STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G735	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 08/27/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REM OCCAZIO LLC	1206 S MAIN ST NEW CASTLE, IN 47362

(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
W 0000 Bldg. 00	This visit was for the investigation of complaint #IN00178434 and complaint #IN00174893. Complaint #IN00178434: Unsubstantiated, due to lack of evidence. Complaint #IN00174893: Substantiated, federal and state deficiencies related to the allegations are cited at: W102, W104, W122, W149, W153, W154, W156, W210, W240, W318 and W331. Dates of Survey: August 13, 14, 26 and 27, 2015. Facility Number: 005553 Provider Number: 15G735 AIM Number: 200854080 These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review of this report completed by #15068 on 9/3/15.	W 0000		
W 0102 Bldg. 00	483.410 GOVERNING BODY AND MANAGEMENT The facility must ensure that specific			

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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	governing body and management requirements are met. Based on observation, record review and interview, the facility failed to meet the Condition of Participation: Governing Body for 4 of 4 sampled clients (A, B, C and D) and for 3 additional clients (E, F and G). The governing body failed to ensure sufficient safeguards were implemented to prevent clients A, B and C from recurring falls and injury from falls, to ensure nursing services assessed and monitored clients' injuries resulting from falls and clients with recurring falls and to ensure nursing services reviewed and revised the clients' Falls Risks Plans (FRPs) after falls to ensure the clients' plans included appropriate client specific safeguards to prevent further falls and injuries. The governing body failed to implement its policy and procedures to ensure all allegations of client to client abuse were reported immediately to the administrator and to the BDDS (Bureau of Developmental Disabilities Services) per IAC 9-3-1(b)(5) and APS (Adult Protective Services) per IC 12-10-3 according to state law, to ensure all injuries of unknown origin were reported immediately to the administrator, to	W 0102	**W102 Governing Bodyand Management** The facility must ensure that the specific governing bodyand management requirements are met. **1. What corrective action will beaccomplished?** •□□□□□□□□Facility nurse will be trained on specific plansof care, risk plans and assessments regarding falls and injuries from falls. •□□□□□□□□Specific plans of care will be developed and riskplans updated and implemented in regard falls by facility nurse. •□□□□□□□□Staff will be trained on plans of care byfacility nurse. •□□□□□□□□A formal procedure will be implemented to consistentlyaddress falls and fall prevention by facility nurse. •□□□□□□□□Staff will be trained on fall procedure byfacility nurse. •□□□□□□□□Staff, Program Coordinator and Program Director(QIDP) will be retrained on reporting and documenting all falls, client toclient abuse and injuries of unknown origin. •□□□□□□□□Program Director will be retrained oninvestigation protocol and timeliness for falls, client to client abuse andinjuries of unknown origin, per state law. •□□□□□□□□Program Coordinator will monitor documentationof falls,	09/26/2015

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	ensure all allegations of abuse and all injuries of unknown origin were thoroughly investigated and to ensure the results of all investigations were reported to the administrator within five working days in accordance with State law for clients A, B, C, D, E, F and G. Findings include: 1. The governing body failed to exercise general policy and operating direction over the facility to ensure sufficient safeguards were implemented to prevent clients A, B and C from recurring falls and injury from falls, to ensure nursing services assessed and monitored clients' injuries resulting from falls and clients with recurring falls and to ensure nursing services reviewed and revised the clients' Falls Risks Plans (FRPs) after falls to ensure the clients' plans included appropriate client specific safeguards to prevent further falls and injuries. Please see W104. 2. The governing body failed to exercise general policy and operating direction over the facility to ensure the facility implemented its policy and procedures to ensure all allegations of client to client abuse were reported immediately to the administrator and to the BDDS (Bureau of Developmental Disabilities Services)		client to client abuse and injuries of unknown origin 3 times perweek. •□□□□□□□□Program Director (QIDP) and facility nurse willmonitor documentation of falls, client to client abuse and injuries of unknownorigin weekly. •□□□□□□□□Monthly, the facility nurse, Program Coordinatorand Program Director (QIDP) will meet to review client needs, all client careand risk plans and ensure fall protocol training completed for existing and newstaff. **2. How will we identify other residents havingthe potential to be affected by the same deficient practice and what correctiveaction will be taken?** •□□□□□□□□All residents have the potential to be affectedby the same deficient practice. •□□□□□□□□Facility nurse will be trained on specific plansof care, risk plans and assessments regarding falls and injuries from falls. •□□□□□□□□Specific plans of care will be developed andrisk plans updated and implemented in regard falls by facility nurse. •□□□□□□□□Staff will be trained on plans of care byfacility nurse. •□□□□□□□□A formal procedure will be implemented toconsistently address falls and fall prevention by facility nurse.	

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	per IAC 9-3-1(b)(5) and APS (Adult Protective Services) per IC 12-10-3 according to state law, to ensure all injuries of unknown origin were reported immediately to the administrator, to ensure all allegations of abuse and all injuries of unknown origin were thoroughly investigated and to ensure the results of all investigations were reported to the administrator within five working days in accordance with State law for clients A, B, C, D, E, F and G. The governing body failed to ensure the facility met the Condition of Participation: Client Protections. The governing body failed to ensure the facility implemented its written policy and procedures to prevent recurring falls and injuries from falls for clients A, B and C. The governing body failed to ensure sufficient safeguards were implemented to prevent clients A, B and C from recurring falls and injury from falls, to ensure nursing services assessed and monitored clients' injuries resulting from falls and clients with recurring falls and to ensure nursing services reviewed and revised the clients' FRPs after falls to ensure the clients' plans included appropriate client specific safeguards to prevent further falls and injuries. The governing body failed to implement		•□□□□□□□□Staff will be trained on fall procedure byfacility nurse. •□□□□□□□□Staff, Program Coordinator and Program Director(QIDP) will be retrained on reporting and documenting all falls, client toclient abuse and injuries of unknown origin. •□□□□□□□□Program Director will be retrained oninvestigation protocol and timeliness for falls, client to client abuse andinjuries of unknown origin, per state law. •□□□□□□□□Program Coordinator will monitor documentationof falls, client to client abuse and injuries of unknown origin 3 times perweek. •□□□□□□□□Program Director (QIDP) and facility nurse willmonitor documentation of falls, client to client abuse and injuries of unknownorigin weekly. •□□□□□□□□Monthly, the facility nurse, Program Coordinatorand Program Director (QIDP) will meet to review client needs, all client careand risk plans and ensure fall protocol training completed for existing and newstaff. **3. What measures will be put into place orwhat systemic changes will be made to ensure that the deficient practice doesnot recur:** •□□□□□□□Facility nurse will be trained on specific plansof care, risk plans and assessments regarding falls and injuries from	

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	its policy and procedures to ensure all allegations of client to client abuse were reported immediately to the administrator and to the BDDS (Bureau of Developmental Disabilities Services) per IAC 9-3-1(b)(5) and APS (Adult Protective Services) per IC 12-10-3 according to state law, to ensure all injuries of unknown origin were reported immediately to the administrator, to ensure all allegations of abuse and all injuries of unknown origin were thoroughly investigated and to ensure the results of all investigations were reported to the administrator within five working days in accordance with State law for clients A, B, C, D, E, F and G. Please see W122. 3. The governing body failed to meet the Condition of Participation: Health Care Services for clients A, B and C. The governing body failed to ensure health care services met the health care needs of clients A, B and C. The governing body failed to ensure nursing services assessed and monitored clients A, B and C after falls with injury, head injury, client wounds and/or excessive bruising due to recurring falls. The governing body failed to ensure health care services reviewed and revised client A's, B's and C's Falls Risks Plans (FRPs) after recurring falls to ensure the clients' plans included		falls. •□□□□□□□Specific plans of care will be developed andrisk plans updated and implemented in regard falls by facility nurse. •□□□□□□□Staff will be trained on plans of care byfacility nurse. •□□□□□□□A formal procedure will be implemented toconsistently address falls and fall prevention by facility nurse. •□□□□□□□Staff will be trained on fall procedure byfacility nurse. •□□□□□□□Staff, Program Coordinator and Program Director(QIDP) will be retrained on reporting and documenting all falls, client toclient abuse and injuries of unknown origin. •□□□□□□□Program Director will be retrained oninvestigation protocol and timeliness for falls, client to client abuse andinjuries of unknown origin, per state law. •□□□□□□□Program Coordinator will monitor documentationof falls, client to client abuse and injuries of unknown origin 3 times perweek. •□□□□□□□Program Director (QIDP) and facility nurse willmonitor documentation of falls, client to client abuse and injuries of unknownorigin weekly. •□□□□□□□Monthly, the facility nurse, Program Coordinatorand Program Director (QIDP) will meet to review client needs, all client careand risk plans and ensure fall protocol training completed for existing and	

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	appropriate client specific safeguards to prevent further falls and injuries resulting from falls and to ensure the plans included the use of all adaptive equipment required to protect the clients from further falls, included how and when the equipment was to be used in regard to the client and included how the staff were to supervise and assist the clients throughout the day to ensure no further falls and/or injury from falls to ensure the clients' safety. The governing body failed to ensure nursing services provided timely assessments and documentation of care provided for clients A, B and C. Please see W318. This federal tag relates to complaint #IN00174893. 9-3-1(a)		newstaff. **4. How will the corrective action be monitoredto ensure the deficient practice will not recur?** •□□□□□□□Facility nurse will be trained on specific plansof care, risk plans and assessments regarding falls and injuries from falls. •□□□□□□□Specific plans of care will be developed andrisk plans updated and implemented in regard falls by facility nurse. •□□□□□□□Staff will be trained on plans of care byfacility nurse. •□□□□□□□A formal procedure will be implemented toconsistently address falls and fall prevention by facility nurse. •□□□□□□□Staff will be trained on fall procedure byfacility nurse. •□□□□□□□Staff, Program Coordinator and Program Director(QIDP) will be retrained on reporting and documenting all falls, client toclient abuse and injuries of unknown origin. •□□□□□□□Program Director will be retrained oninvestigation protocol and timeliness for falls, client to client abuse andinjuries of unknown origin, per state law. •□□□□□□□Program Coordinator will monitor documentationof falls, client to client abuse and injuries of unknown origin 3 times perweek. •□□□□□□□Program Director	

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			(QIDP) and facility nurse willmonitor documentation of falls, client to client abuse and injuries of unknownorigin weekly. •□□□□□□□Monthly, the facility nurse, Program Coordinatorand Program Director (QIDP) will meet to review client needs, all client careand risk plans and ensure fall protocol training completed for existing and newstaff. **5. What is the date by which the systemicchanges will be completed?** **9/26/15**	
W 0104 Bldg. 00	483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility. Based on observation, interview and record review for 4 of 4 sampled clients (A, B, C and D) and for 3 additional clients (E, F and G), the governing body failed to exercise general policy and operating direction over the facility to ensure sufficient safeguards were implemented to prevent clients A, B and C from recurring falls and injury from falls, to ensure nursing services assessed and monitored clients' injuries resulting from falls and clients with recurring falls and to ensure nursing services reviewed	W 0104	**W104 Governing Bodyand Management** The governing body must exercise general policy, budget andoperating direction over the facility. The facility must ensure that the specific governing bodyand management requirements are met. **1. What corrective action will beaccomplished?** •□□□□□□□□Facility nurse will be trained on specific plansof care, risk plans and assessments	09/26/2015

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	and revised the clients' Falls Risks Plans (FRPs) after falls to ensure the clients' plans included appropriate client specific safeguards to prevent further falls and injuries. The governing body failed to exercise general policy and operating direction over the facility to ensure the facility implemented its policy and procedures to ensure all allegations of client to client abuse were reported immediately to the administrator and to the BDDS (Bureau of Developmental Disabilities Services) per IAC 9-3-1(b)(5) and APS (Adult Protective Services) per IC 12-10-3 according to state law, to ensure all injuries of unknown origin were reported immediately to the administrator, to ensure all allegations of abuse and all injuries of unknown origin were thoroughly investigated and to ensure the results of all investigations were reported to the administrator within five working days in accordance with State law for clients A, B, C, D, E, F and G. Findings include: 1. The facility's governing body failed to exercise general policy and operating direction over the facility to implement its policy and procedures to ensure sufficient safeguards were implemented		regarding falls and injuries from falls. •□□□□□□□□Specific plans of care will be developed andrisk plans updated and implemented in regard falls by facility nurse. •□□□□□□□□Staff will be trained on plans of care byfacility nurse. •□□□□□□□□A formal procedure will be implemented toconsistently address falls and fall prevention by facility nurse. •□□□□□□□□Staff will be trained on fall procedure byfacility nurse. •□□□□□□□□Staff, Program Coordinator and Program Director(QIDP) will be retrained on reporting and documenting all falls, client toclient abuse and injuries of unknown origin. •□□□□□□□□Program Director will be retrained oninvestigation protocol and timeliness for falls, client to client abuse andinjuries of unknown origin, per state law. •□□□□□□□□Program Coordinator will monitor documentationof falls, client to client abuse and injuries of unknown origin 3 times perweek. •□□□□□□□□Program Director (QIDP) and facility nurse willmonitor documentation of falls, client to client abuse and injuries of unknownorigin weekly. •□□□□□□□□Monthly, the facility nurse, Program Coordinatorand Program Director (QIDP) will meet to review client needs, all client careand risk plans and ensure fall protocol training	

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	to prevent clients A, B and C from recurring falls and injury from falls, to ensure nursing services assessed and monitored clients' injuries resulting from falls and clients with recurring falls and to ensure nursing services reviewed and revised the clients' Falls Risks Plans (FRPs) after falls to ensure the clients' plans included appropriate client specific safeguards to prevent further falls and injuries. The governing body failed to ensure the facility implemented its policy and procedures to ensure all allegations of client to client abuse were reported immediately to the administrator and to the BDDS (Bureau of Developmental Disabilities Services) per IAC 9-3-1(b)(5) and APS (Adult Protective Services) per IC 12-10-3 according to state law, to ensure all injuries of unknown origin were reported immediately to the administrator, to ensure all allegations of abuse and all injuries of unknown origin were thoroughly investigated and to ensure the results of all investigations were reported to the administrator within five working days in accordance with State law for clients A, B, C, D, E, F and G. Please see W149. 2. The facility's governing body failed to		completed for existing and newstaff. **2. How will we identify other residents havingthe potential to be affected by the same deficient practice and what correctiveaction will be taken?** •□□□□□□□□All residents have the potential to be affectedby the same deficient practice. •□□□□□□□□Facility nurse will be trained on specific plansof care, risk plans and assessments regarding falls and injuries from falls. •□□□□□□□□Specific plans of care will be developed andrisk plans updated and implemented in regard falls by facility nurse. •□□□□□□□□Staff will be trained on plans of care byfacility nurse. •□□□□□□□□A formal procedure will be implemented toconsistently address falls and fall prevention by facility nurse. •□□□□□□□□Staff will be trained on fall procedure byfacility nurse. •□□□□□□□□Staff, Program Coordinator and Program Director(QIDP) will be retrained on reporting and documenting all falls, client toclient abuse and injuries of unknown origin. •□□□□□□□□Program Director will be retrained oninvestigation protocol and timeliness for falls, client to client abuse andinjuries of unknown origin, per state law. •□□□□□□□□Program Coordinator	

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	exercise general policy and operating direction over the facility to ensure all allegations of abuse and injuries of unknown origin were reported immediately to the administrator and all allegations of abuse were reported to the BDDS (Bureau of Developmental Disabilities Services) per IAC 9-3-1(b)(5) and APS (Adult Protective Services) per IC 12-10-3 according to state law for clients A, B, C, D and E. Please see W153. 3. The facility's governing body failed to exercise general policy and operating direction over the facility to ensure all investigations were conducted thoroughly and to ensure all allegations of abuse were investigated for clients A, B, C, D, E, F and G. Please see W154. 4. The facility's governing body failed to exercise general policy and operating direction over the facility to ensure the results of all investigations were reported to the administrator within five working days in accordance with State law for clients C, E, F and G. Please see W156. 5. The facility's governing body failed to exercise general policy and operating direction over the facility to ensure the clients' ISPs (Individualized Support Plans) and/or the clients' FRPs (Falls		will monitor documentationof falls, client to client abuse and injuries of unknown origin 3 times perweek. •□□□□□□□□Program Director (QIDP) and facility nurse willmonitor documentation of falls, client to client abuse and injuries of unknownorigin weekly. •□□□□□□□□Monthly, the facility nurse, Program Coordinatorand Program Director (QIDP) will meet to review client needs, all client careand risk plans and ensure fall protocol training completed for existing and newstaff. **3. What measures will be put into place orwhat systemic changes will be made to ensure that the deficient practice doesnot recur:** •□□□□□□□Facility nurse will be trained on specific plansof care, risk plans and assessments regarding falls and injuries from falls. •□□□□□□□Specific plans of care will be developed andrisk plans updated and implemented in regard falls by facility nurse. •□□□□□□□Staff will be trained on plans of care byfacility nurse. •□□□□□□□A formal procedure will be implemented toconsistently address falls and fall prevention by facility nurse. •□□□□□□□Staff will be trained on fall procedure byfacility nurse. •□□□□□□□Staff, Program	

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	Risk Plans) included the clients' adaptive equipment required for mobility, when the equipment was to be used and how the staff were to supervise, monitor and assist the clients while at home and while at the day program throughout the day to ensure no further falls and/or injury from falls and to ensure client C's ISP/FRP included what the staff were to do when client C refused to comply with the use of bed/seat alarms. Please see W240. 6. The facility's governing body failed to exercise general policy and operating direction over the facility to ensure nursing services met the health care needs of clients A, B and C and to ensure nursing services assessed and monitored clients A, B and C after falls with injury, head injury, client wounds and/or excessive bruising due to recurring falls. The facility's governing body failed to exercise general policy and operating direction over the facility to ensure client A's, B's and C's Falls Risks Plans (FRPs) were reviewed and revised after recurring falls, to ensure the clients' plans included appropriate client specific safeguards to prevent further falls and injuries resulting from falls, to ensure the client FRPs included the use of all adaptive equipment required to protect the clients from further falls, included how and		Coordinator and Program Director(QIDP) will be retrained on reporting and documenting all falls, client toclient abuse and injuries of unknown origin. •□□□□□□□Program Director will be retrained oninvestigation protocol and timeliness for falls, client to client abuse andinjuries of unknown origin, per state law. •□□□□□□□Program Coordinator will monitor documentationof falls, client to client abuse and injuries of unknown origin 3 times perweek. •□□□□□□□Program Director (QIDP) and facility nurse willmonitor documentation of falls, client to client abuse and injuries of unknownorigin weekly. •□□□□□□□Monthly, the facility nurse, Program Coordinatorand Program Director (QIDP) will meet to review client needs, all client careand risk plans and ensure fall protocol training completed for existing and newstaff. **4. How will the corrective action be monitoredto ensure the deficient practice will not recur?** •□□□□□□□Facility nurse will be trained on specific plansof care, risk plans and assessments regarding falls and injuries from falls. •□□□□□□□Specific plans of care will be developed andrisk plans	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G735	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 08/27/2015

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REM OCCAZIO LLC	1206 S MAIN ST NEW CASTLE, IN 47362

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	when the equipment was to be used in regard to the client and included how the staff were to supervise and assist the clients throughout the day to ensure no further falls and/or injury from falls to ensure the clients' safety. Please see W331. This federal tag relates to complaint #IN00174893. 9-3-1(a)		updated and implemented in regard falls by facility nurse. •□□□□□□□Staff will be trained on plans of care byfacility nurse. •□□□□□□□A formal procedure will be implemented toconsistently address falls and fall prevention by facility nurse. •□□□□□□□Staff will be trained on fall procedure byfacility nurse. •□□□□□□□Staff, Program Coordinator and Program Director(QIDP) will be retrained on reporting and documenting all falls, client toclient abuse and injuries of unknown origin. •□□□□□□□Program Director will be retrained oninvestigation protocol and timeliness for falls, client to client abuse andinjuries of unknown origin, per state law. •□□□□□□□Program Coordinator will monitor documentationof falls, client to client abuse and injuries of unknown origin 3 times perweek. •□□□□□□□Program Director (QIDP) and facility nurse willmonitor documentation of falls, client to client abuse and injuries of unknownorigin weekly. •□□□□□□□Monthly, the facility nurse, Program Coordinatorand Program Director (QIDP) will meet to review client needs, all client careand risk plans and ensure fall protocol training completed for existing and newstaff.	

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	15G735		08/27/2015

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			5. What is the date by which the systemicchanges will be completed? **9/26/15**	
W 0122 Bldg. 00	483.420 CLIENT PROTECTIONS The facility must ensure that specific client protections requirements are met. Based on observation, record review and interview, the facility failed to meet the Condition of Participation: Client Protections for 4 of 4 sampled clients, (A, B, C and D) and 3 additional clients (E, F and G). The facility failed to implement its policy and procedures to ensure sufficient safeguards were implemented to prevent clients A, B and C from recurring falls and injury from falls, to ensure nursing services assessed and monitored clients' injuries resulting from falls and clients with recurring falls and to ensure nursing services reviewed and revised the clients' Falls Risks Plans (FRPs) after falls to ensure the clients' plans included appropriate client specific safeguards to prevent further falls and injuries. The facility failed to implement its policy and procedures to ensure all allegations of client to client abuse were reported immediately to the administrator and to the BDDS (Bureau of Developmental	W 0122	**W 122 ClientProtections** The facility must ensure that certain client protectionsrequirements are met. The facility must ensure that the specific governing bodyand management requirements are met. **1. What corrective action will beaccomplished?** •□□□□□□□□Facility nurse will be trained on specific plansof care, risk plans and assessments regarding falls and injuries from falls. •□□□□□□□□Specific plans of care will be developed andrisk plans updated and implemented in regard falls by facility nurse. •□□□□□□□□Staff will be trained on plans of care byfacility nurse. •□□□□□□□□A formal procedure will be implemented toconsistently address falls and fall prevention by facility nurse. •□□□□□□□□Staff will be trained on fall procedure byfacility nurse. •□□□□□□□□Staff, Program Coordinator and Program Director(QIDP) will be retrained on reporting and documenting all	09/26/2015

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	Disabilities Services) per IAC 9-3-1(b)(5) and APS (Adult Protective Services) per IC 12-10-3 according to state law, to ensure all injuries of unknown origin were reported immediately to the administrator, to ensure all allegations of abuse and all injuries of unknown origin were thoroughly investigated and to ensure the results of all investigations were reported to the administrator within five working days in accordance with State law for clients A, B, C, D, E, F and G. Findings include: 1. The facility failed to implement its policy and procedures to ensure sufficient safeguards were implemented to prevent clients A, B and C from recurring falls and injury from falls, to ensure nursing services assessed and monitored clients' injuries resulting from falls and clients with recurring falls and to ensure nursing services reviewed and revised the clients' Falls Risks Plans (FRPs) after falls to ensure the clients' plans included appropriate client specific safeguards to prevent further falls and injuries. The facility failed to implement its policy and procedures to ensure all allegations of client to client abuse were reported immediately to the administrator and to		falls, client toclient abuse and injuries of unknown origin. •□□□□□□□□Program Director will be retrained oninvestigation protocol and timeliness for falls, client to client abuse andinjuries of unknown origin, per state law. •□□□□□□□□Program Coordinator will monitor documentationof falls, client to client abuse and injuries of unknown origin 3 times perweek. •□□□□□□□□Program Director (QIDP) and facility nurse willmonitor documentation of falls, client to client abuse and injuries of unknownorigin weekly. •□□□□□□□□Monthly, the facility nurse, Program Coordinatorand Program Director (QIDP) will meet to review client needs, all client careand risk plans and ensure fall protocol training completed for existing and newstaff. **2. How will we identify other residents havingthe potential to be affected by the same deficient practice and what correctiveaction will be taken?** •□□□□□□□□All residents have the potential to be affectedby the same deficient practice. •□□□□□□□□Facility nurse will be trained on specific plansof care, risk plans and assessments regarding falls and injuries from falls. •□□□□□□□□Specific plans of care	

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	the BDDS (Bureau of Developmental Disabilities Services) per IAC 9-3-1(b)(5) and APS (Adult Protective Services) per IC 12-10-3 according to state law, to ensure all injuries of unknown origin were reported immediately to the administrator, to ensure all allegations of abuse and all injuries of unknown origin were thoroughly investigated and to ensure the results of all investigations were reported to the administrator within five working days in accordance with State law for clients A, B, C, D, E, F and G. Please see W149. 2. The facility failed to implement its policy and procedures to ensure all allegations of abuse and injuries of unknown origin were reported immediately to the administrator and all allegations of abuse were reported to the BDDS (Bureau of Developmental Disabilities Services) per IAC 9-3-1(b)(5) and APS (Adult Protective Services) per IC 12-10-3 according to state law for clients A, B, C, D and E. Please see W153. 3. The facility failed to implement its policy and procedures to ensure all investigations were conducted thoroughly and to ensure all allegations of abuse were investigated for clients A, B, C, D, E, F and G. Please see W154.		will be developed andrisk plans updated and implemented in regard falls by facility nurse. •□□□□□□□□Staff will be trained on plans of care byfacility nurse. •□□□□□□□□A formal procedure will be implemented toconsistently address falls and fall prevention by facility nurse. •□□□□□□□□Staff will be trained on fall procedure byfacility nurse. •□□□□□□□□Staff, Program Coordinator and Program Director(QIDP) will be retrained on reporting and documenting all falls, client to clientabuse and injuries of unknown origin. •□□□□□□□□Program Director will be retrained oninvestigation protocol and timeliness for falls, client to client abuse andinjuries of unknown origin, per state law. •□□□□□□□□Program Coordinator will monitor documentationof falls, client to client abuse and injuries of unknown origin 3 times perweek. •□□□□□□□□Program Director (QIDP) and facility nurse willmonitor documentation of falls, client to client abuse and injuries of unknownorigin weekly. •□□□□□□□□Monthly, the facility nurse, Program Coordinatorand Program Director (QIDP) will meet to review client needs, all client careand risk plans and ensure fall protocol training completed for existing and newstaff.	

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	4. The facility failed to implement its policy and procedures to ensure the results of all investigations were reported to the administrator within five working days in accordance with State law for clients C, E, F and G. Please see W156. This federal tag relates to complaint #IN00174893. 9-3-2(a)		**3. What measures will be put into place orwhat systemic changes will be made to ensure that the deficient practice doesnot recur:** •□□□□□□□Facility nurse will be trained on specific plansof care, risk plans and assessments regarding falls and injuries from falls. •□□□□□□□Specific plans of care will be developed andrisk plans updated and implemented in regard falls by facility nurse. •□□□□□□□Staff will be trained on plans of care byfacility nurse. •□□□□□□□A formal procedure will be implemented toconsistently address falls and fall prevention by facility nurse. •□□□□□□□Staff will be trained on fall procedure byfacility nurse. •□□□□□□□Staff, Program Coordinator and Program Director(QIDP) will be retrained on reporting and documenting all falls, client toclient abuse and injuries of unknown origin. •□□□□□□□Program Director will be retrained oninvestigation protocol and timeliness for falls, client to client abuse andinjuries of unknown origin, per state law. •□□□□□□□Program Coordinator will monitor documentationof falls, client to client abuse and injuries of unknown origin 3 times perweek. •□□□□□□□Program Director (QIDP) and facility nurse willmonitor documentation of falls,	

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			client to client abuse and injuries of unknownorigin weekly. •□□□□□□□Monthly, the facility nurse, Program Coordinatorand Program Director (QIDP) will meet to review client needs, all client careand risk plans and ensure fall protocol training completed for existing and newstaff. **4. How will the corrective action be monitoredto ensure the deficient practice will not recur?** •□□□□□□□Facility nurse will be trained on specific plansof care, risk plans and assessments regarding falls and injuries from falls. •□□□□□□□Specific plans of care will be developed andrisk plans updated and implemented in regard falls by facility nurse. •□□□□□□□Staff will be trained on plans of care byfacility nurse. •□□□□□□□A formal procedure will be implemented toconsistently address falls and fall prevention by facility nurse. •□□□□□□□Staff will be trained on fall procedure byfacility nurse. •□□□□□□□Staff, Program Coordinator and Program Director(QIDP) will be retrained on reporting and documenting all falls, client toclient abuse and injuries of unknown origin. •□□□□□□□Program Director will be retrained oninvestigation	

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			protocol and timeliness for falls, client to client abuse andinjuries of unknown origin, per state law. •□□□□□□□Program Coordinator will monitor documentationof falls, client to client abuse and injuries of unknown origin 3 times perweek. •□□□□□□□Program Director (QIDP) and facility nurse willmonitor documentation of falls, client to client abuse and injuries of unknownorigin weekly. •□□□□□□□Monthly, the facility nurse, Program Coordinatorand Program Director (QIDP) will meet to review client needs, all client careand risk plans and ensure fall protocol training completed for existing and newstaff. **5. What is the date by which the systemicchanges will be completed?** **9/26/15**	
W 0149 Bldg. 00	483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. Based on observation, record review and interview for 3 of 4 sampled clients (A, B and C), the facility failed to implement its policy and procedures to ensure sufficient safeguards were implemented to prevent clients A, B and C from recurring falls and injury from falls, to ensure nursing	W 0149	**W149 Staff Treatmentof Clients** The facility must develop and implement written policies and proceduresthat prohibit mistreatment, neglect or abuse of the client. The facility must ensure that the specific governing bodyand	09/26/2015

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	services assessed and monitored clients' injuries resulting from falls and clients with recurring falls and to ensure nursing services reviewed and revised the clients' Falls Risks Plans (FRPs) after falls to ensure the clients' plans included appropriate client specific safeguards to prevent further falls and injuries. The facility failed to implement its policy and procedures to ensure all allegations of client to client abuse were reported immediately to the administrator and to the BDDS (Bureau of Developmental Disabilities Services) per IAC 9-3-1(b)(5) and APS (Adult Protective Services) per IC 12-10-3 according to state law, to ensure all injuries of unknown origin were reported immediately to the administrator, to ensure all allegations of abuse and all injuries of unknown origin were thoroughly investigated and to ensure the results of all investigations were reported to the administrator within five working days in accordance with State law for clients A, B, C, D, E, F and G. Findings include: Observations were conducted at the group home on 8/13/15 between 3:40 PM and 6 PM. During this observation period the following was observed:		management requirements are met. **1. What corrective action will be accomplished?** •□□□□□□□□Facility nurse will be trained on specific plansof care, risk plans and assessments regarding falls and injuries from falls. •□□□□□□□□Specific plans of care will be developed andrisk plans updated and implemented in regard falls by facility nurse. •□□□□□□□□Staff will be trained on plans of care byfacility nurse. •□□□□□□□□A formal procedure will be implemented toconsistently address falls and fall prevention by facility nurse. •□□□□□□□□Staff will be trained on fall procedure byfacility nurse. •□□□□□□□□Staff, Program Coordinator and Program Director(QIDP) will be retrained on reporting and documenting all falls, client toclient abuse and injuries of unknown origin. •□□□□□□□□Program Director will be retrained oninvestigation protocol and timeliness for falls, client to client abuse andinjuries of unknown origin, per state law. •□□□□□□□□Program Coordinator will monitor documentationof falls, client to client abuse and injuries of unknown origin 3 times perweek. •□□□□□□□□Program Director (QIDP) and facility nurse willmonitor documentation of falls,	

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	__There were four staff in the home with seven clients. __Client B was a tall large woman that ambulated with a slow unsteady gait. __Client B wore a gait belt and staff provided hands on assistance while ambulating inside and outside of the home by holding the back of client B's gait belt while walking with client B. __Client B had a large greenish, blue and yellow bruise covering her left shoulder that extended down her left arm approximately six inches, a dark purple bruise on the inside of her inner knee and a healing wound on the left side of her head with staples. __Client C was a tall thin male that ambulated with a forward stance and an unsteady gait. __Client C wore a gait belt and staff provided hands on assistance while ambulating inside and outside of the home by holding the back of client C's gait belt and walking with client C. __At 4:16 PM two staff left with clients C, E, F and H and two staff remained in the home with clients B, D and F. __At 4:29 PM staff #3 was preparing the evening meal while client B sat at the dining room table. Staff #3 was standing at the kitchen sink with her back to client B when the staff asked client B if she would like to assist with setting the table. Client B got up out of her chair and		client to client abuse and injuries of unknownorigin weekly. •□□□□□□□□Monthly, the facility nurse, Program Coordinatorand Program Director (QIDP) will meet to review client needs, all client careand risk plans and ensure fall protocol training completed for existing and newstaff. **1. How will we identify other residents havingthe potential to be affected by the same deficient practice and what correctiveaction will be taken?** •□□□□□□□□All residents have the potential to be affectedby the same deficient practice. •□□□□□□□□Facility nurse will be trained on specific plansof care, risk plans and assessments regarding falls and injuries from falls. •□□□□□□□□Specific plans of care will be developed andrisk plans updated and implemented in regard falls by facility nurse. •□□□□□□□□Staff will be trained on plans of care byfacility nurse. •□□□□□□□□A formal procedure will be implemented toconsistently address falls and fall prevention by facility nurse. •□□□□□□□□Staff will be trained on fall procedure byfacility nurse. •□□□□□□□□Staff, Program Coordinator and Program Director(QIDP) will be retrained on reporting and documenting all	

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	walked to the corner of the dining room table approximately 12 feet from where she was when staff #3 turned around and saw client B up without staff assistance. Staff #3 immediately went to client B and reminded client B she was to ask for assistance prior to ambulating and assisted client B to set the table while holding onto client B's gait belt. The facility's reportable and investigative records were reviewed on 8/13/15 at 1 PM. The 5/19/15 BDDS report indicated "On Monday May 18th 2015 at 6:50 AM [client C] was taken to the ER for a fall that required medical treatment. [Client C] was walking in the kitchen when he fell and hit his head on the window's edge. Program Director [(PC - Name of Program Coordinator)] saw that [client C] had a wound on his head that was about 1/2 inch long and appeared to be deep. PC took [client C] to the hospital for evaluation. At the hospital they completed a head/neck CT (Computerized Tomography - a combined series of X-ray images taken at different angles) and completed labs. It was also noticed that [client C] has a knot on his left hand. An X-ray was completed. All results came back normal and [client C] received 3 staples on (sic)		falls, client toclient abuse and injuries of unknown origin. •□□□□□□□□Program Director will be retrained oninvestigation protocol and timeliness for falls, client to client abuse andinjuries of unknown origin, per state law. •□□□□□□□□Program Coordinator will monitor documentationof falls, client to client abuse and injuries of unknown origin 3 times perweek. •□□□□□□□□Program Director (QIDP) and facility nurse willmonitor documentation of falls, client to client abuse and injuries of unknownorigin weekly. •□□□□□□□□Monthly, the facility nurse, Program Coordinatorand Program Director (QIDP) will meet to review client needs, all client careand risk plans and ensure fall protocol training completed for existing and newstaff. **2. What measures will be put into place orwhat systemic changes will be made to ensure that the deficient practice doesnot recur:** •□□□□□□□Facility nurse will be trained on specific plansof care, risk plans and assessments regarding falls and injuries from falls. •□□□□□□□Specific plans of care will be developed andrisk plans updated and implemented in regard falls by facility nurse. •□□□□□□□Staff will be trained on	

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	his head." __The 8/4/15 Follow Up BDDS report to the fall of 5/18/15 indicated client C had tripped over a chair that was pushed up to the dining room table. The report indicated client C's Falls Risk Plan was followed, staff monitored client C without further issues and the staples were removed one week later. __The QAS (Quality Assurance Supervisor) indicated review of the 5/18/15 investigative summary on 7/16/15. The record indicated client C had physician's orders dated 8/24/14 for PRN (as needed) use of a wheelchair and a walker and an order written on 5/21/15 for client C to utilize a bed/chair alarm. The review indicated "Evidence does not support specific guidelines are included in [client C's] risk plan for use of his wheelchair or walker." The 5/11/15 BDDS report indicated date of incident 4/29/15 at 8:10 AM and date of knowledge was 5/8/15. The report indicated "While completing home review with consumer [client B] and staff at the group home on 5/8/15 [name of BDDS representative] noticed large bruise on consumer's (client B's) forearm and scrape on forehead. Upon questioning house manager [name of house manager] about what caused these injuries, [the house manager] reported		plans of care byfacility nurse. •□□□□□□□A formal procedure will be implemented toconsistently address falls and fall prevention by facility nurse. •□□□□□□□Staff will be trained on fall procedure byfacility nurse. •□□□□□□□Staff, Program Coordinator and Program Director(QIDP) will be retrained on reporting and documenting all falls, client toclient abuse and injuries of unknown origin. •□□□□□□□Program Director will be retrained oninvestigation protocol and timeliness for falls, client to client abuse andinjuries of unknown origin, per state law. •□□□□□□□Program Coordinator will monitor documentationof falls, client to client abuse and injuries of unknown origin 3 times perweek. •□□□□□□□Program Director (QIDP) and facility nurse willmonitor documentation of falls, client to client abuse and injuries of unknownorigin weekly. •□□□□□□□Monthly, the facility nurse, Program Coordinatorand Program Director (QIDP) will meet to review client needs, all client careand risk plans and ensure fall protocol training completed for existing and newstaff. **3. How will the corrective action be monitoredto ensure the deficient practice will not**	

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	that consumer (client B) tipped over her wheelchair and fell. [The house manager] provided [the BDDS representative] with a printed report of the incident, however, no actual incident report was completed. The written report of the incident is included below: On 4/29/15 '[Client B] was going to the van to go to work. Staff asked her to let them help push her down the sidewalk. [Client B] refused and screamed and started to hit her face. Staff walked up behind [client B] and when staff looked away [client B's] chair hit the ledge of the sidewalk tipping over her chair. Staff assisted [client B] up and checked her for injuries. She had a small scrape above (sic) her left eye where her helmet moved and a scrape on her left knee. No other injuries was (sic) noted at the time.' [The house manager] reported that the bruise did show up later and was still visible when [the BDDS representative] completed the home review on 5/8/15. [The BDDS representative] also observed while completing the home review on 5/8/15 that consumer (client B) was not using her seat belt alarm. [The house manager] reported they are waiting for a written discontinuation from the doctor for that particular alarm. [The BDDS		**recur?** •□□□□□□□Facility nurse will be trained on specific plansof care, risk plans and assessments regarding falls and injuries from falls. •□□□□□□□Specific plans of care will be developed andrisk plans updated and implemented in regard falls by facility nurse. •□□□□□□□Staff will be trained on plans of care byfacility nurse. •□□□□□□□A formal procedure will be implemented toconsistently address falls and fall prevention by facility nurse. •□□□□□□□Staff will be trained on fall procedure byfacility nurse. •□□□□□□□Staff, Program Coordinator and Program Director(QIDP) will be retrained on reporting and documenting all falls, client toclient abuse and injuries of unknown origin. •□□□□□□□Program Director will be retrained oninvestigation protocol and timeliness for falls, client to client abuse andinjuries of unknown origin, per state law. •□□□□□□□Program Coordinator will monitor documentationof falls, client to client abuse and injuries of unknown origin 3 times perweek. •□□□□□□□Program Director (QIDP) and facility nurse willmonitor documentation of falls, client to client abuse and injuries of unknownorigin weekly. •□□□□□□□Monthly, the facility nurse, Program Coordinatorand	

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	representative] informed her (the house manager) that the seat belt alarm must be used at all times until the doctor gives them a written discontinuation. [The house manager] also reported that the bed alarm and new seat alarm that were ordered have still not arrived. [The BDDS representative] provided information to [the house manager] on the necessity of ensuring incident reports are completed with BDDS. [The BDDS] representative called and spoke with Program Director [name of PD] who reported that she would complete an incident report since she was unaware of the fall and had therefore not ensured one was completed immediately after the incident. [The BDDS representative] did not see an incident report in the system this morning [5/11/15] and so is completing this report now." The 5/22/15 BDDS report indicated "On 5/21/15 during home review [name of BDDS representative] noticed daily note entered detailing a fall consumer (client B) had that no incident report had been completed for. [Name of BDDS representative] obtained the details from staff (the RM) and is completing the report below: On 5/9/15 'After [client B] pulled herself out of wheel chair she went to reach for support on toilet railing		Program Director (QIDP) will meet to review client needs, all client careand risk plans and ensure fall protocol training completed for existing and newstaff. **4. What is the date by which the systemicchanges will be completed?** **9/26/15**	

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	and was not balanced before she moved and fell on her bottom. Staff did have a supportive hand on [client B]. [Client B] was assessed for injuries and has small red spot on the left side of her bottom. She (client B) did not hit her head.... Staff will follow up to ensure all safety precautions are in place for consumer. [Name of BDDS representative] will continue to follow up with group home staff'." The report indicated it was reported to BDDS on 8/4/15 by the PD and no injuries were reported. The 6/2/15 BDDS report indicated: __"On May 21st (2015) at 8:55 PM, [client A] was in the restroom and lost his balance causing him to fall on his buttock. [Client A] stated that his knee was hurting and that he fell due to his knee hurting. Staff assisted [client A] up and checked him for injuries. No injuries were present at the time. Staff were to remind and encourage [client A] to use his walker and gait belt when ambulating. There were no environmental factors that caused this fall. Since the fall occurred in the restroom, there were no witnesses. Staff monitored [client A] throughout the night. [Client A] was fine throughout the night and had no other falls that night. PC			

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	(Program Coordinator), PD (Program Director) and nurse were all notified. The nurse checked [client A] out. He was sitting in his w/c (wheelchair). He did have his oxygen on, his O2 (oxygen) sat (saturation) was 95. His heart rate was 100-105 and that was sitting. Ortho (Orthopedic) appointment is on June 9th (2015)." __"On May 25th at 9:45 PM [client A] was going to the bathroom to complete oral hygiene tasks and fell hitting his back and buttock. Staff assisted [client A] up off the floor and he started yelling his knee hurt. Staff assisted him on the toilet to check his knee. At the time there did not appear to be any swelling or marks. Staff took [client A] to the ER since he would not put any pressure on his knee. At the ER they completed a series of X-rays on his knee. ER stated there was no fracture and only slight swelling. ER referred to an orthopedics doctor to look at his knee further and put his knee in a stabilizer and encouraged him to walk on his leg using a rollator walker (a four wheeled rolling walker)." __"On May 27th (2015) [client A] complained of a lot of pain while walking and staff reported a large red area on the right side of his groin. PC came to observe [client A] walk and to check the red area. [Client A's] right thigh appeared to be a larger size than his left thigh and			

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	the red area was warm to touch. [Client A] was taken back to the ER for additional observation and additional X-rays. The ER took a hip X-ray and discovered the ball of his hip joint was broken and he would need surgery to repair. [Client A] was informed of the situation and gave verbal confirmation for the surgery 5/27/15." __"The plan is that after the surgery [client A] will be staying in the hospital until his HCR (Health Care Representative) has decided which nursing facility to admit [client A] into to come (sic) his rehab (rehabilitation) at. As of June 2 (2015), [client A] is recovering well from surgery." The 8/6/15 Bureau of Developmental Disabilities Services (BDDS) report indicated on 6/16/15 at 12 PM "[Client A] had a fall that caused him to be admitted into the hospital. The ER (Emergency Room) took a hip X-ray and discovered the ball of his (client A's) hip joint was broken and he would need surgery to repair it. After the surgery [client A] was admitted into a NF (Nursing Facility). [Client A] was admitted into the hospital then transferred to a nursing facility. [Client A] was discharged from Indiana Mentor's services on 6/16/15."			

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	The 7/15/15 BDDS report indicated on 7/14/15 at 3 PM "[Name of the BDDS representative] visited with consumer (client B) at the Mentor Day Program Services site. While visiting [the BDDS representative] noticed large bruise on consumer's left upper arm. Bruise appeared to be in beginning stages of healing and was multi-colored. Bruise was large covering approx (approximately) 3-4 inches long across consumer's arm and approx 2 inches wide. Consumer also had another bruise on her knee that appeared to be approx. 2 inches long. This bruise appeared to be older than the other one. Consumer was unable to provide details of how these injuries occurred and Day Program Staff did not know. [The BDDS representative] also visited the home of consumer this day where house staff reported they thought she had fallen and hit herself on a chair last week." The 8/4/15 BDDS report submitted by the BDDS representative indicated "While [name of BDDS representative] was visiting consumer [client B] at her group home, consumer fell and was injured. [Name of BDDS representative] observed consumer (client B) stand from her chair at the kitchen table without waiting for staff to assist her with her gait belt. Staff were assisting other consumers			

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	at this time and were not able to get to her quickly enough. [Name of BDDS representative] encouraged consumer (client B) to sit down and wait for staff to assist her. At this time another consumer entered the kitchen from a side room and collided with consumer [client B] who then lost her balance and fell hitting her head on the corner of the wall leading into the hallway. Consumer's (client B's) head received a large gash which began bleeding. Two staff immediately assisted consumer and applied pressure to the wound while another staff person gathered the remaining consumers, except one who would not go and took them on a van ride. [Name of BDDS representative] called 911 to request ambulance while staff attended to consumer's wound. EMTs arrived and bandaged consumer's wound before transporting her to [name of hospital] for further evaluations and treatment. Two staff persons followed the ambulance to the hospital. Staff will continue to monitor to ensure consumer's health and safety and follow ER doctor's recommendations. [Name of BDDS representative] will continue to follow up to ensure consumer's health and safety." The 8/5/15 BDDS report submitted by the PD indicated on 8/4/15 at 3:15 PM "[Client B] got up from the table without			

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	assistance. She was asked to wait for staff and while she was looking at that person another peer bumped into her. [Client B] fell and hit the corner of the wall hitting the left side of her upper body. [Client B] appeared to have a deep gash on her head and bruising was present on her left cheek. An ambulance was called to transport [client B] to the hospital.... The ER (Emergency Room) doctor implemented staples to close the gash [client B] has on the upper left side of her head. The ER nurse wrapped [client B's] head to keep area dry and clean and gave orders for [client B's] head to stay wrapped for 48 hours. The ER sent pain medication for [client B] to have every 6 hours as needed. [Client B's] vitals are being taken every 4 hours for the first 24 hours also." The 8/13/15 BDDS report indicated on 8/12/15 at 6:30 AM client B fell. The report indicated according to the staff while walking client B to the bathroom for a shower client B kept dropping down to the floor "while being escorted." Client B then tripped over one staff and fell onto another staff. The staff assessed client B for injury and found none. The report indicated client B "came to Indiana Mentor in a wheelchair. [Client B's] doctor elevated her and determined that she doesn't need a wheelchair. Just			

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	recently [client B] has started to have issues with falling. [Client B] has a falls risk plan in place. Staff informed the PC (Program Coordinator) who informed the PDs (Program Directors) and the nurse. Staff are to monitor [client B] for any future injuries caused by this fall." The 8/13/15 BDDS report indicated on 8/12/15 at 8 PM "Staff was walking with [client C] holding onto his gate (sic) belt for extra support. [Client C] was walking fast and staff verbally redirected [client C] to slow down because he could fall. [Client C] tripped on the front door threshold and fell down and received an abrasion on his right knee. Staff will continue to follow [client C's] risk plan concerning falls." 1. Review of client A's GERs (General Events Reports) on 8/14/15 at 5 PM indicated the following incidents: On 10/11/14 at 9:30 AM: "[Client A] was in the bathtub and stated that he lost his footing and fell. He stated that he just hit his lower back. There is a small bruise size of a half dollar on his lower back." The GER indicated the RN reviewed the report on 10/17/14 with no documented comments. On 11/19/14 at 8 AM: "[Client A] was			

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	getting off the van and a staff was assisting since the [name of day services] parking lot was covered with ice. [Client A] slipped and staff eased his fall. [Client A] landed on staff's foot on his bottom. [Client A] did not complain of any pain." The GER indicated the RN reviewed the report on 11/20/14 with no documented comments. On 11/30/14 while on a home visit: "[Client A] was at his sister's house for the holidays. She (client A's sister) stated that he (client A) fell four times in his 3.5 day visit. Fall questions according to his sister [name of sister]. The falls occurred at his sister's house. [Client A] fell twice going outside to smoke in which he tripped over the doorway, once he fell in the bathroom and once he tripped over a rug. The falls occurred between 11/27 (2014) - 11/30 (2014). [Client A] was with his family during the falls. His sister witnessed all the falls except for the one in the shower. [Client A] was checked for injuries upon returning to the group home but none were found." The GER indicated the RN reviewed the report on 12/1/14 with no documented comments. On 1/12/15 at 3:15 PM: "[Client A] walking inside house and fell and bumped head slightly Small resulting in a scratch and small abrasion on forehead			

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	(sic)." The GER indicated no review by the RN. On 2/1/15 at 6:30 PM: "[Client A] was sitting in the chair in the kitchen. All of a sudden he just slid out of the chair. When staff questioned him about why he fall (sic), he just stated that he just fell down. Staff assessed for injuries and none were found. Staff continued to monitor him." The GER indicated no review by the RN. On 2/1/15 at 8:25 PM: "[Client A] was sweeping the kitchen floor. He fell and hit his head on the kitchen table. Staff rushed to help him into a chair. Once in the chair he leaned over to the side and started excessively drooling. This is when he began convulsing. Staff moved [client A] to the floor and held his head so that it didn't hit the floor. We also rolled him to his side. After the convulsing stopped [client A] was still unresponsive. He was not blinking and his eyes glazed completlely (sic) over. His face turned purple. Per the paramedics instructions staff did not do CPR. I (staff) was able to find a faint pulse. Paramedics took over at this point and he was taken to the hospital." The GER indicated no review by the RN. On 2/6/15 at 6:15 PM: "[Client A] was using the bathroom and having a BM.			

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	During the daily toileting duties after having a BM he had fallen onto the toilet. He had lost (his) balance and fell, but the toilet had caught him and staff was there to assist him and help him up. He fell in the bathroom while performing daily toiletry duties. No injuries were inflicted during the fall." The GER indicated no review by the RN. On 2/14/15 at 7:15 PM: "[Client A] had just finished his shower, shaved, and dressed. [Client A] told staff he needed to have a bm (bowel movement) and asked if he could have some privacy. Staff stepped outside the bathroom door and was waiting for [client A] to finish." The report indicated when the staff returned to client A the staff noticed a small scratch on client A's back. The report did not indicate the origin of the injury. __The report indicated corrective action taken: "[Client A] will be supervised to and from as well as in the bathroom by staff. Staff will use gait belt to better support [client A]." The GER indicated the RN reviewed the report on 2/14/15 with no documented comments. On 3/23/15 at 6:40 AM: "[Client A] fell when he was getting out of bed. He was trying to go to the bathroom without his walker. He yelled for help and staff immediately went to help. Staff helped			

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	15G735		08/27/2015

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	him up and checked him for injuries. None were found." The GER indicated no review by the RN. On 4/13/15 at 7:15 AM: "[Client A] was walking out of his room and tripped over his oxygen tubing. Staff was walking down the hall and saw the incident. Staff was able to get to him before he fell to the ground. Staff put their arm under his and helped guide him to the floor. [Client A] did not hit the floor hard and landed on his right hip and arm. [Client A] was checked for injuries and none was present at the time." The GER indicated the RN reviewed the report on 4/17/15 with no documented comments. On 5/13/15 at 2:45 PM while at the day services: "Staff went into workshop to pick up clients. Staff woke [client A] up and started to unhook his O2 tubes. [Client A] stood up to hang up his tube and went to sit back down and fell on his butt. [Client A] stated his legs was (sic) asleep. Staff checked him over for injuries when we (staff and clients) arrived home and none was present at the time." The GER indicated the RN reviewed the report on 5/19/15 with no documented comments. On 5/21/15 at 8:55 PM: "[Client A] was in the restroom and lost his balance and			

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	fell on his butt. He stated his knee hurt and it popped causing him to loose (sic) his balance. Staff assisted him up and checked for injuries. None was present at the time. Staff asked [client A] to sleep in the living room so staff can monitor more closely." The GER indicated the RN reviewed the report on 5/21/15 with no documented comments. On 5/25/15 at 9:45 PM: "[Client A] was going to the bathroom to complete oral hygiene and fell hitting his back and buttock. Staff assisted him up off the floor and he started yelling his knee hurt. Staff assisted him on the toilet to check his knee. At the time there did not appear to be any swelling or marks. Staff took [client A] to the ER since he would not put any pressure on his knee. At the ER they completed a series of X-Rays on his knee. ER stated there was no fracture and only slight swelling. ER referred to an orthopedics doctor to look at his knee further and put his knee in a stabilizer and encouraged him to walk on his leg using a rollator walker." The GER indicated the RN reviewed the report on 5/27/15 with no documented comments. Client A's record was reviewed on 8/14/15 at 11 AM. Client A's record indicated diagnoses of, but not limited to, Lung Cancer, COPD (Congestive			

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	Obstructive Pulmonary Disease - damage to the lungs causing difficulty with breathing), Dementia, Seizure Disorder, GERD (Gastric Esophageal Reflux Disease), Eczema, Psoriasis and Arthritis. Client A's quarterly physician's orders dated 3/5/15 indicated the following orders: Walker. Gait belt as needed. Oxygen: "Oxygen should be set on 2 liters while at rest. When individual engages in physical activity (walking, showering etc.) oxygen should be set on 4 liters of oxygen. After physical activity wait 15 minutes then set oxygen back to 2 liters." Clotrimazole cream and Betamethasone to affected areas twice a day for Psoriasis. Client A's 2/4/15 T-log (Therap-log; computer/digital client record) note from the HM (Home Manager) indicated "On 2-1-15 staff reported to HM that [client A] was having a seizure at approx 8:25 PM. Staff called HM back to report that he (client A) was turning blue/purple and the other staff was calling an ambulance. When the ambulance arrived they stated he (client A) was not breathing enough to sustain life and was intubated (a			

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	procedure by which a tube is inserted through the mouth down the throat to supply air when someone is unable to breathe adequately on their own)." Client A was taken to the hospital to the ICU (Intensive Care Unit) and placed on a ventilator (a machine that supports breathing and sustains life). Client A was removed from the ventilator on 2/2/15 and released to return home to the group home on 2/3/15. __Client A's record indicated no physical assessments and or notes from the RN after client A's return to the group home from the hospital. Client A's 5/25/15 hospital discharge record indicated a diagnosis of right knee traumatic effusion (fluid in and around the knee caused by a trauma). Client A's 2014/2015 nursing notes indicated: __On 5/27/15 at 6:30 PM the RN went to the group home to assess client A. "He (client A) was sitting in his w/c (wheelchair).... Sitting in the chair the lower part of his right leg looked turned out. I (the RN) don't know if he always sits like that or not but it didn't look right to me. I had him get up to walk as staff was instructed by ER to ambulate him with walker to keep him from getting still (sic), the leg looked the same when he			

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	tried to walk, turned out and he c/o (complained of) a lot of pain. Assisted him back into chair. Instructed staff not to ambulate him until we can get him into ortho (orthopedics). [The Residential Manager] said his (client A's) ortho appointment isn't until June 9th. I'm going to call in the am and see if we (staff) can get him in tomorrow." __On 5/28/15 at 10:30 AM indicated "On 5/25/15 [Client A] fell while in the restroom. He was taken to the hospital by PC (Program Coordinator). [Name of hospital] ER completed an X-ray on his right knee and chest. ER stated they found no injury and sent [client A] home with a knee stabilizer and asked to encourage [client A] to walk. On 5/27/15 [client A] complained of a lot of pain while walking and staff reported a large red area on the right side of his groin. PC came to observe [client A] walk and to check the red area. [Client A's] right thigh appeared to be a larger size than his left thigh and the red area was warm to touch. PC took [client A] to the ER. The ER took a hip X-ray and discovered the ball of his hip joint was broken and he would need surgery to repair. [Client A] was admitted to the hospital at approx 1 AM on 5/28/15 and is scheduled to have the surgery same day." __Client A's nursing notes indicated no further assessments and/or			

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	documentation from the RN in regard to client A's falls from January 2015 through May 2015. Client A's nursing notes indicated no nursing notes and/or assessments in regard to client A's reported falls on the following dates: 10/11/14 11/19/14 11/30/14 01/12/15 02/01/15 02/06/15 03/23/15 04/13/15 05/13/15 05/21/15 05/25/15 Client A's 4/3/15 FRP indicated: __"Definition: A fall risk is someone who has the tendency to lose balance leading to falls, has a diagnosis that places them at a greater risk for falls or uses adaptive equipment. The fall may or may not cause injury.... The most common complication of falls is injury to the person. Injury may be minor requiring only minor first aid. More serious injuries will require emergency medical treatment. __The environment should be kept clear of hazards.			

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	__Staff are to assist clients as needed with ambulation [(walking)]. __Staff are trained in the possible side effects of medications and should provide added assistance for clients who need help because of side effects. __Plan: Staff are trained in Body Mechanics [(use of adaptive devices)]. __Use of adaptive devices is followed by a doctor and proper fit is monitored on a regular basis. Environmental hazards are removed by staff, more complex environmental issues are reported to maintenance on a monthly basis." Client A's FRP indicated the plan was updated by the RN on 4/3/15. Client A's FRP failed to indicate: __How the staff were to supervise, monitor and assist client A while at home and while at the day program to ensure client A's safety in regard to recurring falls and injury from falls. __The adaptive equipment client A required for ambulation, when the equipment was to be used and how it was to be used. Client A's skin and wound records indicated: __10/11/14 "[Client A] has a small bruise on his lower back from a bathtub fall on 10-11-14." __10/12/14 "[Client A] has a slight			

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	bruise on his lower back area due to a bathtub fall." __12/17/14 "The rash on his (client A's) back is just about cleared up." __2/9/15 "[Client A] has a scratch on his arm it is in a healing no infections are present (sic)." __2/22/15 "[Client A] has a reddish rash all across his lower back area." __2/26/15 "[Client A] has a red rashy (sic) area on his lower back." __3/2/15 "I (the staff) notice (sic) red marks on [client A's] left upper arm and ask (sic) [client A] how did happen and he doesn't know what happen." __3/14/15 "There is an area on his L (left) shoulder. It is small and has a couple of little scabs on it." __3/15/15 "Spot on [client A's] shoulder blade as reported previously is better today." __3/18/15 "[Client A] has a skin breakdown on the upper part of his back." __3/21/15 "Previous reported spot on left shoulder blade has lost a couple scabs and looks much better, dry skin now around area. Area is pink and no longer red." __3/22/15 "[Client A] has raw areas behind each ear. These areas appear to be from his oxygen tubes that sit there." __3/25/15 "[Client A] has some dry skin patches on his back." __3/28/15 "Lotion applied to entire body			

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	after shower due to dry skin. No redness." __3/31/15 "[Client A] has dry skin, staff applied lotion to entire body after shower." __4/4/15 "Lotion applied to whole body dry skin after shower." __4/6/15 "He (client A) has a raw area on each ear where his o2 (oxygen) tubing sits. This is almost healed." __4/7/15 "Dry skin, lotion applied after shower." __4/11/15 "The red areas on the back of his (client A's) ears is (sic) getting better." __4/12/15 "Dry skin, lotion applied after shower." __4/14/15 "Dry skin, lotion applied." __4/16/15 "Dry skin, lotion applied." __4/30/15 "Scratches and red due to [client A] scratching at dry skin, lotion and treatments applied. Will continue to monitor." __5/6/15 "There is a small patch of dry skin on his upper back. His cream was applied extra well." __5/7/15 "[Client A's] back still has the small dry patch. Staff assisted with making sure it got washed well and his creams were applied." __5/8/15 "The dry patch looks better but staff still assisted with washing it and applying treatment to the area." __5/12/15 "[Client A] has some dry skin patches on his back. His cream was			

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	applied." __5/13/15 "The dry patches on [client A's] back appear to be healing." __5/22/15 "[Client A] is getting a few dry patches on his back. Staff assisted him with putting lotion on it and applying his treatments." Client A's record indicated no plan of care in regard to skin integrity and reported dry skin/rashes. Client A's record indicated no nursing notes and/or assessments in regard to client A's chronic skin problems. Client A's record indicated client A was on oxygen due to COPD and Lung Cancer. Client A's record indicated no nursing notes and/or assessments in regard to client A's lungs and respiratory needs. Client A's record failed to indicate nursing services monitored client A's lung sounds and/or respiratory needs. Client A's record indicated no PT/OT (Physical Therapy/Occupational Therapy) evaluation of client A's fine and gross motor skills, the supervision level client A required to ambulate safely and the adaptive equipment client A required for ambulation. Client A's Residential IPOP (Individual Plan of Protective Oversight) dated			

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	9/3/14 indicated client A had no adaptive equipment and was independent within the home with staff present and was on fifteen minute checks 24/7 due to a history of seizures. The IPOP indicated client A could be outside and unsupervised as long as he was within the fenced in yard. Client A's GERs indicated 13 falls within 8 months. Client A's record indicated no IDT (Interdisciplinary Team) notes in regard to client A's continued falls. Client A's ISP and Falls Risk Plan indicated no changes in regard to client A's continued falls. 2. Review of client B's GERs on 8/14/15 at 5 PM indicated the following incidents: On 4/29/15 at 8:10 AM: "[Client B] was going out to the van to go to work. Staff asked her to let them help push her down the sidewalk. [Client B] refused and screamed and started to hit her face. Staff walked behind [client B] and when staff looked away [client B's] chair hit the ledge of the sidewalk tipping over her chair. Staff assisted [client B] up and checked her for injuries. She (client B) had a small scrape above her left eye where her helmet moved and a scrape on her left knee. No other injuries was (sic)			

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	noted at the time." The GER indicated the RN reviewed the report on 5/4/15 with no documented comments. On 5/9/15 at 6:40 PM: "After [client B] pulled herself out of wheel chair she went to reach for support on toilet railing and was not balanced before she moved and fell on her bottom. Staff did have a supportive hand on [client B]. [Client B] was assessed for injuries and has small red spot on the left side of her bottom. She did not hit her head." The GER indicated the RN reviewed the report on 5/11/15 with no documented comments. On 6/12/15 at 8 AM: "We (the staff) were driving down the road and [client B] took off her seatbelt and she feel (sic) onto the floor of the van. Both staff then helped up [client B] and began looking over her for any injuries. She (client B) had red mark from her right side of forehead to the side of her eye. Its (sic) was red at first and then disappeared after a little time. Home manager was called right away about this situation and staff had to keep reminding [client B] to keep her seat belt on the rest of way to Day Services." __The report indicated corrective action taken was "Make sure [client B] sits by window and remind her to keep her seatbelt on." The GER indicated the RN reviewed the report on 6/15/15 with no			

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	documented comments. On 7/11/15 at 3:30 PM: "[Client B] was being assisted walking into the home. She tripped over the threshold of the front door. Staff caught [client B] using her gait belt but she hit her arm on a rocking chair on the front porch. She had a bruise on her upper left arm. No other injuries was (sic) apparent at the time." The GER indicated the RN reviewed the report on 7/14/15 with no documented comments. On 8/4/15 at 3:15 PM: "[Client B] got up from the table without assistance. She was asked to wait for staff and while she was looking at that person another peer bumped into her. [Client B] fell and hit the corner of the wall hitting the left side of her upper body. [Client B] appeared to have a deep gash on her head and bruising was present on her left cheek. An ambulance was called to transport [client B] to the hospital." The GER indicated the RN reviewed the report on 8/6/15 with no documented comments. On 8/12/15 at 6:30 AM "While walking client (B) to bathroom for shower client (B) kept dropping down to floor. Client (B) then tripped staff and fell onto staff to the floor. Being escorted by 2 staff to bathroom for shower because client kept dropping to floor while being escorted."			

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	The GER indicated the RN reviewed the report on 8/13/15 with no documented comments. Client B's record was reviewed on 8/14/15 at 12 PM. Client B's record indicated a diagnosis of, but not limited to, Osteoarthrosis (a degenerative joint disease). Client B's 2015 Skin and Wound tracking record indicated: __4/26/15 "These were recorded down on Thursday April 23rd 2015. R (right) - arm Yellowish bruise by her elbow three bluish green bruises also by her elbow. L (left) -arm small bluish bruise on her upper arm by her armpit. R-leg purple bluish bruise on her upper thigh L-leg three dark bruises by her knee, several scratches on her shin down to her ankle. Back-no apparent bruises Chest no apparent bruises butt-small bruise on her L lower buttocks." __4/28/15 "All of [client B's] bruises are healing as expected. There are no other issues to report." __5/4/15 "[Client B's] bruises are all almost healed." __6/12/15 "[Client B] has a red area on the side of her right eye and a bruise above her right eye." __6/14/15 "R breast bruise-purple in color, R wrist 2 bruises - purple in color,			

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	R knee - faded purpleish (sic) in color, bruise R calf bruise - yellowish in color, L forearm bruise -purple in color, L upper thigh-faded yellowish in color, L knee 2 bruises - purple, L arm back of elbow-light purple and above right eye bruise - light purple." __7/16/15 "Large bruise on left arm which looks to be healing. Bruising on left knee which is healing. Was checked out at ER on 7/15/15." __7/17/15 "Bruise on left arm and left knee are healing. No other skin/wounds to report." __7/18/15 "Bruise on left arm and left knee are healing. No new skin/wound to report." __7/22/15 "Bruise on left arm and bruises on left knee are healing." __7/23/15 "Bruise on left arm is healing and the bruise on left knee is healing." __7/24/15 "Bruise on left arm is healing and bruise on left knee is healing." __7/27/15 "Bruise on left arm is healing and bruise on left knee is healing." __7/30/15 "Bruise on left arm is healing and bruise on left knee is healing." __7/31/15 "Bruise on left knee is healed and bruise on left arm is healing." __8/2/15 "[Client B] has a red area with broken skin on her upper chest by her neck, it appears that [client B] has scratched at it and opened it. The area does not appear to be infected. Staff will			

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	continue to monitor." __8/5/15 "[Client B's] left eye is swollen and bruised in a red/ purple color. She (client B) has another red bruise above her cheek bone on her left side. On the left side of her collar bone there is a reddish circular bruise about 1 inch in diameter that is surrounded by a faint blue bruise about 3 inches in diameter. On her left shoulder, there is a red bruise about 4-5 in long and 3 inches wide. On her right butt cheek she has a square abrasion about an inch wide. Just above her left knee is another bruise about an inch in diameter. Her right calf is red and is a very faint blue." __8/6/15 "We (the staff) took the bandage off of [client B's] head today and cleaned it as best we could. We have noticed that she is bruising from a yellow color, to purple to blur (sic) all along the left side of her face. She also has some bruising on her scalp, near the staples. [Client B] also has a small swollen area on her left ear that is bruising." __8/7/15 "During [client B's] shower tonight we noticed that there is an area on the top of her head, above the staples that is still open. It appears to have small amounts of a green substance oozing out of it. Also the bruise on her left shoulder is still getting larger and is warm to touch. [Client B] does not like it when you get anywhere near all the staples."			

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	__8/8/15 "[Client B] has staples on the front right side of her head. Staples appear to be in good shape, no visual signs of bleeding, almost no swelling is present. During shower [client B] did not seem to be bothered by cleaning over the staples or bruises." __8/9/15 "[Client B] has multiple bruises (already reported) that are turning yellow in color, all bruises are different colors and in different stages of healing. No new bruises or skin concerns to report today. [Client B] also has some red areas on right buttocks, staff applied Desitin and will continue to monitor." __8/10/15 "[Client B] has a bruise on her face, left shoulder, and left knee that appear to be in the healing stage." __8/11/15 "[Client B] has a bruise on the left side of her face, left shoulder, and left knee that appear to be in the healing stage." __8/12/15 "Wound on head is healing, bruised left eye is healing, bruising on left shoulder and left arm is healing. Other bruising from fall is healing." __8/13/15 "Wound on left side of forehead is healing. Bruises on left shoulder and arm are healing. Bruises on left knee are healing." Client B's 2014/2015 appointment records indicated: __On 5/11/15 client B had a PT			

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	assessment. The assessment indicated "Pt (patient) ok to ambulate with gait belt/HHA/CGA (Hand Over Hand Assistance/Contact Guard Assistance) within group home environment. She is to have HHA/CGA for transfers in and out of van and up/down steps/curbs. She is to use w/c (wheelchair) for primary mode of transportation in the community." __On 6/25/15 client B saw her PCP (Primary Care Physician) for "chronic conditions." The record indicated "Walking with some assistance, stable on feet, no falls." __On 7/15/15 client B was seen at the ER for a contusion (a deep bruise caused by a blow, trauma or direct force) of face and upper arm as a result of a fall. __7/15/15 Hospital imaging reports (X-rays) of client B's left ankle and left arm. The X-ray of the left ankle indicated "Fall, swelling. No visible acute fracture." The X-ray of the left arm indicated "Fall, Ecchymosis (a discoloration of the skin resulting from bleeding under the skin, typically caused by bruising).... There are healed lower left rib fractures." __On 7/28/15 client B saw her PCP for a follow after fall. The report indicated "fell onto porch, tried to get up out of chair on her own, tripped on threshold, went to ER 7/15 (2015) - no injuries other than bruises. Ambulating well with			

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	assistance of one and gait belt." __On 8/4/15 client B was seen at the ER for a laceration to her head from a fall. Client B was discharged with an ace wrap (an elastic bandage) dressing around her head that was to be left on for 48 hours. The record indicated client B was to see her PCP to remove the staples in 7 to 10 days. __On 8/14/15 client B saw her PCP for removal of staples in her head. Client B's April (2015) nursing assessment indicated: 4/22/15 client B "Transferred from ECF (Extended Care Facility) that closed down. Answers simple questions. Seems happy, smiles a lot. Wearing helmet, in w/c (wheelchair). Staff reports she has not attempted to get up on her own. Able to move self in w/c. Able to amb (ambulate) with assist of staff for safety. To have PT/OT eval (evaluation)." The report indicated client B had bruising on her skin. The report did not give a descriptive note of the bruising or indicate where the bruising was located. Client B's notes from the RN in Therap (an electronic record) indicated: __8/13/15 late entry for 7/13/15 at 10:00 AM "Received call from [name of PC], PC requesting me to come assess [client B] d/t possible bruising to right eye			

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	reported by staff. Went to home and assessed [client B], there was no new bruising noted to right eye. There was slight discoloration around eye, pale green. Possible old bruising. PEARL (Pupils Equal and Reactive to Light). Denies c/o pain. Also assessed bruising to left upper arm received after fall 7/11. No swelling noted, arm soft. [Client B] is able to move left arm without complaints. Instructed staff to report any changes." __8/13/15 late entry for 7/11/15 at 4:55 PM "Went by [name of street] group home to assess [client B] after fall, no one was home. Notified [name of PC], PC who said the clients and staff went for a ride. [The RN] is going to see another client and will try again later this evening." __8/13/15 late entry for 7/11/15 at 7:39 PM "Went to group home again to see [client B] but again no one was home. Contacted [name of PC] PC and informed her that I (the RN) was unable to assess [client B] d/t (due to) her not being home. Instructed her to have staff monitor [client B] and if she is c/o (complaining of) pain and/or unable to move left upper arm, have staff take her to ER." __8/13/15 late entry for 7/15/15 (time not indicated) "Received report from [name of PC], PC that [client B's] left upper arm was now swollen with increased bruising. Writer (the RN) went to home to assess			

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	and left arm is now firm to touch with increased edema, no warmth, increased bruising, dark and light purple and blue/green bruising. [Client B] continues to be able to move left arm but now c/o pain when area is touched. Instructed [name of PC], PC to take pt to ER for eval. Informed PD and AD." __8/5/15 at 7:59 PM "Went to home to assess client (B) after fall yest (yesterday). She (client B) was sitting on couch when [the RN] arrived. Ace wrap wrapped around the top of her head, around face, around chin. Applied firmly but [RN] able to put 2 fingers under ace wrap. Good circulation. Eyes open, PEARL (Pupils Equal and Reactive to Light), able to follow directions. Client (B) refuses to allow staff to apply ice to head. Instructed to given (sic) prn (as needed) medication as needed for pain. V/s (vital signs) stable. Pt (patient) wearing gait belt, staff to walk with client when ambulating, client to use w/c (wheelchair) prn. Report given to PC (Program Coordinator), PD and AD. Requested a PT (Physical Therapy) eval (evaluation) for [client B] on 8-20-15. NP (Nurse Practitioner) stated she would request the order and physical therapy will call PC to set up the appointment." __"8/13/15 at 7:59 PM [Client B] had another fall yest (yesterday). This one without injury. [Client B] has a scheduled			

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	appointment tomorrow for follow up after fall with head injury. MD to remove staples tomorrow. Instructed [name of PC], PC to ask for PT/OT evaluation tomorrow at MD appointment. Also instructed [name of PC], PC to ask MD about getting order back for helmet for client's safety. Gait belt is used on client for safety. Instructed [name of PC], PC to have staff use wheel chair when client is having increased weakness, difficulty ambulating and if client would have to go very long distances. Voiced understanding." Client B's Falls High Risk Plan dated 4/20/15 and updated 8/13/15 indicated: __"1. Staff should monitor environmental concerns at home (wet floor, anything on floor that should be picked up). __2. Staff should monitor environment on outings for weather-related hazards. __3. Notify HM immediately when fall occurs she/he will report to PD and nurse. __4. HM will then follow protocol for falls (located in communication book). After a fall occurs: __1. Take vital signs. __2. Check eyes for dilation. __3. If unconscious, call 911 immediately. __4. Check for injuries before moving person. __5. Document in Therap (GER).			

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	__Staff are to be with [client B] when she is ambulating. Gait belt is to be used for safety. Wheel chair to be used when client is having difficulty walking, increased weakness, or has to go long distances." Client B's ISP dated 4/21/15 indicated "Adaptive equipment: Helmet, wheelchair with stabilizer, gait belt...." The ISP failed to indicate when the adaptive equipment was to be used and how the equipment was to be used. Client B's ISP and Falls Risk Plan failed to indicate how the staff were to supervise, monitor and assist client B while at home and while at the day program to ensure client B's safety in regard to recurring falls and to prevent further injury due to falls. Client B's GERs indicated 6 falls from 4/29/15 to 8/12/15. Client B's record indicated no IDT notes in regard to client B's continued falls. Client B's record indicated no changes in client B's ISP and/or Risk plan in regard to continued falls. Client B's record indicated no additional assessments from PT/OT since client B's admission assessment of 5/11/15 in regard to continued falls.			

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	3. Review of client C's GERs on 8/14/15 at 5 PM indicated the following incidents: On 11/20/14 at 7:30 AM: "[Client C] was in the bathroom, staff heard a fall and went in to check on [client C] and noticed [client C] on the floor. [Client C] had slipped in his urine that was on the floor." The GER indicated the RN reviewed the report on 11/20/14 with no documented comments. On 11/25/14 at 8:29 PM: "[Client C] had just gotten out of the shower and was walking to his chair. He tripped over a rug and fell. Staff caught most of the fall. He did lightly hit his head on the front door.... [Client C] has a small bruise on his left arm between his elbow and wrist." The GER indicated the RN reviewed the report on 12/1/14 with no documented comments. On 1/3/15 at 12 PM: "[Client C] was sitting at the table in a chair and appeared to loose (sic) his balance tipping over his chair. Staff caught the chair so [client C] did not fall all the way to the ground. Staff reported that he hit the left side of his body on the arms of the chair. Staff took him to his room to sit so they could take vitals. [Client C] fell forward on the bed while sitting and staff again stopped			

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	him from falling. Staff reported that [client C] did not appear to focus his eyes on staff and his eyes was (sic) rolling back in his head. Nurse was notified and instructed staff to call an ambulance. [The home manager] met [client C] at the hospital. After running blood work, urinalysis, and an EKG the doctors stated he had a UTI (Urinary Tract Infection). Staff was instructed to start a new antibiotic and follow up with PCP (Primary Care Physician) within 5 days." The GER indicated no review of the report by the RN. On 1/5/15 at 6:13 PM: "Staff was in the bathroom assisting [client C]. Staff was standing in front of [client C] assisting him with pulling his pants down. While staff was doing so [client C] tried to turn and began to fall. Before staff was able to catch [client C] from his fall [client C] has (sic) shifted his weight towards the staff causing himself and staff to fall. Staff was able to position herself during the fall to catch [client C's] head and upper body." The report indicated a reddened area on client C's buttocks. The GER indicated no review of the report by the RN. On 1/6/15 at 10:35 PM: "Staff was coming out of the office from clocking in. [Client C] was in the process of standing			

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	up. When he (client C) was getting up he fell and hit the right side of his body. He has a small cut above his right eye, scraps (sic) down his right side and his side on the right was red. [Client C] complained of pain and was given ibuprophen (sic) (a pain medication). After he (client C) fell he would not respond well to staff's questions. He (client C) was mumbling but staff could hardly understand him. Staff stayed with [client C] on the floor between his rocking chair and the table with a pillow under his head. We (the staff) kept talking to him until home manager arrived. When home manager talked to him he responded right away telling her he fell. After asking him a few questions she asked [client C] if he would like to get up. Staff assist (sic) [client C] from the floor to the rocking chair. [Client C] continued to answer HM's (Home Manager's) questions then stated he needed to use the bathroom. Three staff assist (sic) him to the restroom. [Client C] appeared to shuffle his right side and saying he hurt. [Client C] was checked over for further injuries. After using the bathroom [client C] was assisted in a recliner in the living room to sleep for the night. [Client C] agreed to sleep in the living room for tonight.... [Client C] cut his head right above his right eye." The GER indicated the RN reviewed the report on 1/7/15 with no			

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	documented comments. On 1/7/15 at 6 PM: "[Client C] was walking to the bathroom and staff noticed that [client C] was having a hard time walking on his right leg. He had a fall the previous night on that side. HM called the Nurse and was instructed to take [client C] to the ER to be evaluated. While at the ER [client C] had an X-Ray of his right hip, blood work, urinalysis, and a CT (Computerized Tomography - special X-ray tests that produce cross-sectional images of the human body using X-rays and a computer) scan of his head. All tests came back normal. The PA (Physician's Assistant) stated that his (client C's) UTI appeared to be improving and his sodium levels had improved. He (client C) is to follow up with his PCP, which is 1/15/15." On 1/9/15 at 1 PM: "[Client C] was sitting in the rocking chair in the kitchen. The chair broke while he was sitting in it causing him to fall. [Client C] fell on his right side. At the time there was no bruising or redness." The GER indicated no review of the report by the RN. On 1/28/15 at 8:14 PM: "[Client C] was in the kitchen trying to help himself get coffee. He tried to stand up from his wheel chair and he fell. Staff immediately			

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	went to help him." No injury was reported. The GER indicated no review of the report by the RN. On 3/18/15 at 7:56 AM: "Staff assisted [client C] onto the van. Once [client C] was over his seat, he slid off the seat. Other peers assisted in catching the fall, however he did land on his butt. Staff assessed [client C] and there were no injuries found." The GER indicated no review of the report by the RN. On 4/5/15 at 2 AM: "[Client C] was trying to get out of bed and fell. When staff went to check on him he stumbled against the door. Staff assisted him to the restroom and checked him over for injuries. He has a large red area that appears to be bruising on his left hand above his thumb and a scrape on his left knee cap. At the time he did not appear to have any other injuries." The GER indicated the RN reviewed the report on 4/17/15 with no documented comments. On 4/7/15 at 7 PM: "[Client C] slipped on noodles on the kitchen floor, staff had a hold of gait belt but [client C] fell over and hit arm and head on pantry door. Did not fall on the floor." The actions taken indicated "staff prevented [client C] from going to floor by stabling (sic) him with his gait belt, floor was also swept and			

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	cleaned up. Plan of Future Corrective Actions: make sure that the path [client C] is walking is clear of all objects, continue to use gait belt and walk with staff at all times." The GER indicated the RN reviewed the report on 4/15/15 with no documented comments. On 5/7/15 at 7:55 PM: "We (staff and clients) were on our way home from church, other behaviors were going on. At some point [client C] unbuckled his seat belt. Staff went to pull over to assist with the behaviors and [client C] slid off his seat onto his knees. Both his knees ended up skinned up. There was no blood. Staff cleaned the wound. No bandages were needed." The GER indicated the RN reviewed the report on 5/11/15 with no documented comments. On 5/18/15 at 6:50 AM: "[Client C] fell in the kitchen and hit his head on the window's edge. His wound was approx 1/2" (inch) and appeared to be deep. He was taken to the ER for evaluation. They completed a head/neck CT and completed labs. While there staff noticed a knot on his hand. An X-Ray was completed. All results came back normal and [client C] received 3 staples (to his head)." The GER indicated the RN reviewed the report on 5/19/15 with no documented comments.			

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	15G735		08/27/2015

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	On 6/4/15 at 5:55 PM: "[Client C] had been sitting on the porch following dinner for about 20 minutes. He (client C) told the staff outside with him that he wanted to go inside because he was hot. Staff assisted [client C] with walking inside to the kitchen table. [Client C] sat down and was drinking coffee. A few minutes later staff noticed that [client C] had laid his head down on the table. Staff prompted [client C] four or five times asking if he was ok. [Client C] was unresponsive. Staff sat [client C] up and asked again if he was ok. He was still unresponsive. Staff noticed however that [client C] was drooling and was just staring straight ahead with his left eye squinted shut. Because [client C] has a seizure risk plan staff assisted [client C] to the floor. He was still unresponsive. Paramedics were called. By the time they got to the house, [client C] was saying that 'it hurts' 'side hurts' when paramedics asked what hurt [client C] told them his stomach. At the hospital he was diagnosed with Vasovagal Syncope (a sudden drop in heart rate and blood pressure causing a person to faint). He (client C) was discharged at 8:26 PM." The GER indicated the RN reviewed the report on 6/15/15 with no documented comments. On 6/30/15 at 10 PM: "[Client C] stood			

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	up to walk into the house and fell on his knees." The report indicated client C scraped both knees. The GER indicated the RN reviewed the report on 7/7/15 with no documented comments. On 8/6/15 at 5 PM: "[Client C] was sitting on the front porch. When he was walking in, he fell and landed on his butt. Staff assisted him with getting up and assessed him for injuries. We (the staff) did not find any. [Client C] stated that he was just fine." The GER indicated the RN reviewed the report on 8/10/15 with no documented comments. On 8/12/15 at 8 PM: "[Client C] was walking fast going out on to the front porch, I (the staff) repeatedly said slow down and held his belt but he tripped on the threshold and went down on one need (sic) to cause an abrasion." __The report indicated "Corrective Action Taken: To stop [client C] from advancing forward while he is hurrying until he knowledge (sic) the command to slow down. Plan of Future Corrective Action: to make recommendation to the staff." The GER indicated the RN reviewed the report on 8/14/15 with no documented comments. Client C's record was reviewed on 8/14/15 at 1 PM. Client C's record			

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	indicated diagnoses of, but not limited to, Seizure disorder, Hypertension, (high blood pressure) and Vasovagal Syncope and left hip periprosthetic fracture (a broken bone that occurs around the components or implants of a total hip replacement). Client C's 2014/2015 appointment records indicated the following: __On 10/14/14 client C had a PT evaluation post hip fracture. The evaluation indicated "[Client C] to utilize SW (standard walker) for ambulation at all times." __On 1/7/15 client C was seen at the ER for a "fall, unsteady gait and injury to head." __On 1/15/15 client C saw his PCP due to "gait disturbance. Has had unsteady gait for last two weeks or so. Has fallen multiple times. Takes two people to assist with ambulation." The record indicated client C was to be re-evaluated by PT. __On 1/21/15 client C was re-evaluated by PT. The evaluation indicated "Decreased left hip extension. For terminal stage. Decreased left hip flexion. Forward swing and forward progression. Increased trunk flexion during gait and poor... standing balance." __On 5/18/15 client C was seen at the ER for a head injury with a laceration. __On 5/21/15 client C saw his PCP and			

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	was asked to provide an order for a bed/chair alarm. The record indicated "Pt (patient) recently fell without asking for assistance and now has a wound on the back of his head. Having increase in falls from getting up by himself." Client C's updated 2014 FRP indicated __"Definition - A fall risk is someone who has the tendency to lose balance leading to falls. The fall may or may not cause injury.... The most common complication of falls is injury to the person. Injury may be minor requiring only minor first aid. More serious injuries will require emergency medical treatment. __Prevention: Staff are to ensure that any adaptive devices are in good repair, broken equipment should be reported to the PD (Program Director) immediately. The environment should be kept clear of hazards. Staff are to assist clients as needed with ambulation [(walking)]. Staff are trained in the possible side effects of medications and should provide added assistance for clients who need help because of side effects. __Plan Staff are trained in Body Mechanics [(use of adaptive devices)]. Use of adaptive devices is followed by a doctor and proper fit is monitored on a regular basis. [Client C] may use gait belt, walker with wheels and wheel chair			

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	as needed for safety. Environmental hazards are removed by staff, more complex environmental issues are reported to maintenance on a monthly basis." Client C's FRP failed to indicate __How the staff were to supervise, monitor and assist client C while at home and while at the day program to ensure client C's safety in regard to recurring falls. __When client C was to wear the gait belt. __The use of a chair/bed alarm, when it was to be used and how the staff were to ensure the alarms were functioning. Client C's skin and wound records indicated: __2/16/15 "Staff notice (sic) two bruises today one on his (client C's) right chest and one on his right arm while giving [client C] a shower tonight (sic). Staff reported to HM." __2/21/15 "[Client C] has broken skin on the top of his right foot from where his shoe has been rubbing. There is also a small, lightly colored bruise on his chest in the area where the gait belt is." __3/20/15 "There's a red scrape on his (client C's) left knee. [Client C] said he fell at the day program today. It is about the size of a 50 cent piece."			

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	__3/21/15 "The scrape on his L knee is getting better." __3/22/15 "[Client C] has two bruises on his Right side thigh. He stated Friday that he fell at day services program. He also had a small red scrape on his left knee." __3/24/15 "[Client C] has bruises on his upper left arm and both legs. He claims he fell at workshop." __3/25/15 "[Client C] still has the bruises on his upper left arm. On the upper part of both of his legs there are bruises. All were reported to the home manager." __3/27/15 "[Client C] still has the bruises on the upper part of both legs and on his left arm. He also scratched himself on the upper part of his right leg." __3/26/15 "[Client C] still has the bruises on his legs and his left arm. No new injuries." __3/28/15 "The bruises on [Client C's] upper thighs are purple in color with yellowing around them. No other new areas to report." __3/30/15 "No new wounds were found. He (client C) still has the same bruises." __4/6/15 "[Client C] has a few bruises on his upper thighs that are almost healed." __4/7/15 "Refer to GER. [Client C] started to fall and fell into pantry door. Scraped his left arm on the door handle. No other new concerns." __4/8/15 "[Client C] has some bruising and a couple small scratches from his fall			

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	yesterday." __4/9/15 "No new areas for [client C] today, some bruising from Tuesday's 'fall' (reported in GER)." __5/3/15 "[Client C's] buttocks is (sic) more red than usual around his crack, it appears to be from where he sits a lot. Spots have been there for awhile but seems to be dry/peeling. Staff applied A&D ointment to buttocks after shower." __5/8/15 "[Client C] has a bruise on his right hip area. Its (sic) light in color and the size of a 50 cent piece. __5/10/15 "[Client C] has a small faded bruise on his right fore arm. There are no other issues to report." __5/18/15 "[Client C] fell this morning and hit his head and had to get stitches. When pressure is applied to the wound it does still bleed. Staff cleaned the wound with soap and water. There is also a little swelling in [client C's] right hand from the fall this morning. __5/19/15 "I (the staff) cleaned the wound on the back of [client C's] head with soap and water. It did begin bleeding a small amount again but stopped within a few minutes. The swelling on the back of his right hand has went (sic) down. No new wounds were found." __5/			
W 0153 Bldg. 00	483.420(d)(2) STAFF TREATMENT OF CLIENTS The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as			

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	injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures. Based on record review and interview for 5 of 10 allegations of client to client abuse and for 12 of 12 injuries of unknown origin for clients A, B, C, D and E, the facility failed to ensure all allegations of abuse and injuries of unknown origin were reported immediately to the administrator and all allegations of abuse were reported to the BDDS (Bureau of Developmental Disabilities Services) per IAC 9-3-1(b)(5) and APS (Adult Protective Services) per IC 12-10-3 according to state law. Findings include: The facility's reportable and investigative records were reviewed on 8/13/15 at 1 PM. The 7/15/15 BDDS (Bureau of Developmental Disabilities Services) report indicated on 7/14/15 at 3 PM "[Name of the BDDS representative] visited with consumer (client B) at the Mentor Day Program Services site. While visiting [the BDDS representative] noticed large bruise on consumer's left upper arm. Bruise appeared to be in beginning stages of healing and was multi-colored. Bruise was large covering	W 0153	**W153 Staff Treatmentof Clients** The facility must ensure that all allegations of mistreatment, neglector abuse, as well as injuries of unknown source, are reported immediately tothe administrator or to other officials in accordance with State law through establishedprocedures. **1. What corrective action will beaccomplished?** •□□□□□□□□ All staff,Program Coordinator and Program Director (QIDP) will be retrained on protocolfor reporting client abuse, neglect or injuries of unknown origin. •□□□□□□□□Staff will notify Program Coordinator of anyincidents. •□□□□□□□□Program Coordinator will notify Program Director(QIDP) of any incidents. •□□□□□□□□Program Director (QIDP) will report allincidents of client to client abuse or injuries of unknown origin will bereported to BDDS and APS, per state law **2. How will we identify other residents havingthe potential to be affected by the same deficient practice and what correctiveaction will be taken?**	09/26/2015

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	approx (approximately) 3-4 inches long across consumer's arm and approx 2 inches wide. Consumer also had another bruise on her knee that appeared to be approx. 2 inches long. This bruise appeared to be older than the other one. Consumer was unable to provide details of how these injuries occurred and Day Program Staff did not know. [The BDDS representative] also visited the home of consumer this day where house staff reported they thought she had fallen and hit herself on a chair last week. Review of client A's, B's, C's and D's (General Events Reports - Internal incident records) for 2014/2015 on 8/14/15 at 5 PM indicated the following: __On 7/18/15 at 7 PM while walking down the hallway, client C slapped one of his female housemates. The facility records indicated this was not reported to BDDS and APS. __On 6/11/15 while at the counselors office, client B was smacked with an open hand by client C. The facility records indicated this was not reported to BDDS and APS. __On 3/26/15 client A was smacked by a peer after refusing to move for a peer to step off the van. Client A smacked the other client back and threatened to punch him. Clients continued to hit each other until staff stepped between them to block		•□□□□□□□□All residents have the potential to be affectedby the same deficient practice. •□□□□□□□□All staff, Program Coordinator and ProgramDirector (QIDP) will be retrained on protocol for reporting client abuse,neglect or injuries of unknown origin. •□□□□□□□□Staff will notify Program Coordinator of anyincidents. •□□□□□□□□Program Coordinator will notify Program Director(QIDP) of any incidents. •□□□□□□□□Program Director (QIDP) will report allincidents of client to client abuse or injuries of unknown origin will bereported to BDDS and APS, per state law **3. What measures will be put into place orwhat systemic changes will be made to ensure that the deficient practice doesnot recur:** •□□□□□□□□All staff, Program Coordinator and ProgramDirector (QIDP) will be retrained on protocol for reporting client abuse,neglect or injuries of unknown origin. •□□□□□□□□Staff will notify Program Coordinator of any incidents. •□□□□□□□□Program Coordinator will notify Program Director(QIDP) of any incidents. •□□□□□□□□Program Director (QIDP) will report allincidents of client to client abuse or injuries of	

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	the hits. The facility records indicated this was not reported to BDDS and APS. __On 3/18/15 client E "was talking to a staff about wanting to go to the hospital over her wrist hurting. The staff had asked her what was wrong with her wrist and [client E] then yelled that it was hurt at workshop from a 'beat down.' Her peer had walked to the end of the table and [client E] yelled again. Her peer ran up to her and hit her on the left side of her left breast." The facility records indicated this was not reported to BDDS and APS. __On 1/26/15 client D was walking out the door to get on the van and was "punched" in the back by a peer. The facility records indicated this was not reported to BDDS and APS. Client C's record was reviewed on 8/14/15 at 1 PM. Client C's skin and wound records indicated: __2/16/15 "Staff notice (sic) two bruises today one on his (client C's) right chest and one on his right arm while giving [client C] a shower tonight (sic). Staff reported to HM (Home Manager)." __3/20/15 "There's a red scrape on his (client C's) left knee. [Client C] said he fell at the day program today. It is about the size of a 50 cent piece." __3/22/15 "[Client C] has two bruises on his Right side thigh. He stated Friday that he fell at day services program. He also		unknown origin will bereported to BDDS and APS, per state law **4. How will the corrective action be monitoredto ensure the deficient practice will not recur?** •□□□□□□□□All staff, Program Coordinator and ProgramDirector (QIDP) will be retrained on protocol for reporting client abuse,neglect or injuries of unknown origin. •□□□□□□□□Staff will notify Program Coordinator of anyincidents. •□□□□□□□□Program Coordinator will notify Program Director(QIDP) of any incidents. •□□□□□□□□Program Director (QIDP) will report allincidents of client to client abuse or injuries of unknown origin will bereported to BDDS and APS, per state law **5. What is the date by which the systemicchanges will be completed?** 9/26/15	

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	had a small red scrape on his left knee." __3/24/15 "[Client C] has bruises on his upper left arm and both legs. He claims he fell at workshop." __5/8/15 "[Client C] has a bruise on his right hip area. Its (sic) light in color and the size of a 50 cent piece. __7/2/15 "He (client C) has a purple colored half dollar size bruise on his chin. His right and left arms have red and purple bruising with some scabbed scratch marks from him scratching his dry skin on his arms." __7/3/15 "[Client C] has a dark purple bruise the size of a half dollar on the bottom right corner of his chin. I am uncertain on how it got there at this time. [Client C] has red and purple colored bruises with some small scabs in the bruising areas due to him scratching his right and left arms." __7/3/15 "Has some purple bruising on his left knee with a dime size scab that is in the healing stage and has no sign of infection. On his right knee there is (sic) a couple light purple bruising dots that are in the healing stage and surrounding the bruising dots there's a nickle (sic) size patch of dried, peeling, skin." __8/10/15 "When staff got [client C] out of the shower we noticed bruising light blue color with darker blue spots in the middle on his right wrist that was about 7 inches long and three inches wide. There			

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	was a part that was swollen up appearing to look like a knot. Ibprophen (sic) was given after his shower." __8/11/15 "[Client C] has bruising on his right wrist and hand small bruises on his right thigh" __8/13/15 "No new wounds were found on [client C]. His right wrist is still bruised. He also has bruising on his legs and inner thighs." The facility records indicated the injuries of unknown origin for client C were not reported immediately to the administrator. During interview with the AD (Area Director) on 8/13/15 at 12:50, the AD: __Indicated the facility followed the BDDS reporting and investigation policy and procedure. __Indicated all allegations of abuse and injuries of unknown origin were to be immediately reported to the administrator. __Indicated according to state law all allegations of abuse were to be reported to BDDS and APS. During interview with the PD (Program Director) on 8/14/15 at 1 PM, the PD: __Indicated all allegations of abuse and injuries of unknown origin were to be immediately reported to the			

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	administrator. __Indicated according to state law all allegations of abuse were to be reported to BDDS and APS. This federal tag relates to complaint #IN00174893. 9-3-2(a)			
W 0154 Bldg. 00	483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated. Based on interview and record review for 13 of 13 allegations of client to client abuse and 6 of 6 additional investigations reviewed for clients A, B, C, D, E, F and G, the facility failed to ensure all investigations were conducted thoroughly and to ensure all allegations of abuse were investigated. Findings include: The facility's reportable and investigative records were reviewed on 8/13/15 at 1 PM. The 4/27/15 BDDS report indicated on 4/26/15 at 4 PM client F began calling client E names and hit client E in her right arm.	W 0154	**W154 Staff Treatmentof Clients** The facility must ensure that all alleged violations are thoroughlyinvestigated. **1. What corrective action will beaccomplished?** •□□□□□□□□ All staffwill be retrained on protocol for reporting client abuse, neglect or injuriesof unknown origin. •□□□□□□□□Staff will notify Program Coordinator of anyincidents immediately. •□□□□□□□□Program Coordinator will notify Program Directorof any incidents immediately upon being informed. •□□□□□Program Director will report all incidents ofclient to client abuse or injuries of unknown origin will be reported to BDDSand APS within 24 hours of	09/26/2015

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NAME OF PROVIDER OR SUPPLIER REM OCCAZIO LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 1206 S MAIN ST NEW CASTLE, IN 47362	

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	__The 4/26/15 Investigative Summary indicated dates of investigation were 5/8/15, 5/11/15 and 5/22/15. The investigative Summary indicated interviews with one staff and client E and client F. The report failed to indicate all staff and clients in the home at the time of the incident. The summary indicated no further interviews. The facility records failed to indicate a thorough investigation. The 5/11/15 BDDS report indicated on 5/10/15 at 10:30 AM client F "became verbally and physically aggressive with staff and his peers." The report indicated client F was placed in a PIA (Physical Intervention Alternatives to manage aggressive behaviors). __The facility records indicated an investigation was conducted. The Investigative Summary indicated interviews with one staff and client F. The report failed to indicate all staff and clients present in the group home at the time of the incident. The summary indicated no further interviews. The facility records failed to indicate a thorough investigation. The 5/12/15 BDDS report indicated on 5/8/15 at 6 PM client F got upset with client E and pulled client E's hair and tried to bite client E.		knowledge. •□□□□□Program Director will investigate any reports ofclient to client abuse and report findings, per policy and state law. •□□□□□Area Director will monitor all BDDS reports andinvestigations weekly. •□□□□□Monthly, the facility nurse, Program Coordinatorand Program Director (QIDP) will meet to review client needs, all clientspecific training and head injury protocol training completed for existing andnew staff. **2. How will we identify other residents havingthe potential to be affected by the same deficient practice and what correctiveaction will be taken?** •□□□□□□□□All residents have the potential to be affectedby the same deficient practice. •□□□□□□□□All staff will be retrained on protocol forreporting client abuse, neglect or injuries of unknown origin. •□□□□□□□□Staff will notify Program Coordinator of anyincidents. •□□□□□□□□Program Coordinator will notify Program Directorof any incidents. •□□□□□□□□Program Director will report all incidents ofclient to client abuse or injuries of unknown origin will be reported to BDDSand APS within 24 hours of knowledge.	

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	__The 5/8/15 Investigative Summary indicated dates of investigation 5/8/15, 5/13/15 and 5/23/15. The Summary indicated interviews with two staff, client E and client F. The report failed to indicate all staff and clients present in the group home at the time of the incident. The summary indicated no further interviews. The facility records failed to indicate a thorough investigation. The 5/15/15 BDDS report indicated on 5/14/15 at 3:45 PM client F became verbally and physically aggressive with staff and his peers. The report indicated client F was placed in a PIA. __The facility records indicated an investigation was conducted. The Summary indicated interviews with one staff and client F. The report failed to indicate all staff and clients present in the group home at the time of the incident. The summary indicated no further interviews. The facility records failed to indicate a thorough investigation. The 5/19/15 BDDS report indicated "On Monday May 18th, 2015 at 6:50 AM [client C] was taken to the ER (Emergency Room) for a fall that required medical treatment. [Client C] was walking in the kitchen when he fell and hit his head on the window's edge. Program Director [(PC - Name of		•□□□□□□□□Program Director will investigate any reports ofclient to client abuse and report findings, per policy and state law. **3. What measures will be put into place orwhat systemic changes will be made to ensure that the deficient practice doesnot recur:** •□□□□□□□□All staff will be retrained on protocol forreporting client abuse, neglect or injuries of unknown origin. •□□□□□□□□Staff will notify Program Coordinator of anyincidents. •□□□□□□□□Program Coordinator will notify Program Directorof any incidents. •□□□□□□□□Program Director will report all incidents ofclient to client abuse or injuries of unknown origin will be reported to BDDSand APS within 24 hours of knowledge. •□□□□□□□□Program Director will investigate any reports ofclient to client abuse and report findings, per policy and state law. •□□□□□□□□Area Director will monitor all BDDS reportableincidents weekly. **4. How will the corrective action be monitoredto ensure the deficient practice will not recur?** •□□□□□□□□All staff will be	

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	Program Coordinator)] saw that [client C] had a wound on his head that was about 1/2 inch long and appeared to be deep. PC took [client C] to the hospital for evaluation. At the hospital they completed a head/neck CT and completed labs. It was also noticed that [client C] has a knot on his left hand. An X-ray was completed. All results came back normal and [client C] received 3 staples on (sic) his head." __The 5/18/15 Investigative Summary indicated dates of the investigation from 5/18/15 to 7/9/15. The investigation indicated interviews with the PC, one DSP and client C. The summary indicated no further interviews. The facility records failed to indicate a thorough investigation. The 5/20/15 BDDS report indicated on 5/19/15 at 3 PM client C grabbed client F's shirt and began to hit client F in the stomach and the back. Staff stepped in between the clients and separated them. The report indicated the incident happened on the van outside of the day services. __The 5/19/15 Investigative Summary indicated interviews one staff and both clients. The report indicated both clients were able to make their needs known but "may not recall details accurately." The report indicated client C indicated he was		retrained on protocol forreporting client abuse, neglect or injuries of unknown origin. •□□□□□□□□Staff will notify Program Coordinator of anyincidents. •□□□□□□□□Program Coordinator will notify Program Directorof any incidents. •□□Program Director will report all incidents ofclient to client abuse or injuries of unknown origin will be reported to BDDSand APS within 24 hours of knowledge. •□□Program Director will investigate any reports ofclient to client abuse and report findings, per policy and state law. •□□Area Director will monitor all BDDS reportableincidents, monthly. **5. What is the date by which the systemicchanges will be completed?** **9/26/15**	

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	up and client F "didn't understand what was being asked of him." The summary failed to indicate all the clients on the van and/or all staff involved were interviewed. The summary indicated no further interviews. The facility records failed to indicate a thorough investigation. The 5/21/15 BDDS report indicated on 5/7/15 at 7:55 PM client G was placed in a PIA hold to prevent self injury of hitting himself. __The facility records indicated an investigation was conducted. The Investigative Summary indicated interview with one staff. The report indicated client G was non-verbal. The report failed to indicate all staff and clients in the home at the time of the incident were interviewed. The summary indicated no further interviews. The facility records failed to indicate a thorough investigation. The 6/2/15 BDDS report indicated: __"On May 21st (2015) at 8:55 PM, [client A] was in the restroom and lost his balance causing him to fall on his buttock. [Client A] stated that his knee was hurting and that he fell due to his knee hurting. Staff assisted [client A] up and checked him for injuries. No injuries were present at the time."			

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	__"On May 25th at 9:45 PM [client A] was going to the bathroom to complete oral hygiene tasks and fell hitting his back and buttock. Staff assisted [client A] up off the floor and he started yelling his knee hurt. Staff assisted him on the toilet to check his knee. At the time there did not appear to be any swelling or marks. Staff took [client A] to the ER since he would not put any pressure on his knee. At the ER they completed a series of X-rays on his knee. ER stated there was no fracture and only slight swelling. ER referred to an orthopedics doctor to look at his knee further and put his knee in a stabilizer and encouraged him to walk on his leg using a rollator walker (a four wheeled rolling walker)." __"On May 27th (2015) [client A] complained of a lot of pain while walking and staff reported a large red area on the right side of his groin. PC came to observe [client A] walk and to check the red area. [Client A's] right thigh appeared to be a larger size than his left thigh and the red area was warm to touch. [Client A] was taken back to the ER for additional observation and additional X-rays. The ER took a hip X-ray and discovered the ball of his hip joint was broken and he would need surgery to repair. __The 5/27/15 investigative report indicated interviews with two DSPs			

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	(Direct Support Professionals) and client A. The report failed to indicate all staff and clients present in the group home at the time of the incidents were interviewed. The summary indicated no further interviews. The facility records failed to indicate a thorough investigation. The 6/3/15 BDDS report indicated on 5/21/15 at 3:35 PM client F became verbally and physically aggressive with staff and was placed in a PIA. __The investigative summary indicated interviews with two staff and an interview with client F. The report failed to indicate all staff and clients present in the group home at the time of the incident were interviewed. The summary indicated no further interviews. The facility records failed to indicate a thorough investigation. The 6/9/15 BDDS report indicated on 6/8/15 at 3:50 PM client D told the BDDS representative that client C had hit her on the side of the head and pulled at the back of her shirt while on the facility van during transport. The report indicated client D had some redness to the back of her neck. __The facility records indicated no investigation of the client to client abuse.			

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	The 7/15/15 BDDS report indicated on 7/14/15 at 3 PM "[Name of the BDDS representative] visited with consumer (client B) at the Mentor Day Program Services site. While visiting [the BDDS representative] noticed large bruise on consumer's left upper arm. Bruise appeared to be in beginning stages of healing and was multi-colored. Bruise was large covering approx (approximately) 3-4 inches long across consumer's arm and approx 2 inches wide. Consumer also had another bruise on her knee that appeared to be approx. 2 inches long. This bruise appeared to be older than the other one. Consumer was unable to provide details of how these injuries occurred and Day Program Staff did not know. [The BDDS representative] also visited the home of consumer this day where house staff reported they thought she had fallen and hit herself on a chair last week. __The facility records indicated no investigation in regard to client B's injuries of unknown origin. The 7/20/15 BDDS report indicated on 7/19/15 at 6:30 PM client C hit client E. __The facility records indicated no investigation of the client to client abuse. Review of client A's, B's, C's and D's GERs (General Events Reports also			

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	known as Incident/Accident reports) for 2014/2015 on 8/14/15 at 5 PM, the GERs indicated the following: __On 7/18/15 at 7 PM while walking down the hallway, client C slapped one of his female housemates. The facility records indicated no investigation. __On 6/11/15 while at the counselors office, client B was smacked with an open hand by client C. The facility records indicated no investigation. __On 3/26/15 client A was smacked by peer after refusing to move for a peer to step off the van. Client A smacked the other client back and threatened to punch him. Clients continued to hit each other until staff stepped between them to block the hits. The facility records indicated no investigation. __On 3/18/15 client E "was talking to a staff about wanting to go to the hospital over her wrist hurting. The staff had asked her what was wrong with her wrist and [client E] then yelled that it was hurt at workshop from a 'beat down.' Her peer had walked to the end of the table and [client E] yelled again. Her peer ran up to her and hit her on the left side of her left breast." The facility records indicated no investigation. __On 1/26/15 client D was walking out the door to get on the van and was "punched" in the back by a peer. The facility records indicated no			

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	investigation. During interview with the AD (Area Director) on 8/13/15 at 12:50, the AD: __Indicated the facility followed the BDDS reporting and investigation policy and procedure. __Indicated all allegations of abuse and injuries of unknown origin were to be thoroughly investigated. During interview with the PD (Program Director) on 8/14/15 at 1 PM, the PD: __Indicated all allegations of abuse and injuries of unknown origin were to be thoroughly investigated. __Indicated all facility investigations were to be thorough. __Indicated all individuals at the home and/or all individuals around the area of the incident were to be interviewed for the investigation to be considered a thorough investigation. __Indicated all investigations were to be conducted thoroughly to ensure quality of care and clients' safety. This federal tag relates to complaint #IN00174893. 9-3-2(a)			

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W 0156 Bldg. 00	483.420(d)(4) STAFF TREATMENT OF CLIENTS 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. Based on interview and record review for 8 of 10 investigations reviewed for allegations of abuse, injuries of unknown source and client restraints, the facility failed to ensure the results of all investigations were reported to the administrator within five working days in accordance with State law for clients C, E, F and G. Findings include: The facility's reportable and investigative records were reviewed on 8/13/15 at 1 PM. The 4/27/15 BDDS report indicated on 4/26/15 at 4 PM client F began calling client E names and hit client E in her right arm. __The 4/26/15 Investigative Summary indicated dates of investigation were 5/8/15, 5/11/15 and 5/22/15. The facility records indicated the result of the investigation was not reported to the administrator in accordance with State law within five working days of the	W 0156	**W156 Staff Treatmentof Clients** The results of all investigations must be reported to the administratoror designated representative or to other officials in accordance with State lawwithin five working days of the incident. **1. What corrective action will beaccomplished?** •□□□□□□□□All staff, Program Coordinator and ProgramDirector (QIDP) will be retrained on protocol for reporting client abuse,neglect, injuries of unknown origin and restraint. •□□□□□□□□Program Director (QIDP) will be trained oninvestigation protocol and timeliness. •□□□□□□□□Staff will notify Program Coordinator of anyincidents. •□□□□□□□□Program Coordinator will notify Program Director(QIDP) of any incidents. •□□□□□□□□Program Director (QIDP) will report allincidents of alleged abuse, injuries of unknown origin or restraint will bereported to BDDS and APS, per state law.	09/26/2015

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	incident. The 5/11/15 BDDS report indicated on 5/10/15 at 10:30 AM client F became verbally and physically aggressive with staff and his peers. The report indicated client F was placed in a PIA (Physical Intervention Alternatives to manage aggressive behaviors). __The facility records indicated an investigation was conducted. The Investigative Summary indicated the dates of the investigation were 5/10/15, 5/12/15 and 5/23/15. The facility records indicated the result of the investigation was not reported to the administrator in accordance with State law within five working days of the incident. The 5/12/15 BDDS report indicated on 5/8/15 at 6 PM client F got upset with client E and pulled client E's hair and tried to bite client E. __The 5/8/15 Investigative Summary indicated the dates of the investigation were 5/8/15, 5/13/15 and 5/23/15. The facility records indicated the result of the investigation was not reported to the administrator in accordance with State law within five working days of the incident. The 5/15/15 BDDS report indicated on 5/14/15 at 3:45 PM client F became		•□□□□□□□□Program Director (QIDP) will investigate anyinjuries of unknown origin, alleged abuse or client restraint and reportfindings, per policy and state law. •□□□□□□□□Area Director will monitor completion andtimeliness of reports and investigations monthly. **2. How will we identify other residents havingthe potential to be affected by the same deficient practice and what correctiveaction will be taken?** •□□□□□□□□All staff, Program Coordinator and ProgramDirector (QIDP) will be retrained on protocol for reporting client abuse,neglect, injuries of unknown origin and restraint. •□□□□□□□□Program Director (QIDP) will be trained oninvestigation protocol and timeliness. •□□□□□□□□Staff will notify Program Coordinator of anyincidents. •□□□□□□□□Program Coordinator will notify Program Director(QIDP) of any incidents. •□□□□□□□□Program Director (QIDP) will report allincidents of alleged abuse, injuries of unknown origin or restraint will bereported to BDDS and APS, per state law. •□□□□□□□□Program Director (QIDP) will investigate anyinjuries	

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	verbally and physically aggressive with staff and his peers. The report indicated client F was placed in a PIA. __The facility records indicated an investigation was conducted. The Investigative Summary indicated the dates of the investigation were 5/14/15, 5/15/15 and 5/23/15. The facility records indicated the result of the investigation was not reported to the administrator in accordance with State law within five working days of the incident. The 5/19/15 BDDS report indicated "On Monday May 18th, 2015 at 6:50 AM [client C] was taken to the ER for a fall that required medical treatment. [Client C] was walking in the kitchen when he fell and hit his head on the window's edge. Program Director [(PC - Name of Program Coordinator)] saw that [client C] had a wound on his head that was about 1/2 inch long and appeared to be deep. PC took [client C] to the hospital for evaluation. At the hospital they completed a head/neck CT and completed labs. It was also noticed that [client C] has a knot on his left hand. An X-ray was completed. All results came back normal and [client C] received 3 staples on (sic) his head." __The 5/18/15 Investigative Summary indicated the dates of the investigation were from 5/18/15 to 7/9/15. The		of unknown origin, alleged abuse or client restraint and reportfindings, per policy and state law. •□□□□□□□□Area Director will monitor completion andtimeliness of reports and investigations monthly. **3. What measures will be put into place orwhat systemic changes will be made to ensure that the deficient practice doesnot recur:** •□□□□□□□□All staff, Program Coordinator and ProgramDirector (QIDP) will be retrained on protocol for reporting client abuse,neglect, injuries of unknown origin and restraint. •□□□□□□□□Program Director (QIDP) will be trained on investigationprotocol and timeliness. •□□□□□□□□Staff will notify Program Coordinator of anyincidents. •□□□□□□□□Program Coordinator will notify Program Director(QIDP) of any incidents. •□□□□□□□□Program Director (QIDP) will report allincidents of alleged abuse, injuries of unknown origin or restraint will bereported to BDDS and APS within 5 days of knowledge, per state law. •□□□□□□□□Program Director (QIDP) will investigate anyinjuries of unknown origin, alleged abuse or client restraint and	

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	Investigative Summary indicated the AD (Area Director) was notified of the results of the investigation on 7/10/15. The facility records indicated the result of the investigation was not reported to the administrator in accordance with State law within five working days of the incident. The 5/20/15 BDDS report indicated on 5/19/15 at 3 PM client C grabbed client F's shirt and began to hit client F in the stomach and the back. Staff stepped in between the clients and separated them. The report indicated the incident happened on the van outside of the day services. __The 5/19/15 Investigative Summary indicated the dates of the investigation were 5/19/15 and 7/9/15. The facility records indicated the result of the investigation was not reported to the administrator in accordance with State law within five working days of the incident. The 5/21/15 BDDS report indicated on 5/7/15 at 7:55 PM client G was placed in a PIA hold to prevent self injury of hitting and biting himself. __The Investigative Summary indicated the dates of the investigation were 5/20/15 and 7/9/15. The facility records indicated the results of the investigation		reportfindings, per policy and state law. •□□□□□□□□Area Director will monitor completion andtimeliness of reports and investigations monthly. **4. How will the corrective action be monitoredto ensure the deficient practice will not recur?** •□□□□□□□□All staff, Program Coordinator and ProgramDirector (QIDP) will be retrained on protocol for reporting client abuse,neglect, injuries of unknown origin and restraint. •□□□□□□□□Program Director (QIDP) will be trained oninvestigation protocol and timeliness. •□□□□□□□□Staff will notify Program Coordinator of anyincidents. •□□□□□□□□Program Coordinator will notify Program Director(QIDP) of any incidents. •□□□□□□□□Program Director (QIDP) will report allincidents of alleged abuse, injuries of unknown origin or restraint will bereported to BDDS and APS within 5 days of knowledge, per state law. •□□□□□□□□Program Director (QIDP) will investigate anyinjuries of unknown origin, alleged abuse or client restraint and reportfindings, per policy and state law. •□□□□□□□□Area Director will	

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	was not reported to the administrator in accordance with State law within five working days of the incident. The 6/3/15 BDDS report indicated on 5/21/15 at 3:35 PM client F became verbally and physically aggressive with staff and was placed in a PIA. __The investigative summary indicated the dates of the investigation were 5/21/15, 5/22/15 and 6/3/15. The facility records indicated the results of the investigation were not reported to the administrator in accordance with State law within five working days of the incident. During interview with the AD (Area Director) on 8/13/15 at 12:50 PM, the AD indicated the results of all investigations were to be reported to the administrator or designated representative in accordance with State law within five working days from the date of the incident. This federal tag relates to complaint #IN00174893. 9-3-2(a)		monitor completion andtimeliness of reports and investigations monthly. **5. What is the date by which the systemicchanges will be completed?** 9/26/15	
W 0210	483.440(c)(3) INDIVIDUAL PROGRAM PLAN			

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Bldg. 00	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 3 of 4 sampled clients (A, B and C), the facility failed to ensure a PT/OT (Physical Therapy/Occupational Therapy) evaluation was conducted to assess and/or re-assess the clients' ambulatory needs, adaptive equipment used/needed and level of staff assistance and supervision required throughout the day to ensure the clients' safety due to falls and recurring injury and to ensure the clients were assessed for their ability to get on and off the facility van and ability to go up and down steps. Findings include: 1. The facility's reportable and investigative records were reviewed on 8/13/15 at 1 PM. The 8/6/15 Bureau of Developmental Disabilities Services (BDDS) report indicated on 6/16/15 at 12 PM "[Client A] had a fall that caused him to be admitted into the hospital. The ER (Emergency Room) took a hip X-ray and discovered the ball of his (client A's) hip joint was broken and he would need surgery to repair it. After the surgery	W 0210	**W 210 INDIVIDUAL PROGRAM PLAN** Within 30 days after admission, the interdisciplinary team must performaccurate assessments or reassessments as needed to supplement the preliminaryevaluation conducted prior to admission. **1. What corrective action will beaccomplished?** •□□□□□□□□Program Coordinator will schedule clients forOT/PT evaluation. •□□□□□□□□Program Director (QIDP) and Program Coordinatorwill be retrained on completing assessments and reassessments in a timelymanner. •□□□□□□□□All recommendations from assessment will beimplemented. •□□□□□□□□All risk plans will be updated per OT/PTrecommendations. •□□□□□□□□All recommended adaptive equipment will bereadily available and maintained in working order. •□□□□□□□□Staff will be trained on updated risk plans andany adaptive equipment ordered. •□□□□□□□□Monthly, the facility	09/26/2015

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	[client A] was admitted into a NF (Nursing Facility). [Client A] was admitted into the hospital then transferred to a nursing facility. [Client A] was discharged from Indiana Mentor's services on 6/16/15." The 6/2/15 BDDS report indicated: __"On May 21st (2015) at 8:55 PM, [client A] was in the restroom and lost his balance causing him to fall on his buttock. [Client A] stated that his knee was hurting and that he fell due to his knee hurting. Staff assisted [client A] up and checked him for injuries. No injuries were present at the time. Staff were to remind and encourage [client A] to use his walker and gait belt when ambulating. There were no environmental factors that caused this fall. Since the fall occurred in the restroom, there were no witnesses. Staff monitored [client A] throughout the night. [Client A] was fine throughout the night and had no other falls that night. PC (Program Coordinator), PD (Program Director) and nurse were all notified. The nurse checked [client A] out. He was sitting in his w/c (wheelchair). He did have his oxygen on, his O2 (oxygen) sat (saturation) was 95. His heart rate was 100-105 and that was sitting. Ortho (Orthopedic) appointment is on June 9th (2015)." __"On May 25th at 9:45 PM [client A]		nurse, Program Coordinatorand Program Director (QIDP) will meet to review client needs (assessments,reassessments, implementation, etc), all client specific training and fallprotocol training completed for existing and new staff. **2. How will we identify other residents havingthe potential to be affected by the same deficient practice and what correctiveaction will be taken?** •□□□□□□□□All residents have the potential to be affectedby the same deficient practice •□□□□□□□□Program Coordinator will schedule clients forOT/PT evaluation. •□□□□□□□□Program Director (QIDP) and Program Coordinatorwill be retrained on completing assessments and reassessments in a timelymanner. •□□□□□□□□All recommendations from assessment will beimplemented. •□□□□□□□□All risk plans will be updated per OT/PTrecommendations. •□□□□□□□□All recommended adaptive equipment will bereadily available and maintained in working order. •□□□□□□□□Staff will be trained on updated risk plans andany adaptive equipment ordered. •□□□□□□□□Monthly, the facility nurse, Program Coordinatorand	

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	was going to the bathroom to complete oral hygiene tasks and fell hitting his back and buttock. Staff assisted [client A] up off the floor and he started yelling his knee hurt. Staff assisted him on the toilet to check his knee. At the time there did not appear to be any swelling or marks. Staff took [client A] to the ER since he would not put any pressure on his knee. At the ER they completed a series of X-rays on his knee. ER stated there was no fracture and only slight swelling. ER referred to an orthopedics doctor to look at his knee further and put his knee in a stabilizer and encouraged him to walk on his leg using a rollator walker (a four wheeled rolling walker)." __"On May 27th (2015) [client A] complained of a lot of pain while walking and staff reported a large red area on the right side of his groin. PC came to observe [client A] walk and to check the red area. [Client A's] right thigh appeared to be a larger size than his left thigh and the red area was warm to touch. [Client A] was taken back to the ER for additional observation and additional X-rays. The ER took a hip X-ray and discovered the ball of his hip joint was broken and he would need surgery to repair. [Client A] was informed of the situation and gave verbal confirmation for the surgery 5/27/15."		Program Director (QIDP) will meet to review client needs (assessments,reassessments, implementation, etc), all client specific training and fallprotocol training completed for existing and new staff. **3. What measures will be put into place orwhat systemic changes will be made to ensure that the deficient practice doesnot recur:** •□□□□□□□Program Coordinator will schedule clients forOT/PT evaluation. •□□□□□□□Program Director (QIDP) and Program Coordinatorwill be retrained on completing assessments and reassessments in a timelymanner. •□□□□□□□All recommendations from assessment will beimplemented. •□□□□□□□All risk plans will be updated per OT/PTrecommendations. •□□□□□□□All recommended adaptive equipment will bereadily available and maintained in working order. •□□□□□□□Staff will be trained on updated risk plans andany adaptive equipment ordered. •□□□□□□□Monthly, the facility nurse, Program Coordinatorand Program Director (QIDP) will meet to review client needs (assessments,reassessments,	

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	Review of client A's GERs (General Events Reports) on 8/14/15 at 5 PM indicated the following incidents: On 10/11/14 at 9:30 AM: "[Client A] was in the bathtub and stated that he lost his footing and fell. He stated that he just hit his lower back. There is a small bruise size of a half dollar on his lower back." On 11/19/14 at 8 AM: "[Client A] was getting off the van and a staff was assisting since the [name of day services] parking lot was covered with ice. [Client A] slipped and staff eased his fall. [Client A] landed on staff's foot on his bottom. [Client A] did not complain of any pain." On 11/30/14 while on a home visit: "[Client A] was at his sister house for the holidays. She (client A's sister) stated that he (client A) fell four times in his 3.5 day visit. Fall questions according to his sister [name of sister]. The falls occurred at his sister's house. [Client A] fell twice going outside to smoke in which he tripped over the doorway, once he fell in the bathroom and once he tripped over a rug. The falls occurred between 11/27 (2014) - 11/30 (2014). [Client A] was with his family during the falls. His sister witnessed all the falls except for the one in the shower. [Client A] was checked for injuries upon returning to the group home		implementation, etc), all client specific training and fallprotocol training completed for existing and new staff. **4. How will the corrective action be monitoredto ensure the deficient practice will not recur?** •□□□□□□□Program Coordinator will schedule clients forOT/PT evaluation. •□□□□□□□Program Director (QIDP) and Program Coordinatorwill be retrained on completing assessments and reassessments in a timelymanner. •□□□□□□□All recommendations from assessment will beimplemented. •□□□□□□□All risk plans will be updated per OT/PTrecommendations. •□□□□□□□All recommended adaptive equipment will bereadily available and maintained in working order. •□□□□□□□Staff will be trained on updated risk plans andany adaptive equipment ordered. •□□□□□□□Monthly, the facility nurse, Program Coordinatorand Program Director (QIDP) will meet to review client needs (assessments,reassessments, implementation, etc), all client specific training and fallprotocol training completed for existing and new staff.	

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	but none were found." On 1/12/15 at 3:15 PM: "[Client A] walking inside house and fell and bumped head slightly Small resulting in a scratch and small abrasion on forehead (sic)." On 2/1/15 at 6:30 PM: "[Client A] was sitting in the chair in the kitchen. All of a sudden he just slid out of the chair. When staff questioned him about why he fall (sic), he just stated that he just fell down. Staff assessed for injuries and none were found. Staff continued to monitor him." On 2/1/15 at 8:25 PM: "[Client A] was sweeping the kitchen floor. He fell and hit his head on the kitchen table. Staff rushed to help him into a chair. Once in the chair he leaned over to the side and started excessively drooling. This is when he began convulsing. Staff moved [client A] to the floor and held his head so that it didn't hit the floor. We also rolled him to his side. After the convulsing stopped [client A] was still unresponsive. He was not blinking and his eyes glazed completlely (sic) over. His face turned purple. Per the paramedics instructions staff did not do CPR. I (staff) was able to find a faint pulse. Paramedics took over at this point and he was taken to the hospital."		**5. What is the date by which the systemicchanges will be completed?** 9/26/15	

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	On 2/6/15 at 6:15 PM: Client A was going to the bathroom, lost his balance and fell onto the toilet. On 2/14/15 at 7:15 PM: "[Client A] had just finished his shower, shaved, and dressed. [Client A] told staff he needed to have a bm (bowel movement) and asked if he could have some privacy. Staff stepped outside the bathroom door and was waiting for [client A] to finish." The report indicated when the staff returned to client A the staff noticed a small scratch on client A's back. The report did not indicate the origin of the injury. On 3/23/15 at 6:40 AM: Client A fell when he was getting out of bed and trying to go to the bathroom without his walker. On 4/13/15 at 7:15 AM: "[Client A] was walking out of his room and tripped over his oxygen tubing. Staff was walking down the hall and saw the incident. Staff was able to get to him before he fell to the ground. Staff put their arm under his and helped guide him to the floor. [Client A] did not hit the floor hard and landed on his right hip and arm. [Client A] was checked for injuries and none was present at the time." On 5/13/15 at 2:45 PM while at the day			

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	services: "Staff went into workshop to pick up clients. Staff woke [client A] up and started to unhook his O2 tubes. [Client A] stood up to hang up his tube and went to sit back down and fell on his butt. [Client A] stated his legs was (sic) asleep. Staff checked him over for injuries when we (staff and clients) arrived home and none was present at the time." On 5/21/15 at 8:55 PM: "[Client A] was in the restroom and lost his balance and fell on his butt. He stated his knee hurt and it popped causing him to loose (sic) his balance. Staff assisted him up and checked for injuries. None was present at the time. Staff asked [client A] to sleep in the living room so staff can monitor more closely." On 5/25/15 at 9:45 PM: "[Client A] was going to the bathroom to complete oral hygiene and fell hitting his back and buttock. Staff assisted him up off the floor and he started yelling his knee hurt. Staff assisted him on the toilet to check his knee. At the time there did not appear to be any swelling or marks. Staff took [client A] to the ER since he would not put any pressure on his knee. At the ER they completed a series of X-Rays on his knee. ER stated there was no fracture and only slight swelling. ER referred to an			

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	orthopedics doctor to look at his knee further and put his knee in a stabilizer and encouraged him to walk on his leg using a rollator walker." Client A's record was reviewed on 8/14/15 at 11 AM. Client A's record indicated diagnoses of, but not limited to, Depression, Lung Cancer, COPD (Congestive Obstructive Pulmonary Disease), Dementia, Seizure Disorder, GERD (Gastric Esophageal Reflux Disease), Arthritis and a history of falls. Client A's quarterly physician's orders dated 4/23/15 to 7/23/15 indicated physician's PRN (as needed) use of a gait belt and an order for a walker. Client A's 5/25/15 hospital discharge record indicated a diagnosis of right knee traumatic effusion (fluid in and around the knee caused by a trauma). Client A's Residential IPOP (Individual Plan of Protective Oversight) dated 9/3/14 indicated client A had no adaptive equipment and was independent within the home with staff present and was on fifteen minute checks 24/7 due to a history of seizures. The IPOP indicated client A could be outside and			

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	unsupervised as long as he was within the fenced in yard. Client A's record indicated no PT/OT (Physical Therapy/Occupational Therapy) evaluation of client A's fine and gross motor skills, client A's ability to go up and down steps and to get on and off the facility van, the level of staff supervision and assistance client A required to ambulate safely in and out of the home and the specific equipment client A required to ensure safe ambulation. During interview with the RM (Residential Manager) on 8/13/15 at 5:30 PM, the RM: __Indicated client A was currently in an extended nursing facility due to a fall he had in May 2015 resulting in a fractured hip. __Indicated client A utilized a gait belt and a walker while ambulating. __Indicated the staff were to assist client A as need while ambulating. __Indicated no knowledge of at PT/OT assessment being conducted within the past year. During interview with the PD (Program Director) on 8/14/15 at 3 PM, the PD indicated no knowledge of a PT/OT assessment being conducted within the past year for client A.			

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(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
	2. Observations and interviews were conducted at the group home on 8/13/15 between 3:40 PM and 6 PM. During this observation period the following was observed: __Client B was a tall large woman that ambulated with a slow unsteady gait. __Client B wore a gait belt and staff provided hands on assistance while ambulating inside and outside of the home by holding the back of the gait belt while walking with client B. __Client B had a large greenish, blue and yellow bruise covering her left shoulder that extended down her left arm approximately six inches, a dark purple bruise on the inside of her inner knee and a healing wound on the left side of her head with staples. Review of client B's GERs on 8/14/15 at 5 PM indicated the following incidents: On 4/29/15 at 8:10 AM: "[Client B] was going out to the van to go to work. Staff asked her to let them help push her down the sidewalk. [Client B] refused and screamed and started to hit her face. Staff walked behind [client B] and when staff looked away [client B's] chair hit the ledge of the sidewalk tipping over her			

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	15G735		08/27/2015

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	chair. Staff assisted [client B] up and checked her for injuries. She (client B) had a small scrape above her left eye where her helmet moved and a scrape on her left knee. No other injuries was (sic) noted at the time." On 5/9/15 at 6:40 PM: "After [client B] pulled herself out of wheel chair she went to reach for support on toilet railing and was not balanced before she moved and fell on her bottom. Staff did have a supportive hand on [client B]. [Client B] was assessed for injuries and has small red spot on the left side of her bottom. She did not hit her head." On 6/12/15 at 8 AM: "We (the staff) were driving down the road and [client B] took off her seatbelt and she feel (sic) onto the floor of the van. Both staff then helped up [client B] and began looking over her for any injuries. She (client B) had red mark from her right side of forehead to the side of her eye. Its (sic) was red at first and then disappeared after a little time. Home manager was called right away about this situation and staff had to keep reminding [client B] to keep her seat belt on the rest of way to Day			

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	Services." On 7/11/15 at 3:30 PM: "[Client B] was being assisted walking into the home. She tripped over the threshold of the front door. Staff caught [client B] using her gait belt but she hit her arm on a rocking chair on the front porch. She had a bruise on her upper left arm. No other injuries was (sic) apparent at the time." On 8/4/15 at 3:15 PM: "[Client B] got up from the table without assistance. She was asked to wait for staff and while she was looking at that person another peer bumped into her. [Client B] fell and hit the corner of the wall hitting the left side of her upper body. [Client B] appeared to have a deep gash on her head and bruising was present on her left cheek. An ambulance was called to transport [client B] to the hospital." On 8/12/15 at 6:30 AM "While walking client (B) to bathroom for shower client (B) kept dropping down to floor. Client (B) then tripped staff and fell onto staff to the floor. Being escorted by 2 staff to bathroom for shower because client kept dropping to floor while being escorted."			

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	Client B's record was reviewed on 8/14/15 at 12 PM. Client B's record indicated diagnosis of, but not limited to, Osteoarthrosis (a degenerative joint disease). Client B's April (2015) nursing assessment indicated: 4/22/15 client B "Transferred from ECF (Extended Care Facility) that closed down. Answers simple questions. Seems happy, smiles a lot. Wearing helmet, in w/c (wheelchair). Staff reports she has not attempted to get up on her own. Able to move self in w/c. Able to amb (ambulate) with assist of staff for safety. To have PT/OT eval (evaluation)." The report indicated client B had bruising on her skin. The report did not give a descriptive note of the bruising or indicate where the bruising was located. Client B's 2014/2015 appointment records indicated: On 5/11/15 client B had a PT assessment. The assessment indicated "Pt (patient) ok to ambulate with gait belt/HHA/CGA (Hand Over Hand Assistance/Contact Guard Assistance) within group home environment. She is to have HHA/CGA for transfers in and out of van and up/down steps/curbs. She is to use w/c (wheelchair) for primary mode of			

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	transportation in the community." On 5/26/15 client B saw her PCP (Primary Care Physician). The physician indicated "May walk in home with gait belt, use wheelchair for longer distances, stop bedside mat and alarm, stop helmet, remove padding from wheelchair arms." On 6/25/15 client B saw her PCP (Primary Care Physician) for "chronic conditions." The record indicated "Walking with some assistance, stable on feet, no falls." On 7/15/15 client B was seen at the ER for a "contusion (a deep bruise caused by a blow, trauma or direct force) of face and upper arm as a result of a fall...." The X-ray of the left ankle indicated "Fall, swelling. No visible acute fracture." The X-ray of the left arm indicated "Fall, Ecchymosis (a discoloration of the skin resulting from bleeding under the skin, typically caused by bruising).... There are healed lower left rib fractures." On 7/28/15 client B saw her PCP for a follow after fall. The report indicated "fell onto porch, tried to get up out of chair on her own, tripped on threshold, went to ER 7/15 (2015) - no injuries other than bruises. Ambulating well with assistance of one and gait belt."			

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	On 8/4/15 client B was seen at the ER for a laceration to her head from a fall. Client B was discharged with an ace wrap (an elastic bandage) dressing around her head that was to be left on for 48 hours. The record indicated client B was to see her PCP to remove the staples in 7 to 10 days On 8/14/15 client B saw her PCP for removal of staples in her head. Client B's record indicated no re-assessment from PT/OT of client B's fine and gross motor skills, client B's ability to go up and down steps and to get on and off the facility van, the level of staff supervision and assistance client B required to ambulate safely in and out of the home and the specific equipment client B required to ensure safe ambulation. Client B's record indicated no further assessment after having additional falls with injury since client B's admission assessment of 5/11/15. During interview with the RM on 8/13/15 at 5:30 PM, the RM: __Indicated client B was admitted to the group home in April of 2015. __Indicated upon admission client B used a wheelchair with extra padding for all ambulatory needs, wore a helmet, utilized a bed alarm, a chair alarm and had a mat			

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	beside her bed in case the client would fall from her bed. __Indicated currently client B utilized a wheelchair for long distance ambulation and stated, "Her doctor wanted her up out of her wheelchair and wants her up walking. For awhile she did pretty good but she's started having falls again." __Indicated client B no longer used the wheelchair, a protective helmet, a bed alarm, a seat alarm and a protective bedside mat. __Indicated client B was to wear a gait belt while ambulating and was to wait for staff assistance before getting up. __Indicated client B frequently would not wait for staff and would get up on her own without staff assistance. __Indicated if the staff saw client B getting up from a seated position or getting out of bed the staff were to immediately assist client B. __Indicated there were 3 to 4 staff in the home at all times when all clients were home. __Indicated client B had a PT evaluation upon admission and had not had any further assessments with the continued falls. During interview with the PD on 8/14/15 at 3 PM, the PD indicated no further assessment from PT since the assessment of 5/11/15 for client B.			

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	3. Observations and interviews were conducted at the group home on 8/13/15 between 3:40 PM and 6 PM. During this observation period the following was observed: __Client C was a tall thin male that ambulated with a slow unsteady forward stance gait. __Client C wore a gait belt and staff provided hands on assistance while ambulating inside and outside of the home by holding the back of the gait belt and walking with client C. The facility's reportable and investigative records were reviewed on 8/13/15 at 1 PM. The 8/13/15 BDDS report indicated on 8/12/15 at 8 PM "Staff was walking with [client C] holding onto his gate (sic) belt for extra support. [Client C] was walking fast and staff verbally redirected [client C] to slow down because he could fall. [Client C] tripped on the front door threshold and fell down and received an abrasion on his right knee. Staff will continue to follow [client C's] risk plan concerning falls." The 5/19/15 BDDS report indicated "On Monday May 18th 2015 at 6:50 AM [client C] was taken to the ER for a fall			

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	that requires medical treatment. [Client C] was walking in the kitchen when he fell and hit his head on the window's edge. Program Director [(PC - Name of Program Coordinator)] saw that [client C] had a wound on his head that was about 1/2 inch long and appeared to be deep. PC took [client C] to the hospital for evaluation. At the hospital they completed a head/neck CT and completed labs. It was also noticed that [client C] has a knot on his left hand. An X-ray was completed. All results came back normal and [client C] received 3 staples on (sic) his head." Review of client C's GERs on 8/14/15 at 5 PM indicated the following incidents: On 11/20/14 at 7:30 AM: "[Client C] was in the bathroom, staff heard a fall and went in to check on [client C] and noticed [client C] on the floor. [Client C] had slipped in his urine that was on the floor." On 11/25/14 at 8:29 PM: "[Client C] had just gotten out of the shower and was walking to his chair. He tripped over a rug and fell. Staff caught most of the fall. He did lightly hit his head on the front door.... [Client C] has a small bruise on his left arm between his elbow and wrist."			

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	On 1/3/15 at 12 PM: "[Client C] was sitting at the table in a chair and appeared to loose (sic) his balance tipping over his chair. Staff caught the chair so [client C] did not fall all the way to the ground. Staff reported that he hit the left side of his body on the arms of the chair. Staff took him to his room to sit so they could take vitals. [Client C] fell forward on the bed while sitting and staff again stopped him from falling. Staff reported that [client C] did not appear to focus his eyes on staff and his eyes was (sic) rolling back in his head. Nurse was notified and instructed staff to call an ambulance. [The home manager] met [client C] at the hospital. After running blood work, urinalysis, and an EKG the doctors stated he had a UTI (Urinary Tract Infection). Staff was instructed to start a new antibiotic and follow up with PCP (Primary Care Physician) within 5 days." On 1/5/15 at 6:13 PM: "Staff was in the bathroom assisting [client C]. Staff was standing in front of [client C] assisting him with pulling his pants down. While staff was doing so [client C] tried to turn and began to fall. Before staff was able to catch [client C] from his fall [client C] has (sic) shifted his weight towards the staff causing himself and staff to fall. Staff was able to position herself during			

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	the fall to catch [client C's] head and upper body." The report indicated a reddened area on client C's buttocks. On 1/6/15 at 10:35 PM: "Staff was coming out of the office from clocking in. [Client C] was in the process of standing up. When he (client C) was getting up he fell and hit the right side of his body. He has a small cut above his right eye, scraps (sic) down his right side and his side on the right was red. [Client C] complained of pain and was given ibuprophen (sic) (a pain medication). After he (client C) fell he would not respond well to staff's questions. He (client C) was mumbling but staff could hardly understand him. Staff stayed with [client C] on the floor between his rocking chair and the table with a pillow under his head. We (the staff) kept talking to him until home manager arrived. When home manager talked to him he responded right away telling her he fell. After asking him a few questions she asked [client C] if he would like to get up. Staff assist (sic) [client C] from the floor to the rocking chair. [Client C] continued to answer HM's (Home Manager's) questions then stated he needed to use the bathroom. Three staff assist (sic) him to the restroom. [Client C] appeared to shuffle his right side and saying he hurt. [Client C] was checked			

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	over for further injuries. After using the bathroom [client C] was assisted in a recliner in the living room to sleep for the night. [Client C] agreed to sleep in the living room for tonight.... [Client C] cut his head right above his right eye." On 1/7/15 at 6 PM: [Client C] was walking to the bathroom and staff noticed that [client C] was having a hard time walking on his right leg. He had a fall the previous night on that side. HM called the Nurse and was instructed to take [client C] to the ER to be evaluated. While at the ER [client C] had an X-Ray of his right hip, blood work, urinalysis, and a CT (Computerized Tomography - special X-ray tests that produce cross-sectional images of the human body using X-rays and a computer) scan of his head. All tests came back normal. The PA (Physician's Assistant) stated that his (client C's) UTI appeared to be improving and his sodium levels had improved. He (client C) is to follow up with his PCP, which is 1/15/15." On 1/9/15 at 1 PM: "[Client C] was sitting in the rocking chair in the kitchen. The chair broke while he was sitting in it causing him to fall. [Client C] fell on his right side. At the time there was no bruising or redness."			

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	On 1/28/15 at 8:14 PM: "[Client C] was in the kitchen trying to help himself get coffee. He tried to stand up from his wheel chair and he fell. Staff immediately went to help him." No injury was reported. On 3/18/15 at 7:56 AM: "Staff assisted [client C] onto the van. Once [client C] was over his seat, he slid off the seat. Other peers assisted in catching the fall, however he did land on his butt. Staff assessed [client C] and there were no injuries found." On 4/5/15 at 2 AM: "[Client C] was trying to get out of bed and fell. When staff went to check on him he stumbled against the door. Staff assisted him to the restroom and checked him over for injuries. He has a large red area that appears to be bruising on his left hand above his thumb and a scrape on his left knee cap. At the time he did not appear to have any other injuries." On 4/7/15 at 7 PM: "[Client C] slipped on noodles on the kitchen floor, staff had a hold of gait belt but [client C] fell over and hit arm and head on pantry door. Did not fall on the floor." The actions taken indicated "staff prevented [client C] from going to floor by stabling (sic) him with his gait belt, floor was also swept and			

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	cleaned up. Plan of Future Corrective Actions: make sure that the path [client C] is walking is clear of all objects, continue to use gait belt and walk with staff at all times." On 5/7/15 at 7:55 PM: "We (staff and clients) were on our way home from church, other behaviors were going on. At some point [client C] unbuckled his seat belt. Staff went to pull over to assist with the behaviors and [client C] slid off his seat onto his knees. Both his knees ended up skinned up. There was no blood. Staff cleaned the wound. No bandages were needed." On 5/18/15 at 6:50 AM: "[Client C] fell in the kitchen and hit his head on the window's edge. His wound was approx 1/2" (inch) and appeared to be deep. He was taken to the ER for evaluation. They completed a head/neck CT and completed labs. While there staff noticed a knot on his hand. An X-Ray was completed. All results came back normal and [client C] received 3 staples (to his head)." On 6/4/15 at 5:55 PM: "[Client C] had been sitting on the porch following dinner for about 20 minutes. He (client C) told the staff outside with him that he wanted to go inside because he was hot.			

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	Staff assisted [client C] with walking inside to the kitchen table. [Client C] sat down and was drinking coffee. A few minutes later staff noticed that [client C] had laid his head down on the table. Staff prompted [client C] four or five times asking if he was ok. [Client C] was unresponsive. Staff sat [client C] up and asked again if he was ok. He was still unresponsive. Staff noticed however that [client C] was drooling and was just staring straight ahead with his left eye squinted shut. Because [client C] has a seizure risk plan staff assisted [client C] to the floor. He was still unresponsive. Paramedics were called. By the time they got to the house, [client C] was saying that 'it hurts' 'side hurts' when paramedics asked what hurt [client C] told them his stomach. At the hospital he was diagnosed with Vasovagal Syncope (a sudden drop in heart rate and blood pressure causing a person to faint). He (client C) was discharged at 8:26 PM." On 6/30/15 at 10 PM: "[Client C] stood up to walk into the house and fell on his knees." The reported indicated client C scraped both knees. On 8/6/15 at 5 PM: "[Client C] was sitting on the front porch. When he was walking in, he fell and landed on his butt. Staff assisted him with getting up and			

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	assessed him for injuries. We (the staff) did not find any. [Client C] stated that he was just fine." On 8/12/15 at 8 PM: "[Client C] was walking fast going out on to the front porch, I (the staff) repeatedly said slow down and held his belt but he tripped on the threshold and went down on one need (sic) to cause an abrasion." __The report indicated "Corrective Action Taken: To stop [client C] from advancing forward while he is hurrying until he knowledge (sic) the command to slow down. Plan of Future Corrective Action: to make recommendation to the staff." Client C's record was reviewed on 8/14/15 at 1 PM. Client C's record indicated diagnoses of, but not limited to, Seizure disorder, Hypertension, (high blood pressure) and Vasovagal Syncope. Client C's 2014/2015 appointment records indicated: A hospital physician's History and Physical dated 8/25/14 indicated client C had a diagnosis of "left hip periprosthetic fracture (a broken bone that occurs around the components or implants of a total hip replacement)."			

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	On 10/14/14 client C had a PT evaluation post hip fracture. The evaluation indicated "[Client C] was to utilize SW (standard walker) for ambulation at all times." On 1/7/15 client C was seen at the ER for a "fall, unsteady gait and injury to head." On 1/15/15 client C saw his PCP due to "gait disturbance. Has had unsteady gait for last two weeks or so. Has fallen multiple times. Takes two people to assist with ambulation." The record indicated client C was to be re-evaluated by PT. On 1/21/15 client C was re-evaluated by PT. The evaluation indicated "Decreased left hip extension. For terminal stage. Decreased left hip flexion. Forward swing and forward progression. Increased trunk flexion during gait and poor... standing balance." Client C received physical therapy treatments and was discharged from PT on 3/25/15. On 5/18/15 client C was seen at the ER for a head injury with a laceration. On 5/21/15 client C saw his PCP and was asked to provide an order for a bed/chair alarm. The record indicated "Pt (patient) recently fell without asking for assistance and now has a wound on the back of his			

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	head. Having increase in falls from getting up by himself. Client C's record indicated four additional falls after client C was discharged from PT on 3/25/15. During interview with the RM on 8/13/15 at 5:30 PM, the RM: __Indicated client C was to wear a gait belt when up and ambulating. __Indicated client C was to ask for assistance when getting up but would often get up on his own without staff assistance. __Stated the staff "should keep an eye on him" and if the staff saw client C getting up from a seated position or getting out of bed, the staff were to assist client C immediately. __Indicated client C was supposed to utilize a bed/chair alarm to alert the staff when he got up from a sitting position. __Indicated client C would not leave the bed/chair alarm had broken the clasp on the alarm. __The RM pulled the alarm from her desk drawer in her office and stated, "This is [client C's] chair alarm, but it's broken and he won't use it." During interview with the PD on 8/14/15 at 3 PM, the PD indicated no further PT assessment of client C's mobility needs			

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	and level of staff supervision since client C's discharge from Pt on 3/25/15. This federal tag relates to complaint #IN00174893. 9-3-4(a)			
W 0240 Bldg. 00	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 3 of 4 sampled clients (A, B and C), the facility failed to ensure client A's, B's and C's ISPs (Individualized Support Plans) and/or FRPs (Falls Risk Plans) included the use of the adaptive equipment each client required for mobility, when the equipment was to be used and how the staff were to supervise, monitor and assist each client while at home and while at the day program throughout the day to ensure no further falls and/or injury from falls and to ensure client C's ISP/FRP included what the staff were to do when client C refused to comply with the use of the bed/seat alarms.	W 0240	**W 240 INDIVIDUAL PROGRAM PLAN** The individual program plan must describe relevant interventions tosupport the individual toward independence. **1. What corrective action will beaccomplished?** •□□□□□□□□Program Coordinator will schedule clients forOT/PT evaluation. •□□□□□□□□All recommendations from assessment will beimplemented. •□□□□□□□□All risk plans will be updated per OT/PTrecommendations. •□□□□□□□□All recommended adaptive equipment will bereadily available and maintained in	09/26/2015

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	Findings include: 1. The facility's reportable and investigative records were reviewed on 8/13/15 at 1 PM. The 8/6/15 BDDS (Bureau of Developmental Disabilities Services) report indicated on 6/16/15 at 12 PM "[Client A] had a fall that caused him to be admitted into the hospital. The ER (Emergency Room) took a hip X-ray and discovered the ball of his (client A's) hip joint was broken and he would need surgery to repair it. After the surgery [client A] was admitted into a NF (Nursing Facility). [Client A] was admitted into the hospital then transferred to a nursing facility. [Client A] was discharged from Indiana Mentor's services on 6/16/15." The 6/2/15 BDDS report indicated: __"On May 21st (2015) at 8:55 PM, [client A] was in the restroom and lost his balance causing him to fall on his buttock. [Client A] stated that his knee was hurting and that he fell due to his knee hurting. Staff assisted [client A] up and checked him for injuries. No injuries were present at the time. Staff were to remind and encourage [client A] to use his walker and gait belt when ambulating."		working order. •□□□□□□□□Program Director (QIDP) will be trained onupdating ISPs to reflect changes in adaptive equipment, as ordered. •□□□□□□□□Facility nurse will be retrained on updatingRisk Plans to reflect changes in adaptive equipment, as ordered. •□□□□□□□□Staff will be trained on updated risk plans andany adaptive equipment ordered. •□□□□□□□□Monthly, the facility nurse, Program Coordinatorand Program Director (QIDP) will meet to review client needs (assessments,reassessments, implementation, etc), all client specific training and fallprotocol training completed for existing and new staff. **2. How will we identify other residents havingthe potential to be affected by the same deficient practice and what correctiveaction will be taken?** •□□□□□□□□All residents have the potential to be affectedby the same deficient practice •□□□□□□□□Program Coordinator will schedule clients forOT/PT evaluation. •□□□□□□□□All recommendations from assessment will beimplemented. •□□□□□□□□All risk plans will be updated per OT/PTrecommendations. •□□□□□□□□All recommended adaptive equipment will bereadily	

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	__"On May 25th at 9:45 PM [client A] was going to the bathroom to complete oral hygiene tasks and fell hitting his back and buttock. Staff assisted [client A] up off the floor and he started yelling his knee hurt. Staff assisted him on the toilet to check his knee. At the time there did not appear to be any swelling or marks. Staff took [client A] to the ER since he would not put any pressure on his knee. At the ER they completed a series of X-rays on his knee. ER stated there was no fracture and only slight swelling. ER referred to an orthopedics doctor to look at his knee further and put his knee in a stabilizer and encouraged him to walk on his leg using a rollator walker (a four wheeled rolling walker)." __"On May 27th (2015) [client A] complained of a lot of pain while walking and staff reported a large red area on the right side of his groin. PC came to observe [client A] walk and to check the red area. [Client A's] right thigh appeared to be a larger size than his left thigh and the red area was warm to touch. [Client A] was taken back to the ER for additional observation and additional X-rays. The ER took a hip X-ray and discovered the ball of his hip joint was broken and he would need surgery to repair. [Client A] was informed of the situation and gave verbal confirmation for the surgery 5/27/15."		available and maintained in working order. •□□□□□□□□Program Director (QIDP) will be trained onupdating ISPs to reflect changes in adaptive equipment, as ordered. •□□□□□□□□Facility nurse will be retrained on updatingRisk Plans to reflect changes in adaptive equipment, as ordered. •□□□□□□□□Staff will be trained on updated risk plans andany adaptive equipment ordered. •□□□□□□□□Monthly, the facility nurse, Program Coordinatorand Program Director (QIDP) will meet to review client needs (assessments,reassessments, implementation, etc), all client specific training and fallprotocol training completed for existing and new staff. **3. What measures will be put into place orwhat systemic changes will be made to ensure that the deficient practice doesnot recur:** •□□□□□□□Program Coordinator will schedule clients forOT/PT evaluation. •□□□□□□□All recommendations from assessment will beimplemented. •□□□□□□□All risk plans will be updated per OT/PTrecommendations. •□□□□□□□All recommended adaptive equipment will bereadily available and maintained in	

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	Review of client A's GERs (General Events Reports) on 8/14/15 at 5 PM indicated the following incidents: On 10/11/14 at 9:30 AM: "[Client A] was in the bathtub and stated that he lost his footing and fell. He stated that he just hit his lower back. There is a small bruise size of a half dollar on his lower back." On 11/19/14 at 8 AM: "[Client A] was getting off the van and a staff was assisting since the [name of day services] parking lot was covered with ice. [Client A] slipped and staff eased his fall. [Client A] landed on staff's foot on his bottom. [Client A] did not complain of any pain." On 11/30/14 while on a home visit: "[Client A] was at his sister house for the holidays. She (client A's sister) stated that he (client A) fell four times in his 3.5 day visit. Fall questions according to his sister [name of sister]. The falls occurred at his sister's house. [Client A] fell twice going outside to smoke in which he tripped over the doorway, once he fell in the bathroom and once he tripped over a rug. The falls occurred between 11/27 (2014) - 11/30 (2014). [Client A] was with his family during the falls. His sister witnessed all the falls except for the one in the shower. [Client A] was checked for		working order. •□□□□□□□Program Director (QIDP) will be trained onupdating ISPs to reflect changes in adaptive equipment, as ordered. •□□□□□□□Facility nurse will be retrained on updatingRisk Plans to reflect changes in adaptive equipment, as ordered. •□□□□□□□Staff will be trained on updated risk plans andany adaptive equipment ordered. •□□□□□□□Monthly, the facility nurse, Program Coordinatorand Program Director (QIDP) will meet to review client needs (assessments,reassessments, implementation, etc), all client specific training and fallprotocol training completed for existing and new staff. **4. How will the corrective action be monitoredto ensure the deficient practice will not recur?** •□□□□□□□Program Coordinator will schedule clients forOT/PT evaluation. •□□□□□□□All recommendations from assessment will beimplemented. •□□□□□□□All risk plans will be updated per OT/PTrecommendations. •□□□□□□□All recommended adaptive equipment will be readilyavailable and maintained in working order. •□□□□□□□Program Director (QIDP) will be trained onupdating	

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	injuries upon returning to the group home but none were found." On 1/12/15 at 3:15 PM: "[Client A] walking inside house and fell and bumped head slightly Small resulting in a scratch and small abrasion on forehead (sic)." On 2/1/15 at 6:30 PM: "[Client A] was sitting in the chair in the kitchen. All of a sudden he just slid out of the chair. When staff questioned him about why he fall (sic), he just stated that he just fell down. Staff assessed for injuries and none were found. Staff continued to monitor him." On 2/1/15 at 8:25 PM: "[Client A] was sweeping the kitchen floor. He fell and hit his head on the kitchen table. Staff rushed to help him into a chair. Once in the chair he leaned over to the side and started excessively drooling. This is when he began convulsing." 911 was called and client A was transported to the hospital. On 2/6/15 at 6:15 PM: "[Client A] was using the bathroom and having a BM (Bowel Movement). During the daily toileting duties after having a BM he had fallen onto the toilet. He had lost (his) balance and fell, but the toilet had caught him and staff was there to assist him and help him up."		ISPs to reflect changes in adaptive equipment, as ordered. •□□□□□□□Facility nurse will be retrained on updatingRisk Plans to reflect changes in adaptive equipment, as ordered. •□□□□□□□Staff will be trained on updated risk plans andany adaptive equipment ordered. •□□□□□□□Monthly, the facility nurse, Program Coordinatorand Program Director (QIDP) will meet to review client needs (assessments,reassessments, implementation, etc), all client specific training and fallprotocol training completed for existing and new staff. **5. What is the date by which the systemicchanges will be completed?** 9/26/15	

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	On 2/14/15 at 7:15 PM: "[Client A] had just finished his shower, shaved, and dressed. [Client A] told staff he needed to have a BM and asked if he could have some privacy. Staff stepped outside the bathroom door and was waiting for [client A] to finish. Small scratch and red area on back in middle and to left of spine." The report indicated "[Client A] will be supervised to and from as well as in the bathroom by staff. Staff will use gait belt to better support [client A]." On 3/23/15 at 6:40 AM: "[Client A] fell when he was getting out of bed. He was trying to go to the bathroom without his walker. He yelled for help and staff immediately went to help." On 4/13/15 at 7:15 AM: "[Client A] was walking out of his room and tripped over his oxygen tubing. Staff was walking down the hall and saw the incident. Staff was able to get to him before he fell to the ground. Staff put their arm under his and helped guide him to the floor. [Client A] did not hit the floor hard and landed on his right hip and arm." On 5/13/15 at 2:45 PM while at the day services: "Staff went into workshop to pick up clients. Staff woke [client A] up and started to unhook his O2 tubes.			

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	[Client A] stood up to hang up his tube and went to sit back down and fell on his butt. [Client A] stated his legs was (sic) asleep." On 5/21/15 at 8:55 PM: "[Client A] was in the restroom and lost his balance and fell on his butt. He stated his knee hurt and it popped causing him to loose (sic) his balance." The report indicated the staff had client A sleep in the living room so they could keep an eye on him. On 5/25/15 at 9:45 PM: "[Client A] was going to the bathroom to complete oral hygiene and fell hitting his back and buttock. Staff assisted him up off the floor and he started yelling his knee hurt. Staff assisted him on the toilet to check his knee. At the time there did not appear to be any swelling or marks. Staff took [client A] to the ER since he would not put any pressure on his knee. At the ER they completed a series of X-Rays on his knee. ER stated there was no fracture and only slight swelling. ER referred to an orthopedics doctor to look at his knee further and put his knee in a stabilizer and encouraged him to walk on his leg using a rollator walker." Client A's record was reviewed on 8/14/15 at 11 AM. Client A's record indicated diagnoses of, but not limited to,			

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	Lung Cancer, COPD (Congestive Obstructive Pulmonary Disease - damage to the lungs causing difficulty with breathing), Dementia, Seizure Disorder, GERD (Gastric Esophageal Reflux Disease), Eczema, Psoriasis and Arthritis. Client A's quarterly physician's orders dated 3/5/15 indicated the following orders: Walker. Gait belt as needed. Oxygen: "Oxygen should be set on 2 liters while at rest. When individual engages in physical activity (walking, showering etc.) oxygen should be set on 4 liters of oxygen. After physical activity wait 15 minutes then set oxygen back to 2 liters." Client A's 5/25/15 hospital discharge record indicated a diagnosis of right knee traumatic effusion (fluid in and around the knee caused by a trauma). Client A's Residential IPOP (Individual Plan of Protective Oversight) dated 9/3/14 indicated client A had no adaptive equipment and was independent within the home with staff present and was on fifteen minute checks 24/7 due to a history of seizures. The IPOP indicated client A could be outside and			

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	unsupervised as long as he was within the fenced in yard. Client A's 4/3/15 Falls Risk Plan indicated: __"Definition: A fall risk is someone who has the tendency to lose balance leading to falls, has a diagnosis that places them at a greater risk for falls or uses adaptive equipment. The fall may or may not cause injury.... The most common complication of falls is injury to the person. Injury may be minor requiring only minor first aid. More serious injuries will require emergency medical treatment. __The environment should be kept clear of hazards. __Staff are to assist clients as needed with ambulation [(walking)]. __Staff are trained in the possible side effects of medications and should provide added assistance for clients who need help because of side effects. __Plan: Staff are trained in Body Mechanics [(use of adaptive devices)]. __Use of adaptive devices is followed by a doctor and proper fit is monitored on a regular basis. Environmental hazards are removed by staff, more complex environmental issues are reported to maintenance on a monthly basis." Client A's ISP (Individualized Support			

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	Plan) dated 7/1/14 and client A's Falls Risk Plan failed to include how the staff were to supervise, monitor and assist client A while at home and while at the day program to ensure client A's safety in regard to recurring falls and injury from falls. Client A's ISP and Risk Plan failed to include the use of client A's adaptive equipment required for ambulation, when the equipment was to be used and how it was to be used. During interview with the RM (Residential Manager) on 8/13/15 at 5:30 PM, the RM: __Indicated client A was currently in an extended nursing facility due to a fall he had in May 2015 resulting in a fractured hip. __Indicated client A had a history of falls. __Indicated client A utilized a gait belt and a walker while ambulating. __Indicated the staff were to assist client A as need while ambulating. During interview with the PD (Program Director) on 8/14/15 at 3 PM, the PD: __Indicated all adaptive equipment required for mobility should be in client A's Falls Risk Plan. __Indicated client A's ISP and Risk Plan did not include level of supervision required to ensure client A's safety from			

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	falls. __Indicated client A's ISP and Risk Plan for falls did not include how the staff were to supervise, monitor and assist client A throughout the day. 2. Observations and interviews were conducted at the group home on 8/13/15 between 3:40 PM and 6 PM. During this observation period the following was observed: __There were four staff in the home with seven clients. __Client B was a tall large woman that ambulated with a slow unsteady gait. __Client B wore a gait belt and staff provided hands on assistance while ambulating inside and outside of the home by holding the back of the gait belt while walking with client B. __Client B had a large greenish, blue and yellow bruise in the stages of healing covering her left shoulder and extended down her left arm approximately six inches and a dark purple bruise on the inside of her left inner knee and a healing wound on the left side of her head with staples. __At 4:29 PM staff #3 was preparing the evening meal when she asked client B to help her set the table. Staff #3 was standing at the kitchen sink and had her back to client B. Client B was sitting in a straight chair at the dining room table.			

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	Client B stated, "Yes" and got up out of her chair and walked to the corner of the dining room table approximately 12 feet when staff #3 turned around and saw client B walking without staff assistance. Staff #3 immediately went to client B, held onto client B's gait belt and reminded client B she was to ask for assistance prior to ambulating. The facility's reportable and investigative records were reviewed on 8/13/15 at 1 PM. The 8/4/15 BDDS report submitted by the BDDS representative indicated "While [name of BDDS representative] was visiting consumer [client B] at her group home, consumer fell and was injured. [Name of BDDS representative] observed consumer (client B) stand from her chair at the kitchen table without waiting for staff to assist her with her gait belt. Staff were assisting other consumers at this time and were not able to get to her quickly enough. [Name of BDDS representative] encouraged consumer (client B) to sit down and wait for staff to assist her. At this time another consumer entered the kitchen from a side room and collided with consumer [client B] who then lost her balance and fell hitting her head on the corner of the wall leading into the hallway. Consumer's (client B's) head received a large gash which began bleeding."			

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	The 8/13/15 BDDS report indicated on 8/12/15 at 6:30 AM fell. The report indicated according to the staff while walking client B to the bathroom for a shower client B kept dropping down to the floor "while being escorted." Client B then tripped over one staff and fell onto another staff. The staff assessed client B for injury and found none. The report indicated client B "came to Indiana Mentor in a wheelchair. [Client B's] doctor elevated her and determined that she doesn't need a wheelchair. Just recently [client B] has started to have issues with falling. [Client B] has a falls risk plan in place. Staff informed the PC (Program Coordinator) who informed the PDs (Program Directors) and the nurse. Staff are to monitor [client B] for any future injuries caused by this fall." Review of client B's GERs on 8/14/15 at 5 PM indicated the following incidents: On 4/29/15 at 8:10 AM: "[Client B] was going out to the van to go to work. Staff asked her to let them help push her down the sidewalk. [Client B] refused and screamed and started to hit her face. Staff walked behind [client B] and when staff looked away [client B's] chair hit the			

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	ledge of the sidewalk tipping over her chair. Staff assisted [client B] up and checked her for injuries. She (client B) had a small scrape above her left eye where her helmet moved and a scrape on her left knee. No other injuries was (sic) noted at the time." On 5/9/15 at 6:40 PM: "After [client B] pulled herself out of wheel chair she went to reach for support on toilet railing and was not balanced before she moved and fell on her bottom. Staff did have a supportive hand on [client B]. [Client B] was assessed for injuries and has small red spot on the left side of her bottom. She did not hit her head." On 6/12/15 at 8 AM: "We (the staff) were driving down the road and [client B] took off her seatbelt and she feel (sic) onto the floor of the van. Both staff then helped up [client B] and began looking over her for any injuries. She (client B) had red mark from her right side of forehead to the side of her eye. Its (sic) was red at first and then disappeared after a little time. Home manager was called right away about this situation and staff had to keep reminding [client B] to keep			

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	her seat belt on the rest of way to Day Services." __The report indicated corrective action taken was "Make sure [client B] sits by window and remind her to keep her seatbelt on." On 7/11/15 at 3:30 PM: "[Client B] was being assisted walking into the home. She tripped over the threshold of the front door. Staff caught [client B] using her gait belt but she hit her arm on a rocking chair on the front porch. She had a bruise on her upper left arm. No other injuries was (sic) apparent at the time." On 8/4/15 at 3:15 PM: "[Client B] got up from the table without assistance. She was asked to wait for staff and while she was looking at that person another peer bumped into her. [Client B] fell and hit the corner of the wall hitting the left side of her upper body. [Client B] appeared to have a deep gash on her head and bruising was present on her left cheek. An ambulance was called to transport [client B] to the hospital." On 8/12/15 at 6:30 AM "While walking client (B) to bathroom for shower client			

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	(B) kept dropping down to floor. Client (B) then tripped staff and fell onto staff to the floor. Being escorted by 2 staff to bathroom for shower because client kept dropping to floor while being escorted." Client B's record was reviewed on 8/14/15 at 12 PM. Client B's record indicated diagnosis of, but not limited to, Osteoarthrosis (a degenerative joint disease). Client B's 2014/2015 appointment records indicated: __On 5/11/15 client B had a PT assessment. The assessment indicated "Pt (patient) ok to ambulate with gait belt/HHA/CGA (Hand Over Hand Assistance/Contact Guard Assistance) within group home environment. She is to have HHA/CGA for transfers in and out of van and up/down steps/curbs. She is to use w/c (wheelchair) for primary mode of transportation in the community." __On 6/25/15 client B saw her PCP (Primary Care Physician) for "chronic conditions." The record indicated "Walking with some assistance, stable on feet, no falls." __On 7/15/15 client B was seen at the ER for a contusion (a deep bruise caused by a blow, trauma or direct force) of face and upper arm as a result of a fall.			

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	__7/15/15 Hospital imaging reports (X-rays) of client B's left ankle and left arm. The X-ray of the left ankle indicated "Fall, swelling. No visible acute fracture." The X-ray of the left arm indicated "Fall, Ecchymosis (a discoloration of the skin resulting from bleeding under the skin, typically caused by bruising).... There are healed lower left rib fractures." __On 7/28/15 client B saw her PCP for a follow after fall. The report indicated "fell onto porch, tried to get up out of chair on her own, tripped on threshold, went to ER 7/15 (2015) - no injuries other than bruises. Ambulating well with assistance of one and gait belt." __On 8/4/15 client B was seen at the ER for a laceration to her head from a fall. Client B was discharged with an ace wrap (an elastic bandage) dressing around her head that was to be left on for 48 hours. The record indicated client B was to see her PCP to remove the staples in 7 to 10 days Client B's April (2015) nursing assessment indicated: 4/22/15 client B "Transferred from ECF (Extended Care Facility) that closed down. Answers simple questions. Seems happy, smiles a lot. Wearing helmet, in w/c (wheelchair). Staff reports she has not attempted to get up on her own. Able to move self in w/c.			

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	Able to amb (ambulate) with assist of staff for safety. To have PT/OT eval (evaluation)." The report indicated client B had bruising on her skin. Client B's notes from the RN in Therap (an electronic record) indicated: __8/5/15 at 7:59 PM "Went to home to assess client (B) after fall yest (yesterday). She (client B) was sitting on couch when [the RN] arrived. Ace wrap wrapped around the top of her head, around face, around chin. Applied firmly but [RN] able to put 2 fingers under ace wrap. Good circulation. Eyes open, PEARL (Pupils Equal and Reactive to Light), able to follow directions. Client (B) refuses to allow staff to apply ice to head. Instructed to given (sic) prn (as needed) medication as needed for pain. V/s (vital signs) stable. Pt (patient) wearing gait belt, staff to walk with client when ambulating, client to use w/c (wheelchair) prn. " Client B's Falls High Risk Plan dated 4/20/15 and updated 8/13/15 indicated: __"1. Staff should monitor environmental concerns at home (wet floor, anything on floor that should be picked up). __2. Staff should monitor environment on outings for weather-related hazards. __3. Notify HM immediately when fall occurs she/he will report to PD and nurse.			

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	__4. HM will then follow protocol for falls (located in communication book). After a fall occurs: __1. Take vital signs. __2. Check eyes for dilation. __3. If unconscious, call 911 immediately. __4. Check for injuries before moving person. __5. Document in Therap (GER). __Staff are to be with [client B] when she is ambulating. Gait belt is to be used for safety. Wheel chair to be used when client is having difficulty walking, increased weakness, or has to go long distances." Client B's ISP dated 4/21/15 indicated "Adaptive equipment: Helmet, wheelchair with stabilizer, gait belt...." Client B's ISP and Falls Risk Plan failed to indicate how the staff were to supervise, monitor and assist client B while at home and while at the day program throughout the day to ensure client B's safety in regard to recurring falls and to prevent further injury due to falls. During interview with the RM on 8/13/15 at 5:30 PM, the RM: __Indicated client B was admitted to the group home in April of 2015.			

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	__Indicated upon admission client B used a wheelchair with padded arm rests for all ambulatory needs, wore a helmet and utilized a bed/chair alarm. __Indicated after admission client B had a PT (Physical Therapy) assessment and then saw her PCP (Primary Care Physician). __Indicated client B's PCP assessed client B and wanted client B up and walking. __Indicated client B's PCP discontinued the use of the wheelchair, the helmet and the bed/chair alarms. __Indicated client B now ambulated with staff assistance with contact guard assist using the gait belt. __Indicated client B no longer used the wheelchair, helmet and bed/chair alarm. __Indicated client B was to ask for and wait for staff assistance prior to getting up. __Indicated client B frequently would not wait for staff and would get up on her own without staff assistance. __Indicated if the staff saw client B getting up from a seated position or getting out of bed the staff were to her immediately and assist client B in getting up. __Indicated there were 3 to 4 staff in the home at all times when all clients were home.			

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	During interview with the PD on 8/14/15 at 3 PM, the PD: __Indicated client B's Falls Risk plan indicated staff were to be with client B whenever ambulating. __Indicated client B's ISP and Risk Plan did not include level of supervision required to ensure client B's safety from falls. __Indicated client B's ISP and Risk Plan for falls did not include how the staff were to supervise, monitor and assist client B throughout the day. 3. Observations and interviews were conducted at the group home on 8/13/15 between 3:40 PM and 6 PM. During this observation period the following was observed: __Client C was a tall thin male that ambulated with a slow unsteady forward stance gait. __Client C wore a gait belt and staff provided hands on assistance while ambulating inside and outside of the home by holding the back of the gait belt and walking with client C. __There were four staff working in the home. __While client C was sitting at the dining room table all staff continue with other duties and assisting other clients. The facility's reportable and investigative			

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	records were reviewed on 8/13/15 at 1 PM. The 8/13/15 BDDS report indicated on 8/12/15 at 8 PM "Staff was walking with [client C] holding onto his gate (sic) belt for extra support. [Client C] was walking fast and staff verbally redirected [client C] to slow down because he could fall. [Client C] tripped on the front door threshold and fell down and received an abrasion on his right knee. Staff will continue to follow [client C's] risk plan concerning falls." The 5/19/15 BDDS report indicated "On Monday May 18th 2015 at 6:50 AM [client C] was taken to the ER for a fall that requires medical treatment. [Client C] was walking in the kitchen when he fell and hit his head on the window's edge. Program Director [(PC - Name of Program Coordinator)] saw that [client C] had a wound on his head that was about 1/2 inch long and appeared to be deep. PC took [client C] to the hospital for evaluation. At the hospital they completed a head/neck CT and completed labs. It was also noticed that [client C] has a knot on his left hand. An X-ray was completed. All results came back normal and [client C] received 3 staples on (sic) his head." __The 8/4/15 Follow Up BDDS report to			

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	the fall of 5/18/15 indicated client C had tripped over a chair that was pushed up to the dining room table. The report indicated client C's Falls Risk Plan was followed, staff monitored client C without further issues and the staples were removed one week later. __The QAS (Quality Assurance Supervisor) indicated review of the 5/18/15 investigative summary on 7/16/15. The record indicated client C had physician's orders dated 8/24/15 for PRN (as needed) use of a wheelchair and a walker and an order written on 5/21/15 for client C to utilize a bed/chair alarm. The review indicated "Evidence does not support specific guidelines are included in [client C's] risk plan for use of his wheelchair or walker." Review of client C's GERs on 8/14/15 at 5 PM indicated the following incidents: On 11/20/14 at 7:30 AM: "[Client C] was in the bathroom, staff heard a fall and went in to check on [client C] and noticed [client C] on the floor. [Client C] had slipped in his urine that was on the floor." On 11/25/14 at 8:29 PM: "[Client C] had just gotten out of the shower and was walking to his chair. He tripped over a rug and fell. Staff caught most of the fall.			

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	He did lightly hit his head on the front door.... [Client C] has a small bruise on his left arm between his elbow and wrist." On 1/3/15 at 12 PM: "[Client C] was sitting at the table in a chair and appeared to loose (sic) his balance tipping over his chair. Staff caught the chair so [client C] did not fall all the way to the ground. Staff reported that he hit the left side of his body on the arms of the chair. Staff took him to his room to sit so they could take vitals. [Client C] fell forward on the bed while sitting and staff again stopped him from falling. Staff reported that [client C] did not appear to focus his eyes on staff and his eyes was (sic) rolling back in his head. Nurse was notified and instructed staff to call an ambulance. [The home manager] met [client C] at the hospital. After running blood work, urinalysis, and an EKG the doctors stated he had a UTI (Urinary Tract Infection). Staff was instructed to start a new antibiotic and follow up with PCP (Primary Care Physician) within 5 days." On 1/5/15 at 6:13 PM: "Staff was in the bathroom assisting [client C]. Staff was standing in front of [client C] assisting him with pulling his pants down. While staff was doing so [client C] tried to turn and began to fall. Before staff was able to			

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	catch [client C] from his fall [client C] has (sic) shifted his weight towards the staff causing himself and staff to fall. Staff was able to position herself during the fall to catch [client C's] head and upper body." The report indicated a reddened area on client C's buttocks. On 1/6/15 at 10:35 PM: "Staff was coming out of the office from clocking in. [Client C] was in the process of standing up. When he (client C) was getting up he fell and hit the right side of his body. He has a small cut above his right eye, scraps (sic) down his right side and his side on the right was red. [Client C] complained of pain and was given ibuprophen (sic) (a pain medication). After he (client C) fell he would not respond well to staff's questions. He (client C) was mumbling but staff could hardly understand him. Staff stayed with [client C] on the floor between his rocking chair and the table with a pillow under his head. We (the staff) kept talking to him until home manager arrived. When home manager talked to him he responded right away telling her he fell. After asking him a few questions she asked [client C] if he would like to get up. Staff assist (sic) [client C] from the floor to the rocking chair. [Client C] continued to answer HM's (Home Manager's) questions then stated he			

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	needed to use the bathroom. Three staff assist (sic) him to the restroom. [Client C] appeared to shuffle his right side and saying he hurt. [Client C] was checked over for further injuries. After using the bathroom [client C] was assisted in a recliner in the living room to sleep for the night. [Client C] agreed to sleep in the living room for tonight.... [Client C] cut his head right above his right eye." On 1/7/15 at 6 PM: [Client C] was walking to the bathroom and staff noticed that [client C] was having a hard time walking on his right leg. He had a fall the previous night on that side. HM called the Nurse and was instructed to take [client C] to the ER to be evaluated. While at the ER [client C] had an X-Ray of his right hip, blood work, urinalysis, and a CT (Computerized Tomography - special X-ray tests that produce cross-sectional images of the human body using X-rays and a computer) scan of his head. All tests came back normal. The PA (Physician's Assistant) stated that his (client C's) UTI appeared to be improving and his sodium levels had improved. He (client C) is to follow up with his PCP, which is 1/15/15." On 1/9/15 at 1 PM: "[Client C] was sitting in the rocking chair in the kitchen. The chair broke while he was sitting in it			

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	causing him to fall. [Client C] fell on his right side. At the time there was no bruising or redness." On 1/28/15 at 8:14 PM: "[Client C] was in the kitchen trying to help himself get coffee. He tried to stand up from his wheel chair and he fell. Staff immediately went to help him." No injury was reported. On 3/18/15 at 7:56 AM: "Staff assisted [client C] onto the van. Once [client C] was over his seat, he slid off the seat. Other peers assisted in ca tching the fall, however he did land on his butt. Staff assessed [client C] and there were no injuries found." On 4/5/15 at 2 AM: "[Client C] was trying to get out of bed and fell. When staff went to check on him he stumbled against the door. Staff assisted him to the restroom and checked him over for injuries. He has a large red area that appears to be bruising on his left hand above his thumb and a scrape on his left knee cap. At the time he did not appear to have any other injuries." On 4/7/15 at 7 PM: "[Client C] slipped on noodles on the kitchen floor, staff had a hold of gait belt but [client C] fell over and hit arm and head on pantry door. Did			

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	not fall on the floor." The actions taken indicated "staff prevented [client C] from going to floor by stabling (sic) him with his gait belt, floor was also swept and cleaned up. Plan of Future Corrective Actions: make sure that the path [client C] is walking is clear of all objects, continue to use gait belt and walk with staff at all times." On 5/7/15 at 7:55 PM: "We (staff and clients) were on our way home from church, other behaviors were going on. At some point [client C] unbuckled his seat belt. Staff went to pull over to assist with the behaviors and [client C] slid off his seat onto his knees. Both his knees ended up skinned up. There was no blood. Staff cleaned the wound. No bandages were needed." On 5/18/15 at 6:50 AM: "[Client C] fell in the kitchen and hit his head on the window's edge. His wound was approx 1/2" (inch) and appeared to be deep. He was taken to the ER for evaluation. They completed a head/neck CT and completed labs. While there staff noticed a knot on his hand. An X-Ray was completed. All results came back normal and [client C] received 3 staples (to his head)." On 6/4/15 at 5:55 PM: "[Client C] had been sitting on the porch following dinner			

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	for about 20 minutes. He (client C) told the staff outside with him that he wanted to go inside because he was hot. Staff assisted [client C] with walking inside to the kitchen table. [Client C] sat down and was drinking coffee. A few minutes later staff noticed that [client C] had laid his head down on the table. Staff prompted [client C] four or five times asking if he was ok. [Client C] was unresponsive. Staff sat [client C] up and asked again if he was ok. He was still unresponsive. Staff noticed however that [client C] was drooling and was just staring straight ahead with his left eye squinted shut. Because [client C] has a seizure risk plan staff assisted [client C] to the floor. He was still unresponsive. Paramedics were called. By the time they got to the house, [client C] was saying that 'it hurts' 'side hurts' when paramedics asked what hurt [client C] told them his stomach. At the hospital he was diagnosed with Vasovagal Syncope (a sudden drop in heart rate and blood pressure causing a person to faint). He (client C) was discharged at 8:26 PM." On 6/30/15 at 10 PM: "[Client C] stood up to walk into the house and fell on his knees." The reported indicated client C scraped both knees. On 8/6/15 at 5 PM: "[Client C] was			

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	sitting on the front porch. When he was walking in, he fell and landed on his butt. Staff assisted him with getting up and assessed him for injuries. We (the staff) did not find any. [Client C] stated that he was just fine." On 8/12/15 at 8 PM: "[Client C] was walking fast going out on to the front porch, I (the staff) repeatedly said slow down and held his belt but he tripped on the threshold and went down on one need (sic) to cause an abrasion." __The report indicated "Corrective Action Taken: To stop [client C] from advancing forward while he is hurrying until he knowledge (sic) the command to slow down. Plan of Future Corrective Action: to make recommendation to the staff." Client C's record was reviewed on 8/14/15 at 1 PM. Client C's record indicated diagnoses of, but not limited to, Seizure disorder, Hypertension, (high blood pressure) and Vasovagal Syncope. Client C's 2014/2015 appointment records indicated: __A hospital physician's History and Physical dated 8/25/14 indicated client C had a diagnosis of "left hip periprosthetic fracture (a broken bone that occurs around the components or implants of a			

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	total hip replacement)." __On 10/14/14 client C had a PT evaluation post hip fracture. The evaluation indicated "[Client C] was to utilize SW (standard walker) for ambulation at all times." __On 1/7/15 client C was seen at the ER for a "fall, unsteady gait and injury to head." __On 1/15/15 client C saw his PCP due to "gait disturbance. Has had unsteady gait for last two weeks or so. Has fallen multiple times. Takes two people to assist with ambulation." The record indicated client C was to be re-evaluated by PT. __On 1/21/15 client C was re-evaluated by PT. The evaluation indicated "Decreased left hip extension. For terminal stage. Decreased left hip flexion. Forward swing and forward progression. Increased trunk flexion during gait and poor... standing balance." __On 3/25/15 client C's PT therapy was discontinued. __On 5/18/15 client C was seen at the ER for a head injury with a laceration. __On 5/21/15 client C saw his PCP and was asked to provide an order for a bed/chair alarm. The record indicated "Pt (patient) recently fell without asking for assistance and now has a wound on the back of his head. Having increase in falls from getting up by himself."			

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	Client C's updated 2014 Falls Risk Plan indicated __"Definition - A fall risk is someone who has the tendency to lose balance leading to falls. The fall may or may not cause injury.... The most common complication of falls is injury to the person. Injury may be minor requiring only minor first aid. More serious injuries will require emergency medical treatment. __Prevention: Staff are to ensure that any adaptive devices are in good repair, broken equipment should be reported to the PD (Program Director) immediately. The environment should be kept clear of hazards. Staff are to assist clients as needed with ambulation [(walking)]. Staff are trained in the possible side effects of medications and should provide added assistance for clients who need help because of side effects. __Plan Staff are trained in Body Mechanics [(use of adaptive devices)]. Use of adaptive devices is followed by a doctor and proper fit is monitored on a regular basis. [Client C] may use gait belt, walker with wheels and wheel chair as needed for safety. Environmental hazards are removed by staff, more complex environmental issues are reported to maintenance on a monthly basis."			

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	Client C's 3/4/15 IPOP indicated client C was at high risk for falls. The IPOP indicated client C "Can move about freely within the home with staff present but checks are completed during waking hours." The IPOP indicated client C was on 15 minute checks because client C has seizures. Client C's ISP dated 3/5/15 and Falls Risk Plan failed to indicate how the staff were to supervise, monitor and assist client C while at home and while at the day program to ensure client C's safety in regard to recurring falls. Client C's ISP and Risk Plan failed to include the use of adaptive equipment, what was to be used in regard to ambulation and when it was to be used. During interview with the RM on 8/13/15 at 5:30 PM, the RM: __Indicated client C was to wear a gait belt when up and ambulating. __Indicated client C was to ask for assistance when getting up but would get up on his own without staff assistance. __Stated the staff "should keep an eye on him" and if the staff saw client C getting up from a seated position and/or getting out of bed, the staff were to assist client C immediately. __Indicated client C was supposed to utilize a bed/chair alarm to alert the staff			

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	when he got up from a sitting position. __Indicated client C would not leave the bed/chair alarm alone. __Indicated client C had broken the clasp on the seat/bed alarm and pulled the alarm from her desk drawer in her office and stated, "This is [client C's] chair alarm, but it's broken and he won't use it." During interview with the PD on 8/14/15 at 3 PM, the PD: __Indicated the staff were to follow the clients' program plans. __Indicated no changes were implemented in client C's ISP and/or risk plan in regard to client C's continued falls. __Indicated no staffing change in regard to client C's continued falls. __Indicated client C's ISP and Risk Falls Plan needed to be updated to include the client's adaptive equipment and level of supervision required through out the day. This federal tag relates to complaint #IN00174893. 9-3-4(a)			
W 0318	483.460			

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Bldg. 00	HEALTH CARE SERVICES The facility must ensure that specific health care services requirements are met. Based on observation, interview and record review for 3 of 4 sampled clients (A, B and C), the facility failed to meet the Condition of Participation: Health Care Services. The facility failed to ensure nursing services met the health care needs of clients A, B and C. The facility failed to ensure nursing services assessed and monitored clients A, B and C after falls with injury, head injury, client wounds and/or excessive bruising due to recurring falls. The facility health care services failed to review and revise client A's, B's and C's Falls Risks Plans (FRPs) after recurring falls to ensure the clients' plans included appropriate client specific safeguards to prevent further falls and injuries resulting from falls. The facility failed to ensure the client FRPs included the use of all adaptive equipment required to protect the clients from further falls, included how and when the equipment was to be used in regard to the client and included how the staff were to supervise and assist the clients throughout the day to ensure no further falls and/or injury from falls to ensure the clients' safety.	W 0318	**W 318HEALTH CARE SERVICES** The facility must ensure that specifichealth care services requirements are met. **1. What corrective action will beaccomplished?** •□□□□□□□□Facility nurse will be trained on updating fallrisk plans to include safeguards to prevent future falls and injuries and skinissues. •□□□□□□□□Specific plans of care will be developed andimplemented for health issues of clients, falls with injury, head injury,client wound, excessive bruising and skin issues. •□□□□□□□□Staff will be provided adequate training inimplementing specific health plans. •□□□□□□□□Nursing services will be provided to addressspecific health plans. •□□□□□□□□Program Coordinator will monitor that allmedical recommendations and medications will be consistently implemented, 3times per week and report any concerns to the Facility Nurse and QIDP. •□□□□□□□□Monthly, the facility nurse, Program Coordinatorand Program Director (QIDP) will	09/26/2015

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	Findings include: Please see W331: The facility failed to ensure nursing services assessed and monitored clients A, B and C after falls, to assess and monitor clients with head injury, wounds/lacerations and/or excessive bruising and to monitor clients to due to recurring falls. The facility failed to ensure nursing services documented nursing care provided and/or assessments in a timely manner. The facility failed to ensure client A's, B's and C's Falls Risk Plans were reviewed and updated after recurring falls to ensure adequate safeguards are implemented to prevent further falls. The facility failed to ensure nursing services developed and implemented a plan of care in regard to client A's chronic dry skin related to Eczema (a medical condition in which patches of skin become rough and inflamed sometimes with blisters that cause itching and bleeding) and Psoriasis (a skin disease marked by red, itchy, scaly patches) and to ensure nursing services monitored and assessed client A's health needs in regard to falls, chronic skin problems and respiratory needs.		meet to review client needs, all client specifictraining and protocols training is completed for existing and new staff. **2. How will we identify other residents havingthe potential to be affected by the same deficient practice and what correctiveaction will be taken?** •□□□□□□□□All residents have the potential to be affectedby the same deficient practice. •□□□□□□□□Facility nurse will be trained on updating fallrisk plans to include safeguards to prevent future falls and injuries and skinissues. •□□□□□□□□Specific plans of care will be developed andimplemented for health issues of clients, falls with injury, head injury,client wound, excessive bruising and skin issues. •□□□□□□□□Staff will be provided adequate training inimplementing specific health plans. •□□□□□□□□Nursing services will be provided to addressspecific health plans. •□□□□□□□□Program Coordinator will monitor that allmedical recommendations and medications will be consistently implemented, 3times per week and report any concerns to the Facility Nurse and QIDP. •□□□□□□□□Monthly, the facility nurse, Program Coordinatorand	

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	This federal tag relates to complaint #IN00174893. 9-3-6(a)		Program Director (QIDP) will meet to review client needs, all clientspecific training and protocols training is completed for existing and newstaff. **3. What measures will be put into place orwhat systemic changes will be made to ensure that the deficient practice doesnot recur:** •□□□□□□□□Facility nurse will be trained on updating fallrisk plans to include safeguards to prevent future falls and injuries and skinissues. •□□□□□□□□Specific plans of care will be developed andimplemented for health issues of clients, falls with injury, head injury,client wound, excessive bruising and skin issues. •□□□□□□□□Staff will be provided adequate training inimplementing specific health plans. •□□□□□□□□Nursing services will be provided to address specifichealth plans. •□□□□□□□□Program Coordinator will monitor that allmedical recommendations and medications will be consistently implemented, 3times per week and report any concerns to the Facility Nurse and QIDP. •□□□□□□□□Monthly, the facility nurse, Program Coordinatorand Program Director (QIDP) will meet to review client needs, all clientspecific training and protocols training is completed for	

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			existing and newstaff. **4. How will the corrective action be monitoredto ensure the deficient practice will not recur?** •□□□□□□□□Facility nurse will be trained on updating fallrisk plans to include safeguards to prevent future falls and injuries and skinissues. •□□□□□□□□Specific plans of care will be developed andimplemented for health issues of clients, falls with injury, head injury, clientwound, excessive bruising and skin issues. •□□□□□□□□Staff will be provided adequate training inimplementing specific health plans. •□□□□□□□□Nursing services will be provided to addressspecific health plans. •□□□□□□□□Program Coordinator will monitor that allmedical recommendations and medications will be consistently implemented, 3times per week and report any concerns to the Facility Nurse and QIDP. •□□□□□□□□Monthly, the facility nurse, Program Coordinatorand Program Director (QIDP) will meet to review client needs, all clientspecific training and protocols training is completed for existing and newstaff. **5. What is the date by which the systemicchanges will be**	

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			completed? **9/26/15**	
W 0331 Bldg. 00	483.460(c) NURSING SERVICES The facility must provide clients with nursing services in accordance with their needs. Based on observation, record review and interview for 3 of 4 sampled clients (A, B and C), the facility failed to ensure nursing services assessed and monitored clients A, B and C after falls resulting in head injury, wounds and excessive bruising. The facility failed to ensure nursing services assessed and monitored clients A, B and C after falls and to ensure nursing services reviewed and revised client A's, B's and C's Falls Risks Plans (FRPs) after falls to ensure the plans included: __Appropriate client specific safeguards to prevent further falls and injuries to ensure the client's safety. __The use of adaptive equipment required to protect the clients from further falls. __How the staff were to supervise and assist the clients throughout the day to ensure no further falls and/or injury from falls. The facility failed to ensure nursing services developed and implemented a	W 0331	**W 331 NURSINGSERVICES** The facility must provide nursing services in accordancewith their need. 1. **Whatcorrective action will be accomplished?** •□□□□□□□□Nursing services will be provided to all clientsbased on their need. •□□□□□□□□Nursing staff will be trained on completing anddocumenting assessments and providing appropriate level of services. •□□□□□□□□Program Directors will monitor that nursingservices are being provided through review of Health Care Reports, monthly. •□□□□□□□□Monthly, the facility nurse, Program Coordinatorand Program Director (QIDP) will meet to review client needs, all clientspecific training and head injury protocol training completed for existing andnew staff. 2. **How willwe identify other residents having the potential to be affected by the samedeficient practice and what corrective action will be taken?** •□□□□□□□□All residents have the potential to be affectedby the	09/26/2015

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	plan of care in regard to client A's chronic dry skin related to Eczema (a medical condition in which patches of skin become rough and inflamed sometimes with blisters that cause itching and bleeding) and Psoriasis (a skin disease marked by red, itchy, scaly patches) and to ensure nursing services monitored and assessed client A's health needs in regard to falls, chronic skin problems and respiratory needs. The facility failed to ensure nursing services met the health care needs of clients A, B and C and to ensure nursing services documented services provided to the clients and nursing assessments of the clients. Findings include: Observations were conducted at the group home on 8/13/15 between 3:40 PM and 6 PM. During this observation period the following was observed: __There were four staff and seven clients in the home. __Client B was a tall large woman wearing a gait belt and ambulated with a slow unsteady gait. __The staff provided hands on assistance with clients B and C while ambulating inside and outside of the home by holding the back of the clients' gait belt		same deficient practice. •□□□□□□□□Nursing services will be provided to all clientsbased on their need. •□□□□□□□□Nursing staff will be trained on completing anddocumenting assessments and providing appropriate level of services. •□□□□□□□□Program Directors will monitor that nursingservices are being provided, weekly. 3. **Whatmeasures will be put into place or what systemic changes will be made to ensurethat the deficient practice does not recur:** •□□□□□□□□Nursing services will be provided to all clientsbased on their need. •□□□□□□□□Nursing staff will be trained on completing anddocumenting assessments and providing appropriate level of services. •□□□□□□□□Program Directors will monitor that nursingservices are being provided. 4. **How willthe corrective action be monitored to ensure the deficient practice will notrecur?** •□□□□□□□□Program Directors will monitor that nursingservices are being provided, weekly.	

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	15G735		08/27/2015

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	while walking with them. __Client B had a large greenish, blue and yellow bruise covering her left shoulder that extended down her left arm approximately six inches, a dark purple bruise on the inside of her inner knee and a healing wound on the left side of her head with staples. __Client C was a tall thin male that ambulated with a forward lean and an unsteady step. __Client C wore a gait belt during this observation period. __At 4:16 PM two staff left with clients C, E, F and H and two staff remained in the home with clients B, D and F. __At 4:29 PM staff #3 was preparing the evening meal while client B sat at the dining room table. Staff #3 was standing at the kitchen sink with her back to client B when the staff asked client B if she would like to assist with setting the table. Client B got up out of her chair and walked to the corner of the dining room table approximately 12 feet from where she had been sitting when staff #3 turned around and saw client B walking without staff assistance. Staff #3 immediately went to client B and reminded client B she was to ask for assistance prior to ambulating and assisted client B to set the table while holding onto client B's gait belt.		5. **What isthe date by which the systemic changes will be completed?** 9/26/15	

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	The facility's reportable and investigative records were reviewed on 8/13/15 at 1 PM. The 5/19/15 BDDS report indicated "On Monday May 18th 2015 at 6:50 AM [client C] was taken to the ER for a fall that required medical treatment. [Client C] was walking in the kitchen when he fell and hit his head on the window's edge. Program Director [(PC - Name of Program Coordinator)] saw that [client C] had a wound on his head that was about 1/2 inch long and appeared to be deep. PC took [client C] to the hospital for evaluation. At the hospital they completed a head/neck CT (Computerized Tomography - a combined series of X-ray images taken at different angles) and completed labs. It was also noticed that [client C] has a knot on his left hand. An X-ray was completed. All results came back normal and [client C] received 3 staples on (sic) his head." The 6/2/15 BDDS report indicated: __"On May 21st (2015) at 8:55 PM, [client A] was in the restroom and lost his balance causing him to fall on his buttock. [Client A] stated that his knee was hurting and that he fell due to his knee hurting. Staff assisted [client A] up and checked him for injuries. No injuries			

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	were present at the time. Staff were to remind and encourage [client A] to use his walker and gait belt when ambulating. There were no environmental factors that caused this fall. Since the fall occurred in the restroom, there were no witnesses. Staff monitored [client A] throughout the night. [Client A] was fine throughout the night and had no other falls that night. PC (Program Coordinator), PD (Program Director) and nurse were all notified. The nurse checked [client A] out. He was sitting in his w/c (wheelchair). He did have his oxygen on, his O2 (oxygen) sat (saturation) was 95. His heart rate was 100-105 and that was sitting. Ortho (Orthopedic) appointment is on June 9th (2015)." __"On May 25th at 9:45 PM [client A] was going to the bathroom to complete oral hygiene tasks and fell hitting his back and buttock. Staff assisted [client A] up off the floor and he started yelling his knee hurt. Staff assisted him on the toilet to check his knee. At the time there did not appear to be any swelling or marks. Staff took [client A] to the ER since he would not put any pressure on his knee. At the ER they completed a series of X-rays on his knee. ER stated there was no fracture and only slight swelling. ER referred to an orthopedics doctor to look at his knee further and put his knee in a stabilizer and encouraged him to walk on			

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	his leg using a rollator walker (a four wheeled rolling walker)." __"On May 27th (2015) [client A] complained of a lot of pain while walking and staff reported a large red area on the right side of his groin. PC came to observe [client A] walk and to check the red area. [Client A's] right thigh appeared to be a larger size than his left thigh and the red area was warm to touch. [Client A] was taken back to the ER for additional observation and additional X-rays. The ER took a hip X-ray and discovered the ball of his hip joint was broken and he would need surgery to repair. [Client A] was informed of the situation and gave verbal confirmation for the surgery 5/27/15." The 7/15/15 BDDS report indicated on 7/14/15 at 3 PM [Name of the BDDS representative] visited with consumer (client B) at the Mentor Day Program Services site. While visiting [the BDDS representative] noticed large bruise on consumer's left upper arm. Bruise appeared to be in beginning stages of healing and was multi-colored. Bruise was large covering approx (approximately) 3-4 inches long across consumer's arm and approx 2 inches wide. Consumer also had another bruise on her knee that appeared to be approx. 2 inches long. This bruise appeared to be			

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	older than the other one. Consumer was unable to provide details of how these injuries occurred and Day Program Staff did not know. [The BDDS representative] also visited the home of consumer this day where house staff reported they thought she had fallen and hit herself on a chair last week. The 8/4/15 BDDS report submitted by the BDDS representative indicated "While [name of BDDS representative] was visiting consumer [client B] at her group home, consumer fell and was injured. [Name of BDDS representative] observed consumer (client B) stand from her chair at the kitchen table without waiting for staff to assist her with her gait belt. Staff were assisting other consumers at this time and were not able to get to her quickly enough. [Name of BDDS representative] encouraged consumer (client B) to sit down and wait for staff to assist her. At this time another consumer entered the kitchen from a side room and collided with consumer [client B] who then lost her balance and fell hitting her head on the corner of the wall leading into the hallway. Consumer's (client B's) head received a large gash which began bleeding. Two staff immediately assisted consumer and applied pressure to the would while another staff person gathered the remaining consumers,			

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	except one who would not go and took them on a van ride. [Name of BDDS representative] called 911 to request ambulance while staff attended to consumer's wound. EMTs arrived and bandaged consumer's wound before transporting her to [name of hospital] for further evaluations and treatment. Two staff persons followed the ambulance to the hospital. Staff will continue to monitor to ensure consumer's health and safety and follow ER doctor's recommendations. [Name of BDDS representative] will continue to follow up to ensure consumer's health and safety." An 8/13/15 BDDS report indicated on 8/12/15 at 6:30 AM fell. The report indicated according to the staff while walking client B to the bathroom for a shower client B kept dropping down to the floor "while being escorted." Client B then tripped over one staff and fell onto another staff. The staff assessed client B for injury and found none. The report indicated client B "came to Indiana Mentor in a wheelchair. [Client B's] doctor elevated her and determined that she doesn't need a wheelchair. Just recently [client B] has started to have issues with falling. [Client B] has a falls risk plan in place. Staff informed the PC (Program Coordinator) who informed the PDs (Program Directors) and the nurse.			

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	Staff are to monitor [client B] for any future injuries caused by this fall." An 8/13/15 BDDS report indicated on 8/12/15 at 8 PM "Staff was walking with [client C] holding onto his gate (sic) belt for extra support. [Client C] was walking fast and staff verbally redirected [client C] to slow down because he could fall. [Client C] tripped on the front door threshold and fell down and received an abrasion on his right knee. Staff will continue to follow [client C's] risk plan concerning falls." 1. Review of client A's GERs (General Events Reports) on 8/14/15 at 5 PM indicated the following incidents: On 10/11/14 at 9:30 AM: "[Client A] was in the bathtub and stated that he lost his footing and fell. He stated that he just hit his lower back. There is a small bruise size of a half dollar on his lower back." The GER indicated the RN reviewed the GER on 10/17/15 with no documented comments. On 11/19/14 at 8 AM: "[Client A] was getting off the van and a staff was assisting since the [name of day services] parking lot was covered with ice. [Client A] slipped and staff eased his fall. [Client A] landed on staff's foot on his bottom.			

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	[Client A] did not complain of any pain." The GER indicated the RN reviewed the GER on 11/20/15 with no documented comments. On 11/30/14 while on a home visit: "[Client A] was at his sister's house for the holidays. She (client A's sister) stated that he (client A) fell four times in his 3.5 day visit. Fall questions according to his sister [name of sister]. The falls occurred at his sister's house. [Client A] fell twice going outside to smoke in which he tripped over the doorway, once he fell in the bathroom and once he tripped over a rug. The falls occurred between 11/27 (2014) - 11/30 (2014). [Client A] was with his family during the falls. His sister witnessed all the falls except for the one in the shower. [Client A] was checked for injuries upon returning to the group home but none were found." The GER indicated the RN reviewed the GER on 12/1/15 with no documented comments. On 1/12/15 at 3:15 PM: "[Client A] walking inside house and fell and bumped head slightly small (sic) resulting in a scratch and small abrasion on forehead (sic)." The GER indicated no review by the RN. On 2/1/15 at 6:30 PM: "[Client A] was sitting in the chair in the kitchen. All of a			

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	sudden he just slid out of the chair. When staff questioned him about why he fall (sic), he just stated that he just fell down. Staff assessed for injuries and none were found. Staff continued to monitor him." The GER indicated no review by the RN. The GER indicated no review by the RN. On 2/1/15 at 8:25 PM: "[Client A] was sweeping the kitchen floor. He fell and hit his head on the kitchen table. Staff rushed to help him into a chair. Once in the chair he leaned over to the side and started excessively drooling. This is when he began convulsing. Staff moved [client A] to the floor and held his head so that it didn't hit the floor. We also rolled him to his side. After the convulsing stopped [client A] was still unresponsive. He was not blinking and his eyes glazed completlely (sic) over. His face turned purple. Per the paramedics instructions staff did not do CPR. I (staff) was able to find a faint pulse. Paramedics took over at this point and he was taken to the hospital." The GER indicated no review by the RN. On 2/6/15 at 6:15 PM: "[Client A] was using the bathroom and having a BM. During the daily toileting duties after having a BM he had fallen onto the toilet. He had lost (his) balance and fell, but the toilet had caught him and staff was there			

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	to assist him and help him up. He fell in the bathroom while performing daily toiletry duties. No injuries were inflicted during the fall." The GER indicated no review by the RN. On 2/7/15 at 11:05 AM "[Client A] was using the handicap bathroom. After using the restroom, he (client A] turned to flush the toilet and scratched his arm on the medal of where the handicap handle used to be on the toilet. There was a little bit of bleeding. Staff cleaned with wound wash and bandaged. If asked, [client A] will tell you he doesn't remember what happened." The GER indicated no review by the RN. On 2/14/15 at 7:15 PM: "[Client A] had just finished his shower, shaved, and dressed. [Client A] told staff he needed to have a BM (Bowel Movement) and asked if he could have some privacy. Staff stepped outside the bathroom door and was waiting for [client A] to finish. Small scratch and red area on back in middle and to left of spine." The report indicated "Corrective Action Taken: [Client A] will be supervised to and from as well as in the bathroom by staff. Staff will use gait belt to better support [client A]." The GER indicated the RN reviewed the GER on 2/14/15 with no documented comments.			

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	On 3/23/15 at 6:40 AM: "[Client A] fell when he was getting out of bed. He was trying to go to the bathroom without his walker. He yelled for help and staff immediately went to help. Staff helped him up and checked him for injuries. None were found." The GER indicated the RN reviewed the GER on 3/23/15 with no documented comments. On 4/13/15 at 7:15 AM: "[Client A] was walking out of his room and tripped over his oxygen tubing. Staff was walking down the hall and saw the incident. Staff was able to get to him before he fell to the ground. Staff put their arm under his and helped guide him to the floor. [Client A] did not hit the floor hard and landed on his right hip and arm. [Client A] was checked for injuries and none was present at the time." The GER indicated the RN reviewed the GER on 4/17/15 with no documented comments. On 5/13/15 at 2:45 PM while at the day services: "Staff went into workshop to pick up clients. Staff woke [client A] up and started to unhook his O2 tubes. [Client A] stood up to hang up his tube and went to sit back down and fell on his butt. [Client A] stated his legs was (sic) asleep. Staff checked him over for injuries when we (staff and clients)			

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	arrived home and none was present at the time." The GER indicated the RN reviewed the GER on 5/19/15 with no documented comments. On 5/21/15 at 8:55 PM: "[Client A] was in the restroom and lost his balance and fell on his butt. He stated his knee hurt and it popped causing him to loose (sic) his balance. Staff assisted him up and checked for injuries. None was present at the time. Staff asked [client A] to sleep in the living room so staff can monitor more closely." The GER indicated the RN reviewed the GER on 5/21/15 with no documented comments. On 5/25/15 at 9:45 PM: "[Client A] was going to the bathroom to complete oral hygiene and fell hitting his back and buttock. Staff assisted him up off the floor and he started yelling his knee hurt. Staff assisted him on the toilet to check his knee. At the time there did not appear to be any swelling or marks. Staff took [client A] to the ER since he would not put any pressure on his knee. At the ER they completed a series of X-Rays on his knee. ER stated there was no fracture and only slight swelling. ER referred to an orthopedics doctor to look at his knee further and put his knee in a stabilizer and encouraged him to walk on his leg using a rollator walker." The GER			

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	indicated the RN reviewed the GER on 5/27/15 with no documented comments. Client A's record was reviewed on 8/14/15 at 11 AM. Client A's record indicated diagnoses of, but not limited to, Lung Cancer, COPD (Congestive Obstructive Pulmonary Disease - damage to the lungs causing difficulty with breathing), Dementia, Seizure Disorder, GERD (Gastric Esophageal Reflux Disease), Eczema, Psoriasis and Arthritis. Client A's quarterly physician's orders dated 3/5/15 indicated the following orders: Walker. Gait belt as needed. Oxygen: "Oxygen should be set on 2 liters while at rest. When individual engages in physical activity (walking, showering etc.) oxygen should be set on 4 liters of oxygen. After physical activity wait 15 minutes then set oxygen back to 2 liters." Clotrimazole cream and Betamethasone to affected areas twice a day for Psoriasis. A 2/4/15 T-log (Therap-log; computer/digital client record) note from the HM (Home Manager) indicated "On 2-1-15 staff reported to HM that [client			

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	A] was having a seizure at approx 8:25 PM. Staff called HM back to report that he (client A) was turning blue/purple and the other staff was calling an ambulance. When the ambulance arrived they stated he (client A) was not breathing enough to sustain life and was intubated (a procedure by which a tube is inserted through the mouth down the throat to supply air when someone is unable to breathe adequately on their own)." Client A was taken to the hospital to the ICU (Intensive Care Unit) and placed on a ventilator (a machine that supports breathing and sustains life). Client A was removed from the ventilator on 2/2/15 and released to return home to the group home on 2/3/15. __Client A's record indicated no physical assessments and or notes from the RN after client A's return to the group home from the hospital. Client A's 5/25/15 hospital discharge record indicated a diagnosis of right knee traumatic effusion (fluid in and around the knee caused by a trauma). Client A's 2014/2015 nursing notes in regard to client A's falls indicated, all inclusive: __On 5/27/15 at 6:30 PM the RN went to the group home to assess client A. "He (client A) was sitting in his w/c			

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	(wheelchair).... Sitting in the chair the lower part of his right leg looked turned out. I (the RN) don't know if he always sits like that or not but it didn't look right to me. I had him get up to walk as staff was instructed by ER to ambulate him with walker to keep him from getting still (sic), the leg looked the same when he tried to walk, turned out and he c/o (complained of) a lot of pain. Assisted him back into chair. Instructed staff not to ambulate him until we can get him into ortho (orthopedics). [The Residential Manager] said his (client A's) ortho appointment isn't until June 9th. I'm going to call in the am and see if we (staff) can get him in tomorrow." __On 5/28/15 at 10:30 AM indicated "On 5/25/15 [Client A] fell while in the restroom. He was taken to the hospital by PC (Program Coordinator). [Name of hospital] ER completed an X-ray on his right knee and chest. ER stated they found no injury and sent [client A] home with a knee stabilizer and asked to encourage [client A] to walk. On 5/27/15 [client A] complained of a lot of pain while walking and staff reported a large red area on the right side of his groin. PC came to observe [client A] walk and to check the red area. [Client A's] right thigh appeared to be a larger size than his left thigh and the red area was warm to touch. PC took [client A] to the ER. The			

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	ER took a hip X-ray and discovered the ball of his hip joint was broken and he would need surgery to repair. [Client A] was admitted to the hospital at approx 1 AM on 5/28/15 and is scheduled to have the surgery same day." Client A's nursing notes indicated no nursing notes and/or assessments in regard to client A's reported falls on the following dates: 10/11/14 11/19/14 11/30/14 01/12/15 02/01/15 02/06/15 03/23/15 04/13/15 05/13/15 05/21/15 05/25/15 Client A's 4/3/15 FRP indicated: __"Definition: A fall risk is someone who has the tendency to lose balance leading to falls, has a diagnosis that places them at a greater risk for falls or uses adaptive equipment. The fall may or may not cause injury.... The most common complication of falls is injury to the person. Injury may be minor requiring only minor first aid. More serious injuries will require emergency medical			

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	treatment. __The environment should be kept clear of hazards. __Staff are to assist clients as needed with ambulation [(walking)]. __Staff are trained in the possible side effects of medications and should provide added assistance for clients who need help because of side effects. __Plan: Staff are trained in Body Mechanics [(use of adaptive devices)]. __Use of adaptive devices is followed by a doctor and proper fit is monitored on a regular basis. Environmental hazards are removed by staff, more complex environmental issues are reported to maintenance on a monthly basis." Client A's FRP indicated the plan was updated by the RN on 4/3/15. Client A's Risk Plan failed to indicate: __How the staff were to supervise, monitor and assist client A while at home and while at the day program to ensure client A's safety in regard to recurring falls and injury from falls. __The adaptive equipment client A required for ambulation, when the equipment was to be used and how it was to be used. Client A's skin and wound records indicated: __10/11/14 "[Client A] has a small bruise			

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	on his lower back from a bathtub fall on 10-11-14." __10/12/14 "[Client A] has a slight bruise on his lower back area due to a bathtub fall." __12/17/14 "The rash on his (client A's) back is just about cleared up." __2/9/15 "[Client A] has a scratch on his arm it is in a healing no infections are present (sic)." __2/22/15 "[Client A] has a reddish rash all across his lower back area." __2/26/15 "[Client A] has a red rashy (sic) area on his lower back." __3/2/15 "I (the staff) notice (sic) red marks on [client A's] left upper arm and ask (sic) [client A] how did happen and he doesn't know what happen." __3/14/15 "There is an area on his L (left) shoulder. It is small and has a couple of little scabs on it." __3/15/15 "Spot on [client A's] shoulder blade as reported previously is better today." __3/18/15 "[Client A] has a skin breakdown on the upper part of his back." __3/21/15 "Previous reported spot on left shoulder blade has lost a couple scabs and looks much better, dry skin now around area. Area is pink and no longer red." __3/22/15 "[Client A] has raw areas behind each ear. These areas appear to be from his oxygen tubes that sit there."			

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	__3/25/15 "[Client A] has some dry skin patches on his back." __3/28/15 "Lotion applied to entire body after shower due to dry skin. No redness." __3/31/15 "[Client A] has dry skin, staff applied lotion to entire body after shower." __4/4/15 "Lotion applied to whole body dry skin after shower." __4/6/15 "He (client A) has a raw area on each ear where his o2 (oxygen) tubing sits. This is almost healed." __4/7/15 "Dry skin, lotion applied after shower." __4/11/15 "The red areas on the back of his (client A's) ears is (sic) getting better." __4/12/15 "Dry skin, lotion applied after shower." __4/14/15 "Dry skin, lotion applied." __4/16/15 "Dry skin, lotion applied." __4/30/15 "Scratches and red due to [client A] scratching at dry skin, lotion and treatments applied. Will continue to monitor." __5/6/15 "There is a small patch of dry skin on his upper back. His cream was applied extra well." __5/7/15 "[Client A's] back still has the small dry patch. Staff assisted with making sure it got washed well and his creams were applied." __5/8/15 "The dry patch looks better but staff still assisted with washing it and			

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	applying treatment to the area." __5/12/15 "[Client A] has some dry skin patches on his back. His cream was applied." __5/13/15 "The dry patches on [client A's] back appear to be healing." __5/22/15 "[Client A] is getting a few dry patches on his back. Staff assisted him with putting lotion on it and applying his treatments." Client A's record indicated no plan of care in regard to skin integrity, dry skin and/or rashes. Client A's record indicated no nursing notes and/or assessments in regard to client A's chronic skin problems. Client A's record indicated client A was on oxygen due to COPD and Lung Cancer. Client A's record indicated no nursing notes and/or assessments in regard to client A's lungs and respiratory needs. 2. Review of client B's GERs on 8/14/15 at 5 PM indicated the following incidents: On 4/29/15 at 8:10 AM: "[Client B] was going out to the van to go to work. Staff asked her to let them help push her down the sidewalk. [Client B] refused and screamed and started to hit her face. Staff			

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	walked behind [client B] and when staff looked away [client B's] chair hit the ledge of the sidewalk tipping over her chair. Staff assisted [client B] up and checked her for injuries. She (client B) had a small scrape above her left eye where her helmet moved and a scrape on her left knee. No other injuries was (sic) noted at the time." The GER indicated the RN reviewed the GER on 5/4/15 with no documented comments. On 5/9/15 at 6:40 PM: "After [client B] pulled herself out of wheel chair she went to reach for support on toilet railing and was not balanced before she moved and fell on her bottom. Staff did have a supportive hand on [client B]. [Client B] was assessed for injuries and has small red spot on the left side of her bottom. She did not hit her head." The GER indicated the RN reviewed the GER on 5/11/15 with no documented comments. On 6/12/15 at 8 AM: "We (the staff) were driving down the road and [client B] took off her seatbelt and she feel (sic) onto the floor of the van.... She (client B) had red mark from her right side of forehead to the side of her eye. Its (sic) was red at first and then disappeared after a little time." The GER indicated the RN			

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	reviewed the GER on 6/15/15 with no documented comments. On 7/11/15 at 3:30 PM: "[Client B] was being assisted walking into the home. She tripped over the threshold of the front door. Staff caught [client B] using her gait belt but she hit her arm on a rocking chair on the front porch. She had a bruise on her upper left arm." The GER indicated the RN reviewed the GER on 7/14/15 with no documented comments. On 8/4/15 at 3:15 PM: "[Client B] got up from the table without assistance. She was asked to wait for staff and while she was looking at that person another peer bumped into her. [Client B] fell and hit the corner of the wall hitting the left side of her upper body. [Client B] appeared to have a deep gash on her head and bruising was present on her left cheek. An ambulance was called to transport [client B] to the hospital." The GER indicated the RN reviewed the GER on 8/6/15 with no documented comments. On 8/12/15 at 6:30 AM "While walking client (B) to bathroom for shower client (B) kept dropping down to floor. Client (B) then tripped staff and fell onto staff to the floor. Being escorted by 2 staff to bathroom for shower because client kept dropping to floor while being escorted."			

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	The GER indicated the RN reviewed the GER on 8/13/15 with no documented comments. Client B's record was reviewed on 8/14/15 at 12 PM. Client B's record indicated a diagnosis of, but not limited to, Osteoarthrosis (a degenerative joint disease). Client B's 2015 Skin and Wound tracking record indicated: __4/26/15 "These were recorded down on Thursday April 23rd 2015. R (right) -arm Yellowish bruise by her elbow three bluish green bruises also by her elbow. L (left) -arm small bluish bruise on her upper arm by her armpit. R-leg purple bluish bruise on her upper thigh L-leg three dark bruises by her knee, several scratches on her shin down to her ankle. Back-no apparent bruises Chest no apparent bruises butt-small bruise on her L lower buttocks." __4/28/15 "All of [client B's] bruises are healing as expected. There are no other issues to report." __5/4/15 "[Client B's] bruises are all almost healed." __6/12/15 "[Client B] has a red area on the side of her right eye and a bruise above her right eye." __6/14/15 "R breast bruise-purple in color, R wrist 2 bruises - purple in color,			

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	R knee - faded purpleish (sic) in color, bruise R calf bruise - yellowish in color, L forearm bruise -purple in color, L upper thigh-faded yellowish in color, L knee 2 bruises - purple, L arm back of elbow-light purple and above right eye bruise - light purple." __7/16/15 "Large bruise on left arm which looks to be healing. Bruising on left knee which is healing. Was checked out at ER on 7/15/15." __7/17/15 "Bruise on left arm and left knee are healing. No other skin/wounds to report." __7/18/15 "Bruise on left arm and left knee are healing. No new skin/wound to report." __7/22/15 "Bruise on left arm and bruises on left knee are healing." __7/23/15 "Bruise on left arm is healing and the bruise on left knee is healing." __7/24/15 "Bruise on left arm is healing and bruise on left knee is healing." __7/27/15 "Bruise on left arm is healing and bruise on left knee is healing." __7/30/15 "Bruise on left arm is healing and bruise on left knee is healing." __7/31/15 "Bruise on left knee is heale d and bruise on left arm is healing." __8/2/15 "[Client B] has a red area with broken skin on her upper chest by her neck, it appears that [client B] has scratched at it and opened it. The area does not appear to be infected. Staff will			

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	continue to monitor." __8/5/15 "[Client B's] left eye is swollen and bruised in a red/ purple color. She (client B) has another red bruise above her cheek bone on her left side. On the left side of her collar bone there is a reddish circular bruise about 1 inch in diameter that is surrounded by a faint blue bruise about 3 inches in diameter. On her left shoulder, there is a red bruise about 4-5 in long and 3 inches wide. On her right butt cheek she has a square abrasion about an inch wide. Just above her left knee is another bruise about an inch in diameter. Her right calf is red and is a very faint blue." __8/6/15 "We (the staff) took the bandage off of [client B's] head today and cleaned it as best we could. We have noticed that she is bruising from a yellow color, to purple to blur (sic) all along the left side of her face. She also has some bruising on her scalp, near the staples. [Client B] also has a small swollen area on her left ear that is bruising." __8/7/15 "During [client B's] shower tonight we noticed that there is an area on the top of her head, above the staples that is still open. It appears to have small amounts of a green substance oozing out of it. Also the bruise on her left shoulder is still getting larger and is warm to touch. [Client B] does not like it when you get anywhere near all the staples."			

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	__8/8/15 "[Client B] has staples on the front right side of her head. Staples appear to be in good shape, no visual signs of bleeding, almost no swelling is present. During shower [client B] did not seem to be bothered by cleaning over the staples or bruises." __8/9/15 "[Client B] has multiple bruises (already reported) that are turning yellow in color, all bruises are different colors and in different stages of healing. No new bruises or skin concerns to report today. [Client B] also has some red areas on right buttocks, staff applied Desitin (a skin cream) and will continue to monitor." __8/10/15 "[Client B] has a bruise on her face, left shoulder, and left knee that appear to be in the healing stage." __8/11/15 "[Client B] has a bruise on the left side of her face, left shoulder, and left knee that appear to be in the healing stage." __8/12/15 "Wound on head is healing, bruised left eye is healing, bruising on left shoulder and left arm is healing. Other bruising from fall is healing." __8/13/15 "Wound on left side of forehead is healing. Bruises on left shoulder and arm are healing. Bruises on left knee are healing." Client B's 2014/2015 appointment records indicated:			

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	__On 5/11/15 client B had a PT (Physical Therapy) assessment. The assessment indicated "Pt (patient) ok to ambulate with gait belt/HHA/CGA (Hand Over Hand Assistance/Contact Guard Assistance) within group home environment. She is to have HHA/CGA for transfers in and out of van and up/down steps/curbs. She is to use w/c (wheelchair) for primary mode of transportation in the community." __On 6/25/15 client B saw her PCP (Primary Care Physician) for "chronic conditions." The record indicated "Walking with some assistance, stable on feet, no falls." __On 7/15/15 client B was seen at the ER for a contusion (a deep bruise caused by a blow, trauma or direct force) of face and upper arm as a result of a fall. __7/15/15 Hospital imaging reports (X-rays) of client B's left ankle and left arm. The X-ray of the left ankle indicated "Fall, swelling. No visible acute fracture." The X-ray of the left arm indicated "Fall, Ecchymosis (a discoloration of the skin resulting from bleeding under the skin, typically caused by bruising).... There are healed lower left rib fractures." __On 7/28/15 client B saw her PCP for a follow after fall. The report indicated "fell onto porch, tried to get up out of chair on her own, tripped on threshold, went to ER 7/15 (2015) - no injuries			

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	other than bruises. Ambulating well with assistance of one and gait belt." __On 8/4/15 client B was seen at the ER for a laceration to her head from a fall. Client B was discharged with an ace wrap (an elastic bandage) dressing around her head that was to be left on for 48 hours. The record indicated client B was to see her PCP to remove the staples in 7 to 10 days. __On 8/14/15 client B saw her PCP for removal of staples in her head. Client B's April (2015) nursing assessment indicated: 4/22/15 client B "Transferred from ECF (Extended Care Facility) that closed down. Answers simple questions. Seems happy, smiles a lot. Wearing helmet, in w/c (wheelchair). Staff reports she has not attempted to get up on her own. Able to move self in w/c. Able to amb (ambulate) with assist of staff for safety. To have PT/OT (Physical Therapy/Occupational Therapy) eval (evaluation)." The report indicated client B had bruising on her skin. The report did not give a descriptive note of the bruising or indicate where the bruising was located. Client B's nursing notes indicated: __8/13/15 late entry for 7/13/15 at 10:00 AM "Received call from [name of PC], PC requesting me to come assess [client			

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	B] d/t possible bruising to right eye reported by staff. Went to home and assessed [client B], there was no new bruising noted to right eye. There was slight discoloration around eye, pale green. Possible old bruising. PEARL (Pupils Equal and Reactive to Light). Denies c/o pain. Also assessed bruising to left upper arm received after fall 7/11. No swelling noted, arm soft. [Client B] is able to move left arm without complaints. Instructed staff to report any changes." __8/13/15 late entry for 7/11/15 at 4:55 PM "Went by [name of street] group home to assess [client B] after fall, no one was home. Notified [name of PC], PC who said the clients and staff went for a ride. [The RN] is going to see another client and will try again later this evening." __8/13/15 late entry for 7/11/15 at 7:39 PM "Went to group home again to see [client B] but again no one was home. Contacted [name of PC] PC and informed her that I (the RN) was unable to assess [client B] d/t (due to) her not being home. Instructed her to have staff monitor [client B] and if she is c/o (complaining of) pain and/or unable to move left upper arm, have staff take her to ER." __8/13/15 late entry for 7/15/15 (time not indicated) "Received report from [name of PC], PC that [client B's] left upper arm was now swollen with increased bruising.			

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	Writer (the RN) went to home to assess and left arm is now firm to touch with increased edema, no warmth, increased bruising, dark and light purple and blue/green bruising. [Client B] continues to be able to move left arm but now c/o pain when area is touched. Instructed [name of PC], PC to take pt to ER for eval. Informed PD and AD." __8/5/15 at 7:59 PM "Went to home to assess client (B) after fall yest (yesterday). She (client B) was sitting on couch when [the RN] arrived. Ace wrap wrapped around the top of her head, around face, around chin. Applied firmly but [RN] able to put 2 fingers under ace wrap. Good circulation. Eyes open, PEARL (Pupils Equal and Reactive to Light), able to follow directions. Client (B) refuses to allow staff to apply ice to head. Instructed to given (sic) prn (as needed) medication as needed for pain. V/s (vital signs) stable. Pt (patient) wearing gait belt, staff to walk with client when ambulating, client to use w/c (wheelchair) prn. Report given to PC (Program Coordinator), PD and AD. Requested a PT (Physical Therapy) eval (evaluation) for [client B] on 8-20-15. NP (Nurse Practitioner) stated she would request the order and physical therapy will call PC to set up the appointment." __"8/13/15 at 7:59 PM [Client B] had another fall yest (yesterday). This one			

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	without injury. [Client B] has a scheduled appointment tomorrow for follow up after fall with head injury. MD to remove staples tomorrow. Instructed [name of PC], PC to ask for PT/OT evaluation tomorrow at MD appointment. Also instructed [name of PC], PC to ask MD about getting order back for helmet for client's safety. Gait belt is used on client for safety. Instructed [name of PC], PC to have staff use wheel chair when client is having increased weakness, difficulty ambulating and if client would have to go very long distances. Voiced understanding." Client B's Falls High Risk Plan dated 4/20/15 and updated 8/13/15 indicated: __"1. Staff should monitor environmental concerns at home (wet floor, anything on floor that should be picked up). __2. Staff should monitor environment on outings for weather-related hazards. __3. Notify HM immediately when fall occurs she/he will report to PD and nurse. __4. HM will then follow protocol for falls (located in communication book). After a fall occurs: __1. Take vital signs. __2. Check eyes for dilation. __3. If unconscious, call 911 immediately. __4. Check for injuries before moving person.			

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	__5. Document in Therap (GER). __Staff are to be with [client B] when she is ambulating. Gait belt is to be used for safety. Wheel chair to be used when client is having difficulty walking, increased weakness, or has to go long distances." Client B's FRP failed to indicate how the staff were to supervise, monitor and assist client B while at home and while at the day program to ensure client B's safety in regard to recurring falls and to prevent further injury due to falls. The FRP failed to indicate when client B was to wear a gait belt. During interview with the RM on 8/13/15 at 5:30 PM, the RM: __Indicated client B was admitted to the group home in April of 2015. __Indicated upon admission client B was using a wheelchair 24/7 for all ambulatory needs, wore a helmet and had a bed alarm and a chair alarm. __Indicated currently client B only utilized a wheelchair for long distances and stated, "Her doctor got her out of the wheelchair and wants her up walking now." __Indicated client B no longer used the wheelchair, helmet and bed/chair alarm. __Indicated client B was to wear a gait belt while ambulating and was to wait for			

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	staff assistance before getting up. __Indicated client B frequently would not wait for staff and would get up on her own without staff assistance. __Indicated if they saw client B getting up from a seated position or getting out of bed the staff were to immediately assist client B. 3. Review of client C's GERs on 8/14/15 at 5 PM indicated the following incidents: On 11/20/14 at 7:30 AM: "[Client C] was in the bathroom, staff heard a fall and went in to check on [client C] and noticed [client C] on the floor. [Client C] had slipped in his urine that was on the floor." The GER indicated the RN reviewed the GER on 11/20/14 with no documented comments. On 11/25/14 at 8:29 PM: "[Client C] had just gotten out of the shower and was walking to his chair. He tripped over a rug and fell. Staff caught most of the fall. He did lightly hit his head on the front door.... [Client C] has a small bruise on his left arm between his elbow and wrist." The GER indicated the RN reviewed the GER on 12/1/15 with no documented comments. On 1/3/15 at 12 PM: "[Client C] was			

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	sitting at the table in a chair and appeared to loose (sic) his balance tipping over his chair. Staff caught the chair so [client C] did not fall all the way to the ground. Staff reported that he hit the left side of his body on the arms of the chair. Staff took him to his room to sit so they could take vitals. [Client C] fell forward on the bed while sitting and staff again stopped him from falling. Staff reported that [client C] did not appear to focus his eyes on staff and his eyes was (sic) rolling back in his head. Nurse was notified and instructed staff to call an ambulance. [The home manager] met [client C] at the hospital. After running blood work, urinalysis, and an EKG the doctors stated he had a UTI (Urinary Tract Infection). Staff was instructed to start a new antibiotic and follow up with PCP (Primary Care Physician) within 5 days." The GER indicated no review of the GER by the RN. On 1/5/15 at 6:13 PM: "Staff was in the bathroom assisting [client C]. Staff was standing in front of [client C] assisting him with pulling his pants down. While staff was doing so [client C] tried to turn and began to fall. Before staff was able to catch [client C] from his fall [client C] has (sic) shifted his weight towards the staff causing himself and staff to fall. Staff was able to position herself during			

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	the fall to catch [client C's] head and upper body." The report indicated a reddened area on client C's buttocks. The GER indicated no review of the GER by the RN. On 1/6/15 at 10:35 PM: "Staff was coming out of the office from clocking in. [Client C] was in the process of standing up. When he (client C) was getting up he fell and hit the right side of his body. He has a small cut above his right eye, scraps (sic) down his right side and his side on the right was red. [Client C] complained of pain and was given ibuprophen (sic) (a pain medication). After he (client C) fell he would not respond well to staff's questions. He (client C) was mumbling but staff could hardly understand him. Staff stayed with [client C] on the floor between his rocking chair and the table with a pillow under his head. We (the staff) kept talking to him until home manager arrived. When home manager talked to him he responded right away telling her he fell. After asking him a few questions she asked [client C] if he would like to get up. Staff assist (sic) [client C] from the floor to the rocking chair. [Client C] continued to answer HM's (Home Manager's) questions then stated he needed to use the bathroom. Three staff assist (sic) him to the restroom. [Client C] appeared to shuffle his right			

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	side and saying he hurt. [Client C] was checked over for further injuries. After using the bathroom [client C] was assisted in a recliner in the living room to sleep for the night. [Client C] agreed to sleep in the living room for tonight.... [Client C] cut his head right above his right eye." The GER indicated the RN reviewed the GER on 1/7/15 with no documented comments. On 1/7/15 at 6 PM: "[Client C] was walking to the bathroom and staff noticed that [client C] was having a hard time walking on his right leg. He had a fall the previous night on that side. HM called the Nurse and was instructed to take [client C] to the ER to be evaluated.... All tests came back normal." The GER indicated no review of the GER by the RN. On 1/9/15 at 1 PM: "[Client C] was sitting in the rocking chair in the kitchen. The chair broke while he was sitting in it causing him to fall. [Client C] fell on his right side. At the time there was no bruising or redness." The GER indicated no review of the GER by the RN. On 1/28/15 at 8:14 PM: "[Client C] was in the kitchen trying to help himself get coffee. He tried to stand up from his wheel chair and he fell. Staff immediately went to help him." No injury was			

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	reported. The GER indicated no review of the GER by the RN. On 3/18/15 at 7:56 AM: "Staff assisted [client C] onto the van. Once [client C] was over his seat, he slid off the seat. Other peers assisted in catching the fall, however he did land on his butt. Staff assessed [client C] and there were no injuries found." The GER indicated no review of the GER by the RN. On 4/5/15 at 2 AM: "[Client C] was trying to get out of bed and fell. When staff went to check on him he stumbled against the door. Staff assisted him to the restroom and checked him over for injuries. He has a large red area that appears to be bruising on his left hand above his thumb and a scrape on his left knee cap. At the time he did not appear to have any other injuries." The GER indicated the RN reviewed the GER on 4/17/15 with no documented comments. On 4/7/15 at 7 PM: "[Client C] slipped on noodles on the kitchen floor, staff had a hold of gait belt but [client C] fell over and hit arm and head on pantry door. Did not fall on the floor." The actions taken indicated "staff prevented [client C] from going to floor by stabling (sic) him with his gait belt, floor was also swept and cleaned up. Plan of Future Corrective			

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	Actions: make sure that the path [client C] is walking is clear of all objects, continue to use gait belt and walk with staff at all times." The GER indicated the RN reviewed the GER on 4/15/15 with no documented comments. On 5/7/15 at 7:55 PM: "We (staff and clients) were on our way home from church, other behaviors were going on. At some point [client C] unbuckled his seat belt. Staff went to pull over to assist with the behaviors and [client C] slid off his seat onto his knees. Both his knees ended up skinned up. There was no blood. Staff cleaned the wound. No bandages were needed." The GER indicated the RN reviewed the GER on 5/11/15 with no documented comments. On 5/18/15 at 6:50 AM: "[Client C] fell in the kitchen and hit his head on the window's edge. His wound was approx 1/2" (inch) and appeared to be deep. He was taken to the ER for evaluation. They completed a head/neck CT and completed labs. While there staff noticed a knot on his hand. An X-Ray was completed. All results came back normal and [client C] received 3 staples (to his head)." The GER indicated the RN reviewed the GER on 5/19/15 with no documented comments.			

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	On 6/4/15 at 5:55 PM: "[Client C] had been sitting on the porch following dinner for about 20 minutes. He (client C) told the staff outside with him that he wanted to go inside because he was hot. Staff assisted [client C] with walking inside to the kitchen table. [Client C] sat down and was drinking coffee. A few minutes later staff noticed that [client C] had laid his head down on the table. Staff prompted [client C] four or five times asking if he was ok. [Client C] was unresponsive. Staff sat [client C] up and asked again if he was ok. He was still unresponsive. Staff noticed however that [client C] was drooling and was just staring straight ahead with his left eye squinted shut. Because [client C] has a seizure risk plan staff assisted [client C] to the floor. He was still unresponsive. Paramedics were called. By the time they got to the house, [client C] was saying that 'it hurts' 'side hurts' when paramedics asked what hurt [client C] told them his stomach. At the hospital he was diagnosed with Vasovagal Syncope (a sudden drop in heart rate and blood pressure causing a person to faint). He (client C) was discharged at 8:26 PM." The GER indicated the RN reviewed the GER on 6/15/15 with no documented comments. On 6/30/15 at 10 PM: "[Client C] stood up to walk into the house and fell on his			

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	knees." The report indicated client C scraped both knees. The GER indicated the RN reviewed the GER on 7/7/15 with no documented comments. On 8/6/15 at 5 PM: "[Client C] was sitting on the front porch. When he was walking in, he fell and landed on his butt. Staff assisted him with getting up and assessed him for injuries. We (the staff) did not find any. [Client C] stated that he was just fine." The GER indicated the RN reviewed the GER on 8/10/15 with no documented comments. On 8/12/15 at 8 PM: "[Client C] was walking fast going out on to the front porch, I (the staff) repeatedly said slow down and held his belt but he tripped on the threshold and went down on one need (sic) to cause an abrasion." The GER indicated the RN reviewed the GER on 8/14/15 with no documented comments. Client C's record was reviewed on 8/14/15 at 1 PM. Client C's record indicated diagnoses of, but not limited to, Seizure disorder, Hypertension, (high blood pressure) and Vasovagal Syncope and left hip periprosthetic fracture (a broken bone that occurs around the components or implants of a total hip replacement).			

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	Client C's 2014/2015 appointment records indicated the following: __On 10/14/14 client C had a PT evaluation post hip fracture. The evaluation indicated "[Client C] was to utilize SW (standard walker) for ambulation at all times." __On 1/7/15 client C was seen at the ER for a "fall, unsteady gait and injury to head." __On 1/15/15 client C saw his PCP due to "gait disturbance. Has had unsteady gait for last two weeks or so. Has fallen multiple times. Takes two people to assist with ambulation." The record indicated client C was to be re-evaluated by PT. __On 1/21/15 client C was re-evaluated by PT. The evaluation indicated "Decreased left hip extension. For terminal stage. Decreased left hip flexion. Forward swing and forward progression. Increased trunk flexion during gait and poor... standing balance." __On 5/18/15 client C was seen at the ER for a head injury with a laceration. __On 5/21/15 client C saw his PCP and was asked to provide an order for a bed/chair alarm. The record indicated "Pt (patient) recently fell without asking for assistance and now has a wound on the back of his head. Having increase in falls from getting up by himself." Client C's updated 2014 FRP indicated			

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	__"Definition - A fall risk is someone who has the tendency to lose balance leading to falls. The fall may or may not cause injury.... The most common complication of falls is injury to the person. Injury may be minor requiring only minor first aid. More serious injuries will require emergency medical treatment. __Prevention: Staff are to ensure that any adaptive devices are in good repair, broken equipment should be reported to the PD (Program Director) immediately. The environment should be kept clear of hazards. Staff are to assist clients as needed with ambulation [(walking)]. Staff are trained in the possible side effects of medications and should provide added assistance for clients who need help because of side effects. __Plan Staff are trained in Body Mechanics [(use of adaptive devices)]. Use of adaptive devices is followed by a doctor and proper fit is monitored on a regular basis. [Client C] may use gait belt, walker with wheels and wheel chair as needed for safety. Environmental hazards are removed by staff, more complex environmental issues are reported to maintenance on a monthly basis." Client C's FRP failed to indicate __How the staff were to supervise,			

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	monitor and assist client C while at home and while at the day program to ensure client C's safety in regard to recurring falls. __When client C was to wear the gait belt. __The use of a chair/bed alarm, when it was to be used and how the staff were to ensure the alarms were functioning. Client C's skin and wound records indicated: __2/16/15 "Staff notice (sic) two bruises today one on his (client C's) right chest and one on his right arm while giving [client C] a shower tonight (sic). Staff reported to HM." __2/21/15 "[Client C] has broken skin on the top of his right foot from where his shoe has been rubbing. There is also a small, lightly colored bruise on his chest in the area where the gait belt is." __3/20/15 "There's a red scrape on his (client C's) left knee. [Client C] said he fell at the day program today. It is about the size of a 50 cent piece." __3/21/15 "The scrape on his L knee is getting better." __3/22/15 "[Client C] has two bruises on his Right side thigh. He stated Friday that he fell at day services program. He also had a small red scrape on his left knee." __3/24/15 "[Client C] has bruises on his upper left arm and both legs. He claims			

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REM OCCAZIO LLC	1206 S MAIN ST NEW CASTLE, IN 47362

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	he fell at workshop." __3/25/15 "[Client C] still has the bruises on his upper left arm. On the upper part of both of his legs there are bruises. All were reported to the home manager." __3/27/15 "[Client C] still has the bruises on the upper part of both legs and on his left arm. He also scratched himself on the upper part of his right leg." __3/26/15 "[Client C] still has the bruises on his legs and his left arm. No new injuries." __3/28/15 "The bruises on [Client C's] upper thighs are purple in color with yellowing around them. No other new areas to report." __3/30/15 "No new wounds were found. He (client C) still has the same bruises." __4/6/15 "[Client C] has a few bruises on his upper thighs that are almost healed." __4/7/15 "Refer to GER. [Client C] started to fall and fell into pantry door. Scraped his left arm on the door handle. No other new concerns." __4/8/15 "[Client C] has some bruising and a couple small scratches from his fall yesterday." __4/9/15 "No new areas for [client C] today, some bruising from Tuesday's 'fall' (reported in GER)." __5/3/15 "[Client C's] buttocks is (sic) more red than usual around his crack, it appears to be from where he sits a lot. Spots have been there for awhile but			

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	seems to be dry/peeling. Staff applied A&D ointment to buttocks after shower." __5/8/15 "[Client C] has a bruise on his right hip area. It's light in color and the size of a 50 cent piece. __5/10/15 "[Client C] has a small faded bruise on his right fore arm. There are no other issues to report." __5/18/15 "[Client C] fell this morning and hit his head and had to get stitches. When pressure is applied to the wound it does still bleed. Staff cleaned the wound with soap and water. There is also a little swelling in [client C's] right hand from the fall this morning. __5/19/15 "I (the staff) cleaned the wound on the back of [client C's] head with soap and water. It did begin bleeding a small amount again but stopped within a few minutes. The swelling on the back of his right hand has went (gone) down. No new wounds were found." __5/21/15 "Staff cleaned [client C's] staples with soap and water. There was not any bleeding or any signs of infection." __5/22/15 "[Client C] has a large bruise on the back of his head a few inches underneath his staples. The bruise extends down the side of his neck. Staff are giving [Client C] ibprophen (sic) to help with pain when he complains of it." __5/25/15 "Has the staples in his head, bruise right below staples that is in			

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	healing stage and a small bruise on buttock from the fall that also appears to be in healing stage." __5/26/15 "Staff continuing to monitor head wound and staples. All staple care done by staff this evening. no concerns." __6/1/15 [Client C] had his staples removed today. There is still a bruise on the back of his neck. His wrist is also a little swollen from where he hurt it. No other concerns." __6/16/15 "[Client C's] right knee is still skinned up." __6/16/15 "Bruises are healing to a yellowish color. There are no new skin and wounds to report." __6/30/15 "[Client C] has a small scrape on his knees." __7/2/15 "He (client C) has a purple colored half dollar size bruise on his chin. His right and left arms have red and purple bruising with some scabbed scratch marks from him scratching his dry skin on his arms." __7/2/15 "[Client C] has purple bruising on his left leg, a scab the size of approximately a dime. It appears to be healing nicely and no signs of infection. On his right leg there is (sic) only a couple light purple bruising dots and a nickle (sic) sized area of dried, peeling, skin surrounding the light purple bruising dots." __7/3/15 "[Client C] has a dark purple			

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	bruise the size of a half dollar on the bottom right corner of his chin. I am uncertain on how it got there at this time. [Client C] has red and purple colored bruises with some small scabs in the bruising areas due to him scratching his right and left arms." __7/3/15 "Has some purple bruising on his left knee with a dime size scab that is (sic) in the healing stage and has no sign of infection. On his right knee there is a couple light purple bruising dots that are in the healing stage and surrounding the bruising dots there's a nickle (sic) size patch of dried, peeling, skin." __7/8/15 "Chin:10 cm (centimeters) x (by) 5 cm bruise that has been healing, color of purplish. Little bruising on each arm which is healing." __7/20/15 "His left lower forearm has a small dime shaped bruise, reddish in color and it appears to be from him scratching his arm from dry skin." __7/23/15 "[Client C] right lower forearm has a 3 x 1.5 inch square shaped bruise, red/purple in color from scratching, he also has a tiny round circle healing scab on the top of his right hand, he has a few healing dot scabs from scratching on his lower right forearm." __8/10/15 "When staff got [client C] out of the shower we noticed bruising light blue color with darker blue spots in the middle on his right wrist that was about 7			

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	inches long and three inches wide. There was a part that was swollen up appearing to look like a knot. Ibprophen was given after his shower." __8/11/15 "[Client C] has bruising on his right wrist and hand, small bruises on his right thigh" __8/13/15 "No new wounds were found on [client C]. His right wrist is still bruised. He also has bruising on his legs and inner thighs." __8/15/15 "All bruises previously reported on right wrist and left hip, all in various healing process and different colors. Staff will continue to monitor. No new concerns." Client C's nursing notes from 9/1/14 to present in regard to client C's falls indicated, all inclusive: __1/7/15 "It was reported today by the HM that [client C] fell last night hitting right side of his body. He is c/o (complaining of) right hip pain and has a shuffled gait. Instructed HM to take [client C] to [name of hospital] ER for evaluation per ambulance." Client C's record failed to indicate nursing services assessed and/or monitored client C after falls and/or injury with falls. During interview with the RM on 8/13/15			

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	at 5:30 PM, the RM: __Indicated clients A, B and C had a history of falls with injury and required staff assistance and supervision while ambulating. __Indicated client A was currently in an extended nursing facility due to a fall he had in May 2015 resulting in a fractured hip. __Indicated client A utilized a gait belt and a walker prior to his hospitalization and staff were to assist client A while ambulating. __Indicated client B utilized a gait belt and was to have staff assistance when ambulating. __Indicated upon admission client B was in a wheelchair with padded arm rests, wore a helmet and had a seat belt alarm and a bed alarm. __Indicated client C was to wear a gait belt and have staff assistance whenever he is ambulating. __Indicated the RN was in the group home as needed and at least monthly to assess the clients. __Indicated she (the RM) frequently talked with the RN and kept her updated on the clients' health needs. __Indicated the staff reported to her whenever falls and/or injuries occurred and then she in turn notified the RN and the PD. __Stated the staff "should keep an eye on			

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	him (client C)" and if the staff saw client C getting up from a seated position or getting out of bed, the staff were to assist client C. __Indicated client C was supposed to utilize a bed/chair alarm to alert the staff when he got up from a sitting position. __Indicated client C would not leave the bed/chair alarm alone and had broken the clasp on the seat/bed alarm. The RM pulled the alarm from her desk drawer in her office and stated, "This is [client C's] chair alarm, but it's broken and he won't use it." __Indicated there were 3 to 4 staff in the home at all times when all clients were home plus herself. During interview with the RN on 8/26/15 at 12 PM, the RN: __Indicated she was in the group home with clients (A, B and C) as needed and at minimum once a month. __Indicated client A was currently in the hospital due to a fractured hip. __Stated client A "would probably" be going to a long term care facility after his hospital stay due to all of his medical concerns. __Indicated it was facility policy to send clients to the ER for evaluation if the clients had hit their head during a fall and/or as a result of a fall and stated, "No matter if they have an obvious injury or			

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	not, we (the facility) send them out to get checked." __Indicated the RM called her whenever a client fell. __Indicated she had frequent communication with the RM. __Indicated she did not assess clients A, B and C after each fall and/or after all falls with injury. __Indicated she had conducted some assessments but was behind on her documentation. __Indicated review of the clients' GERs did not indicate a face to face assessment had been conducted, only that the GER was reviewed. __Indicated she reviewed the skin and wound records monthly. __Indicated she was not aware of an issue with client B's staple line. __Indicated she was not aware the staff had documented on 8/7/15 "green ooze" coming from client B's incision line. __Indicated the staff were good at reporting issues with the clients and stated, "I'm surprised someone didn't call me about that. __Indicated the clients' FRPs should include the equipment r			
W 9999 Bldg. 00	State Findings	W 9999	**1. What corrective action will beaccomplished?** •□□□□□□□□All staff, Program	09/26/2015

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	460 IAC 9-3-1(a) Governing Body (b) The residential provider shall report the following circumstances to the division by telephone no later than the first business day followed by written summaries as requested by the division: 14) A significant injury to an individual that includes but is not limited to: a) a fracture. g) any injury requiring more than first aid. 15) A fall resulting in injury, regardless of the severity of the injury. 18) Use of any PRN related to an individual's behavior. 19) Use of any physical or manual restraint. This state rule was not met as evidenced by: Based on record review and interview for 3 of 4 sampled clients (A, B and C) and 3 additional clients (E, F and G), the facility failed to ensure all incidents of falls resulting in injury and incidents requiring the use of physical restraint were reported to the BDDS (Bureau of Developmental Disabilities Services) no later than the first business day following the date of the incident. Findings include:		Coordinator and ProgramDirector (QIDP) will be retrained on protocol for reporting client abuse,neglect, injuries of unknown origin and restraint. •□□□□□□□□Program Director (QIDP) will be trained oninvestigation protocol and timeliness. •□□□□□□□□Staff will notify Program Coordinator of anyincidents. •□□□□□□□□Program Coordinator will notify Program Director(QIDP) of any incidents. •□□□□□□□□Program Director (QIDP) will report allincidents of alleged abuse, injuries of unknown origin or restraint will bereported to BDDS and APS, per state law. •□□□□□□□□Program Director (QIDP) will investigate anyinjuries of unknown origin, alleged abuse or client restraint and reportfindings, per policy and state law. •□□□□□□□□Area Director will monitor completion andtimeliness of reports and investigations monthly. **2. How will we identify other residents havingthe potential to be affected by the same deficient practice and what correctiveaction will be taken?** •□□□□□□□□All staff, Program Coordinator and ProgramDirector (QIDP) will be retrained on	

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	The facility's reportable and investigative records were reviewed on 8/13/15 at 1 PM. The 5/11/15 BDDS report indicated date of incident 4/29/15 at 8:10 AM and date of knowledge was 5/8/15. The report indicated "While completing home review with consumer [client B] and staff at the group home on 5/8/15 [name of BDDS representative] noticed large bruise on consumer's (client B's) forearm and scrape on forehead. Upon questioning house manager [name of house manager] about what caused these injuries, [the house manager] reported that consumer (client B) tipped over her wheelchair and fell. [The house manager] provided [the BDDS representative] with a printed report of the incident, however, no actual incident report was completed. The written report of the incident is included below: 4/29/15 - '[Client B] was going to the van to go to work. Staff asked her to let them help push her down the sidewalk. [Client B] refused and screamed and started to hit her face. Staff walked up behind [client B] and when staff looked away [client B's] chair hit the ledge of the sidewalk tipping over her chair. Staff assisted [client B]		protocol for reporting client abuse,neglect, injuries of unknown origin and restraint. •□□□□□□□□Program Director (QIDP) will be trained oninvestigation protocol and timeliness. •□□□□□□□□Staff will notify Program Coordinator of anyincidents. •□□□□□□□□Program Coordinator will notify Program Director(QIDP) of any incidents. •□□□□□□□□Program Director (QIDP) will report allincidents of alleged abuse, injuries of unknown origin or restraint will bereported to BDDS and APS, per state law. •□□□□□□□□Program Director (QIDP) will investigate anyinjuries of unknown origin, alleged abuse or client restraint and reportfindings, per policy and state law. •□□□□□□□□Area Director will monitor completion andtimeliness of reports and investigations monthly. **3. What measures will be put into place orwhat systemic changes will be made to ensure that the deficient practice doesnot recur:** •□□□□□□□□All staff, Program Coordinator and ProgramDirector (QIDP) will be retrained on protocol for reporting client abuse,neglect, injuries of unknown origin and restraint.	

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	up and checked her for injuries. She had a small scrape above (sic) her left eye where her helmet moved and a scrape on her left knee. No other injuries was (sic) noted at the time.' [The house manager] reported that the bruise did show up later and was still visible when [the BDDS representative] completed the home review on 5/8/15.... [The BDDS representative] provided information to [the house manager] on the necessity of ensuring incident reports are completed with BDDS. [The BDDS] representative called and spoke with Program Director [name of PD] who reported that she would complete an incident report since she was unaware of the fall and had therefore not ensured one was completed immediately after the incident. [The BDDS representative] did not see an incident report in the system this morning [5/11/15] and so is completing this report now." The 5/21/15 BDDS report indicated on 5/7/15 at 7:55 PM client G was placed in a PIA (Physical Intervention Alternative) hold to prevent self injury of hitting and biting himself. __The facility records indicated the use of restraint on client G was not reported to BDDS within 24 hours.		•□□□□□□□□Program Director (QIDP) will be trained on investigationprotocol and timeliness. •□□□□□□□□Staff will notify Program Coordinator of anyincidents. •□□□□□□□□Program Coordinator will notify Program Director(QIDP) of any incidents. •□□□□□□□□Program Director (QIDP) will report allincidents of alleged abuse, injuries of unknown origin or restraint will bereported to BDDS and APS within 5 days of knowledge, per state law. •□□□□□□□□Program Director (QIDP) will investigate anyinjuries of unknown origin, alleged abuse or client restraint and reportfindings, per policy and state law. •□□□□□□□□Area Director will monitor completion andtimeliness of reports and investigations monthly. **4. How will the corrective action be monitoredto ensure the deficient practice will not recur?** •□□□□□□□□All staff, Program Coordinator and ProgramDirector (QIDP) will be retrained on protocol for reporting client abuse,neglect, injuries of unknown origin and restraint. •□□□□□□□□Program Director (QIDP) will be trained oninvestigation protocol and	

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	The 5/22/15 BDDS report indicated "On 5/21/15 during home review [name of BDDS representative] noticed daily note entered detailing a fall consumer (client B) had that no incident report had been completed for. [Name of BDDS representative] obtained the details from staff (the RM) and is completing the report below: On 5/9/15 'After [client B] pulled herself out of wheel chair she went to reach for support on toilet railing and was not balanced before she moved and fell on her bottom. Staff did have a supportive hand on [client B]. [Client B] was assessed for injuries and has small red spot on the left side of her bottom. She (client B) did not hit her head.... Staff will follow up to ensure all safety precautions are in place for consumer. [Name of BDDS representative] will continue to follow up with group home staff'." The report indicated it was reported to BDDS on 8/4/15 by the PD and no injuries were reported. The 6/2/15 BDDS report indicated: __"On May 21st (2015) at 8:55 PM, [client A] was in the restroom and lost his balance causing him to fall on his buttock. [Client A] stated that his knee		timeliness. •□□□□□□□□Staff will notify Program Coordinator of anyincidents. •□□□□□□□□Program Coordinator will notify Program Director(QIDP) of any incidents. •□□□□□□□□Program Director (QIDP) will report allincidents of alleged abuse, injuries of unknown origin or restraint will bereported to BDDS and APS within 5 days of knowledge, per state law. •□□□□□□□□Program Director (QIDP) will investigate anyinjuries of unknown origin, alleged abuse or client restraint and reportfindings, per policy and state law. •□□□□□□□□Area Director will monitor completion andtimeliness of reports and investigations monthly. **5. What is the date by which the systemicchanges will be completed?** 9/26/15	

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	was hurting and that he fell due to his knee hurting. Staff assisted [client A] up and checked him for injuries. No injuries were present at the time. Staff were to remind and encourage [client A] to use his walker and gait belt when ambulating. There were no environmental factors that caused this fall. Since the fall occurred in the restroom, there were no witnesses. Staff monitored [client A] throughout the night. [Client A] was fine throughout the night and had no other falls that night. PC (Program Coordinator), PD (Program Director) and nurse were all notified. The nurse checked [client A] out. He was sitting in his w/c (wheelchair). He did have his oxygen on, his O2 (oxygen) sat (saturation) was 95. His heart rate was 100-105 and that was sitting. Ortho (Orthopedic) appointment is on June 9th (2015)." __"On May 25th at 9:45 PM [client A] was going to the bathroom to complete oral hygiene tasks and fell hitting his back and buttock. Staff assisted [client A] up off the floor and he started yelling his knee hurt. Staff assisted him on the toilet to check his knee. At the time there did not appear to be any swelling or marks. Staff took [client A] to the ER since he would not put any pressure on his knee. At the ER they completed a series of X-rays on his knee. ER stated there was no fracture and only slight swelling. ER			

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	referred to an orthopedics doctor to look at his knee further and put his knee in a stabilizer and encouraged him to walk on his leg using a rollator walker (a. four wheeled rolling walker)." __"On May 27th (2015) [client A] complained of a lot of pain while walking and staff reported a large red area on the right side of his groin. PC came to observe [client A] walk and to check the red area. [Client A's] right thigh appeared to be a larger size than his left thigh and the red area was warm to touch. [Client A] was taken back to the ER for additional observation and additional X-rays. The ER took a hip X-ray and discovered the ball of his hip joint was broken and he would need surgery to repair. [Client A] was informed of the situation and gave verbal confirmation for the surgery 5/27/15." __"The plan is that after the surgery [client A] will be staying in the hospital until his HCR (Health Care Representative) has decided which nursing facility to admit [client A] into to come (sic) his rehab (rehabilitation) at. As of June 2 (2015), [client A] is recovering well from surgery." __The facility report indicated date of knowledge was 5/27/15. The report was submitted to BDDS on 6/2/15. The 6/3/15 BDDS report indicated on			

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	5/21/15 at 3:35 PM client F became verbally and physically aggressive with staff and was placed in a PIA. __The facility records indicated the use of restraint for client F was not reported to BDDS within 24 hours. The 6/9/15 BDDS report indicated on 6/2/15 at 5:42 PM client E became upset and began hitting herself. The report indicated client E was placed in a PIA. __The facility records indicated the use of restraint for client E was not reported to BDDS within 24 hours. The 8/1/15 BDDS report indicated on 6/19/15 at 7:35 AM client F became verbally and physically aggressive with staff and was placed in a PIA. __The facility records indicated the use of restraint for client F was not reported to BDDS within 24 hours. The 8/1/15 BDDS report indicated on 7/12/15 at 9:45 AM client F became verbally and physically aggressive with staff and was placed in a PIA. __The facility records indicated the use of restraint for client F was not reported to BDDS within 24 hours. The 8/1/15 BDDS report indicated on 7/19/15 at 6:40 PM client F became verbally and physically aggressive with			

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	staff and was placed in a PIA. __The facility records indicated the use of restraint for client F was not reported to BDDS within 24 hours. The 8/6/15 Bureau of Developmental Disabilities Services (BDDS) report indicated on 6/16/15 at 12 PM "[Client A] had a fall that caused him to be admitted into the hospital. The ER (Emergency Room) took a hip X-ray and discovered the ball of his (client A's) hip joint was broken and he would need surgery to repair it. After the surgery [client A] was admitted into a NF (Nursing Facility). [Client A] was admitted into the hospital then transferred to a nursing facility. [Client A] was discharged from Indiana Mentor's services on 6/16/15." __The report indicated date of knowledge of client A's health status was 6/16/15. The report indicated the change in client A's health and admission status was not reported to BDDS within 24 hours. Review of client A's, B's and C's General Events Reports (GERs) on 8/15/15 at 5 PM indicated the following incidents: On 1/5/15 at 6:13 PM: "Staff was in the bathroom assisting [client C]. Staff was standing in front of [client C] assisting him with pulling his pants down. While			

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	staff was doing so [client C] tried to turn and began to fall. Before staff was able to catch [client C] from his fall [client C] has (sic) shifted his weight towards the staff causing himself and staff to fall. Staff was able to position herself during the fall to catch [client C's] head and upper body." The report indicated a reddened area on client C's buttocks. __The facility records indicated no BDDS report. On 1/6/15 at 10:35 PM: "Staff was coming out of the office from clocking in. [Client C] was in the process of standing up. When he (client C) was getting up he fell and hit the right side of his body. He has a small cut above his right eye, scraps (sic) down his right side and his side on the right was red. [Client C] complained of pain and was given ibuprophen (sic) (a pain medication). After he (client C) fell he would not respond well to staff's questions. He (client C) was mumbling but staff could hardly understand him. Staff stayed with [client C] on the floor between his rocking chair and the table with a pillow under his head. We (the staff) kept talking to him until home manager arrived. When home manager talked to him he responded right away telling her he fell. After asking him a few questions she asked [client C] if he would like to			

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	get up. Staff assist (sic) [client C] from the floor to the rocking chair. [Client C] continued to answer HM's (Home Manager's) questions then stated he needed to use the bathroom. Three staff assist (sic) him to the restroom. [Client C] appeared to shuffle his right side and saying he hurt. [Client C] was checked over for further injuries. After using the bathroom [client C] was assisted in a recliner in the living room to sleep for the night. [Client C] agreed to sleep in the living room for tonight.... [Client C] cut his head right above his right eye." __The GER indicated the PD filed a report to BDDS. __No BDDS report was provided for review. On 1/7/15 at 6 PM: [Client C] was walking to the bathroom and staff noticed that [client C] was having a hard time walking on his right leg. He had a fall the previous night on that side. HM called the Nurse and was instructed to take [client C] to the ER to be evaluated. While at the ER [client C] had an X-Ray of his right hip, blood work, urinalysis, and a CT (Computerized Tomography - special X-ray tests that produce cross-sectional images of the human body using X-rays and a computer) scan of his head. All test came back normal. The PA (Physician's Assistant) stated that his			

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	(client C's) UTI appeared to be improving and his sodium levels had improved. He (client C) is to follow up with his PCP, which is 1/15/15." __The GER indicated the PD filed a report to BDDS. __No BDDS report was provided for review. On 1/12/15 at 3:15 PM: "[Client A] walking inside house and fell and bumped head slightly Small resulting in a scratch and small abrasion on forehead (sic)." __The GER indicated the PD filed a report to BDDS. __No BDDS report was provided for review. On 2/1/15 at 8:25 PM: "[Client A] was sweeping the kitchen floor. He fell and hit his head on the kitchen table. Staff rushed to help him into a chair. Once in the chair he leaned over to the side and started excessively drooling. This is when he began convulsing. Staff moved [client A] to the floor and held his head so that it didn't hit the floor. We also rolled him to his side. After the convulsing stopped [client A] was still unresponsive. He was not blinking and his eyes glazed completlely (sic) over. His face turned purple. Per the paramedics instructions staff did not do CPR. I (staff) was able to			

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	find a faint pulse. Paramedics took over at this point and he was taken to the hospital." __The GER indicated the PD filed a report to BDDS. __No BDDS report was provided for review. On 2/14/15 at 7:15 PM: "[Client A] had just finished his shower, shaved, and dressed. [Client A] told staff he needed to have a bm (bowel movement) and asked if he could have some privacy. Staff stepped outside the bathroom door and was waiting for [client A] to finish." The report indicated client A as a result of a fall, client A obtained a small scratch and red area on the middle left portion of his back. __The GER indicated the PD filed a report to BDDS. __No BDDS report was provided for review. On 4/5/15 at 2 AM: "[Client C] was trying to get out of bed and fell. When staff went to check on him he stumbled against the door. Staff assisted him to the restroom and checked him over for injuries. He has a large red area that appears to be bruising on his left hand above his thumb and a scrape on his left knee cap. At the time he did not appear to have any other injuries."			

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	__The facility records indicated no BDDS report. On 5/7/15 at 7:55 PM: "We (staff and clients) were on our way home from church, other behaviors were going on. At some point [client C] unbuckled his seat belt. Staff went to pull over to assist with the behaviors and [client C] slid off his seat onto his knees. Both his knees ended up skinned up. There was no blood. Staff cleaned the wound. No bandages were needed." __The facility records indicated no BDDS report. On 6/4/15 at 5:55 PM: "[Client C] had been sitting on the porch following dinner for about 20 minutes. He (client C) told the staff outside with him that he wanted to go inside because he was hot. Staff assisted [client C] with walking inside to the kitchen table. [Client C] sat down and was drinking coffee. A few minutes later staff noticed that [client C] had laid his head down on the table. Staff prompted [client C] four or five times asking if he was ok. [Client C] was unresponsive. Staff sat [client C] up and asked again if he was ok. He was still unresponsive. Staff noticed however that [client C] was drooling and was just staring straight ahead with his left eye squinted shut. Because [client C] has a			

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	seizure risk plan staff assisted [client C] to the floor. He was still unresponsive. Paramedics were called. By the time they got to the house, [client C] was saying that 'it hurts' 'side hurts' when paramedics asked what hurt [client C] told them his stomach. At the hospital he was diagnosed with Vasovagal Syncope (a sudden drop in heart rate and blood pressure causing a person to faint). He (client C) was discharged at 8:26 PM." __The facility records indicated no BDDS report. On 6/12/15 at 8 AM: "We (the staff) were driving down the road and [client B] took off her seatbelt and she feel (sic) onto the floor of the van. Both staff then helped up [client B] and began looking over her for any injuries. She (client B) had red mark from her right side of forehead to the side of her eye. Its (sic) was red at first and then disappeared after a little time. Home manager was called right away about this situation and staff had to keep reminding [client B] to keep her seat belt on the rest of way to Day Services." __The facility records indicated no BDDS report. On 6/30/15 at 10 PM: "[Client C] stood up to walk into the house and fell on his knees." The reported indicated client C			

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	scraped both knees. __The facility records indicated no BDDS report. On 7/11/15 at 3:30 PM: "[Client B] was being assisted walking into the home. She tripped over the threshold of the front door. Staff caught [client B] using her gait belt but she hit her arm on a rocking chair on the front porch. She had a bruise on her upper left arm. No other injuries was (sic) apparent at the time." __The facility records indicated no BDDS report. During interview with the AD (Area Director) on 8/13/15 at 12:50, the AD: __Indicated the facility followed the BDDS policy. __Indicated all falls with injury were to be reported to BDDS within 24 hours from the date of knowledge of the fall. __Indicated any major changes in health status of an individual and/or need of emergency services should be reported to BDDS within 24 hours of knowledge of the changes and/or emergency services. 9-3-1(b)			

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