and procedures in place in regards to the health and safety of clients. Included in this are risk plans developed by trained nurses in conjunction with the QMRP. For clients C and G the nurse and QMRP reviewed their current plans as well as reviewing the fall plans for all other individuals in the house. The House Manager and QMRP did a training with the staff on these plans as well to ensure proper implementation and comprehension was met. On going falls are being reviewed by the complete IDT and will include a discussion on adaptative equipment, staffing, and ensuring the fall protocol still mets the individuals needs. These reports will be sent to the Area Director for review. In addition for the next 6 months the nurse, qmrp, and othe members of management will review all IRs with Area Director on a monthly basis. Responsible Party: QMRP, NurseComplete Date: 1/27/15	01/27/2015

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	bleeding a little so minor first aid was applied and the bleeding stopped. Staff will continue to monitor [client G] and notify the nurse of any changes. THey (sic) will also continue to follow her fall protocol." The facility's 9/24/14 Investigation Summary indicated facility staff was in the kitchen with client G when the client fell. The facility's investigation indicated "...and seen (sic) her lose her balance...." The facility's investigation did not indicate if facility staff was close enough to try and stop the client's fall/ where the facility staff was located in the kitchen. The facility's investigation recommendation/corrective action section indicated "Staff will continue to follow her fall protocol and remind her to use her walker appropriately. Due to multiple falls in short span an appointment has been made with PCP (Primary care Physician) for 9/27/14. Staff to continue sight supervision and use the adaptive equipment to aid [client G]...." -9/26/14 at 4:30 PM, "[Name of day program] staff called Indiana Mentor house manager to report [client G] had fallen at day program and her arm did not seem normal. Residential staff took [client G] (sic) the hospital where she			

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	was diagnosed with a fracture in her right arm and a broken left thumb from the fall. Hospital put a splint on her (sic) thumb and sling for her arm. She will be following up with her primary care. Staff were trained on the discharge instructions and she has PRN (as needed) pain medication. Her fall plan has been reviewed and currently she has a gait belt, walker, and wheelchair as available aids in walking. Staff are continuing to utilize these with [client G]." The facility's 9/28/14 Investigation Summary indicated "...[Name of day program] staff stated the (sic) [client G] was walking by the entryway in the room and got her feet tangled in her walker and fell on her arm. [Name of day program] staff stated there were no trip hazards present at the time of the fall...." The facility's investigation also indicated "...Staff were trained on the discharge orders and procedures. [Client G] has a number of assistive equipment to aid in her mobility including her walker, PRN wheelchair, and belt. She had an appointment set with PCP in regards to falls on date of incident but is being rescheduled due to her being in ER (emergency room) at time of appointment." -9/27/14 at 12:20 AM, "[Client G] was in			

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	the living room and had gotten up to transfer to her wheelchair, staff prompted her to wait for assistance, [client G] refused to wait and got up and fell. [Client G] complained of pain in her arm and head. Staff called EMTs (emergency medical technicians) and she was transferred to the local hospital where she was assessed and admitted for observation and evaluation...." The facility's 10/8/14 Summary of Internal Investigation Report indicated client G got up and tried to sit herself in her wheelchair when she fell and hit her arm and her head. The facility's investigation indicated client G was placed in the hospital's Intensive Care Unit (ICU) due to a fall at the group home. The facility's investigation indicated the hospital was concerned client G may have a "...possible brain injury from the fall that night...." The facility's investigation indicated the hospital did a scan on 9/29 and 10/1/14, at the hospital, and did not find "...no evidence of any bleeding in the brain or head trauma...[Staff #1] stated on 10/8/2014 the hospital informed her that [client G] never broke her arm either but instead had just a muscle tear by her shoulder...." The facility's 10/8/14 investigation indicated "...[staff #3] stated that at around 12:30 am on 9/27/2014 she			

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	was getting ready to do bed checks. [Staff #3] stated [client G] was still sitting on chair in living room and had refused to go to her bed. [Staff #3] stated as she was conducting her checks that another client [client A] was having a seizure and she went and swiped the VNS (Vagal Nerve Stimulator) on her. [Staff #3] stated as she was exiting [client A's] room she saw [client G] standing up and transferring herself to the wheelchair. [Staff #3] stated she told [client G] to wait so she could help her. [Staff #3] stated [client G] would not wait and immediately tried to move to the wheelchair but slipped off the end of it. [Staff #3] stated the wheels were not locked on the chair. [Staff #3] stated as [client G] fell she hit injured arm on the ground and then knocked her head back into the wooden chair...." -10/7/14 "[Client G] was discharged from [name of hospital] and sent to [name of nursing home] for Rehab (rehabilitation) on her arm...." Client G's record was reviewed on 12/17/14 at 3:24 PM. Client G's 9/26/14 Medical Appointment Form indicated "She (client G) altered, fell at work, 5 falls last two days. not (sic) really herself. has (sic) not (sic). fracture (sic) R (right) humeral head (shoulder/upper			

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	arm area) - sling. Left thumb fracture - Splint. Call [name of orthopedic doctor] - see discharge instructions for follow up call - Monday." Client G's 9/26/14 Patient Discharge Disposition Form indicated "Diagnosis Humeral (arm) fracture, Fracture of phalanx of thumb." The discharge form also indicated the hospital had completed labs and x-rays while client G was at the hospital. Client G's discharge form indicated client G was given pain medication for the client's pain and was to call/follow-up with an orthopedic surgeon the following Monday. Client G's discharge instructions indicated "...extra assistance with walking due to not able to walk with her walker with fractures of R arm and L thumb. Try to keep affected area elevated above level of the heart when possible. Apply ice pack for 2-30 minutes every few hours. Use Ibuprofen for pain if not allergic or any other anti-inflammatory medication." The discharge instructions indicated client G was to wear a sling for the client's arm and a splint for the client's thumb. Client G's September 2014 Health care Coordination/Monthly Health Review indicated the following (not all inclusive):			

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	-9/23/14 "[Client G] fell today. Staff noted a cut on Left ear. Staff started fall observation sheet. Staff will use gait belt with [client G] starting today for frequent falls." -9/27/14 "[Client G] fell backwards hitting her head on chair. She was taken by ambulance to [name of hospital] ER. X-rays and labs done. Head ct (cat scan) showed Brain bleed??? X-ray showed broken right radius??? Broken right thumb. She was admitted to ICU at this time." -9/29/14 "CT head scan redone. Shows no brain bleed. New x-ray of right arm shows no broken right radius. Left thumb is broken. Remains in ICU at this time." -9/30/14 "[Client G] moved from ICU at [name of hospital] to room 246 today. She has a sling on her right arm and her left thumb is bandaged. Her family is present at this time." Client G's 5/21/14 Quarterly Nursing Assessment indicated client G "...Uses walker when walking for help with balance without difficulty...." Client G's 8/21/14 Quarterly Nursing			

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	Assessment indicated "...Continues to use walker for balance and frequent falls without difficulty...." Client G's 8/8/14 Fall Observation Flowsheet and fall Assessment sheet indicated client G fell walking to the restroom in the bathroom. The fall assessment indicated client G was using her walker at the time of the fall. Client G's 11/21/14 Quarterly Nursing Assessment indicated "11-21-14 [Client G] placed in rehab [name of nursing home] rehab from fall back on September 27th, 2014 in the living room at the home. [Client G] was released from our services October 10th, 2014." Client G's 3/7/14 Physical examination indicated "Recommended Therapies: PT (Physical Therapy): No, OT (Occupational Therapy): No...." Client G's 4/21/13 Annual Health Care Assessment (current one in record) indicated client G was evaluated by PT. The annual assessment indicated "PT for frequent falls this year." The assessment indicated client G was prescribed a walker to "help with balance" as client G had been falling since 2012. Client G's 11/1/13 Fall Protocol (current			

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	one in record) indicated "[Client G] has unexplainable falls in the past year; currently uses a walker." The fall assessment indicated client G used a 4 wheeled walker with a seat to help prevent falls. The fall protocol sheet indicated specific guidelines facility staff were to follow if client G had a fall, and included who facility staff were to notify. Client G's 11/1/13 fall protocol failed to indicate how facility staff were to monitor/supervise the client to prevent falls/injuries. Client G's 9/23/14 Gait Belt Protocol indicated "Unsteady balance even with walker. Staff use gait belt when [client G] is up ambulating with walker for safety. Encourage remind client that gait belt and assistance is needed. Always use gait belt when walking with, or transferring client...PT evaluation as needed...." Client G's 11/1/13 fall protocol and/or 9/23/14 gait belt protocol did not indicate/include specifically how facility staff were to assist client G to ambulate with a fractured right arm and a broken left thumb to prevent falls/injuries. The above mentioned protocols did not indicate/include the use of a wheelchair. Interview with staff #1 on 12/16/14 at 4:45 PM indicated client G was in a			

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	nursing home due to injuries the client had received from a fall and was no longer able to use her walker when ambulating. Staff #1 stated client G's falls had "severely decreased" and now occurred about "once every other month." Staff #1 stated client G had a "slight increase in falling" prior to client G's going to the nursing home. Staff #1 indicated client G would refuse to use her walker when ambulating at times. Staff #1 indicated client G would be returned to the group home once she finished her rehabilitation therapy at the nursing home. Interview with LPN #1 and administrative staff #1 on 12/17/14 at 3:55 PM indicated client G had a history of falls. LPN #1 indicated client G did not have a history of fractures with falls. LPN #1 indicated client G fell on 8/8/14 and had not fallen until 9/23/14 when the client had several falls. LPN #1 indicated facility staff were to use a wheelchair with client G as client G was not able to use her walker due to her fractured arm and thumb. LPN #1 indicated the hospital stated client G did not have a fractured arm but had a tear in the client's "rotator cuff." LPN #1 indicated facility staff had been trained in regard to gait belt training. LPN #1 indicated LPN #1 had not put any nursing			

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	measures/guidelines in place after the 9/26/14 fall resulting in the fracture. LPN #1 indicated she did not update the client's risk plan. LPN #1 indicated client G's risk plan did not specifically indicate how facility staff was to ambulate with client G with a fractured arm/thumb and/or indicate how facility staff were to assist the client with dressing and/or bathing/showering. LPN #1 indicated client G fell again on 9/27/14 and was sent out to the hospital and had not returned to the group home. LPN #1 indicated client last had a PT evaluation in September of 2012. LPN #1 indicated she was not able to locate the PT evaluation. LPN #1 indicated client G had not been re-assessed. 2. The facility's reportable incident reports and/or investigations were reviewed on 12/16/14 at 1:49 PM. The facility's reportable incident reports and/or investigations indicated the following (not all inclusive): -10/5/14 "On 10/5/14, [client C] tripped over her own feet and bruised her left forearm leaving about a half dollar sized bruise. [Client C] had no further injuries at the time of the report. [Client C] has a fall protocol that was completed. Staff will continue to assist [client C] when necessary and HM (home manager) and			

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	PD (Program Director) will continue to monitor." -12/14/14 "[Client C] went to sit down for dinner and missed the chair and fell onto her rear end and slightly grazing her head on the wall as she went down. Staff helped her up and checked for injuries. No injuries were noted...Staff will continue to monitor her and follow her fall protocol.." During the 12/16/14 observation period between 3:19 PM and 5:00 PM, at the group home, client C did not ambulate independently. Facility staff held the client's arm and walked with the client and/or walked in front of client C as staff walked backwards to assist the client when ambulating. Client C's record was reviewed on 12/17/14 at 12:50 PM. Client C's 11/6/14 physician's orders indicated client C's diagnoses included, but were not limited to, Osteoporosis, Lower Extremity Edema and Osteoarthritis. Client C's 5/2/14 Fall Assessment indicated client C fell walking out of the bathroom without assistance. The 5/2/14 assessment indicated client C had her shoes on at the time of the fall.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G282	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 12/29/2014
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	Client C's 10/21/14 Fall Assessment indicated client C fell standing up from the table. The assessment indicated facility staff was present at time of the fall. Client C's July 2014 Health care Coordination/Monthly Health Review indicated client C had Osteopenia and Osteoporosis and had "Multiple contractures of hands." Client C's 11/3/14 Fall Protocol indicated "[Client C] has contractures of hands and feet from osteoarthritis. She has lower extremity edema and leans to slightly to right side because of osteoporosis. She susceptibility of falls due to diagnosis (sic)." The fall assessment indicated client C walked independently. The assessment indicated "Non-skid shoes on at all times while up and walking during the day. Prompts from staff to slow down while walking. needs assistance when going to bathroom; showering and getting up and down to bed. Client C's 11/13/14 fall protocol indicated what facility staff were to do when the client fell and indicated who facility staff were to contact. Client C's 11/3/14 fall protocol and/or 7/2/14 ISP did not indicate how facility staff were to monitor/supervise the client when she ambulated to ensure the client did not			

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	fall. Client C's 7/2/14 ISP indicated "...She (client C) was seen at the ER on 4-29-13 for a fall which resulted in a dislocation to her shoulder...Ct (cat scan) of head on 1-4-12 was also negative. She had a hairline fracture in mid spine caused by osteoporosis...." Client C's 7/2/14 ISP and/or risk plans/protocols indicated client C did not have a risk plan/protocol for the client's Osteoporosis/Osteopenia diagnoses in regard to potential fractures/injuries from falls. Interview with the QIDP on 12/16/14 at 4:30 PM indicated client C had a history of falls. The QIDP stated client C would fall "an average of 1 to 2 times a month." Interview with staff #2 on 12/16/14 at 4:32 PM indicated client C could ambulate without facility staff. Staff #2 indicated client C would take staff's hand if client C felt she needed assistance. Staff #2 stated client C fell this past Sunday 12/14/14 and "one week ago Friday." Staff #2 indicated client C did not have any injuries at the time of her 12/14/14 fall, but did have bruises later. Staff #2 indicated facility staff monitored client C as the client had hit her head when she fell to the floor on her side.			

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	Interview with staff #4 on 12/16/14 at 4:40 PM indicated client C was a fall risk and had a fall protocol in place. Staff #4 indicated client C did not require assistance when walking but would "grab your arm and hand if assistance needed." Interview with staff #1 on 12/16/14 at 4:45 PM indicated client C had a history of falls. Staff #1 stated client C would fall one time a month and "May go awhile without falling." Staff #1 indicated facility staff assisted client C during the 12/16/14 observation as client C was not used to walking on the new wooden floor that was put in the group home as the group home had carpet in the past. Interview with LPN #1 and administrative staff #1 on 12/17/14 at 3:55 PM indicated client C was at risk for falls. LPN #1 indicated client C did not have a risk plan in place for the client's Osteoporosis diagnosis. LPN #1 indicated client C had not been re-assessed in regard to her recent falls as the client's last PT assessment, was completed in 9/11/11 (not in chart). Administrative staff #1 and LPN #1 indicated client C were to wear her shoes to help prevent the client from falling. LPN #1 stated "It is effective when you can get her to wear her shoes."			

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	Administrative staff #1 and LPN #1 indicated client C's ISP and/or risk plans did not indicate how facility staff were to monitor/supervise the client to prevent falls/injuries. This federal tag relates to complaint #IN00157666. 9-3-6(a)			