STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G417	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 11/26/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REM-INDIANA INC	5625 E 56TH ST INDIANAPOLIS, IN 46226

(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
W0000	This visit was for the investigation of complaint #IN00117912. Complaint #IN00117912: Substantiated, Federal and state deficiencies related to the allegation(s) are cited at W102, W104, W122, W149, W153, W154, W157, W158, W159, W186, W189, W218, W318, W331 and W436. Dates of Survey: November 8, 9, 13, 14, 19, 20, 21, and 26, 2012. Facility Number: 000931 Provider Number: 15G417 AIM Number: 100244550 Surveyor: Susan Reichert, Medical Surveyor III The following federal deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 12/3/12 by Ruth Shackelford, Medical Surveyor III.	W0000		

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

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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W0102	483.410 GOVERNING BODY AND MANAGEMENT The facility must ensure that specific governing body and management requirements are met. Based on record review, observation and interview, the facility failed to meet the Condition of Participation: Governing Body. The governing body failed to provide oversight and direction to ensure implementation of their policy and procedures to protect 1 of 4 sampled clients (client A) by failing to report an incident resulting in significant injury, failed to provide timely assessment and treatment of an injury resulting in a fracture for 1 of 4 sampled clients (client A), failed to implement effective corrective action to protect client A from further injury by failing to ensure staff supervised him as indicated in his plan, failed to ensure a complete and thorough investigation, and failed to develop and implement a system to ensure wheelchairs were in good condition for 3 of 4 clients who used wheelchairs (clients A, C and D). Findings include: 1. Please see W122. The governing body failed to meet the Condition of Participation: Client Protections. The governing body failed to implement their	W0102	Program Director will retrain Home Manager on management oversight responsibilities including documentation review, observation requirements and staff scheduling to include ensuring supervision levels is adequate to the consumer needs. Program Director will retrain staff and Home Manager on incident reporting to include; what to report, when to report and how to report an incident. Program Director will retrain staff on documentation standards and requirements related to client falls and injury. Quality Assurance Director will retrain Quality Assurance Specialist on completing a thorough investigation to include interviewing call clients capable of being interviewed. Nursing Supervisor will retrain facility nurse on nursing responsibilities to include assessments and treatment of clients following an incident. Facility Nurse will assess all wheelchairs in the home to determine need for repairs. Ongoing, facility nurse will assess clients' wheelchairs during quarterly reviews. Responsible Party: Area Director, Program Director, Nursing Supervisor, Facility Nurse	12/26/2012

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	policy and procedures to protect client A by failing to report an incident resulting in significant injury, failed to provide timely assessment and treatment of an injury resulting in a fracture for 1 of 4 sampled clients (client A), failed to implement effective corrective action to protect client A from further injury by failing to ensure staff supervised him as indicated in his plan, failed to ensure a complete and thorough investigation, and failed to develop and implement a system to ensure wheelchairs were in good condition for 3 of 4 clients who used wheelchairs (clients A, C and D). 2. Please see W104. The governing body failed to provide oversight and direction to provide timely medical assessment and treatment of an injury resulting in fracture for 1 of 4 sampled clients (client A), failed to implement effective corrective action to prevent future injury for client A, failed to ensure a complete and thorough investigation, and failed to develop a system to ensure adaptive equipment was in good working condition for 3 of 4 clients who used wheelchairs for mobility (clients A, C and D). 3. Please see W158. The governing body failed to meet the Condition of Participation: Facility Staffing. The governing body failed to provide trained			

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	staff to implement the supervision and health care needs of 3 of 4 sampled clients (clients A, C and D). 3. Please see W318. The governing body failed to meet the Condition of Participation: Health Care Services. The facility failed to provide timely assessment and treatment of an injury resulting in fracture for 1 of 3 sampled clients (client A), failed to ensure implementation of client supervision level to prevent future injury, failed to timely assess 3 of 4 sampled clients' (A, C and D) wheelchairs to ensure they met clients' identified needs for mobility, and failed to ensure adaptive equipment for mobility was in good working condition. This federal tag relates to complaint #IN00117912. 9-3-1(a)			

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W0104	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, the governing body failed to provide oversight and direction to ensure implementation of their policy and procedures to protect client A by failing to report an incident resulting in significant injury, failed to provide timely assessment and treatment of an injury resulting in a fracture for 1 of 4 sampled clients (client A), failed to implement effective corrective action to protect client A from further injury by failing to ensure staff supervised him as indicated in his plan, failed to ensure a complete and thorough investigation, and failed to develop and implement a system to ensure wheelchairs were in good condition for 3 of 4 clients who used wheelchairs (clients A, C and D). Findings include: Observations were completed at the group home on 11/8/12 from 5:00 PM until 6:09 PM. Client A was in the dining room in a wheelchair with a cast on his right foot and a sock covering his right toe. A sign on a white board in the dining room indicated, "[Client A] must be in sight of	W0104	Program Director will hold an IDT meeting for client A to determine adequate supervision level required to meet his needs. Program Director will retrain Home Manager on management oversight responsibilities including documentation review, observation requirements and staff scheduling to include ensuring supervision levels is adequate to the consumer needs. Program Director will retrain staff and Home Manager on incident reporting to include; what to report, when to report and how to report an incident. Program Director will retrain staff on clients current supervision levels, documentation standards and requirements related to client falls and injury. Quality Assurance Director will retrain Quality Assurance Specialist on completing a thorough investigation to include interviewing call clients capable of being interviewed. Nursing Supervisor will retrain facility nurse on nursing	12/26/2012

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	staff at all times when awake." From 5:11 PM until 5:14 PM there was no staff within eyesight of client A. Staff #1 and #2 were in other areas of the house. From 5:20 PM until 5:21 PM staff were not within eyesight of client A. Clients C and D came home from day services at 6:00 PM. Client C's wheelchair did not have a left foot rest. Client C demonstrated that his brakes didn't work, and indicated the nurse was going to get a new chair for him. Client D's wheelchair was missing the right arm rest, and the left arm rest was not cushioned. Neither client's wheelchair had seat cushions. Client A was interviewed on 11/8/12 at 5:05 PM. When asked about his broken foot, he gestured that he fell out of the wheelchair after he unbuckled his seatbelt and he reached forward toward the floor. He indicated his nose and foot hurt. Staff #4 was interviewed on 11/8/12 at 5:30 PM. She indicated she had been with client A on the van when his foot was caught in the wheel. She stated, "At the time, his foot pedals weren't all that great and his foot kept slipping off." She indicated the incident happened about a month ago, and client A didn't complain of pain once it was discovered his foot was caught and it was freed from the wheel. She stated the nurse was not		responsibilities to include assessments and treatment of clients following an incident and providing adequate assessment of adaptive equipment. Facility Nurse will assess all wheelchairs in the home to determine need for repairs. Ongoing, facility nurse will assess clients' wheelchairs during quarterly reviews. Home Manager and Program Director will complete observations twice weekly for the next 4 weeks to ensure staff is meeting supervision levels. Responsible Party: Area Director, Program Director, Nursing Supervisor, Facility Nurse, Quality Assurance Director	

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	notified of the incident and it was "charted." She indicated client A had a fall risk plan. Client A's records in the group home were reviewed on 11/8/12 at 5:36 PM. The records indicated client A had a history of falls, a diagnosis of osteoporosis and had fallen on 8/10/12 previously. An updated fall risk plan dated 10/12 indicated client A was to keep his feet in view while propelling his wheelchair. A High Risk for Fracture protocol dated 10/15/12 indicated staff were to assess client A's skin daily, report bruising to the RN, report complaints of pain, propel wheelchair slowly and use caution through doorways and on the van. Client A was interviewed again on 11/8/12 at 5:41 PM and indicated his foot rests were better now. Staff #4 was interviewed again on 11/8/12 at 5:44 PM. She stated client A's wheelchair fit him "100 percent" better after client A's wheelchair had been evaluated. She indicated the wheelchair had been repaired the same day it was evaluated. She indicated she was unsure of when the nurse was called to evaluate client A's foot after it was caught in the wheel as she was not on duty when the nurse was notified.			

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	The facility's reportable incidents to the Bureau of Developmental Disabilities Services (BDDS) were reviewed on 11/9/12 at 11:16 AM. A report dated 10/10/12 indicated on 10/3/12 staff had noticed client A's right ankle was swollen. The nurse was called. Client A denied pain. Client A's nurse assessed his ankle on 10/5/12 and client A continued to deny pain. On 10/7/12, staff called the nurse again and stated his right foot now looked swollen. Client A was taken to an urgent clinic on 10/10/12 which indicated he has "several" broken bones in his foot. Client A was placed in a protective boot and taken to see an orthopaedic doctor on 10/12/12. The report indicated client A was going to have his wheelchair evaluated. A follow up report dated 10/17/12 indicated an initial investigation "found on 10/1/12, [client A's] right foot was caught between his foot plate and the wheel. During the trip home client A started cussing and shouting, and the van driver pulled over to see why [client A] was cursing. It was at that instance it was found that his foot was caught. Staff removed his foot from area and placed his foot on foot rest properly. Staff asked [client A] if he was feeling any pain and [client A] said NO. Staff documented the incident in the DSR (daily support record) book and told staff on shift to follow up			

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	with his foot later to check for swelling. Investigation is ongoing...Training was held on 10/12/12 on Wheelchair safety, RC fall protocol, and line of sight...Indiana Mentor will continue to follow and monitor [client A's] health and safety needs." An attached investigation dated 10/17/12 into the fracture attached to the above BDDS report was reviewed on 11/9/12 at 11:16 AM. The investigation indicated on 10/10/12, client A was diagnosed with a broken foot with no known cause. Interview with the nurse indicated client A was assessed by the nurse on 10/3/12 following a report it was swollen and slight swelling was observed in his right ankle. Client A denied pain and did not display pain when his ankle was moved. On 10/7/12, the nurse received a message client A's ankle was still swollen and on 10/9/12 the nurse received a report client A's foot was swollen and discolored. He would be assessed at [medical clinic] on 10/10/12, and was diagnosed with 2 metatarsal fractures. On 10/15/12, the nurse received a report client A's foot had become lodged during transport. The nurse indicated client A's "wheelchair does not meet the physical shape of his body because of the severe kyphosis (large hump on his back)." Interview with staff #10 indicated on 10/1/12, he			

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	and staff #4 had completed the afternoon transport for the group home and during the transport client A began cursing. Staff #10 found client A's foot lodged between the footplate and wheel with the footplate sitting on top of his foot. Staff #10 freed client A's foot and assessed it upon return to the group home with no injuries noted and no signs or symptoms of pain/injury displayed by client A. Staff #4 was interviewed and indicated a similar account as staff #10. She indicated "she did not report this to anyone...because she was working that evening and because she was working Monday through Friday and she could monitor [client A]." She indicated she contacted the group home nurse on 10/7/12 while she assisted him with bathing when she noticed bruising and swelling on client A's foot. The nurse indicated she would assess him on 10/7/12. The conclusion indicated "Evidence supports [client A] likely sustained the break on 10/1/12 when foot became lodged. Evidence supports the incident was not reported to anyone in order for [client A] to receive appropriate monitoring for injury." The Area Director #1 was interviewed on 11/9/12 at 11:15 AM. She indicated the failure to obtain medical attention for client A until 10/10/12 was a delay in			

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	treatment. She indicated staff who witnessed the incident on the van on 10/1/12 reported the incident in daily notes, but failed to document it in incident reports. Staff did not report the incident to the nurse because client A did not complain of pain after the incident. She was uncertain if client A was to be within eyesight and indicated the Qualified Mental Retardation Professional (QMRP) had recently left her position and the Area Director was assuming her duties until a new QMRP was hired. She indicated she would check with the house manager to determine client A's current supervision needs and an interdisciplinary team (IDT) meeting would have been held to discontinue the supervision level established after client A's fracture. She indicated staff should have kept client A within eyesight if the line of sight supervision level had not been discontinued. She was uncertain as to the cause of the delay in nursing assessments for client A after the initial nursing assessment on 10/3/12 after swelling was noted on 10/3/12 and medical treatment on 10/10/12 which revealed the fractures in his right foot. She indicated staff had been retrained on reporting and the nurse on assessment requirements. The group home nurse was interviewed on 11/9/12 at 11:50 AM. She indicated			

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	client A's wheelchair had been evaluated and adjusted since his fracture and stated, "It fits him a lot better, including the footrests." When asked about the nursing assessment of client A's foot, she indicated she was unaware of the incident on 10/1/12 and had been unaware of an issue with client A's foot pedals until after he was diagnosed with a fracture. She indicated there was not a system or schedule to evaluate wheelchairs to ensure they were in good condition, and stated, "It would be a good idea to have a monthly inspection to let me know right away if there is a problem." She indicated client C had never had footrests on his wheelchair and self propels himself. She indicated client D's footrests for his wheelchair were in the closet and had an evaluation scheduled for 11/14/12. She indicated client D had another wheelchair, but his family had switched it to the current chair at their request. She indicated client wheelchairs should have arm rests and she would check on seat cushions for clients C and D as not all wheelchairs had cushions. When asked if client A had been assessed by a nurse between 10/3/12 and his visit to the medical clinic on 10/10/12, she stated, "I didn't," and indicated she did not assess client A after being notified of swelling on 10/7/12. She indicated she had assessed his ankle on 10/3/12, but had not			

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	assessed client A's foot since she was unaware of the incident on 10/1/12. She stated client A was taken to the medical clinic on 10/10/12 after staff notified her on 10/9/12 of client A's swelling because "We didn't know there was a cause," and "I had no idea it was a fracture." She indicated she referred client A to the medical clinic as it was less expensive than a hospital examination, and she thought client A had possibly developed edema from a medical cause. She was unaware if client A was to be kept within eyesight to protect him from additional injury. The group home nurses notes regarding client A for October, 2012 were reviewed on 11/9/12 at 2:30 PM. A note dated 10/3/12 indicated "staff called and said ankle has edema. Saw sl(slight) edema in R (right ankle). [Client A] denies pain." On 10/7/12 an entry indicated, "Staff left message about [client A's] ankle." On 10/9/12 an entry indicated "Staff called R foot swollen and discolored. They will take [client A] to [medical clinic] in AM." An entry dated 10/10/12 indicated client A was found with 2 metatarsal fractures in his right foot. There was no evidence of a nursing assessment in the notes from 10/3/12 to 10/10/12. A note dated 10/15/12 indicated client A's fall prevention protocol was updated, and a			

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	high risk for fracture protocol was developed and sent to the PD (program director). A 10/16/12 indicated client A's wheelchair was evaluated and repairs made to the chair were completed and the depth of the seat adjusted so client A's feet "fit in foot peddles (sic) more easily." Client A's DSR for October, 2012 was reviewed on 11/9/12 at 2:15 PM. A note written by staff #5 from 2:00 to 10:00 PM dated 10/1/12 indicated "No behaviors to report." A note written by staff #10 from 2:03 PM to 6:03 PM indicated client A had returned home "and moved about. Had meds (medications) and meals given. Resident needed some extra prompts. Over all no behavior problems. Good day compliant." A note written by staff #1 dated 10/1/12 from 4:00 PM until 10:00 PM indicated "Had dinner and went to his room-in bed." There was no record provided to review that indicated the incident with client A's foot being caught between his wheelchair pedal and the wheel on 10/1/12 was documented. Staff #1 was interviewed on 11/9/12 at 2:00 PM and indicated client A was to be kept within eyesight at all times. Internal incident reports for the time period of Oct, 2012 were reviewed on 11/13/12 at 9:06 AM. There was no			

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	evidence of a report of an injury or incident involving client A's foot. The Area Director #1 was interviewed on 11/19/12 at 2:30 PM and indicated she had checked with the house manager and the house manager had indicated staff were supposed to keep client A within eyesight at all times to prevent other falls and provide assistance to client A. When asked if there had been further incidents involving client A, she indicated client A had fallen out of his wheelchair on 11/18/12 and had been taken to the ER (emergency room) for evaluation and released without finding of injury. She was uncertain if client A's supervision level had been implemented and indicated the incident was under investigation. She further indicated corrective action had been taken to ensure adequate staffing levels were in the home and an interdisciplinary team meeting would be held this week to evaluate client A's needs. A BDDS report dated 11/18/12 was reviewed on 11/20/12 at 8:11 AM. The report indicated staff was helping another client and client A rolled into the bathroom and fell out of his wheelchair. A draft summary of the internal investigation report dated 11/21/12 was			

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	reviewed on 11/26/12 at 12:30 PM. The background information indicated client A was placed on line of sight supervision level following the diagnosis of his broken foot. The on-call supervisor for 11/18/12 indicated he received a call from staff #1 reporting the staff scheduled to work with her had not reported for her shift. 5 minutes after receiving the call he received another call from staff #1 reporting client A had fallen in the bathroom and she was physically unable to assist him up from the floor. The on-call supervisor called staff #11 from another group home to assist and client A was taken to the hospital to evaluate him for injury and released without findings. The on call staff indicated client A was on the floor for 10-15 minutes. Staff #1 indicated the house manager left staff #1 in the home and indicated staff #1 was to call the on call supervisor if staff did not arrive within 15 minutes. She called the on call supervisor and started preparing dinner. Client A was in the living room watching television at this time. "About" 5 minutes later she heard client A cussing and found client A on the floor in a fetal position. Staff #1 contacted the nurse and stayed with client A until staff #11 arrived to assist. She indicated she thought client A was on the floor 15-30 minutes and it "appeared [client A] fell when he attempted to get up after using the			

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	bathroom because there was feces in the toilet." The house manager indicated she had trained staff on wheelchair safety on 10/12/12 to include remaining in sight of client A when he is up and to assist with transferring. She placed a note on the white board reminding staff client A was to be in line of sight at all times. She indicated the QMRP (Qualified Mental Retardation Professional)/PD (Program Director) had indicated to the house manager the protocol was to be in place for a few weeks, but did not provide a specific end date. She indicated there was no IDT to discuss the changes in the plan implemented on 10/12/12. The conclusion of the investigation indicated client A fell when he attempted to get up from the toilet and "evidence supports" he was not provided with line of sight supervision. There was no evidence client A was interviewed as part of the investigation. The Area Director #2 was interviewed on 11/26/12 at 2:41 PM and indicated there were not enough staff to supervise client A to meet his supervision needs when he fell on 11/18/12, and stated client A had not been interviewed as part of the investigation because of his "inability to effectively communicate." This federal tag relates to complaint			

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W0122	483.420 CLIENT PROTECTIONS The facility must ensure that specific client protections requirements are met. Based on observation, interview and record review, the facility failed to meet the Condition of Participation: Client Protections. The facility failed to ensure implementation of their policy and procedures to protect 1 of 4 sampled clients (client A) by failing to report an incident resulting in significant injury, failed to provide timely assessment and treatment of an injury resulting in a fracture for 1 of 4 sampled clients (client A), failed to implement effective corrective action to protect client A from further injury by failing to ensure staff supervised him as indicated in his plan, failed to ensure a complete and thorough investigation, and failed to develop and implement a system to ensure wheelchairs were in good condition for 3 of 4 clients who used wheelchairs (clients A, C and D). Findings include: 1. Please see W149. The facility failed to implement their policy and procedures to protect client A by failing to report an incident resulting in significant injury, failed to provide timely assessment and treatment of an injury resulting in a fracture for 1 of 4 sampled clients (client	W0122	Program Director will retrain Home Manager on management oversight responsibilities including documentation review, observation requirements and staff scheduling to include ensuring supervision levels is adequate to the consumer needs. Program Director will retrain staff and Home Manager on incident reporting to include; what to report, when to report and how to report an incident. Program Director will retrain staff on clients current supervision levels, documentation standards and requirements related to client falls and injury Nursing Supervisor will retrain facility nurse on nursing responsibilities to include assessments and treatment of clients following an incident and providing adequate assessment of adaptive equipment. Facility Nurse will assess all wheelchairs in the home to determine need for repairs. Ongoing, facility nurse will assess clients' wheelchairs during quarterly reviews.	12/26/2012

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	A), failed to implement effective corrective action to protect client A from further injury by failing to ensure staff supervised him as indicated in his plan, and failed to develop and implement a system to ensure wheelchairs were in good condition for 3 of 4 clients who used wheelchairs (clients A, C and D). 2. Please see W153. The facility failed to report an allegation of neglect for 1 of 4 sampled clients (client A) by failing to report an injury resulting in fracture. 3. Please see W157. The facility failed to implement effective corrective action to protect client A from further injury by failing to ensure staff supervised him as indicated in his plan, and failed to develop and implement a system to ensure wheelchairs were in good condition for 3 of 4 clients who used wheelchairs (clients A, C and D). 4. Please see W189. The facility failed to ensure staff were sufficiently trained to follow procedures to report injuries timely and failed to implement 1 of 4 sampled client's (client A) supervision level to protect him from further fractures. This federal tag relates to complaint #IN00117912.		Home Manager and Program Director will complete observations twice weekly for the next 4 weeks to ensure adequate staffing support is provided and staff is meeting supervision levels. Responsible Party: Area Director, Program Director, Nursing Supervisor, Facility Nurse	

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W0149	483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. Based on observation, interview and record review, the facility failed to implement their policy and procedures to protect client A by failing to report an incident resulting in fracture, failed to provide timely assessment and treatment of an injury resulting in a fracture for 1 of 4 sampled clients (client A), failed to implement effective corrective action to protect client A from further injury by failing to ensure staff supervised him as indicated in his plan, failed to ensure a complete and thorough investigation, and failed to develop and implement a system to ensure wheelchairs were in good condition for 3 of 4 clients who used wheelchairs (clients A, C and D). Findings include: Observations were completed at the group home on 11/8/12 from 5:00 PM until 6:09 PM. Client A was in the dining room in a wheelchair with a cast on his right foot and a sock covering his right toe. A sign on a white board in the dining room indicated, "[Client A] must be in sight of staff at all times when awake." From 5:11 PM until 5:14 PM there was no staff	W0149	Program Director will hold an IDT meeting for client A to determine adequate supervision level required to meet his needs. Director will hold an IDT meeting for client A to determine adequate supervision level and needs. Program Director will retrain Home Manager on management oversight responsibilities including documentation review, observation requirements and staff scheduling to include ensuring supervision levels is adequate to the consumer needs. Program Director will retrain staff and Home Manager on incident reporting to include; what to report, when to report and how to report an incident. Program Director will retrain staff on clients current supervision levels, documentation standards and requirements related to client falls and injury. Quality Assurance Director will retrain Quality Assurance Specialist on completing a thorough investigation to include interviewing call clients capable of being	12/26/2012

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	within eyesight of client A. Staff #1 and #2 were in other areas of the house. From 5:20 PM until 5:21 PM staff were not within eyesight of client A. Clients C and D came home from day services at 6:00 PM. Client C's wheelchair did not have a left foot rest. Client C demonstrated that his brakes didn't work, and indicated the nurse was going to get a new chair for him. Client D's wheelchair was missing the right arm rest, and the left arm rest was not cushioned. Neither clients' wheelchairs had seat cushions. Client A was interviewed on 11/8/12 at 5:05 PM. When asked about his broken foot, he gestured that he fell out of the wheelchair after he unbuckled his seatbelt and he reached forward toward the floor. He indicated his nose and foot hurt. Staff #4 was interviewed on 11/8/12 at 5:30 PM. She indicated she had been with client A on the van when his foot was caught in the wheel. She stated, "At the time, his foot pedals weren't all that great and his foot kept slipping off." She indicated the incident happened about a month ago, and client A didn't complain of pain once it was discovered his foot was caught and it was freed from the wheel. She stated the nurse was not notified of the incident and it was "charted." She indicated client A had a		interviewed. Nursing Supervisor will retrain facility nurse on nursing responsibilities to include assessments and treatment of clients following an incident and providing adequate assessment of adaptive equipment. Facility Nurse will assess all wheelchairs in the home to determine need for repairs. Ongoing, facility nurse will assess clients' wheelchairs during quarterly reviews. Home Manager and Program Director will complete observations twice weekly for the next 4 weeks to ensure adequate staffing support is provided and staff is meeting supervision levels. Responsible Party: Area Director, Program Director, Nursing Supervisor, Facility Nurse, Quality Assurance Director	

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	fall risk plan. Client A's records in the group home were reviewed on 11/8/12 at 5:36 PM. The records indicated client A had a history of falls, a diagnosis of osteoporosis and had fallen on 8/10/12 previously. An updated fall risk plan dated 10/12 indicated client A was to keep his feet in view while propelling his wheelchair. A High Risk for Fracture protocol dated 10/15/12 indicated staff were to assess client A's skin daily, report bruising to the RN, report complaints of pain, propel wheelchair slowly and use caution through doorways and on the van. Client A was interviewed again on 11/8/12 at 5:41 PM and indicated his foot rests were better now. Staff #4 was interviewed again on 11/8/12 at 5:44 PM. She stated client A's wheelchair fit him "100 percent" better after client A's wheelchair had been evaluated. She indicated the wheelchair had been repaired the same day it was evaluated. She indicated she was unsure of when the nurse was called to evaluate client A's foot after it was caught in the wheel as she was not on duty when the nurse was notified. The facility's reportable incidents to the			

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	Bureau of Developmental Disabilities Services (BDDS) were reviewed on 11/9/12 at 11:16 AM. A report dated 10/10/12 indicated on 10/3/12 staff had noticed client A's right ankle was swollen. The nurse was called. Client A denied pain. Client A's nurse assessed his ankle on 10/5/12 and client A continued to deny pain. On 10/7/12, staff called the nurse again and stated his right foot now looked swollen. Client A was taken to an urgent clinic on 10/10/12 which indicated he has "several" broken bones in his foot. Client A was placed in a protective boot and taken to see an orthopaedic doctor on 10/12/12. The report indicated client A was going to have his wheelchair evaluated. A follow up report dated 10/17/12 indicated an initial investigation "found on 10/1/12, [client A's] right foot was caught between his foot plate and the wheel. During the trip home client A started cussing and shouting, and the van driver pulled over to see why [client A] was cursing. It was at that instance it was found that his foot was caught. Staff removed his foot from area and placed his foot on foot rest properly. Staff asked [client A] if he was feeling any pain and [client A] said NO. Staff documented the incident in the DSR (daily support record) book and told staff on shift to follow up with his foot later to check for swelling. Investigation is ongoing...Training was			

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	held on 10/12/12 on Wheelchair safety, RC fall protocol, and line of sight...Indiana Mentor will continue to follow and monitor [client A's] health and safety needs." An attached investigation dated 10/17/12 into the fracture attached to the above BDDS report was reviewed on 11/9/12 at 11:16 AM. The investigation indicated on 10/10/12, client A was diagnosed with a broken foot with no known cause. Interview with the nurse indicated client A was assessed by the nurse on 10/3/12 following a report it was swollen and slight swelling was observed in his right ankle. Client A denied pain and did not display pain when his ankle was moved. On 10/7/12, the nurse received a message client A's ankle was still swollen and on 10/9/12 the nurse received a report client A's foot was swollen and discolored. He would be assessed at [medical clinic] on 10/10/12, and was diagnosed with 2 metatarsal fractures. On 10/15/12, the nurse received a report client A's foot had become lodged during transport. The nurse indicated client A's "wheelchair does not meet the physical shape of his body because of the severe kyphosis (large hump on his back)." Interview with staff #10 indicated on 10/1/12, he and staff #4 had completed the afternoon transport for the group home and during			

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	the transport client A began cursing. Staff #10 found client A's foot lodged between the footplate and wheel with the footplate sitting on top of his foot. Staff #10 freed client A's foot and assessed it upon return to the group home with no injuries noted and no signs or symptoms of pain/injury displayed by client A. Staff #4 was interviewed and indicated a similar account as staff #10. She indicated "she did not report this to anyone...because she was working that evening and because she was working Monday through Friday and she could monitor [client A]." She indicated she contacted the group home nurse on 10/7/12 while she assisted him with bathing when she noticed bruising and swelling on client A's foot. The nurse indicated she would assess him on 10/7/12. The conclusion indicated "Evidence supports [client A] likely sustained the break on 10/1/12 when foot became lodged. Evidence supports the incident was not reported to anyone in order for [client A] to receive appropriate monitoring for injury." The Area Director #1 was interviewed on 11/9/12 at 11:15 AM. She indicated the failure to obtain medical attention for client A until 10/10/12 was a delay in treatment. She indicated staff who witnessed the incident on the van on			

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	10/1/12 reported the incident in daily notes, but failed to document it in incident reports. Staff did not report the incident to the nurse because client A did not complain of pain after the incident. She was uncertain if client A was to be within eyesight and indicated the Qualified Mental Retardation Professional (QMRP) had recently left her position and the Area Director was assuming her duties until a new QMRP was hired. She indicated she would check with the house manager to determine client A's current supervision needs and an interdisciplinary team (IDT) meeting would have been held to discontinue the supervision level established after client A's fracture. She indicated staff should have kept client A within eyesight if the line of sight supervision level had not been discontinued. She was uncertain as to the cause of the delay in nursing assessments for client A after the initial nursing assessment on 10/3/12 after swelling was noted on 10/3/12 and medical treatment on 10/10/12 which revealed the fractures in his right foot. She indicated staff had been retrained on reporting and the nurse on assessment requirements. The group home nurse was interviewed on 11/9/12 at 11:50 AM. She indicated client A's wheelchair had been evaluated and adjusted since his fracture and stated,			

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	"It fits him a lot better, including the footrests." When asked about the nursing assessment of client A's foot, she indicated she was unaware of the incident on 10/1/12 and had been unaware of an issue with client A's foot pedals until after he was diagnosed with a fracture. She indicated there was not a system or schedule to evaluate wheelchairs to ensure they were in good condition, and stated, "It would be a good idea to have a monthly inspection to let me know right away if there is a problem." She indicated client C had never had footrests on his wheelchair and self propels himself. She indicated client D's footrests for his wheelchair were in the closet and had an evaluation scheduled for 11/14/12. She indicated client D had another wheelchair, but his family had switched it to the current chair at their request. She indicated client wheelchairs should have arm rests and she would check on seat cushions for clients C and D as not all wheelchairs had cushions. When asked if client A had been assessed by a nurse between 10/3/12 and his visit to the medical clinic on 10/10/12, she stated, "I didn't," and indicated she did not assess client A after being notified of swelling on 10/7/12. She indicated she had assessed his ankle on 10/3/12, but had not assessed client A's foot since she was unaware of the incident on 10/1/12. She			

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	stated client A was taken to the medical clinic on 10/10/12 after staff notified her on 10/9/12 of client A's swelling because "We didn't know there was a cause," and "I had no idea it was a fracture." She indicated she referred client A to the medical clinic as it was less expensive than a hospital examination, and she thought client A had possibly developed edema from a medical cause. She was unaware if client A was to be kept within eyesight to protect him from additional injury. The group home nurses notes regarding client A for October, 2012 were reviewed on 11/9/12 at 2:30 PM. A note dated 10/3/12 indicated "staff called and said ankle has edema. Saw sl(slight) edema in R (right ankle). [Client A] denies pain." On 10/7/12 an entry indicated, "Staff left message about [client A's] ankle." On 10/9/12 an entry indicated "Staff called R foot swollen and discolored. They will take [client A] to [medical clinic] in AM." An entry dated 10/10/12 indicated client A was found with 2 metatarsal fractures in his right foot. There was no evidence of a nursing assessment in the notes from 10/3/12 to 10/10/12. A note dated 10/15/12 indicated client A's fall prevention protocol was updated, and a high risk for fracture protocol was developed and sent to the PD (program			

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	director). A 10/16/12 indicated client A's wheelchair was evaluated and repairs made to the chair were completed and the depth of the seat adjusted so client A's feet "fit in foot peddles (sic) more easily." Client A's DSR for October, 2012 was reviewed on 11/9/12 at 2:15 PM. A note written by staff #5 from 2:00 to 10:00 PM dated 10/1/12 indicated "No behaviors to report." A note written by staff #10 from 2:03 PM to 6:03 PM indicated client A had returned home "and moved about. Had meds (medications) and meals given. Resident needed some extra prompts. Over all no behavior problems. Good day compliant." A note written by staff #1 dated 10/1/12 from 4:00 PM until 10:00 PM indicated "Had dinner and went to his room-in bed." There was no record provided to review that indicated the incident with client A's foot being caught between his wheelchair pedal and the wheel on 10/1/12 was documented. Staff #1 was interviewed on 11/9/12 at 2:00 PM and indicated client A was to be kept within eyesight at all times. Internal incident reports for the time period of Oct, 2012 were reviewed on 11/13/12 at 9:06 AM. There was no evidence of a report of an injury or incident involving client A's foot.			

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	The Area Director #1 was interviewed on 11/19/12 at 2:30 PM and indicated she had checked with the house manager and the house manager had indicated staff were supposed to keep client A within eyesight at all times to prevent other falls and provide assistance to client A. When asked if there had been further incidents involving client A, she indicated client A had fallen out of his wheelchair on 11/18/12 and had been taken to the ER (emergency room) for evaluation and released without finding of injury. She was uncertain if client A's supervision level had been implemented and indicated the incident was under investigation. She further indicated corrective action had been taken to ensure adequate staffing levels were in the home and an interdisciplinary team meeting would be held this week to evaluate client A's needs. A BDDS report dated 11/18/12 was reviewed on 11/20/12 at 8:11 AM. The report indicated staff was helping another client and client A rolled into the bathroom and fell out of his wheelchair. A draft summary of the internal investigation report dated 11/21/12 was reviewed on 11/26/12 at 12:30 PM. The background information indicated client			

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	A was placed on line of sight supervision level following the diagnosis of his broken foot. The on-call supervisor 11/18/12 indicated he received a call from staff 1 reporting the staff scheduled to work with her had not reported for her shift. 5 minutes after receiving the call he received another call from staff #1 reporting client A had fallen in the bathroom and she was physically unable to assist him up from the floor. The on-call supervisor called staff #11 from another group home to assist and client A was taken to the hospital to evaluate him for injury and released without findings. The on call staff indicated client A was on the floor for 10-15 minutes. Staff #1 indicated the house manager left staff #1 in the home and indicated staff #1 was to call the on call supervisor if staff did not arrive within 15 minutes. She called the on call supervisor and started preparing dinner. Client A was in the living room watching television at this time. "About" 5 minutes later she heard client A cussing and found client A on the floor in a fetal position. Staff #1 contacted the nurse and stayed with client A until staff #11 arrived to assist. She indicated she thought client A was on the floor 15-30 minutes and it "appeared [client A] fell when he attempted to get up after using the bathroom because there was feces in the toilet." The house manager indicated she			

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	had trained staff on wheelchair safety on 10/12/12 to include remaining in sight of client A when he is up and to assist with transferring. She placed a note on the white board reminding staff client A was to be in line of sight at all times. She indicated the QMRP (Qualified Mental Retardation Professional)/PD (Program Director) had indicated to the house manager the protocol was to be in place for a few weeks, but did not provide a specific end date. She indicated there was no IDT to discuss the changes in the plan implemented on 10/12/12. The conclusion of the investigation indicated client A fell when he attempted to get up from the toilet and "evidence supports" he was not provided with line of sight supervision. There was no evidence client A was interviewed as part of the investigation. The Area Director #2 was interviewed on 11/26/12 at 2:41 PM and indicated there were not enough staff to supervise client A to meet his supervision needs when he fell on 11/18/12, and stated client A had not been interviewed as part of the investigation because of his "inability to effectively communicate." The facility's Quality and Risk Management policy dated April, 2011 was reviewed on 11/9/12 at 11:30 AM			

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	and indicated, "Indiana MENTOR promotes a high quality of service and seeks to protect individuals receiving Indiana MENTOR services through oversight of management procedures and company operations, close monitoring of service delivery and through a process identifying, evaluating and reducing risk to which individuals are exposed." Incidents reported to BDDS included, "Alleged, suspected, or actual abuse, neglect, or exploitation of an individual...Failure to provide appropriate supervision, care or training...A significant injury to an individual, including: a fracture." This federal tag relates to complaint #IN00117912. 9-3-2(a)			

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W0153	483.420(d)(2) STAFF TREATMENT OF CLIENTS The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures. Based on observation, interview and record review for 1 of 4 sampled clients (client A), the facility failed to immediately report an incident resulting in significant injury/allegation of neglect (fracture) to the Bureau of Developmental Disabilities Services (BDDS) and the administrator in accordance with state law. Findings include: Staff #4 was interviewed on 11/8/12 at 5:30 PM. She indicated she had been with client A on the van when his foot was caught in in the wheel. She stated, "At the time, his foot pedals weren't all that great and his foot kept slipping off." She indicated the incident happened about a month ago, and client A didn't complain of pain once it was discovered his foot was caught and it was freed from the wheel. She stated the nurse was not notified of the incident and it was "charted."	W0153	Program Director will retrain Home Manager on management oversight responsibilities including documentation review, observation requirements and staff scheduling to include ensuring supervision levels is adequate to the consumer needs. Program Director will retrain staff and Home Manager on incident reporting to include; what to report, when to report and how to report an incident. Program Director will retrain staff on clients current supervision levels, documentation standards and requirements related to client falls and injury. Home Manager will complete documentation review twice weekly to include daily support records, med administration records and incident forms to ensure adequate documentations of incidents and that all incidents have been reported. Responsible Party: Program Director, Home Manager	12/26/2012

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	Staff #4 was interviewed again on 11/8/12 at 5:44 PM. She indicated she was unsure of when the nurse was called to evaluate client A's foot after it was caught in the wheel as she was not on duty that day. The facility's reportable incidents to BDDS were reviewed on 11/9/12 at 11:16 AM. A report dated 10/10/12 indicated on 10/3/12 staff had noticed client A's right ankle was swollen. The nurse was called. Client A denied pain. Client A's nurse assessed his ankle on 10/5/12 and client A continued to deny pain. On 10/7/12, staff called the nurse again and stated his right foot now looked swollen. Client A was taken to an urgent clinic on 10/10/12 which indicated he has "several" broken bones in his foot. Client A was placed in a protective boot and taken to see an orthopaedic doctor on 10/12/12. The report indicated client A was going to have his wheelchair evaluated. A follow up report dated 10/17/12 indicated an initial investigation "found on 10/1/12, [client A's] right foot was caught between his foot plate and the wheel. During the trip home client A started cussing and shouting, and the van driver pulled to see why [client A] was cursing. It was at that instance it was found that his foot was caught. Staff removed his foot from area and placed his foot on foot rest properly. Staff asked [client A] if he was feeling			

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	any pain and [client A] said NO. Staff documented the incident in the DSR (daily support record) book and told staff on shift to follow up with his foot later to check for swelling. Investigation is ongoing...Training was held on 10/12/12 on Wheelchair safety, RC fall protocol, and line of sight...Indiana Mentor will continue to follow and monitor [client A's] health and safety needs." An attached investigation dated 10/17/12 into the fracture attached to the above BDDS report was reviewed on 11/9/12 at 11:16 AM indicated on 10/10/12, client A was diagnosed with a broken foot with no known cause. Interview with the nurse indicated client A was assessed by the nurse on 10/3/12 following a report it was swollen and slight swelling was observed in his right ankle. Client A denied pain and did not display pain when his ankle was moved. On 10/7/12, the nurse received a message client A's ankle was still swollen and on 10/9/12 the nurse received a report client A's foot was swollen and discolored. He would be assessed at [medical clinic] on 10/10/12, and was diagnosed with 2 metatarsal fractures. On 10/15/12, the nurse received a report client A's foot had become lodged during transport. The nurse indicated client A's "wheelchair does not meet the physical shape of his			

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	body because of the severe kyphosis (large hump on his back)." Interview with staff #10 indicated on 10/1/12, he and staff #4 had completed the afternoon transport for the group home and during the transport client A began cursing. Staff #10 found client A's foot lodged between the footplate and wheel with the footplate sitting on top of his foot. Staff #10 freed client A's foot and assessed it upon return to the group home with no injuries noted and no signs or symptoms of pain/injury displayed by client A. Staff #4 was interviewed and indicated a similar account as staff #10. Staff #4 indicated "she did not report this to anyone...because she was working that evening and because she was working Monday through Friday and she could monitor [client A]." She indicated she contacted the group home nurse on 10/7/12 while she assisted him with bathing when she noticed bruising and swelling on client A's foot. The nurse indicated she would assess him on 10/7/12. The conclusion indicated "Evidence supports [client A] likely sustained the break on 10/1/12 when foot became lodged. Evidence supports the incident was not reported to anyone in order for [client A] to receive appropriate monitoring for injury." The Area Director #1 was interviewed on			

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	11/9/12 at 11:15 AM. She indicated the failure to obtain medical attention for client A until 10/10/12 was a delay in treatment. She indicated staff who witnessed the incident on the van on 10/1/12 reported the incident in daily notes, but failed to document it in incident reports. She indicated staff had been retrained on reporting and the nurse on assessment requirements. The group home nurse was interviewed on 11/9/12 at 11:50 AM. She indicated client A's wheelchair had been evaluated since his fracture and adjusted and stated, "It fits him him a lot better, including the footrests." When asked about the nursing assessment of client A's foot, she indicated she was unaware of the incident on 10/1/12 and had been unaware of an issue with client A's foot pedals until after he was diagnosed with a fracture. Client A's DSR for October, 2012 was reviewed on 11/9/12 at 2:15 PM. A note written by staff #5 from 2:00 to 10:00 PM dated 10/1/12 indicated "No behaviors to report." A note written by staff #10 from 2:03 PM to 6:03 PM indicated client A had returned home "and moved about. Had meds (medications) and meals given. Resident needed some extra prompts. Over all no behavior problems. Good day compliant." A note written by staff #1			

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	dated 10/1/12 from 4:00 PM until 10:00 PM indicated "Had dinner and went to his room-in bed." There was no record provided to review that indicated the incident with client A's foot being caught between his wheelchair pedal and the wheel on 10/1/12 was documented in DSR notes. Internal incident reports for the time period of Oct, 2012 were reviewed on 11/13/12 at 9:06 AM. There was no evidence of a report of an injury or incident involving client A's foot. This federal tag relates to complaint #IN00117912. 9-3-2(a)			

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W0154	483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated. Based on observation, interview and record review for 1 of 4 sampled clients (client A), the facility failed to failed to ensure a complete and thorough investigation was documented for 2 of 2 investigations involving client A. Findings include: Observations were completed at the group home on 11/8/12 from 5:00 PM until 6:09 PM. Client A was in the dining room in a wheelchair with a cast on his right foot and a sock covering his right toe. Client A was interviewed on 11/8/12 at 5:05 PM. When asked about his broken foot, he gestured that he fell out of the wheelchair after he unbuckled his seatbelt and he reached forward toward the floor. He indicated his nose and foot hurt. Client A was interviewed again on 11/8/12 at 5:41 PM and indicated his foot rests were better now. The facility's reportable incidents to the Bureau of Developmental Disabilities Services (BDDS) were reviewed on	W0154	Quality Assurance Director will retrain Quality Assurance Specialist on completing a thorough investigation to include interviewing call clients capable of being interviewed. Another management staff within governing body will review all investigations to ensure all components are included; including those who need to be interviewed. Quality Assurance Director, Area Director, Regional Director, Quality Assurance Specialist	12/26/2012

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	11/9/12 at 11:16 AM. A report dated 10/10/12 indicated on 10/3/12 staff had noticed client A's right ankle was swollen. The nurse was called. Client A denied pain. Client A's nurse assessed his ankle on 10/5/12 and client A continued to deny pain. On 10/7/12, staff called the nurse again and stated his right foot now looked swollen. Client A was taken to an urgent clinic on 10/10/12 which indicated he has "several" broken bones in his foot. Client A was placed in a protective boot and taken to see an orthopaedic doctor on 10/12/12. An attached investigation dated 10/17/12 into the fracture attached to the above BDDS report was reviewed on 11/9/12 at 11:16 AM indicated on 10/10/12, client A was diagnosed with a broken foot with no known cause. The Program Director/QMRP, group home nurse, staff #10, #4, #5 were interviewed and their statements were included in the investigation. The conclusion of the investigation indicated client A "likely" sustained the break on 10/1/12 when his foot became lodged during transport and the incident was not reported to anyone in order for client A to receive appropriate monitoring for injury. The investigation indicated client A has limited ability to communicate, but is able to indicate illness and/or injury through appropriate			

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	questioning from staff. There was no evidence client A was interviewed for the investigation. A BDDS report dated 11/18/12 was reviewed on 11/20/12 at 8:11 AM. The report indicated staff was helping another client and client A rolled into the bathroom and fell out of his wheelchair. A report dated 11/15/12 indicated client C had fallen out of his wheelchair after he reached down to unplug his TV. No additional information was provided to indicate the cause of client A and C's falls. A draft summary of the internal investigation report dated 11/21/12 was reviewed on 11/26/12 at 12:30 PM. The background information indicated client A was placed on line of sight supervision level following the diagnosis of his broken foot. The investigation included statements from staff #1, staff #11, the on-call supervisor and the house manager. The conclusion of the investigation indicated client A fell when he attempted to get up from the toilet and "evidence supports" he was not provided with line of sight supervision. The investigation indicated client A has limited ability to communicate, but is able to indicate illness and/or injury through appropriate questioning from staff. There was no			

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	evidence client A was interviewed as part of the investigation. The Area Director #2 was interviewed on 11/26/12 at 2:41 PM and stated client A had not been interviewed as part of the investigation because of his "inability to effectively communicate." This federal tag relates to complaint #IN00117912. 9-3-2(a)			

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W0157	483.420(d)(4) STAFF TREATMENT OF CLIENTS If the alleged violation is verified, appropriate corrective action must be taken. Based on observation, interview and record review, the facility failed to implement effective corrective action to protect 1 of 4 sampled clients (client A) from further injury by failing to ensure staff supervised him as indicated in his plan, and failed to develop and implement a system to ensure wheelchairs were in good condition for 3 of 4 clients who used wheelchairs (clients A, C and D). Findings include: Observations were completed at the group home on 11/8/12 from 5:00 PM until 6:09 PM. Client A was in the dining room in a wheelchair with a cast on his right foot and a sock covering his right toe. A sign on a white board in the dining room indicated, "[Client A] must be in sight of staff at all times when awake." From 5:11 PM until 5:14 PM there was no staff within eyesight of client A. Staff #1 and #2 were in other areas of the house. From 5:20 PM until 5:21 PM staff were not within eyesight of client A. Clients C and D came home from day services at 6:00 PM. Client C's wheelchair did not have a left foot rest. Client C demonstrated that his brakes didn't work, and indicated the	W0157	Program Director will hold an IDT meeting for client A to determine adequate supervision level required to meet his needs Program Director will retrain Home Manager on management oversight responsibilities including documentation review, observation requirements and staff scheduling to include ensuring supervision levels is adequate to the consumer needs. Program Director will retrain staff on appropriate staffing levels for all consumers in the home; including client A Nursing Supervisor will retrain facility nurse on nursing responsibilities to include assessments and treatment of clients following an incident and providing adequate assessment of adaptive equipment. Facility Nurse will assess all wheelchairs in the home to determine need for repairs. Ongoing, facility nurse will assess clients' wheelchairs during quarterly reviews. Home Manager and Program	12/26/2012

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	nurse was going to get a new chair for him. Client D's wheelchair was missing the right arm rest, and the left arm rest was not cushioned. Neither client's wheelchair had seat cushions. Client A was interviewed on 11/8/12 at 5:05 PM. When asked about his broken foot, he gestured that he fell out of the wheelchair after he unbuckled his seatbelt and he reached forward toward the floor. He indicated his nose and foot hurt. Staff #4 was interviewed on 11/8/12 at 5:30 PM. She indicated she had been with client A on the van when his foot was caught in in the wheel. She stated, "At the time, his foot pedals weren't all that great and his foot kept slipping off." She indicated the incident happened about a month ago, and client A didn't complain of pain once it was discovered his foot was caught and it was freed from the wheel. She stated the nurse was not notified of the incident and it was "charted." She indicated client A had a fall risk plan. Client A's records in the group home were reviewed on 11/8/12 at 5:36 PM. The records indicated client A had a history of falls, a diagnosis of osteoporosis and had fallen on 8/10/12 previously. An updated fall risk plan dated 10/12 indicated client		Director will complete observations twice weekly for the next 4 weeks to ensure staff is meeting supervision levels. Responsible Party: Area Director, Program Director, Nursing Supervisor, Facility Nurse	

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	A was to keep his feet in view while propelling his wheelchair. A High Risk for Fracture protocol dated 10/15/12 indicated staff were to assess client A's skin daily, report bruising to the RN, report complaints of pain, propel wheelchair slowly and use caution through doorways and on the van. Client A was interviewed again on 11/8/12 at 5:41 PM and indicated his foot rests were better now. Staff #4 was interviewed again on 11/8/12 at 5:44 PM. She stated client A's wheelchair fit him "100 percent" better after client A's wheelchair had been evaluated. She indicated the wheelchair had been repaired the same day it was evaluated. She indicated she was unsure of when the nurse was called to evaluate client A's foot after it was caught in the wheel as she was not on duty that day. The facility's reportable incidents to the Bureau of Developmental Disabilities Services (BDDS) were reviewed on 11/9/12 at 11:16 AM. A report dated 10/10/12 indicated on 10/3/12 staff had noticed client A's right ankle was swollen. The nurse was called. Client A denied pain. Client A's nurse assessed his ankle on 10/5/12 and client A continued to deny pain. On 10/7/12, staff called the nurse			

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	again and stated his right foot now looked swollen. Client A was taken to an urgent clinic on 10/10/12 which indicated he has "several" broken bones in his foot. Client A was placed in a protective boot and taken to see an orthopaedic doctor on 10/12/12. The report indicated client A was going to have his wheelchair evaluated. A follow up report dated 10/17/12 indicated an initial investigation "found on 10/1/12, [client A's] right foot was caught between his foot plate and the wheel. During the trip home client A started cussing and shouting, and the van driver pulled over to see why [client A] was cursing. It was at that instance it was found that his foot was caught. Staff removed his foot from area and placed his foot on foot rest properly. Staff asked [client A] if he was feeling any pain and [client A] said NO. Staff documented the incident in the DSR (daily support record) book and told staff on shift to follow up with his foot later to check for swelling. Investigation is ongoing...Training was held on 10/12/12 on Wheelchair safety, RC fall protocol, and line of sight...Indiana Mentor will continue to follow and monitor [client A's] health and safety needs." An attached investigation dated 10/17/12 into the fracture attached to the above BDDS report was reviewed on 11/9/12 at			

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	11:16 AM. The investigation indicated on 10/10/12, client A was diagnosed with a broken foot with no known cause. Interview with the nurse indicated client A's "wheelchair does not meet the physical shape of his body because of the severe kyphosis (large hump on his back)." Interview with staff #10 indicated on 10/1/12, he and staff #4 had completed the afternoon transport for the group home and during the transport client A began cursing. Staff #10 found client A's foot lodged between the footplate and wheel with the footplate sitting on top of his foot. Staff #10 freed client A's foot and assessed it upon return to the group home with no injuries noted and no signs or symptoms of pain/injury displayed by client A. Staff #4 was interviewed and indicated a similar account as staff #10. She indicated "she did not report this to anyone...because she was working that evening and because she was working Monday through Friday and she could monitor [client A]." She indicated she contacted the group home nurse on 10/7/12 while she assisted him with bathing when she noticed bruising and swelling on client A's foot. The conclusion indicated "Evidence supports [client A] likely sustained the break on 10/1/12 when foot became lodged. Evidence supports the incident was not reported to anyone in order for [client A]			

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	to receive appropriate monitoring for injury." The Area Director #1 was interviewed on 11/9/12 at 11:15 AM. She indicated staff who witnessed the incident on the van on 10/1/12 reported the incident in daily notes, but failed to document it in incident reports. Staff did not report the incident to the nurse because client A did not complain of pain after the incident. She indicated the failure to obtain medical attention for client A until 10/10/12 was a delay in treatment. She was uncertain if client A was to be within eyesight and indicated the Qualified Mental Retardation Professional (QMRP) had recently left her position and the Area Director was assuming her duties until a new QMRP was hired. She indicated she would check with the house manager to determine client A's current supervision needs and an interdisciplinary team (IDT) meeting would have been held to discontinue the supervision level established after client A's fracture. She indicated staff should have kept client A within eyesight if the line of sight supervision level had not been discontinued. She indicated staff had been retrained on reporting and the nurse on assessment requirements. The group home nurse was interviewed			

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	on 11/9/12 at 11:50 AM. She indicated client A's wheelchair had been evaluated and adjusted since his fracture and stated, "It fits him a lot better, including the footrests." When asked about the nursing assessment of client A's foot, she indicated she was unaware of the incident on 10/1/12 and had been unaware of an issue with client A's foot pedals until after he was diagnosed with a fracture. She indicated there was not a system or schedule to evaluate wheelchairs to ensure they were in good condition, and stated, "It would be a good idea to have a monthly inspection to let me know right away if there is a problem." She indicated client C had never had footrests on his wheelchair and self propels himself. She indicated client D's footrests for his wheelchair were in the closet and had an evaluation scheduled for 11/14/12. She indicated client D had another wheelchair, but his family had switched it to the current chair at their request. She indicated client wheelchairs should have arm rests and she would check on seat cushions for clients C and D as not all wheelchairs had cushions. When asked if client A had been assessed by a nurse between 10/3/12 and his visit to the medical clinic on 10/10/12, she stated, "I didn't," and indicated she did not assess client A after being notified of swelling on 10/7/12. She indicated she had			

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	assessed his ankle on 10/3/12, but had not assessed client A's foot since she was unaware of the incident on 10/1/12. She indicated client A was taken to the medical clinic on 10/10/12 after staff notified her on 10/9/12 of client A's swelling since it was less expensive than a hospital and she thought client A had possibly developed edema from a medical cause. She stated, "I had no idea it was a fracture." She was unaware if client A was to be kept within eyesight to protect him from additional injury. The group home nurses notes regarding client A for October, 2012 were reviewed on 11/9/12 at 2:30 PM. A note dated 10/3/12 indicated "staff called and said ankle has edema. Saw sl(slight) edema in R (right ankle). [Client A] denies pain." On 10/7/12 an entry indicated, "Staff left message about [client A's] ankle." On 10/9/12 an entry indicated "Staff called R foot swollen and discolored. They will take [client A] to [medical clinic] in AM." An entry dated 10/10/12 indicated client A was found with 2 metatarsal fractures in his right foot. There was no evidence of a nursing assessment in the notes from 10/3/12 to 10/10/12. A note dated 10/15/12 indicated client A's fall prevention protocol was updated, and a high risk for fracture protocol was developed and sent to the PD (program			

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	director). A 10/16/12 indicated client A's wheelchair was evaluated and repairs made to the chair were completed and the depth of the seat adjusted so client A's feet "fit in foot peddles (sic) more easily." Client A's DSR for October, 2012 was reviewed on 11/9/12 at 2:15 PM. A note written by staff #5 from 2:00 to 10:00 PM dated 10/1/12 indicated "No behaviors to report." A note written by staff #10 from 2:03 PM to 6:03 PM indicated client A had returned home "and moved about. Had meds (medications) and meals given. Resident needed some extra prompts. Over all no behavior problems. Good day compliant." A note written by staff #1 dated 10/1/12 from 4:00 PM until 10:00 PM indicated "Had dinner and went to his room-in bed." There was no record provided to review that indicated the incident with client A's foot being caught between his wheelchair pedal and the wheel on 10/1/12 was documented. Staff #1 was interviewed on 11/9/12 at 2:00 PM and indicated client A was to be kept within eyesight at all times. Internal incident reports for the time period of Oct, 2012 were reviewed on 11/13/12 at 9:06 AM. There was no evidence of a report of an injury or incident involving client A's foot.			

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	The Area Director #1 was interviewed on 11/19/12 at 2:30 PM and indicated she had checked with the house manager and the house manager had indicated staff were supposed to keep client A within eyesight at all times to prevent other falls and provide assistance to client A. When asked if there had been further incidents involving client A, she indicated client A had fallen out of his wheelchair on 11/18/12 and had been taken to the ER (emergency room) for evaluation and released without finding of injury. She was uncertain if client A's supervision level had been implemented and indicated the incident was under investigation. She further indicated corrective action had been taken to ensure adequate staffing levels were in the home and an interdisciplinary team meeting would be held this week to evaluate client A's needs. A BDDS report dated 11/18/12 was reviewed on 11/20/12 at 8:11 AM. The report indicated staff was helping another client and client A rolled into the bathroom and fell out of his wheelchair. There was no further information available in the report as to the cause of client A's fall or specific corrective action to reduce the risk of falls to client A.			

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	A draft summary of the internal investigation report dated 11/21/12 was reviewed on 11/26/12 at 12:30 PM. The background information indicated client A was placed on line of sight supervision level following the diagnosis of his broken foot. The on-call supervisor 11/18/12 indicated he received a call from staff 1 reporting the staff scheduled to work with her had not reported for her shift. 5 minutes after receiving the call he received another call from staff #1 reporting client A had fallen in the bathroom and she was physically unable to assist him up from the floor. The on-call supervisor called staff #11 from another group home to assist and client A was taken to the hospital to evaluate him for injury and released without findings. The on call staff indicated client A was on the floor for 10-15 minutes. Staff #1 indicated the house manager left staff #1 in the home and indicated staff #1 was to call the on call supervisor if staff did not arrive within 15 minutes. She called the on call supervisor and started preparing dinner. Client A was in the living room watching television at this time. "About" 5 minutes later she heard client A cussing and found client A on the floor in a fetal position. Staff #1 contacted the nurse and stayed with client A until staff #11 arrived to assist. She indicated she thought client A was on the floor 15-30 minutes and it			

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	"appeared [client A] fell when he attempted to get up after using the bathroom because there was feces in the toilet." The house manager indicated she had trained staff on wheelchair safety on 10/12/12 to include remaining in sight of client A when he is up and to assist with transferring. She placed a note on the white board reminding staff client A was to be in line of sight at all times. She indicated the QMRP (Qualified Mental Retardation Professional)/PD (Program Director) had indicated to the house manager the protocol was to be in place for a few weeks, but did not provide a specific end date. She indicated there was no IDT to discuss the changes in the plan implemented on 10/12/12. The conclusion of the investigation indicated client A fell when he attempted to get up from the toilet and "evidence supports" he was not provided with line of sight supervision. The investigation recommended staff were to be retrained on supervision needs for client A, fall risk protocol, emergency on-call procedures, use of a Hoyer lift to use in an emergency, possible use of a gait belt, corrective action to ensure appropriate supervision was provided to clients, and retrain mangers of scheduling requirements. The Area Director #2 was interviewed on 11/26/12 at 2:41 PM and indicated there			

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	were not enough staff to supervise client A to meet his supervision needs when he fell on 11/18/12. This federal tag relates to complaint #IN00117912. 9-3-2(a)			

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W0158	483.430 FACILITY STAFFING The facility must ensure that specific facility staffing requirements are met. Based on record review, interview, and observation, the Condition of Participation of Facility Staffing is not met as the facility failed to provide sufficiently trained staff to implement the supervision and health care needs of 3 of 4 sampled clients (clients A, C and D). Findings include: 1. Please see W159. The Qualified Mental Retardation Professional (QMRP) failed to take action to integrate and coordinate services and ensure staff were trained to implement 1 of 4 sampled client's (client A) supervision level to protect him from further fractures, and failed to develop and implement a system to ensure wheelchairs were in good condition for 3 of 4 clients who used wheelchairs (clients A, C and D). 2. Please see W189. The facility failed to ensure staff were sufficiently trained to follow procedures to timely report injuries and failed to implement 1 of 4 sampled clients' (client A) supervision level to protect him from further fractures. 3. Please see W186. The facility failed to	W0158	Program Director will hold an IDT meeting for client A to determine adequate supervision level required to meet his needs. Program Director will retrain Home Manager on management oversight responsibilities including documentation review, observation requirements and staff scheduling to include ensuring supervision levels is adequate to the consumer needs. Program Director will retrain staff on incident reporting and appropriate staffing levels for all consumers in the home; including client A Home Manager and Program Director will complete observations twice weekly for the next 4 weeks to ensure adequate staffing support is provided and staff is meeting supervision levels. Responsible Party: Program Director, Home Manager	12/26/2012

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	provide sufficient staff to provide for the identified supervision needs of 1 of 4 sampled clients (client A). This federal tag relates to complaint #IN00117912. 9-3-3(a)			

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W0159	483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional. Based upon record review, observation and interview, the Qualified Mental Retardation Professional (QMRP) failed to take action to integrate and coordinate services and ensure staff were sufficiently trained to implement 1 of 4 sampled clients (client A) supervision level to protect him from further fractures, and failed to develop and implement a system to ensure wheelchairs were in good condition for 3 of 4 clients who used wheelchairs (clients A, C and D). Findings include: Observations were completed at the group home on 11/8/12 from 5:00 PM until 6:09 PM. Client A was in the dining room in a wheelchair with a cast on his right foot and a sock covering his right toe. A sign on a white board in the dining room indicated, "[Client A] must be in sight of staff at all times when awake." From 5:11 PM until 5:14 PM there was no staff within eyesight of client A. Staff #1 and #2 were in other areas of the house. From 5:20 PM until 5:21 PM staff were not within eyesight of client A. Clients C and	W0159	Program Director will hold an IDT meeting for client A to determine adequate supervision level required to meet his needs. Program Director will retrain staff on the supervision level requirements for all consumers in the home. Nursing Supervisor will retrain facility nurse on nursing responsibilities to include assessments and treatment of clients following an incident and providing adequate assessment of adaptive equipment. Facility Nurse will assess all wheelchairs in the home to determine need for repairs. Ongoing, facility nurse will assess clients' wheelchairs during quarterly reviews. Responsible Party: Program Director, Home Manager, Nursing Supervisor, Facility Nurse	12/26/2012

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	D came home from day services at 6:00 PM. Client C's wheelchair did not have a left foot rest. Client C demonstrated that his brakes didn't work, and indicated the nurse was going to get a new chair for him. Client D's wheelchair was missing the right arm rest, and the left arm rest was not cushioned. Neither clients' wheelchairs had seat cushions. Client A was interviewed on 11/8/12 at 5:05 PM. When asked about his broken foot, he gestured that he fell out of the wheelchair after he unbuckled his seatbelt and he reached forward toward the floor. He indicated his nose and foot hurt. Staff #1 was interviewed on 11/8/12 at 6:04 PM. She indicated client C had a motorized wheelchair stored in the garage that had been there ever since she started working there a year ago. Client D was interviewed on 11/8/12 at 6:05 PM and indicated the nurse talked about taking him to check on a new wheelchair, and stated,"Evidently she hasn't yet." Staff #4 was interviewed on 11/8/12 at 5:30 PM. She indicated she had been with client A on the van when his foot was caught in in the wheel. She stated, "At the time, his foot pedals weren't all			

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	that great and his foot kept slipping off." She indicated the incident happened about a month ago, and client A didn't complain of pain once it was discovered his foot was caught and it was freed from the wheel. She stated the nurse was not notified of the incident and it was "charted." She indicated client A had a fall risk plan. Client A's records in the group home were reviewed on 11/8/12 at 5:36 PM. The records indicated client A had a history of falls, a diagnosis of osteoporosis and had fallen on 8/10/12 previously. An updated fall risk plan dated 10/12 indicated client A was to keep his feet in view while propelling his wheelchair. A High Risk for Fracture protocol dated 10/15/12 indicated staff were to assess client A's skin daily, report bruising to the RN, report complaints of pain, propel wheelchair slowly and use caution through doorways and on the van. The plans did not address client A's needs for supervision to prevent future injury. There was no other evidence in the record of client A's needs for supervision. Client A was interviewed again on 11/8/12 at 5:41 PM and indicated his foot rests were better for him now. Staff #4 was interviewed again on 11/8/12			

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	at 5:44 PM. She stated client A's wheelchair fit him "100 percent" better after client A's wheelchair had been evaluated. She indicated the wheelchair had been repaired the same day it was evaluated. She indicated she was unsure of when the nurse was called to evaluate client A's foot after it was caught in the wheel as she was not on duty that day. The facility's reportable incidents to the Bureau of Developmental Disabilities Services (BDDS) were reviewed on 11/9/12 at 11:16 AM. A report dated 10/10/12 indicated on 10/3/12 staff had noticed client A's right ankle was swollen. The nurse was called. Client A denied pain. Client A's nurse assessed his ankle on 10/5/12 and client A continued to deny pain. On 10/7/12, staff called the nurse again and stated his right foot now looked swollen. Client A was taken to an urgent clinic on 10/10/12 which indicated he has "several" broken bones in his foot. Client A was placed in a protective boot and taken to see an orthopaedic doctor on 10/12/12. The report indicated client A was going to have his wheelchair evaluated. A follow up report dated 10/17/12 indicated an initial investigation "found on 10/1/12, [client A's] right foot was caught between his foot plate and the wheel. During the trip home client A started cussing and shouting, and the van			

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	driver pulled to see why [client A] was cursing. It was at that instance it was found that his foot was caught. Staff removed his foot from area and placed his foot on foot rest properly. Staff asked [client A] if he was feeling any pain and [client A] said NO. Staff documented the incident in the DSR (daily support record) book and told staff on shift to follow up with his foot later to check for swelling. Investigation is ongoing...Training was held on 10/12/12 on Wheelchair safety, RC fall protocol, and line of sight...Indiana Mentor will continue to follow and monitor [client A's] health and safety needs." An attached investigation dated 10/17/12 into the fracture attached to the above BDDS report was reviewed on 11/9/12 at 11:16 AM indicated on 10/10/12, client A was diagnosed with a broken foot with no known cause. Interview with the nurse indicated client A was assessed by the nurse on 10/3/12 following a report it was swollen and slight swelling was observed in his right ankle. Client A denied pain and did not display pain when his ankle was moved. On 10/7/12, the nurse received a message client A's ankle was still swollen and on 10/9/12 the nurse received a report client A's foot was swollen and discolored. He would be assessed at [medical clinic] on 10/10/12,			

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	and was diagnosed with 2 metatarsal fractures. On 10/15/12, the nurse received a report client A's foot had become lodged during transport. The nurse indicated client A's "wheelchair does not meet the physical shape of his body because of the severe kyphosis (large hump on his back)." Interview with staff #10 indicated on 10/1/12, he and staff #4 had completed the afternoon transport for the group home and during the transport client A began cursing. Staff #10 found client A's foot lodged between the footplate and wheel with the footplate sitting on top of his foot. Staff #10 freed client A's foot and assessed it upon return to the group home with no injuries noted and no signs or symptoms of pain/injury displayed by client A. Staff #4 was interviewed and indicated a similar account as staff #10. She indicated "she did not report this to anyone...because she was working that evening and because she was working Monday through Friday and she could monitor [client A]." She indicated she contacted the group home nurse on 10/7/12 while she assisted him with bathing when she noticed bruising and swelling on client A's foot. The nurse indicated she would assess him on 10/7/12. The conclusion indicated "Evidence supports [client A] likely sustained the break on 10/1/12 when foot			

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	became lodged. Evidence supports the incident was not reported to anyone in order for [client A] to receive appropriate monitoring for injury." The Area Director #1 was interviewed on 11/9/12 at 11:15 AM. She indicated staff who witnessed the incident on the van on 10/1/12 reported the incident in daily notes, but failed to document it in incident reports. Staff did not report the incident to the nurse because he did not complain of pain after the incident. She indicated the failure to obtain medical attention for client A until 10/10/12 was a delay in treatment. She was uncertain if client A was to be within eyesight and indicated the Qualified Mental Retardation Professional (QMRP) had recently left her position and the Area Director was assuming her duties until a new QMRP was hired. She indicated she would check with the house manager to determine client A's current supervision needs and an interdisciplinary team (IDT) meeting would have been held to discontinue the supervision level established after client A's fracture. She indicated staff should have kept client A within eyesight if the line of sight supervision level had not been discontinued. She was uncertain as to the cause of the delay in nursing assessments for client A after the initial nursing assessment on 10/3/12 after			

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	swelling was noted on 10/3/12 and medical treatment on 10/10/12 which revealed the fractures in his right foot. She indicated staff had been retrained on reporting and the nurse on assessment requirements. The group home nurse was interviewed on 11/9/12 at 11:50 AM. She indicated client A's wheelchair had been evaluated since his fracture and adjusted and stated, "It fits him him a lot better, including the footrests." When asked about the nursing assessment of client A's foot, she indicated she was unaware of the incident on 10/1/12 and had been unaware of an issue with client A's foot pedals until after he was diagnosed with a fracture. She indicated there was not a system or schedule to evaluate wheelchairs to ensure they were in good condition, and stated, "It would be a good idea to have a monthly inspection to let me know right away if there is a problem." She indicated client C had never had footrests on his wheelchair and self propels himself. She indicated client D's footrests for his wheelchair were in the closet and had an evaluation scheduled for 11/14/12. She indicated client D had another wheelchair, but his family had switched it to the current chair at their request. She indicated client wheelchairs should have arm rests and she would check on seat			

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	cushions for clients C and D as not all wheelchairs had cushions. When asked if client A had been assessed by a nurse between 10/3/12 and his visit to the medical clinic on 10/10/12, she stated, "I didn't," and indicated she did not assess client A after being notified of swelling on 10/7/12. She indicated she had assessed his ankle on 10/3/12, but had not assessed client A's foot since she was unaware of the incident on 10/1/12. She indicated client A was taken to the medical clinic on 10/10/12 after staff notified her on 10/9/12 of client A's swelling because "We didn't know there was a cause," and "I had no idea it was a fracture." She indicated she referred client A to the medical clinic since it was less expensive than a hospital examination, and she thought client A had possibly developed edema from a medical cause. She was unaware if client A was to be kept within eyesight to protect him from additional injury. The group home nurses notes regarding client A for October, 2012 were reviewed on 11/9/12 at 2:30 PM. A note dated 10/3/12 indicated "staff called and said ankle has edema. Saw sl(slight) edema in R (right ankle). [Client A] denies pain." On 10/7/12 an entry indicated, "Staff left message about [client A's] ankle." On 10/9/12 an entry indicated "Staff called R			

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	foot swollen and discolored. They will take [client A] to [medical clinic] in AM." An entry dated 10/10/12 indicated client A was found with 2 metatarsal fractures in his right foot. There was no evidence of a nursing assessment in the notes from 10/3/12 to 10/10/12. A note dated 10/15/12 indicated client A's fall prevention protocol was updated, and a high risk for fracture protocol was developed and sent to the PD (program director). A 10/16/12 indicated client A's wheelchair was evaluated and repairs made to the chair were completed and the depth of the seat adjusted so client A's feet "fit in foot peddles (sic) more easily." Client A's DSR for October, 2012 was reviewed on 11/9/12 at 2:15 PM. A note written by staff #5 from 2:00 to 10:00 PM dated 10/1/12 indicated "No behaviors to report." A note written by staff #10 from 2:03 PM to 6:03 PM indicated client A had returned home "and moved about. Had meds (medications) and meals given. Resident needed some extra prompts. Over all no behavior problems. Good day compliant." A note written by staff #1 dated 10/1/12 from 4:00 PM until 10:00 PM indicated "Had dinner and went to his room-in bed." There was no record provided to review that indicated the incident with client A's foot being caught between his wheelchair pedal and the			

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	wheel on 10/1/12 was documented. Staff #1 was interviewed on 11/9/12 at 2:00 PM and indicated client A was to be kept within eyesight at all times. Internal incident reports for the time period of Oct, 2012 were reviewed on 11/13/12 at 9:06 AM. There was no evidence of a report of an injury or incident involving client A's foot. The Area Director #1 was interviewed on 11/19/12 at 2:30 PM and indicated she had checked with the house manager and the house manager had indicated staff were supposed to keep client A within eyesight at all times to prevent other falls and provide assistance to client A. When asked if there had been further incidents involving client A, she indicated client A had fallen out of his wheelchair on 11/18/12 and had been taken to the ER (emergency room) for evaluation and released without finding of injury and client C had fallen from his wheelchair while reaching down to unplug his TV. She was uncertain if client A's supervision level had been implemented and indicated the incidents were under investigation. She further indicated corrective action had been taken to ensure adequate staffing levels were in the home and an interdisciplinary team meeting			

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	would be held this week to evaluate client A and C's needs to prevent future occurrence. A BDDS report dated 11/18/12 was reviewed on 11/20/12 at 8:11 AM. The report indicated staff was helping another client and client A rolled into the bathroom and fell out of his wheelchair. There was no indication in the report of the cause of client A's fall. A report dated 11/15/12 indicated client C fell out of his chair while bending down to unplug his TV. A draft summary of the internal investigation report dated 11/21/12 was reviewed on 11/26/12 at 12:30 PM. The background information indicated client A was placed on line of sight supervision level following the diagnosis of his broken foot. The on-call supervisor 11/18/12 indicated he received a call from staff 1 reporting the staff scheduled to work with her had not reported for her shift. 5 minutes after receiving the call he received another call from staff #1 reporting client A had fallen in the bathroom and she was physically unable to assist him up from the floor. The on-call supervisor called staff #11 from another group home to assist and client A was taken to the hospital to evaluate him for injury and released without findings.			

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	The on call staff indicated client A was on the floor for 10-15 minutes. Staff #1 indicated the house manager left staff #1 in the home and indicated staff #1 was to call the on call supervisor if staff did not arrive within 15 minutes. She called the on call supervisor and started preparing dinner. Client A was in the living room watching television at this time. "About" 5 minutes later she heard client A cussing and found client A on the floor in a fetal position. Staff #1 contacted the nurse and stayed with client A until staff #11 arrived to assist. She indicated she thought client A was on the floor 15-30 minutes and it "appeared [client A] fell when he attempted to get up after using the bathroom because there was feces in the toilet." The house manager indicated she had trained staff on wheelchair safety on 10/12/12 to include remaining in sight of client A when he is up and to assist with transferring. She placed a note on the white board reminding staff client A was to be in line of sight at all times. She indicated the QMRP (Qualified Mental Retardation Professional)/PD (Program Director) had indicated to the house manager the protocol was to be in place for a few weeks, but did not provide a specific end date. She indicated there was no IDT to discuss the changes in the plan implemented on 10/12/12. The conclusion of the investigation indicated			

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	client A fell when he attempted to get up from the toilet and "evidence supports" he was not provided with line of sight supervision. The Area Director #2 was interviewed on 11/26/12 at 2:41 PM and indicated it was the job of the QMRP to ensure staff were trained to ensure clients' needs were met and plans implemented. She further indicated the former QMRP was no longer in the position and the Area Director was filling in until a new QMRP was hired. This federal tag relates to complaint #IN00117912. 9-3-3(a)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G417	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 11/26/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REM-INDIANA INC	5625 E 56TH ST INDIANAPOLIS, IN 46226

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W0186	483.430(d)(1-2) DIRECT CARE STAFF The facility must provide sufficient direct care staff to manage and supervise clients in accordance with their individual program plans. Direct care staff are defined as the present on-duty staff calculated over all shifts in a 24-hour period for each defined residential living unit. Based upon observation, record review and interview, the facility failed to provide sufficient staff to provide for the identified supervision needs of 1 of 4 sampled clients (client A). Findings include: Observations were completed at the group home on 11/8/12 from 5:00 PM until 6:09 PM. Client A was in the dining room in a wheelchair with a cast on his right foot and a sock covering his right toe. A sign on a white board in the dining room indicated, "[Client A] must be in sight of staff at all times when awake." From 5:11 PM until 5:14 PM there was no staff within eyesight of client A. Staff #1 and #2 were in other areas of the house. From 5:20 PM until 5:21 PM staff were not within eyesight of client A. Client A was interviewed on 11/8/12 at 5:05 PM. When asked about his broken	W0186	Program Director will hold an IDT meeting for client A to determine adequate supervision level required to meet his needs. Program Director will retrain staff on the supervision level requirements for all consumers in the home. Program Director will retrain Home Manager on management oversight responsibilities including documentation review, observation requirements and staff scheduling to include ensuring supervision levels is adequate to the consumer needs. Home Manager and Program Director will complete observations twice weekly for the next 4 weeks to ensure adequate staffing support is provided and staff is meeting supervision levels. Responsible Party: Program Director, Home Manager	12/26/2012

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	foot, he gestured that he fell out of the wheelchair after he unbuckled his seatbelt and he reached forward toward the floor. He indicated his nose and foot hurt. Client A's records in the group home were reviewed on 11/8/12 at 5:36 PM. The records indicated client A had a history of falls, a diagnosis of osteoporosis and had fallen on 8/10/12 previously. An updated fall risk plan dated 10/12 indicated client A was to keep his feet in view while propelling his wheelchair. A High Risk for Fracture protocol dated 10/15/12 indicated staff were to assess client A's skin daily, report bruising to the RN, report complaints of pain, propel wheelchair slowly and use caution through doorways and on the van. The facility's reportable incidents to the Bureau of Developmental Disabilities Services (BDDS) were reviewed on 11/9/12 at 11:16 AM. A report dated 10/10/12 indicated on 10/3/12 staff had noticed client A's right ankle was swollen. The nurse was called. Client A denied pain. Client A's nurse assessed his ankle on 10/5/12 and client A continued to deny pain. On 10/7/12, staff called the nurse again and stated his right foot now looked swollen. Client A was taken to an urgent clinic on 10/10/12 which indicated he has "several" broken bones in his foot. The			

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	report indicated training was held on 10/12/12 on Wheelchair safety, RC fall protocol, and line of sight...Indiana Mentor will continue to follow and monitor [client A's] health and safety needs." Staff #1 was interviewed on 11/9/12 at 2:00 PM and indicated client A was to be kept within eyesight at all times. The Area Director #1 was interviewed on 11/19/12 at 2:30 PM and indicated she had checked with the house manager and the house manager had indicated staff were supposed to keep client A within eyesight at all times to prevent other falls and provide assistance to client A. When asked if there had been further incidents involving client A, she indicated client A had fallen out of his wheelchair on 11/18/12 and had been taken to the ER (emergency room) for evaluation and released without finding of injury. She was uncertain if client A's supervision level had been implemented and indicated the incident was under investigation. She further indicated corrective action had been taken to ensure adequate staffing levels were in the home and an interdisciplinary team meeting would be held this week to evaluate client A's needs.			

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	A BDDS report dated 11/18/12 was reviewed on 11/20/12 at 8:11 AM. The report indicated staff was helping another client and client A rolled into the bathroom and fell out of his wheelchair. A draft summary of the internal investigation report dated 11/21/12 was reviewed on 11/26/12 at 12:30 PM. The background information indicated client A was placed on line of sight supervision level following the diagnosis of his broken foot. The on-call supervisor 11/18/12 indicated he received a call from staff 1 reporting the staff scheduled to work with her had not reported for her shift. 5 minutes after receiving the call he received another call from staff #1 reporting client A had fallen in the bathroom and she was physically unable to assist him up from the floor. The on-call supervisor called staff #11 from another group home to assist and client A was taken to the hospital to evaluate him for injury and released without findings. The on call staff indicated client A was on the floor for 10-15 minutes. Staff #1 indicated the house manager left staff #1 in the home and indicated staff #1 was to call the on call supervisor if staff did not arrive within 15 minutes. She called the on call supervisor and started preparing dinner. Client A was in the living room watching television at this time. "About"			

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	5 minutes later she heard client A cussing and found client A on the floor in a fetal position. Staff #1 contacted the nurse and stayed with client A until staff #11 arrived to assist. She indicated she thought client A was on the floor 15-30 minutes and it "appeared [client A] fell when he attempted to get up after using the bathroom because there was feces in the toilet." The house manager indicated she had trained staff on wheelchair safety on 10/12/12 to include remaining in sight of client A when he is up and to assist with transferring. She placed a note on the white board reminding staff client A was to be in line of sight at all times. She indicated the QMRP (Qualified Mental Retardation Professional)/PD (Program Director) had indicated to the house manager the protocol was to be in place for a few weeks, but did not provide a specific end date. She indicated there was no IDT to discuss the changes in the plan implemented on 10/12/12. The conclusion of the investigation indicated client A fell when he attempted to get up from the toilet and "evidence supports" he was not provided with line of sight supervision. The Area Director #2 was interviewed on 11/26/12 at 2:41 PM and indicated there were not enough staff to supervise client A to meet his supervision needs when he			

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	fell on 11/18/12. This federal tag relates to complaint #IN00117912. 9-3-3(a)			

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W0189	483.430(e)(1) STAFF TRAINING PROGRAM The facility must provide each employee with initial and continuing training that enables the employee to perform his or her duties effectively, efficiently, and competently. Based upon record review and interview, the facility failed to ensure staff were trained to follow procedures to timely report an incident resulting in significant injury and failed to implement 1 of 4 sampled client's (client A) supervision level to protect him from further fractures. Findings include: Observations were completed at the group home on 11/8/12 from 5:00 PM until 6:09 PM. Client A was in the dining room in a wheelchair with a cast on his right foot and a sock covering his right toe. A sign on a white board in the dining room indicated, "[Client A] must be in sight of staff at all times when awake." From 5:11 PM until 5:14 PM there was no staff within eyesight of client A. Staff #1 and #2 were in other areas of the house. From 5:20 PM until 5:21 PM staff were not within eyesight of client A. Clients C and D came home from day services at 6:00 PM. Client C's wheelchair did not have a left foot rest. Client C demonstrated that his brakes didn't work, and indicated the	W0189	Program Director will hold an IDT meeting for client A to determine adequate supervision level required to meet his needs. Program Director will retrain staff on incident reporting and on the supervision level requirements for all consumers in the home. Program Director will retrain Home Manager on management oversight responsibilities including documentation review, observation requirements and staff scheduling to include ensuring supervision levels is adequate to the consumer needs. Home Manager and Program Director will complete observations twice weekly for the next 4 weeks to ensure adequate staffing support is provided and staff is meeting supervision levels. Responsible Party: Program Director, Home Manager	12/26/2012

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	nurse was going to get a new chair for him. Client D's wheelchair was missing the right arm rest, and the left arm rest was not cushioned. Neither clients' wheelchairs had seat cushions. Client A was interviewed on 11/8/12 at 5:05 PM. When asked about his broken foot, he gestured that he fell out of the wheelchair after he unbuckled his seatbelt and he reached forward toward the floor. He indicated his nose and foot hurt. Staff #1 was interviewed on 11/8/12 at 6:04 PM. She indicated client C had a motorized wheelchair stored in the garage that had been there ever since she started working there a year ago. Client D was interviewed on 11/8/12 at 6:05 PM and indicated the nurse talked about taking him to check on a new wheelchair, and stated,"Evidently she hasn't yet." Staff #4 was interviewed on 11/8/12 at 5:30 PM. She indicated she had been with client A on the van when his foot was caught in in the wheel. She stated, "At the time, his foot pedals weren't all that great and his foot kept slipping off." She indicated the incident happened about a month ago, and client A didn't complain of pain once it was discovered his foot			

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	was caught and it was freed from the wheel. She stated the nurse was not notified of the incident and it was "charted." She indicated client A had a fall risk plan. Client A's records in the group home were reviewed on 11/8/12 at 5:36 PM. The records indicated client A had a history of falls, a diagnosis of osteoporosis and had fallen on 8/10/12 previously. An updated fall risk plan dated 10/12 indicated client A was to keep his feet in view while propelling his wheelchair. A High Risk for Fracture protocol dated 10/15/12 indicated staff were to assess client A's skin daily, report bruising to the RN, report complaints of pain, propel wheelchair slowly and use caution through doorways and on the van. The plans did not address client A's needs for supervision to prevent future injury. There was no other evidence in the record of client A's needs for supervision. Client A was interviewed again on 11/8/12 at 5:41 PM and indicated his foot rests were better for him now. Staff #4 was interviewed again on 11/8/12 at 5:44 PM. She stated client A's wheelchair fit him "100 percent" better after client A's wheelchair had been evaluated. She indicated the wheelchair			

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	had been repaired the same day it was evaluated. She indicated she was unsure of when the nurse was called to evaluate client A's foot after it was caught in the wheel as she was not on duty that day. The facility's reportable incidents to the Bureau of Developmental Disabilities Services (BDDS) were reviewed on 11/9/12 at 11:16 AM. A report dated 10/10/12 indicated on 10/3/12 staff had noticed client A's right ankle was swollen. The nurse was called. Client A denied pain. Client A's nurse assessed his ankle on 10/5/12 and client A continued to deny pain. On 10/7/12, staff called the nurse again and stated his right foot now looked swollen. Client A was taken to an urgent clinic on 10/10/12 which indicated he has "several' broken bones in his foot. Client A was placed in a protective boot and taken to see an orthopaedic doctor on 10/12/12. The report indicated client A was going to have his wheelchair evaluated. A follow up report dated 10/17/12 indicated an initial investigation "found on 10/1/12, [client A's] right foot was caught between his foot plate and the wheel. During the trip home client A started cussing and shouting, and the van driver pulled to see why [client A] was cursing. It was at that instance it was found that his foot was caught. Staff removed his foot from area and placed his			

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	foot on foot rest properly. Staff asked [client A] if he was feeling any pain and [client A] said NO. Staff documented the incident in the DSR (daily support record) book and told staff on shift to follow up with his foot later to check for swelling. Investigation is ongoing...Training was held on 10/12/12 on Wheelchair safety, RC fall protocol, and line of sight...Indiana Mentor will continue to follow and monitor [client A's] health and safety needs." An attached investigation dated 10/17/12 into the fracture attached to the above BDDS report was reviewed on 11/9/12 at 11:16 AM indicated on 10/10/12, client A was diagnosed with a broken foot with no known cause. Interview with the nurse indicated client A was assessed by the nurse on 10/3/12 following a report it was swollen and slight swelling was observed in his right ankle. Client A denied pain and did not display pain when his ankle was moved. On 10/7/12, the nurse received a message client A's ankle was still swollen and on 10/9/12 the nurse received a report client A's foot was swollen and discolored. He would be assessed at [medical clinic] on 10/10/12, and was diagnosed with 2 metatarsal fractures. On 10/15/12, the nurse received a report client A's foot had become lodged during transport. The			

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	nurse indicated client A's "wheelchair does not meet the physical shape of his body because of the severe kyphosis (large hump on his back)." Interview with staff #10 indicated on 10/1/12, he and staff #4 had completed the afternoon transport for the group home and during the transport client A began cursing. Staff #10 found client A's foot lodged between the footplate and wheel with the footplate sitting on top of his foot. Staff #10 freed client A's foot and assessed it upon return to the group home with no injuries noted and no signs or symptoms of pain/injury displayed by client A. Staff #4 was interviewed and indicated a similar account as staff #10. She indicated "she did not report this to anyone...because she was working that evening and because she was working Monday through Friday and she could monitor [client A]." She indicated she contacted the group home nurse on 10/7/12 while she assisted him with bathing when she noticed bruising and swelling on client A's foot. The nurse indicated she would assess him on 10/7/12. The conclusion indicated "Evidence supports [client A] likely sustained the break on 10/1/12 when foot became lodged. Evidence supports the incident was not reported to anyone in order for [client A] to receive appropriate monitoring for injury."			

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	The Area Director #1 was interviewed on 11/9/12 at 11:15 AM. She indicated the failure to obtain medical attention for client A until 10/10/12 was a delay in treatment. She indicated staff who witnessed the incident on the van on 10/1/12 reported the incident in daily notes, but failed to document it in incident reports. Staff did not report the incident to the nurse because he did not complain of pain after the incident. She was uncertain if client A was to be within eyesight and indicated the Qualified Mental Retardation Professional (QMRP) had recently left her position and the Area Director was assuming her duties until a new QMRP was hired. She indicated she would check with the house manager to determine client A's current supervision needs and an interdisciplinary team (IDT) meeting would have been held to discontinue the supervision level established after client A's fracture. She indicated staff should have kept client A within eyesight if the line of sight supervision level had not been discontinued. She was uncertain as to the cause of the delay in nursing assessments for client A after the initial nursing assessment on 10/3/12 after swelling was noted on 10/3/12 and medical treatment on 10/10/12 which revealed the fractures in his right foot. She indicated staff had			

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	been retrained on reporting and the nurse on assessment requirements. The group home nurse was interviewed on 11/9/12 at 11:50 AM. She indicated client A's wheelchair had been evaluated since his fracture and adjusted and stated, "It fits him him a lot better, including the footrests." When asked about the nursing assessment of client A's foot, she indicated she was unaware of the incident on 10/1/12 and had been unaware of an issue with client A's foot pedals until after he was diagnosed with a fracture. She indicated there was not a system or schedule to evaluate wheelchairs to ensure they were in good condition, and stated, "It would be a good idea to have a monthly inspection to let me know right away if there is a problem." She indicated client C had never had footrests on his wheelchair and self propels himself. She indicated client D's footrests for his wheelchair were in the closet and had an evaluation scheduled for 11/14/12. She indicated client D had another wheelchair, but his family had switched it to the current chair at their request. She indicated client wheelchairs should have arm rests and she would check on seat cushions for clients C and D as not all wheelchairs had cushions. When asked if client A had been assessed by a nurse between 10/3/12 and his visit to the			

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	medical clinic on 10/10/12, she stated, "I didn't," and indicated she did not assess client A after being notified of swelling on 10/7/12. She indicated she had assessed his ankle on 10/3/12, but had not assessed client A's foot since she was unaware of the incident on 10/1/12. She indicated client A was taken to the medical clinic on 10/10/12 after staff notified her on 10/9/12 of client A's swelling because "We didn't know there was a cause," and "I had no idea it was a fracture." She indicated she referred client A to the medical clinic since it was less expensive than a hospital examination, and she thought client A had possibly developed edema from a medical cause. She was unaware if client A was to be kept within eyesight to protect him from additional injury. The group home nurses notes regarding client A for October, 2012 were reviewed on 11/9/12 at 2:30 PM. A note dated 10/3/12 indicated "staff called and said ankle has edema. Saw sl(slight) edema in R (right ankle). [Client A] denies pain." On 10/7/12 an entry indicated, "Staff left message about [client A's] ankle." On 10/9/12 an entry indicated "Staff called R foot swollen and discolored. They will take [client A] to [medical clinic] in AM." An entry dated 10/10/12 indicated client A was found with 2 metatarsal fractures			

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	in his right foot. There was no evidence of a nursing assessment in the notes from 10/3/12 to 10/10/12. A note dated 10/15/12 indicated client A's fall prevention protocol was updated, and a high risk for fracture protocol was developed and sent to the PD (program director). A 10/16/12 indicated client A's wheelchair was evaluated and repairs made to the chair were completed and the depth of the seat adjusted so client A's feet "fit in foot peddles (sic) more easily." Client A's DSR for October, 2012 was reviewed on 11/9/12 at 2:15 PM. A note written by staff #5 from 2:00 to 10:00 PM dated 10/1/12 indicated "No behaviors to report." A note written by staff #10 from 2:03 PM to 6:03 PM indicated client A had returned home "and moved about. Had meds (medications) and meals given. Resident needed some extra prompts. Over all no behavior problems. Good day compliant." A note written by staff #1 dated 10/1/12 from 4:00 PM until 10:00 PM indicated "Had dinner and went to his room-in bed." There was no record provided to review that indicated the incident with client A's foot being caught between his wheelchair pedal and the wheel on 10/1/12 was documented. Staff #1 was interviewed on 11/9/12 at 2:00 PM and indicated client A was to be			

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	kept within eyesight at all times. Internal incident reports for the time period of Oct, 2012 were reviewed on 11/13/12 at 9:06 AM. There was no evidence of a report of an injury or incident involving client A's foot. Staff training records were reviewed on 11/13/12 at 9:06 AM and indicated staff had been trained on reporting incidents that could cause significant injury immediately to the Home Manager, Program Director and/or the Program Nurse, and documented on DSRs and incident reports completed as needed. There was no evidence of staff training regarding client A's supervision needs. The Area Director #1 was interviewed on 11/19/12 at 2:30 PM and indicated she had checked with the house manager and the house manager had indicated staff were supposed to keep client A within eyesight at all times to prevent other falls and provide assistance to client A. When asked if there had been further incidents involving client A, she indicated client A had fallen out of his wheelchair on 11/18/12 and had been taken to the ER (emergency room) for evaluation and released without finding of injury. She was uncertain if client A's supervision level had been implemented and indicated			

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	the incident was under investigation. She further indicated corrective action had been taken to ensure adequate staffing levels were in the home and an interdisciplinary team meeting would be held this week to evaluate client A's needs. A BDDS report dated 11/18/12 was reviewed on 11/20/12 at 8:11 AM. The report indicated staff was helping another client and client A rolled into the bathroom and fell out of his wheelchair. There was no evidence in the report to indicate if client A's supervision needs or fall risk plan were being implemented at the time of the incident. A draft summary of the internal investigation report dated 11/21/12 was reviewed on 11/26/12 at 12:30 PM. The background information indicated client A was placed on line of sight supervision level following the diagnosis of his broken foot. The conclusion of the investigation indicated client A fell when he attempted to get up from the toilet and "evidence supports" he was not provided with line of sight supervision. This federal tag relates to complaint #IN00117912. 9-3-3(a)			

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W0218	483.440(c)(3)(v) INDIVIDUAL PROGRAM PLAN The comprehensive functional assessment must include sensorimotor development. Based on observation, interview and record review, the facility failed to provide updated assessments of clients' mobility supports (wheelchairs) to ensure their needs were being met for 3 of 4 sampled clients (clients A, C and D). Findings include: Observations were completed at the group home on 11/8/12 from 5:00 PM until 6:09 PM. Client A was in the dining room in a wheelchair with a cast on his right foot and a sock covering his right toe. Clients C and D came home from day services at 6:00 PM. Client C's wheelchair did not have a left foot rest. Client C demonstrated that his brakes didn't work, and indicated the nurse was going to get a new chair for him. Client D's wheelchair was missing the right arm rest, and the left arm rest was not cushioned. Neither clients' wheelchairs had seat cushions. Client A was interviewed on 11/8/12 at 5:05 PM. When asked about his broken foot, he gestured that he fell out of the wheelchair after he unbuckled his seatbelt and he reached forward toward the floor. He indicated his nose and foot hurt.	W0218	Area Director will retrain newly covering Program Director on ISP requirements, to include; ensuring appropriate assessments are completed including sensory-motor. Program Director will review all current ISPs completed by previous PD to ensure all required components of an ISP have been completed. Area Director and Quality Assurance Specialist will review all revised ISP to ensure thoroughly completed with all needed assessments. Responsible Party: Area Director, Program Director, Quality Assurance Specialist	12/26/2012

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	Staff #4 was interviewed on 11/8/12 at 5:30 PM. She indicated she had been with client A on the van when his foot was caught in in the wheel. She stated, "At the time, his foot pedals weren't all that great and his foot kept slipping off." She indicated the incident happened about a month ago, and client A didn't complain of pain once it was discovered his foot was caught and it was freed from the wheel. Client A's records in the group home were reviewed on 11/8/12 at 5:36 PM. The records indicated client A had a history of falls, a diagnosis of osteoporosis and had fallen on 8/10/12 previously. An updated fall risk plan dated 10/12 indicated client A was to keep his feet in view while propelling his wheelchair. A High Risk for Fracture protocol dated 10/15/12 indicated staff were to assess client A's skin daily, report bruising to the RN, report complaints of pain, propel wheelchair slowly and use caution through doorways and on the van. There was no evidence of an assessment of client A's mobility needs in the record. Client A was interviewed again on 11/8/12 at 5:41 PM and indicated his foot rests were better for him now. Staff #4 was interviewed again on 11/8/12			

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	at 5:44 PM. She stated client A's wheelchair fit him "100 percent" better after client A's wheelchair had been evaluated. She indicated the wheelchair had been repaired the same day it was evaluated. She indicated she was unsure of when the nurse was called to evaluate client A's foot after it was caught in the wheel as she was not on duty that day. Staff #1 was interviewed on 11/8/12 at 6:04 PM. She indicated client C had a motorized wheelchair stored in the garage that had been there ever since she started working there a year ago. Client D was interviewed on 11/8/12 at 6:05 PM and indicated the nurse talked about taking him to check on a new wheelchair, and stated,"Evidently she hasn't yet." The Area Director was interviewed on 11/9/12 at 11:15 AM. She indicated wheelchairs should be assessed annually and as issues were noted. She indicated issues noted with client wheelchairs should reported immediately. She indicated client C had a motorized wheelchair, but it did not work out for him and stated "he didn't do well" with a motorized chair. She indicated wheelchairs should be in good working condition with no missing footrests.			

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	The facility's reportable incidents to the Bureau of Developmental Disabilities Services (BDDS) were reviewed on 11/9/12 at 11:16 AM. A report dated 10/10/12 indicated on 10/3/12 staff had noticed client A's right ankle was swollen. The nurse was called. Client A denied pain. Client A's nurse assessed his ankle on 10/5/12 and client A continued to deny pain. On 10/7/12, staff called the nurse again and stated his right foot now looked swollen. Client A was taken to an urgent clinic on 10/10/12 which indicated he has "several' broken bones in his foot. Client A was placed in a protective boot and taken to see an orthopaedic doctor on 10/12/12. The report indicated client A was going to have his wheelchair evaluated. A follow up report dated 10/17/12 indicated an initial investigation "found on 10/1/12, [client A's] right foot was caught between his foot plate and the wheel. During the trip home client A started cussing and shouting, and the van driver pulled to see why [client A] was cursing. It was at that instance it was found that his foot was caught. Staff removed his foot from area and placed his foot on foot rest properly. Staff asked [client A] if he was feeling any pain and [client A] said NO. Staff documented the incident in the DSR (daily support record) book and told staff on shift to follow up			

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	with his foot later to check for swelling. Investigation is ongoing...Training was held on 10/12/12 on Wheelchair safety, RC fall protocol, and line of sight...Indiana Mentor will continue to follow and monitor [client A's] health and safety needs." An attached investigation dated 10/17/12 into the fracture attached to the above BDDS report was reviewed on 11/9/12 at 11:16 AM. The investigation indicated on 10/15/12, the nurse received a report client A's foot had become lodged during transport. The nurse indicated client A's "wheelchair does not meet the physical shape of his body because of the severe kyphosis (large hump on his back)." Interview with staff #10 indicated on 10/1/12, he and staff #4 had completed the afternoon transport for the group home and during the transport client A began cursing. Staff #10 found client A's foot lodged between the footplate and wheel with the footplate sitting on top of his foot. The conclusion indicated "Evidence supports [client A] likely sustained the break on 10/1/12 when foot became lodged. Evidence supports the incident was not reported to anyone in order for [client A] to receive appropriate monitoring for injury." The group home nurse was interviewed			

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	on 11/9/12 at 11:50 AM. She indicated client A's wheelchair had been evaluated since his fracture and adjusted and stated, "It fits him him a lot better, including the footrests." When asked about the nursing assessment of client A's foot, she indicated she was unaware of the incident on 10/1/12 and had been unaware of an issue with client A's foot pedals until after he was diagnosed with a fracture. She indicated there was not a system or schedule to evaluate wheelchairs to ensure they were in good condition, and stated, "It would be a good idea to have a monthly inspection to let me know right away if there is a problem." She indicated client C had never had footrests on his wheelchair and self propels himself. She indicated client D's footrests for his wheelchair were in the closet and had an evaluation scheduled for 11/14/12. She indicated client D had another wheelchair, but his family had switched it to the current chair at their request. She indicated client wheelchairs should have arm rests and she would check on seat cushions for clients C and D as not all wheelchairs had cushions. Client C's records were reviewed on 11/9/12 at 1:55 PM. A record dated 8/13/08 indicated client C had been fitted for a motorized wheelchair. There was no other evidence in client C's file of an			

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	updated assessment. Client D's records were reviewed on 11/9/12 at 2:05 PM and did not include evidence of an assessment of client D's support needs for mobility. The group home nurse was interviewed on 11/9/12 at 2:06 PM and indicated client D had received his wheelchair from his parents at their request and he had an appointment on November 14, 2012 for an evaluation of his wheelchair. The group home nurses notes regarding client A for October, 2012 were reviewed on 11/9/12 at 2:30 PM. A note dated 10/16/12 indicated client A's wheelchair was evaluated and repairs made to the chair were completed and the depth of the seat adjusted so client A's feet "fit in foot peddles (sic) more easily." The group home nurse was interviewed on 11/9/12 at 2:30 PM and provided a Health Care Coordination/Monthly Review dated January, 2012 that indicated client C had slid to the floor during transfer-no injury. and on 1/15/12-"new wheelchair." There was no additional evidence provided in the record to document an assessment of client C's support needs for mobility.			

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	Client A's DSR for October, 2012 was reviewed on 11/9/12 at 2:15 PM. There was no record provided to review that indicated the incident with client A's foot being caught between his wheelchair pedal and the wheel on 10/1/12 was documented and no evidence of the status of client A's wheelchair's foot pedals and his feet slipping from them. The Area Director was interviewed on 11/19/12 at 2:30 PM. She indicated client A had fallen out of his wheelchair on 11/18/12 and had been taken to the ER (emergency room) for evaluation and released without finding of injury and client C had fallen from his wheelchair while reaching down to unplug his TV. She indicated the incidents were under investigation. She further indicated corrective action had been taken to ensure adequate staffing levels were in the home and an interdisciplinary team meeting would be held this week to evaluate client A and C's needs to prevent future occurrence. A BDDS report dated 11/18/12 was reviewed on 11/20/12 at 8:11 AM. The report indicated staff was helping another client and client A rolled into the bathroom and fell out of his wheelchair. There was no indication in the report of the cause of client A's fall. A report dated			

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	11/15/12 indicated client C fell out of his chair while bending down to unplug his TV. This federal tag relates to complaint #IN00117912. 9-3-4(a)			

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W0318	483.460 HEALTH CARE SERVICES The facility must ensure that specific health care services requirements are met. Based on record review and interview, the facility failed to meet the Condition of Participation: Health Care Services. The facility's nursing services failed to provide timely assessment and treatment of an injury resulting in fracture for 1 of 3 sampled clients (client A), failed to ensure implementation of client supervision level to prevent future injury, failed to timely assess 3 of 4 sampled clients' (A, C and D) wheelchairs to ensure they met clients identified needs for mobility, and failed to ensure adaptive equipment for mobility was in good working condition. Findings include: 1. Please refer to W331. The facility's nursing services failed to provide timely assessment and treatment of an injury resulting in fracture for 1 of 4 sampled clients (client A), failed to ensure implementation of client supervision level to prevent future injury and failed to timely assess 3 of 4 sampled clients' (A, C and D) wheelchairs to ensure they met clients identified needs for mobility. 2. Please refer to W436. The facility failed to ensure wheelchairs were in good	W0318	Program Director will hold an IDT meeting for client A to determine adequate supervision level required to meet his needs. Program Director will retrain staff on incident reporting and on the supervision level requirements for all consumers in the home. Program Director will retrain Home Manager on management oversight responsibilities including documentation review, observation requirements and staff scheduling to include ensuring supervision levels is adequate to the consumer needs. Nursing Supervisor will retrain facility nurse on nursing responsibilities to include assessments and treatment of clients following an incident and providing adequate assessment of adaptive equipment. Facility Nurse will assess all wheelchairs in the home to determine need for repairs. Ongoing, facility nurse will assess clients' wheelchairs during quarterly reviews. Home Manager and Program	12/26/2012

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	condition for 3 of 4 clients who used wheelchairs (clients A, C and D). 9-3-6(a)		Director will complete observations twice weekly for the next 4 weeks to ensure adequate staffing support is provided and staff is meeting supervision levels Responsible Party: Program Director, Home Manager, Nursing Supervisor, Facility Nurse	

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W0331	483.460(c) NURSING SERVICES The facility must provide clients with nursing services in accordance with their needs. Based on record review and interview, the facility's nursing services failed to provide timely assessment and treatment of an injury resulting in fracture for 1 of 4 sampled clients (client A), failed to ensure implementation of client supervision level to prevent future injury and failed to timely assess 3 of 4 sampled clients' (A, C and D) wheelchairs to ensure they met clients identified needs for mobility. Findings include: Observations were completed at the group home on 11/8/12 from 5:00 PM until 6:09 PM. Client A was in the dining room in a wheelchair with a cast on his right foot and a sock covering his right toe. A sign on a white board in the dining room indicated, "[Client A] must be in sight of staff at all times when awake." From 5:11 PM until 5:14 PM there was no staff within eyesight of client A. Staff #1 and #2 were in other areas of the house. From 5:20 PM until 5:21 PM staff were not within eyesight of client A. Clients C and D came home from day services at 6:00 PM. Client C's wheelchair did not have a left foot rest. Client C demonstrated that his brakes didn't work, and indicated the	W0331	Program Director will hold an IDT meeting for client A to determine adequate supervision level required to meet his needs. Program Director will retrain staff on incident reporting and on the supervision level requirements for all consumers in the home. Program Director will retrain Home Manager on management oversight responsibilities including documentation review, observation requirements and staff scheduling to include ensuring supervision levels is adequate to the consumer needs. Nursing Supervisor will retrain facility nurse on nursing responsibilities to include assessments and treatment of clients following an incident and providing adequate assessment of adaptive equipment. Facility Nurse will assess all wheelchairs in the home to determine need for repairs. Ongoing, facility nurse will assess clients' wheelchairs during quarterly reviews. Home Manager and Program	12/26/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G417	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 11/26/2012

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	nurse was going to get a new chair for him. Client D's wheelchair was missing the right arm rest, and the left arm rest was not cushioned. Neither clients' wheelchairs had seat cushions. Client A was interviewed on 11/8/12 at 5:05 PM. When asked about his broken foot, he gestured that he fell out of the wheelchair after he unbuckled his seatbelt and he reached forward toward the floor. He indicated his nose and foot hurt. Staff #4 was interviewed on 11/8/12 at 5:30 PM. She indicated she had been with client A on the van when his foot was caught in in the wheel. She stated, "At the time, his foot pedals weren't all that great and his foot kept slipping off." She indicated the incident happened about a month ago, and client A didn't complain of pain once it was discovered his foot was caught and it was freed from the wheel. She stated the nurse was not notified of the incident and it was "charted." She indicated client A had a fall risk plan. Client A's records in the group home were reviewed on 11/8/12 at 5:36 PM. The records indicated client A had a history of falls, a diagnosis of osteoporosis and had fallen on 8/10/12 previously. An updated fall risk plan dated 10/12 indicated client		Director will complete observations twice weekly for the next 4 weeks to ensure adequate staffing support is provided and staff is meeting supervision levels Responsible Party: Program Director, Home Manager, Nursing Supervisor, Facility Nurse	

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	A was to keep his feet in view while propelling his wheelchair. A High Risk for Fracture protocol dated 10/15/12 indicated staff were to assess client A's skin daily, report bruising to the RN, report complaints of pain, propel wheelchair slowly and use caution through doorways and on the van. Client A was interviewed again on 11/8/12 at 5:41 PM and indicated his foot rests were better now. Staff #4 was interviewed again on 11/8/12 at 5:44 PM. She stated client A's wheelchair fit him "100 percent" better after client A's wheelchair had been evaluated. She indicated the wheelchair had been repaired the same day it was evaluated. She indicated she was unsure of when the nurse was called to evaluate client A's foot after it was caught in the wheel as she was not on duty that day. The facility's reportable incidents to the Bureau of Developmental Disabilities Services (BDDS) were reviewed on 11/9/12 at 11:16 AM. A report dated 10/10/12 indicated on 10/3/12 staff had noticed client A's right ankle was swollen. The nurse was called. Client A denied pain. Client A's nurse assessed his ankle on 10/5/12 and client A continued to deny pain. On 10/7/12, staff called the nurse			

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	again and stated his right foot now looked swollen. Client A was taken to an urgent clinic on 10/10/12 which indicated he has "several" broken bones in his foot. Client A was placed in a protective boot and taken to see an orthopaedic doctor on 10/12/12. The report indicated client A was going to have his wheelchair evaluated. A follow up report dated 10/17/12 indicated an initial investigation "found on 10/1/12, [client A's] right foot was caught between his foot plate and the wheel. During the trip home client A started cussing and shouting, and the van driver pulled over to see why [client A] was cursing. It was at that instance it was found that his foot was caught. Staff removed his foot from area and placed his foot on foot rest properly. Staff asked [client A] if he was feeling any pain and [client A] said NO. Staff documented the incident in the DSR (daily support record) book and told staff on shift to follow up with his foot later to check for swelling. Investigation is ongoing...Training was held on 10/12/12 on Wheelchair safety, RC fall protocol, and line of sight...Indiana Mentor will continue to follow and monitor [client A's] health and safety needs." An attached investigation dated 10/17/12 into the fracture attached to the above BDDS report was reviewed on 11/9/12 at			

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	11:16 AM. The investigation indicated on 10/10/12, client A was diagnosed with a broken foot with no known cause. Interview with the nurse indicated client A was assessed by the nurse on 10/3/12 following a report it was swollen and slight swelling was observed in his right ankle. Client A denied pain and did not display pain when his ankle was moved. On 10/7/12, the nurse received a message client A's ankle was still swollen and on 10/9/12 the nurse received a report client A's foot was swollen and discolored. He would be assessed at [medical clinic] on 10/10/12, and was diagnosed with 2 metatarsal fractures. On 10/15/12, the nurse received a report client A's foot had become lodged during transport. The nurse indicated client A's "wheelchair does not meet the physical shape of his body because of the severe kyphosis (large hump on his back)." Interview with staff #10 indicated on 10/1/12, he and staff #4 had completed the afternoon transport for the group home and during the transport client A began cursing. Staff #10 found client A's foot lodged between the footplate and wheel with the footplate sitting on top of his foot. Staff #10 freed client A's foot and assessed it upon return to the group home with no injuries noted and no signs or symptoms of pain/injury displayed by client A. Staff #4 was interviewed and indicated a			

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	similar account as staff #10. She indicated "she did not report this to anyone...because she was working that evening and because she was working Monday through Friday and she could monitor [client A]." She indicated she contacted the group home nurse on 10/7/12 while she assisted him with bathing when she noticed bruising and swelling on client A's foot. The nurse indicated she would assess him on 10/7/12. The conclusion indicated "Evidence supports [client A] likely sustained the break on 10/1/12 when foot became lodged. Evidence supports the incident was not reported to anyone in order for [client A] to receive appropriate monitoring for injury." The Area Director was interviewed on 11/9/12 at 11:15 AM. She indicated the failure to obtain medical attention for client A until 10/10/12 was a delay in treatment. She indicated staff who witnessed the incident on the van on 10/1/12 reported the incident in daily notes, but failed to document it in incident reports. Staff did not report the incident to the nurse because client A did not complain of pain after the incident. She was uncertain if client A was to be within eyesight. She indicated staff should have kept client A within eyesight if the line of sight supervision level had not been			

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	discontinued. She was uncertain as to the cause of the delay in nursing assessments for client A after the initial nursing assessment on 10/3/12 after swelling was noted on 10/3/12 and medical treatment on 10/10/12 which revealed the fractures in his right foot. She indicated staff had been retrained on reporting and the nurse on assessment requirements. The group home nurse was interviewed on 11/9/12 at 11:50 AM. She indicated client A's wheelchair had been evaluated and adjusted since his fracture and stated, "It fits him a lot better, including the footrests." When asked about the nursing assessment of client A's foot, she indicated she was unaware of the incident on 10/1/12 and had been unaware of an issue with client A's foot pedals until after he was diagnosed with a fracture. She indicated there was not a system or schedule to evaluate wheelchairs to ensure they were in good condition, and stated, "It would be a good idea to have a monthly inspection to let me know right away if there is a problem." She indicated client C had never had footrests on his wheelchair and self propels himself. She indicated client D's footrests for his wheelchair were in the closet and had an evaluation scheduled for 11/14/12. She indicated client D had another wheelchair, but his family had switched it to the			

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	current chair at their request. She indicated client wheelchairs should have arm rests and she would check on seat cushions for clients C and D as not all wheelchairs had cushions. When asked if client A had been assessed by a nurse between 10/3/12 and his visit to the medical clinic on 10/10/12, she stated, "I didn't," and indicated she did not assess client A after being notified of swelling on 10/7/12. She indicated she had assessed his ankle on 10/3/12, but had not assessed client A's foot since she was unaware of the incident on 10/1/12. She indicated client A was taken to the medical clinic on 10/10/12 after staff notified her on 10/9/12 of client A's swelling because "We didn't know there was a cause," and "I had no idea it was a fracture." She indicated she referred client A to the medical clinic since it was less expensive than a hospital examination, and she thought client A had possibly developed edema from a medical cause. She was unaware if client A was to be kept within eyesight to protect him from additional injury. Client C's records were reviewed on 11/9/12 at 1:55 PM. A record dated 8/13/08 indicated client C had been fitted for a motorized wheelchair. There was no other evidence in client C's file of an updated assessment.			

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	Client D's records were reviewed on 11/9/12 at 2:05 PM and did not include evidence of an assessment of client D's support needs for mobility. The group home nurse was interviewed on 11/9/12 at 2:06 PM and indicated client D had received his wheelchair from his parents at their request and he had an appointment on November 14, 2012 for an evaluation of his wheelchair. The group home nurses notes regarding client A for October, 2012 were reviewed on 11/9/12 at 2:30 PM. A note dated 10/3/12 indicated "staff called and said ankle has edema. Saw sl(slight) edema in R (right ankle). [Client A] denies pain." On 10/7/12 an entry indicated, "Staff left message about [client A's] ankle." On 10/9/12 an entry indicated "Staff called R foot swollen and discolored. They will take [client A] to [medical clinic] in AM." An entry dated 10/10/12 indicated client A was found with 2 metatarsal fractures in his right foot. There was no evidence of a nursing assessment in the notes from 10/3/12 to 10/10/12. A note dated 10/15/12 indicated client A's fall prevention protocol was updated, and a high risk for fracture protocol was developed and sent to the PD (program director). A 10/16/12 indicated client A's			

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	wheelchair was evaluated and repairs made to the chair were completed and the depth of the seat adjusted so client A's feet "fit in foot peddles (sic) more easily." Client A's DSR for October, 2012 was reviewed on 11/9/12 at 2:15 PM. A note written by staff #5 from 2:00 to 10:00 PM dated 10/1/12 indicated "No behaviors to report." A note written by staff #10 from 2:03 PM to 6:03 PM indicated client A had returned home "and moved about. Had meds (medications) and meals given. Resident needed some extra prompts. Over all no behavior problems. Good day compliant." A note written by staff #1 dated 10/1/12 from 4:00 PM until 10:00 PM indicated "Had dinner and went to his room-in bed." There was no record provided to review that indicated the incident with client A's foot being caught between his wheelchair pedal and the wheel on 10/1/12 was documented and reported to the nurse. Staff #1 was interviewed on 11/9/12 at 2:00 PM and indicated client A was to be kept within eyesight at all times. Internal incident reports for the time period of Oct, 2012 were reviewed on 11/13/12 at 9:06 AM. There was no evidence of a report of an injury or incident involving client A's foot.			

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	The Area Director #1 was interviewed on 11/19/12 at 2:30 PM and indicated she had checked with the house manager and the house manager had indicated staff were supposed to keep client A within eyesight at all times to prevent other falls and provide assistance to client A. When asked if there had been further incidents involving client A, she indicated client A had fallen out of his wheelchair on 11/18/12 and had been taken to the ER (emergency room) for evaluation and released without finding of injury. She was uncertain if client A's supervision level had been implemented and indicated the incident was under investigation. She further indicated corrective action had been taken to ensure adequate staffing levels were in the home and an interdisciplinary team meeting would be held this week to evaluate client A's needs. She indicated client C had fallen out of his wheelchair on 11/15/12 while reaching to unplug his chair. She indicated the incident was under investigation and an IDT team would be held to determine client C's needs to prevent falls. A BDDS report dated 11/18/12 was reviewed on 11/20/12 at 8:11 AM. The report indicated staff was helping another client and client A rolled into the			

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	bathroom and fell out of his wheelchair. A report dated 11/15/12 indicated client C had fallen out of his wheelchair after he reached down to unplug his TV. No additional information was provided to indicate the cause of client A and C's falls. This federal tag relates to complaint #IN00117912. 9-3-6(a)			

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W0436	483.470(g)(2) SPACE AND EQUIPMENT The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client. Based on observation, interview and record review, the facility failed to ensure wheelchairs were in good condition for 3 of 4 clients who used wheelchairs (clients A, C and D). Findings include: Observation were completed at the group home on 11/8/12 from 5:00 PM until 6:09 PM. Client A was in the dining room in a wheelchair with a cast on his right foot and a sock covering his right toe. Clients C and D came home from day services at 6:00 PM. Client C's wheelchair did not have a left foot rest. Client C demonstrated that his brakes didn't work, and indicated the nurse was going to get a new chair for him. Client D's wheelchair was missing the right arm rest, and the left arm rest was not cushioned. Neither clients' wheelchairs had seat cushions. Client A was interviewed on 11/8/12 at 5:05 PM. When asked about his broken foot, he gestured that he fell out of the	W0436	Nursing Supervisor will retrain facility nurse on nursing responsibilities to include assessments and treatment of clients following an incident and providing adequate assessment of adaptive equipment. Facility Nurse will assess all wheelchairs in the home to determine need for repairs. Ongoing, facility nurse will assess clients' wheelchairs during quarterly reviews. Responsible Party: Nursing Supervisor, Facility Nurse	12/26/2012

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	wheelchair after he unbuckled his seatbelt and he reached forward toward the floor. He indicated his nose and foot hurt. Staff #4 was interviewed on 11/8/12 at 5:30 PM. She indicated she had been with client A on the van when his foot was caught in in the wheel. She stated, "At the time, his foot pedals weren't all that great and his foot kept slipping off." She indicated the incident happened about a month ago, and client A didn't complain of pain once it was discovered his foot was caught and it was freed from the wheel. Client A's records in the group home were reviewed on 11/8/12 at 5:36 PM. The records indicated client A had a history of falls, a diagnosis of osteoporosis and had fallen on 8/10/12 previously. An updated fall risk plan dated 10/12 indicated client A was to keep his feet in view while propelling his wheelchair. A High Risk for Fracture protocol dated 10/15/12 indicated staff were to assess client A's skin daily, report bruising to the RN, report complaints of pain, propel wheelchair slowly and use caution through doorways and on the van. There was no evidence of an assessment of client A's mobility needs in the record. Client A was interviewed again on			

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	11/8/12 at 5:41 PM and indicated his foot rests were better now. Staff #4 was interviewed again on 11/8/12 at 5:44 PM. She stated client A's wheelchair fit him "100 percent" better after client A's wheelchair had been evaluated. She indicated the wheelchair had been repaired the same day it was evaluated. She indicated she was unsure of when the nurse was called to evaluate client A's foot after it was caught in the wheel as she was not on duty that day. Staff #1 was interviewed on 11/8/12 at 6:04 PM. She indicated client C had a motorized wheelchair stored in the garage that had been there ever since she started working there a year ago. Client D was interviewed on 11/8/12 at 6:05 PM and indicated the nurse talked about taking him to check on a new wheelchair, and stated, "Evidently she hasn't yet." The Area Director was interviewed on 11/9/12 at 11:15 AM. She indicated wheelchairs should be assessed annually and as issues were noted. She indicated issues noted with client wheelchairs should reported immediately. She indicated client C had a motorized wheelchair, but it did not work out for			

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	him and stated "he didn't do well" with a motorized chair. She indicated wheelchairs should be in good working condition with no missing footrests. The facility's reportable incidents to the Bureau of Developmental Disabilities Services (BDDS) were reviewed on 11/9/12 at 11:16 AM. A report dated 10/10/12 indicated on 10/3/12 staff had noticed client A's right ankle was swollen. The nurse was called. Client A denied pain. Client A's nurse assessed his ankle on 10/5/12 and client A continued to deny pain. On 10/7/12, staff called the nurse again and stated his right foot now looked swollen. Client A was taken to an urgent clinic on 10/10/12 which indicated he has "several" broken bones in his foot. Client A was placed in a protective boot and taken to see an orthopaedic doctor on 10/12/12. The report indicated client A was going to have his wheelchair evaluated. A follow up report dated 10/17/12 indicated an initial investigation "found on 10/1/12, [client A's] right foot was caught between his foot plate and the wheel. During the trip home client A started cussing and shouting, and the van driver pulled over to see why [client A] was cursing. It was at that instance it was found that his foot was caught. Staff removed his foot from area and placed his foot on foot rest properly. Staff asked			

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	[client A] if he was feeling any pain and [client A] said NO. Staff documented the incident in the DSR (daily support record) book and told staff on shift to follow up with his foot later to check for swelling. Investigation is ongoing...Training was held on 10/12/12 on Wheelchair safety, RC fall protocol, and line of sight...Indiana Mentor will continue to follow and monitor [client A's] health and safety needs." An attached investigation dated 10/17/12 into the fracture attached to the above BDDS report was reviewed on 11/9/12 at 11:16 AM. The investigation indicated on 10/15/12, the nurse received a report client A's foot had become lodged during transport. The nurse indicated client A's "wheelchair does not meet the physical shape of his body because of the severe kyphosis (large hump on his back)." Interview with staff #10 indicated on 10/1/12, he and staff #4 had completed the afternoon transport for the group home and during the transport client A began cursing. Staff #10 found client A's foot lodged between the footplate and wheel with the footplate sitting on top of his foot. The conclusion indicated "Evidence supports [client A] likely sustained the break on 10/1/12 when foot became lodged. Evidence supports the incident was not reported to anyone in			

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	order for [client A] to receive appropriate monitoring for injury." The group home nurse was interviewed on 11/9/12 at 11:50 AM. She indicated client A's wheelchair had been evaluated and adjusted since his fracture and stated, "It fits him a lot better, including the footrests." When asked about the nursing assessment of client A's foot, she indicated she was unaware of the incident on 10/1/12 and had been unaware of an issue with client A's foot pedals until after he was diagnosed with a fracture. She indicated there was not a system or schedule to evaluate wheelchairs to ensure they were in good condition, and stated, "It would be a good idea to have a monthly inspection to let me know right away if there is a problem." She indicated client C had never had footrests on his wheelchair and self propels himself. She indicated client D's footrests for his wheelchair were in the closet and had an evaluation scheduled for 11/14/12. She indicated client D had another wheelchair, but his family had switched it to the current chair at their request. She indicated client wheelchairs should have arm rests and she would check on seat cushions for clients C and D as not all wheelchairs had cushions. Client C's records were reviewed on			

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	11/9/12 at 1:55 PM. A record dated 8/13/08 indicated client C had been fitted for a motorized wheelchair. There was no other evidence in client C's file of an updated assessment. Client D's records were reviewed on 11/9/12 at 2:05 PM and did not include evidence of an assessment of client D's support needs for mobility. The group home nurse was interviewed on 11/9/12 at 2:06 PM and indicated client D had received his wheelchair from his parents at their request and he had an appointment on November 14, 2012 for an evaluation of his wheelchair. The group home nurses notes regarding client A for October, 2012 were reviewed on 11/9/12 at 2:30 PM. A note dated 10/16/12 indicated client A's wheelchair was evaluated and repairs made to the chair were completed and the depth of the seat adjusted so client A's feet "fit in foot peddles (sic) more easily." The group home nurse was interviewed on 11/9/12 at 2:30 PM and provided a Health Care Coordination/Monthly Review dated January, 2012 that indicated client C had slid to the floor during transfer-no injury. and on 1/15/12-"new wheelchair." There was no			

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	additional evidence provided in the record to document an assessment of client C's support needs for mobility. Client A's DSR for October, 2012 was reviewed on 11/9/12 at 2:15 PM. There was no record provided to review that indicated the incident with client A's foot being caught between his wheelchair pedal and the wheel on 10/1/12 was documented and no evidence of the status of client A's wheelchair's foot pedals and his feet slipping from them. The Area Director #1 was interviewed on 11/19/12 at 2:30 PM. She indicated client A had fallen out of his wheelchair on 11/18/12 and had been taken to the ER (emergency room) for evaluation and released without finding of injury and client C had fallen from his wheelchair while reaching down to unplug his TV. She indicated the incidents were under investigation. She further indicated corrective action had been taken to ensure adequate staffing levels were in the home and an interdisciplinary team meeting would be held this week to evaluate client A and C's needs to prevent future occurrence. A BDDS report dated 11/18/12 was reviewed on 11/20/12 at 8:11 AM. The report indicated staff was helping another			

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	client and client A rolled into the bathroom and fell out of his wheelchair. There was no indication in the report of the cause of client A's fall. A report dated 11/15/12 indicated client C fell out of his chair while bending down to unplug his TV. This federal tag relates to complaint #IN00117912. 9-3-7(a)			