

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  01/09/2013
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NAME OF PROVIDER OR SUPPLIER  REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 5625 E 56TH ST INDIANAPOLIS, IN 46226
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W0000	<p>This visit was for the post certification revisit to the investigation of complaint #IN00117912.</p> <p>Complaint #IN00117912: Not corrected.</p> <p>Dates of Survey: January 2, 3, 4, 7, 8 and 9, 2013.</p> <p>Facility Number: 000931 Provider Number: 15G417 AIM Number: 100244550</p> <p>Surveyor: Susan Reichert, Medical Surveyor III</p> <p>The following federal deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 1/14/13 by Ruth Shackelford, Medical Surveyor III.</p>	W0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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

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W0104	<p>483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility.</p> <p>Based on observation, interview and record review, the governing body failed to provide oversight and direction to ensure effective corrective action was implemented to protect 1 additional client (client F) from further injury by failing to timely assess and update her fall risk protocol after a significant injury resulted from transfer, failed to adequately train staff to prevent future injury resulting from transfers and failed to ensure wheelchairs were in good condition for 2 of 4 clients who used wheelchairs (clients A and B).</p> <p>Findings include:</p> <p>1. The Area Director #2 and Program Director indicated on 1/2/13 at 2:55 PM there were no incidents of falls or of reportable incidents to the Bureau of Developmental Disabilities Services (BDDS) since the exit conference of the last visit to the facility on 11/26/12.</p> <p>Staff training records were reviewed on 1/2/13 at 2:55 PM. Training records indicated staff had been trained on client support levels, documentation and use of</p>	W0104	<p>Client F's fall protocol was updated and all staff were given competency based training on specific ways to transfer Client F to prevent any further injuries from transferring her.</p> <p>The Program Nurse was retrained by the Nursing Supervisor regarding timely assessment of any reported consumer injuries or incidents that could cause potential injuries. The Program Nurse was also retrained on ensuring that consumers fall protocols are reviewed and updated after any reported fall, ensuring staff are trained on updates and modifications to fall protocols. The Program Nurse was also retrained on ensuring documentation of all consumers medical appointments, evaluations, reports from therapies such as OT, PT, speech, etc. are all present in all consumers' files and are available for review.</p> <p>Ongoing, the Program Nurse will review and update all consumers fall protocols following any falls that occur. The Program Nurse will work with the Program Director to ensure that all staff are trained on any updates to the</p>	02/08/2013			

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	<p>a Hoyer lift on 12/17/12. There was no evidence of training on client F's fall risk protocol and transfer support needs.</p> <p>Staff #1 and #2 were interviewed on 1/2/13 at 5:10 PM and indicated there had been no falls since 11/26/12. Staff #2 stated, "We would report it." Staff #1 indicated the nurse indicated client A was to receive a new wheelchair and client B's wheelchair repair parts were on order.</p> <p>The group home's January, 2013 staff log was reviewed on 1/2/13 at 5:45 PM and indicated an entry dated 1/2/13 indicating OT (occupational therapy) had provided services to client F regarding her wheelchair.</p> <p>Client F's Fall Risk Plan and nurse's monthly notes were reviewed on 1/3/13 at 1:05 PM at the facility office. A fall risk protocol dated 8/10/12 indicated client F was at risk for falls due to decreased mobility and strength in her arms and legs and required staff assistance during transfers to and from her wheelchair and the shower chair. The protocol did not specify the type of staff assistance client F required to transfer to her wheelchair or shower chair. A December, 2012 Healthcare Coordination/Monthly Health Review indicated staff #5 had called the nurse on 12/5/12 at 8:30 (AM or PM not</p>		<p>fall protocol as needed. The Area Director will review any investigations and recommendations after a fall to ensure that all recommendations have been completed, fall protocols have been updated and training has been provided to staff as needed.</p> <p>All consumers' wheelchairs were professionally evaluated and repairs have been made as recommended by the evaluations. In addition, all missing components were replaced as needed. The Program Nurse was retrained on the need to ensure follow up is completed on all recommendations for repairs for all consumers' wheelchairs and that all components such as seat cushions, leg rests, arm rests, etc. are in good repair and are present on the wheelchair as needed.</p> <p>Staff were trained on the need to ensure any issues regarding consumers wheelchairs needing repairs are reported immediately the Home Manager and Program Nurse so that repairs can be completed in a timely manner. Ongoing, the Home Manager will look over all consumers wheelchairs at least weekly to determine if they are in good working order and if any repairs need to be made. The Program Nurse will look over all of the consumers wheelchairs at least</p>				

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	indicated) to report client F had complained of arm pain. Client F had stated she fell, but there had been no witnesses of a fall at home or a report of a fall at day services. The nurse gave instructions for staff to report back to the nurse if client F exhibited bruising or redness. On 12/6/12 at 7:00 AM, staff (unidentified) called. Client F was unable to lift her left arm. Client F was taken to an urgent care center on 12/6/12 at 1:30 PM, was diagnosed with a dislocated shoulder and taken to the emergency room for outpatient shoulder adjustment. An entry dated 12/12/12 indicated a follow up visit to client F's physician in which PT/OT was ordered. An entry dated 12/16/12 indicated PT evaluated client F. "Spoke with PT about shoulder and need for training and/or exercises for shoulder and transfers." An entry dated 12/18/12 indicated OT was in the home, on 12/20/12 OT/PT in the home, on 12/24/12 PT was in the home, on 12/28/12 OT/PT was in the home. A 12/31/12 entry indicated the OT called and said she got an order for a new wheelchair, and the OT said she has done training with "most of the staff" on transferring safely and client F's exercises. There was no evidence in client F's records provided of the documentation of OT and PT assessment of client F's needs for staff assistance during transfer, of the		monthly to ensure that they are in good working order and determine if any repairs need to be made. The Program Nurse will document this on the monthly nursing notes. The Area Director and/or Nursing Supervisor will review the nursing notes a minimum of quarterly to ensure that documentation of the Program Nurse reviewing the status of all consumers wheelchairs is being documented. The Program Nurse will get all consumers wheelchairs professionally evaluated a minimum of annually to ensure they are in good working order.  Responsible Party: Home Manager, Program Director, Area Director, Program Nurse, Nursing Supervisor	

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	<p>OT and PT visits with client F, an updated fall risk protocol, or evidence of competency based staff training for all staff working in the group home.</p> <p>The Area Director #2 and Program Director were interviewed on 1/3/13 at 1:35 PM and indicated they had overlooked providing the reported possible fall with injury to client F and a BDDS report had been made of the incident. They indicated interventions had been put in place for 2 staff to transfer client F, or to use a Hoyer lift to assist client F during transfer. They indicated the physician who treated client F indicated she was at risk for dislocation due to the structure of her shoulder and her condition was not previously known. They indicated the fall risk protocol should be specific for client F's support needs for transfer, the fall protocol had not been updated and did not include the assessment recommendations from medical professionals including OT and PT. They indicated it was the nurse's responsibility to update the fall protocol and the nurse and the Program Director's responsibility to ensure the fall risk protocol was updated.</p> <p>The BDDS report dated 12/5/12 of the incident involving client F was reviewed on 1/3/13 at 1:45 PM. The BDDS report</p>						

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	<p>indicated client F reported to staff that her arm hurt and client F stated she fell, but indicated she fell in the bathroom, the living room, in the kitchen and at day program. There were no witnesses to a fall, and staff checked client F for injury and found no injuries or marks/bruising. Client F was taken to an urgent care center to be checked on 12/6/12 and the doctor stated she had dislocated her shoulder and he instructed staff to take her to the emergency room for evaluation and treatment. The report indicated an investigation was underway to determine the origin of her injury.</p> <p>The investigation dated 12/18/12 into the incident involving client F was reviewed on 1/3/13 at 1:45 PM. The investigation summary indicated the evidence did not support a fall as the cause of injury to client F's shoulder, and was "likely" dislocated the evening of 12/5/12 while completing personal hygiene. Recommendations included an assessment of client F's shoulder weakness, OT evaluation to develop transfer procedures and any other recommendations needed, develop a step-by step protocol for recommended transfers to include need for competency based assessment of staff before they may transfer clients A, B, E and F, develop a competency based assessment of transfers</p>			

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	<p>for clients A, B, E and F, retrain staff on transfer protocol and any other recommendations resulting from client F's OT evaluation, competency based assessment of transfers with current staff and ongoing, complete "frequent" observations of client transfers for 30 days following retraining.</p> <p>An Indiana Mentor Nursing Progress Note dated 1/2/13 was reviewed on 1/4/13 at 10:10 AM. The note indicated client F had been seen by an OT "to address left upper extremity range of motion and strength, safety with functional transfers and self care, safe positioning, prevention of pressure ulcer, caregiver education, and establishment of a home exercise program." The note indicated staff had been educated on a "safe way to transfer patient with a gait belt as well as not to pull on shoulder joints when lifting to prevent injury. Staff verbalized understanding." There was no further evidence of competency based training provided for staff regarding safe transfer techniques for client F.</p> <p>Area Director #1 was interviewed on 1/8/13 at 3:35 PM. When asked if the follow up appointment dated 1/2/13 was timely to address client F's needs related to transfers and her dislocated shoulder, she indicated she would check with the</p>						

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	<p>nurse on the timing of client F's OT and PT assessment to follow up after her dislocated shoulder. She indicated sometimes a period of time was required because of the availability of therapies and stated, "We are at the mercy of the availability," and "The sooner the better." She indicated she would investigate the status of the competency based staff training records that were recommended by the investigation into the incident involving client F's dislocated shoulder.</p> <p>2. The Area Director #2 and Program Director were interviewed on 1/2/13 at 2:55 PM. The Area Director #2 indicated wheelchair evaluations had been completed for clients who used wheelchairs in the home and 2 wheelchairs required repair and one had been replaced. They indicated the nurse would have the evaluations available in the client records located at the group home.</p> <p>During the observation at the group home on 1/2/13 from 4:35 PM until 6:25 PM, client A's wheelchair was missing the seat cushion, one arm pad on the left arm rest bar and was missing the left foot rest. Client B's wheelchair was missing a seat cushion, the foot rests and was missing an arm rest on the right side.</p>			

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	<p>Staff #1 was interviewed on 1/2/12 at 5:10 PM. Staff #1 indicated the nurse had indicated client A was to receive a new wheelchair and client B's wheelchair repair parts were on order.</p> <p>Client A was interviewed on 1/3/13 at 4:45 PM. He pointed to the wheelchair cushion propped up against the wall in his bedroom and indicated the use of the cushion made the seat too high. He indicated the foot rest was in the closet. Client A indicated he wanted the missing items restored and the arm rest repaired.</p> <p>Client B was interviewed on 1/3/13 at 4:55 PM. He indicated he would like to have a seat cushion, foot rests and an arm rest for his wheelchair and stated, "I don't know if they're going to fix it or get a new one. I don't have any idea when."</p> <p>Client A's records were reviewed at the group home on 1/2/13 at 5:16 PM. Client A's annual physical exam dated 8/15/12 indicated he was "wheelchair dependent." A physician's order dated 11/28/12 indicated a prescription for OT/PT (Occupational Therapy/Physical Therapy) wheelchair evaluation. A quarterly nursing note dated 12/12/12 indicated a new wheelchair recommendation was sent to client A's physician. A December 2012 Healthcare Coordination/Monthly Health</p>						

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	<p>Review included an entry dated 12/10/12 that indicated an appointment was made for client A to receive a wheelchair evaluation. "On 12/19/12 PT called. Said they recommend a new wheelchair and will send to MD (medical doctor)."</p> <p>Client B's records were reviewed at the agency's office on 1/3/13 at 12:55 PM. A Fall Protocol dated 8/10/12 indicated client B had unstable gait due to cerebral palsy and knee "problems... Currently using wheelchair but transfers to and from chair. Needs supervision during transfers and to and from chair." A December 2012 Healthcare Coordination/Monthly Health Review included an entry dated 12/6/12 which indicated the nurse spoke with the wheelchair evaluation company. "They lost w/c (wheelchair) evaluation for Nov 14th. Faxed them my copy. They will call to make repairs on chair." An entry dated 12/11/12 indicated the nurse had called the wheelchair evaluation company about client B's wheelchair. "They forgot to call back last week. They will order needed parts. Should be in in (sic) 1 1/2 weeks. Made an appt (appointment) for 12/28/12 for repairs." An entry dated 12/27/12 indicated the wheelchair company called and the parts were not in yet for client B's wheelchair and the appointment was rescheduled for 1/11/13.</p>						

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	<p>The Area Director #2 and the Program Director were interviewed on 1/3/13 at 1:35 PM and indicated it was not unusual to wait a month for parts to a wheelchair, and the company was within usual timeframes to provide needed services for clients' wheelchair needs.</p> <p>The Area Director #1 was interviewed on 1/9/13 at 12:30 PM and indicated it was the Area Director's responsibility to ensure recommendations from investigations were implemented and to ensure wheelchairs were maintained in good condition.</p> <p>This deficiency was cited on 11/26/12. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>9-3-1(a)</p>				

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W0111	<p>483.410(c)(1) CLIENT RECORDS</p> <p>The facility must develop and maintain a recordkeeping system that documents the client's health care, active treatment, social information, and protection of the client's rights.</p> <p>Based on observation, record review and interview, the facility failed for 2 of 4 sampled clients (clients A and B), and 1 additional client (client F) to maintain a record keeping system to document medical and program plan implementation information in the clients' records.</p> <p>Findings include:</p> <p>The Area Director #2 and Program Director were interviewed on 1/2/13 at 2:55 PM. The Area Director #2 indicated wheelchair evaluations had been completed for clients who used wheelchairs in the home and 2 wheelchairs required repair and one had been replaced.</p> <p>The House Manager was interviewed on 1/2/13 at 4:45 PM and indicated the wheelchair assessments had been completed for clients A, B and F and the nurse would have the documentation.</p> <p>Client A's medical records were reviewed</p>	W0111	<p>All Direct Support Staff were trained on the need to ensure that necessary paperwork was taken to every consumer medical appointment including wheelchair evaluations, OT and PT sessions, etc. The Home Manager was retrained on the need to follow up with staff following all client medical appointments to make sure recommendations were being reported to the nurse and paperwork from the appointment was given to the nurse to file. The Program Nurse was retrained on ensuring that consumers fall protocols are reviewed and updated after any reported fall, ensuring staff are trained on updates and modifications to fall protocols. The Program Nurse was also retrained on ensuring documentation of all consumers medical appointments, evaluations, reports from therapies such as OT, PT, speech, etc. are all present in all consumers' files and are available for review.</p> <p>Ongoing, the Program Nurse will review and update all consumers fall protocols following any falls that occur. The Program Nurse</p>	02/08/2013			

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	<p>in the group home on 1/2/13 at 5:16 PM. Client A's record did not include a wheelchair evaluation.</p> <p>Client B's medical records were unavailable to review in the group home on 1/2/13 as the record was in the office.</p> <p>The nurse was interviewed on 1/2/13 at 5:30 PM. She indicated the group home staff had not taken a medical appointment form with them when client A and B's wheelchair evaluations had been made and she was attempting to get the medical records from the clients' physician's office.</p> <p>Client A's wheelchair evaluation dated 12/19/12 was reviewed on 1/3/13 at 1:00 PM at the office and indicated his wheelchair was missing the left foot rest and the breaks were not holding.</p> <p>Client B's medical record was reviewed at the office on 1/3/13 at 12:35 PM. A separate work order for his wheelchair dated 11/14/12 indicated repairs were needed to client B's wheelchair including a missing right arm rest, overall tightening, leg rests missing, wheel assemblies are "worn badly," seat and back upholstery worn.</p> <p>Client F's Fall Risk Plan and nurse's</p>		<p>will work with the Program Director to ensure that all staff are trained on any updates to the fall protocol as needed. The Area Director will review any investigations and recommendations after a fall to ensure that all recommendations have been completed, fall protocols have been updated and training has been provided to staff as needed.</p> <p>Responsible Party: Home Manager, Program Director, Area Director, Program Nurse, Nursing Supervisor</p>				

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	<p>monthly notes were reviewed on 1/3/13 at 1:05 PM at the facility office. A fall risk protocol dated 8/10/12 indicated client F was at risk for falls due to decreased mobility and strength in her arms and legs and required staff assistance during transfers to and from her wheelchair and the shower chair. The protocol did not specify the type of staff assistance client F required to transfer to her wheelchair or shower chair. A December, 2012 Healthcare Coordination/Monthly Health Review indicated client F had been diagnosed with a dislocated shoulder and taken to the emergency room for outpatient shoulder adjustment. An entry dated 12/12/12 indicated a follow up visit to client F's physician in which PT/OT was ordered. An entry dated 12/16/12 indicated PT evaluated client F. "Spoke with PT about shoulder and need for training and/or exercises for shoulder and transfers." An entry dated 12/18/12 indicated OT was in the home, on 12/20/12 OT/PT in the home, on 12/24/12 PT was in the home, on 12/28/12 OT/PT was in the home. A 12/31/12 entry indicated the OT called and said she got an order for a new wheelchair, and the OT said she has done training with "most of the staff" on transferring safely and client F's exercises. There was no evidence in client F's records provided of the documentation of OT and PT assessment</p>			

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	<p>of client F's needs for staff assistance during transfer, of the OT and PT visits with client F, or of an updated fall risk protocol.</p> <p>The Area Director #2 was interviewed on 1/3/13 at 2:30 PM and indicated the clients' medical information should have been in the file.</p> <p>Area Director #1 was interviewed on 1/8/13 at 3:35 PM. She indicated it was the nurses role to ensure medical information was in the clients' records.</p> <p>An Indiana Mentor Nursing Progress Note dated 1/2/13 was provided via e-mail on 1/4/13 and reviewed on 1/4/13 at 10:10 AM. The note indicated client F had been seen by an OT "to address left upper extremity range of motion and strength, safety with functional transfers and self care, safe positioning, prevention of pressure ulcer, caregiver education, and establishment of a home exercise program." The note indicated staff had been educated on "safe way to transfer patient with a gait belt as well as not to pull on shoulder joints when lifting to prevent injury. Staff verbalized understanding." There was no further evidence of an updated fall risk plan for client F to prevent further injury during transfers.</p>						

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	<p>The Area Director was interviewed on 1/9/13 at 12:30 PM and indicated there was no further documentation available in client F's medical record regarding OT and PT evaluations and visits.</p> <p>9-3-1(a)</p>			

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W0157	<p>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 additional client (client F) from further injury by failing to timely assess and update her fall risk protocol after a significant injury resulted from transfer, failed to adequately train staff to prevent future injury resulting from transfers and failed to ensure wheelchairs were in good condition for 2 of 4 clients who used wheelchairs (clients A and B).</p> <p>Findings include:</p> <p>1. The Area Director #2 and Program Director indicated on 1/2/13 at 2:55 PM there were no incidents of falls or of reportable incidents to the Bureau of Developmental Disabilities Services (BDDS) since the exit conference of the last visit to the facility on 11/26/12.</p> <p>Staff training records were reviewed on 1/2/13 at 2:55 PM. Training records indicated staff had been trained on client support levels, documentation and use of a Hoyer lift on 12/17/12. There was no evidence of training on client F's fall risk protocol and transfer support needs.</p>	W0157	<p>Client F's fall protocol was updated and all staff were given competency based training on specific ways to transfer Client F to prevent any further injuries from transferring her. The Home Manager, Program Director and Program Nurse will completed observations at least 3 times weekly for 4 weeks to ensure that staff are completing transfers correctly. After the 4 weeks observations will be completed at least weekly to ensure that staff are completing transfers correctly.</p> <p>The Program Nurse was retrained by the Nursing Supervisor regarding timely assessment of any reported consumer injuries or incidents that could cause potential injuries. The Program Nurse was also retrained on ensuring that consumers fall protocols are reviewed and updated after any reported fall, ensuring staff are trained on updates and modifications to fall protocols. The Program Nurse was also retrained on ensuring documentation of all consumers medical appointments, evaluations, reports from therapies such as OT, PT, speech, etc. are all present in all consumers' files and are available</p>	02/08/2013			

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	<p>Staff #1 and #2 were interviewed on 1/2/13 at 5:10 PM and indicated there had been no falls since 11/26/12. Staff #2 stated, "We would report it." Staff #1 indicated the nurse indicated client A was to receive a new wheelchair and client B's wheelchair repair parts were on order.</p> <p>The group home's January, 2013 staff log was reviewed on 1/2/13 at 5:45 PM and indicated an entry dated 1/2/13 indicating OT had provided services to client F regarding her wheelchair.</p> <p>Client F's Fall Risk Plan and nurse's monthly notes were reviewed on 1/3/13 at 1:05 PM at the facility office. A fall risk protocol dated 8/10/12 indicated client F was at risk for falls due to decreased mobility and strength in her arms and legs and required staff assistance during transfers to and from her wheelchair and the shower chair. The protocol did not specify the type of staff assistance client F required to transfer to her wheelchair or shower chair. A December, 2012 Healthcare Coordination/Monthly Health Review indicated staff #5 had called the nurse on 12/5/12 at 8:30 (AM or PM not indicated) to report client F had complained of arm pain. Client F had stated she fell, but there had been no witnesses of a fall at home or a report of a fall at day services. The nurse gave</p>		<p>for review.</p> <p>Ongoing, the Program Nurse will review and update all consumers fall protocols following any falls that occur. The Program Nurse will work with the Program Director to ensure that all staff are trained on any updates to the fall protocol as needed. The Area Director will review any investigations and recommendations after a fall to ensure that all recommendations have been completed, fall protocols have been updated and training has been provided to staff as needed.</p> <p>All consumers' wheelchairs were professionally evaluated and repairs have been made as recommended by the evaluations. In addition, all missing components were replaced as needed. The Program Nurse was retrained on the need to ensure follow up is completed on all recommendations for repairs for all consumers' wheelchairs and that all components such as seat cushions, leg rests, arm rests, etc. are in good repair and are present on the wheelchair as needed.</p> <p>Staff were trained on the need to ensure any issues regarding consumers wheelchairs needing repairs are reported immediately the Home Manager and Program Nurse so that repairs can be</p>	

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	instructions for staff to report back to the nurse if client F exhibited bruising or redness. On 12/6/12 at 7:00 AM, staff (unidentified) called. Client F was unable to lift her left arm. Client F was taken to an urgent care center on 12/6/12 at 1:30 PM, was diagnosed with a dislocated shoulder and taken to the emergency room for outpatient shoulder adjustment. An entry dated 12/12/12 indicated a follow up visit to client F's physician in which PT/OT was ordered. An entry dated 12/16/12 indicated PT evaluated client F. "Spoke with PT about shoulder and need for training and/or exercises for shoulder and transfers." An entry dated 12/18/12 indicated OT was in the home, on 12/20/12 OT/PT in the home, on 12/24/12 PT was in the home, on 12/28/12 OT/PT was in the home. A 12/31/12 entry indicated the OT called and said she got an order for a new wheelchair, and the OT said she has done training with "most of the staff" on transferring safely and client F's exercises. There was no evidence in client F's records provided of the documentation of OT and PT assessment of client F's needs for staff assistance during transfer, of the OT and PT visits with client F, an updated fall risk protocol, or evidence of competency based staff training for all staff working in the group home.		completed in a timely manner. Ongoing, the Home Manager will look over all consumers wheelchairs at least weekly to determine if they are in good working order and if any repairs need to be made. The Program Nurse will look over all of the consumers wheelchairs at least monthly to ensure that they are in good working order and determine if any repairs need to be made. The Program Nurse will document this on the monthly nursing notes. The Area Director and/or Nursing Supervisor will review the nursing notes a minimum of quarterly to ensure that documentation of the Program Nurse reviewing the status of all consumers wheelchairs is being documented. The Program Nurse will get all consumers wheelchairs professionally evaluated a minimum of annually to ensure they are in good working order.  Responsible Party: Home Manager, Program Director, Area Director, Program Nurse, Nursing Supervisor				

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	<p>The Area Director #2 and Program Director were interviewed on 1/3/13 at 1:35 PM and indicated they had overlooked providing the reported possible fall with injury to client F and a BDDS report had been made of the incident. They indicated interventions had been put in place for 2 staff to transfer client F, or to use a Hoyer lift to assist client F during transfer. They indicated the physician who treated client F indicated she was at risk for dislocation due to the structure of her shoulder and her condition was not previously known. They indicated the fall risk protocol should be specific for client F's support needs for transfer, the fall protocol had not been updated and did not include the assessment recommendations from medical professionals including OT and PT. They indicated it was the nurse's responsibility to update the fall protocol and the nurse and the Program Director's responsibility to ensure the fall risk protocol was updated.</p> <p>The BDDS report dated 12/5/12 of the incident involving client F was reviewed on 1/3/13 at 1:45 PM. The BDDS report indicated client F reported to staff that her arm hurt and client F stated she fell, but indicated she fell in the bathroom, the living room, in the kitchen and at day program. There were no witnesses to a</p>						

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	<p>fall, and staff checked client F for injury and found no injuries or marks/bruising. Client F was taken to an urgent care center to be checked on 12/6/12 and the doctor stated she had dislocated her shoulder and he instructed staff to take her to the emergency room for evaluation and treatment. The report indicated an investigation was underway to determine the origin of her injury.</p> <p>The investigation dated 12/18/12 into the incident involving client F was reviewed on 1/3/13 at 1:45 PM. The investigation summary indicated the evidence did not support a fall as the cause of injury to client F's shoulder, and was "likely" dislocated the evening of 12/5/12 while completing personal hygiene. Recommendations included an assessment of client F's shoulder weakness, OT evaluation to develop transfer procedures and any other recommendations needed, develop a step-by step protocol for recommended transfers to include need for competency based assessment of staff before they may transfer clients A, B, E and F, develop a competency based assessment of transfers for clients A, B, E and F, retrain staff on transfer protocol and any other recommendations resulting from client F's OT evaluation, competency based assessment of transfers with current staff</p>						

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	<p>and ongoing, complete "frequent" observations of client transfers for 30 days following retraining.</p> <p>An Indiana Mentor Nursing Progress Note dated 1/2/13 was reviewed on 1/4/13 at 10:10 AM. The note indicated client F had been seen by an OT "to address left upper extremity range of motion and strength, safety with functional transfers and self care, safe positioning, prevention of pressure ulcer, caregiver education, and establishment of a home exercise program." The note indicated staff had been educated on "safe way to transfer patient with a gait belt as well as not to pull on shoulder joints when lifting to prevent injury. Staff verbalized understanding." There was no further evidence of competency based training provided for staff regarding safe transfer techniques for client F.</p> <p>Area Director #1 was interviewed on 1/8/13 at 3:35 PM. When asked if the follow up appointment dated 1/2/13 was timely to address client F's needs related to transfers and her dislocated shoulder, she indicated she would check with the nurse on the timing of client F's OT and PT assessment to follow up after her dislocated shoulder. She indicated sometimes a period of time was required because of the availability of therapies</p>						

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	<p>and stated, "We are at the mercy of the availability," and "The sooner the better." She indicated she would investigate the status of the competency based staff training records that were recommended by the investigation into the incident involving client F's dislocated shoulder.</p> <p>2. The Area Director #2 and Program Director were interviewed on 1/2/13 at 2:55 PM. The Area Director #2 indicated wheelchair evaluations had been completed for clients who used wheelchairs in the home and 2 wheelchairs required repair and one had been replaced. They indicated the nurse would have the evaluations available in the client records located at the group home.</p> <p>During the observation at the group home on 1/2/13 from 4:35 PM until 6:25 PM, client A's wheelchair was missing the seat cushion, one arm pad on the left arm rest bar and was missing the left foot rest. Client B's wheelchair was missing a seat cushion, the foot rests and was missing an arm rest on the right side.</p> <p>Staff #1 was interviewed on 1/2/13 at 5:10 PM. Staff #1 indicated the nurse had indicated client A was to receive a new wheelchair and client B's wheelchair repair parts were on order.</p>				

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	<p>Client A was interviewed on 1/3/13 at 4:45 PM. He pointed to the wheelchair cushion propped up against the wall in his bedroom and indicated the use of the cushion made the seat too high. He indicated the foot rest was in the closet. Client A indicated he wanted the missing items restored and the arm rest repaired.</p> <p>Client B was interviewed on 1/3/13 at 4:55 PM. He indicated he would like to have a seat cushion, foot rests and an arm rest for his wheelchair and stated, "I don't know if they're going to fix it or get a new one. I don't have any idea when."</p> <p>Client A's records were reviewed at the group home on 1/2/13 at 5:16 PM. Client A's annual physical exam dated 8/15/12 indicated he was "wheelchair dependent." A physician's order dated 11/28/12 indicated a prescription for OT/PT (Occupational Therapy/Physical Therapy) wheelchair evaluation. A quarterly nursing note dated 12/12/12 indicated a new wheelchair recommendation was sent to client A's physician. A December 2012 Healthcare Coordination/Monthly Health Review included an entry dated 12/10/12 that indicated an appointment was made for client A to receive a wheelchair evaluation. "On 12/19/12 PT called. Said they recommend a new wheelchair and</p>						

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	<p>will send to MD (medical doctor)."</p> <p>Client B's records were reviewed at the agency's office on 1/3/13 at 12:55 PM. A Fall Protocol dated 8/10/12 indicated client B had unstable gait due to cerebral palsy and knee "problems... Currently using wheelchair but transfers to and from chair. Needs supervision during transfers and to and from chair." A December 2012 Healthcare Coordination/Monthly Health Review included an entry dated 12/6/12 which indicated the nurse spoke with the wheelchair evaluation company. "They lost w/c (wheelchair) evaluation for Nov 14th. Faxed them my copy. They will call to make repairs on chair." An entry dated 12/11/12 indicated the nurse had called the wheelchair evaluation company about client B's wheelchair. "They forgot to call back last week. They will order needed parts. Should be in in (sic) 1 1/2 weeks. Made an appt (appointment) for 12/28/12 for repairs." An entry dated 12/27/12 indicated the wheelchair company called and the parts were not in yet for client B's wheelchair and the appointment was rescheduled for 1/11/13.</p> <p>The Area Director #2 and the Program Director were interviewed on 1/3/13 at 1:35 PM and indicated it was not unusual to wait a month for parts to a wheelchair, and the company was within usual</p>				

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	<p>timeframes to provide needed services for clients' wheelchair needs.</p> <p>This deficiency was cited on 11/26/12. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>9-3-2(a)</p>			

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W0159	<p>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.</p> <p>Based upon record review and interview, the Program Director/Qualified Mental Retardation Professional (QMRP) failed to integrate and coordinate health care services to ensure staff were sufficiently trained to provide safe transfers to prevent further injury for 1 additional client (client F), failed to coordinate services to ensure wheelchairs were in good condition for 2 of 4 sampled clients who used wheelchairs (clients A and B), and failed for 2 of 4 sampled clients (clients A and B), and 1 additional client (client F) to maintain a record keeping system to document medical and program plan implementation information in the client's record.</p> <p>Findings include:</p> <p>1. The Area Director #2 and Program Director indicated on 1/2/13 at 2:55 PM there were no incidents of falls or of reportable incidents to the Bureau of Developmental Disabilities Services (BDDS) since the exit conference of the last visit to the facility on 11/26/12.</p>	W0159	<p>Client F's fall protocol was updated and all staff were given competency based training on specific ways to transfer Client F to prevent any further injuries from transferring her. The Home Manager, Program Director and Program Nurse will completed observations at least 3 times weekly for 4 weeks to ensure that staff are completing transfers correctly. After the 4 weeks observations will be completed at least weekly to ensure that staff are completing transfers correctly.</p> <p>The Program Nurse was retrained by the Nursing Supervisor regarding timely assessment of any reported consumer injuries or incidents that could cause potential injuries. The Program Nurse was also retrained on ensuring that consumers fall protocols are reviewed and updated after any reported fall, ensuring staff are trained on updates and modifications to fall protocols. The Program Nurse was also retrained on ensuring documentation of all consumers medical appointments, evaluations, reports from therapies such as OT, PT,</p>	02/08/2013	

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	<p>Staff training records were reviewed on 1/2/13 at 2:55 PM. Training records indicated staff had been trained on client support levels, documentation and use of a Hoyer lift on 12/17/12. There was no evidence of training on client F's fall risk protocol and transfer support needs.</p> <p>The group home's January, 2013 staff log was reviewed on 1/2/13 at 5:45 PM and indicated an entry dated 1/2/13 indicating OT had provided services to client F regarding her wheelchair.</p> <p>Client F's Fall Risk Plan and nurse's monthly notes were reviewed on 1/3/13 at 1:05 PM at the facility office. A fall risk protocol dated 8/10/12 indicated client F was at risk for falls due to decreased mobility and strength in her arms and legs and required staff assistance during transfers to and from her wheelchair and the shower chair. The protocol did not specify the type of staff assistance client F required to transfer to her wheelchair or shower chair. A December, 2012 Healthcare Coordination/Monthly Health Review indicated staff #5 had called the nurse on 12/5/12 at 8:30 (AM or PM not indicated) to report client F had complained of arm pain. Client F had stated she fell, but there had been no witnesses of a fall at home or a report of a fall at day services. The nurse gave</p>		<p>speech, etc. are all present in all consumers' files and are available for review.</p> <p>Ongoing, the Program Nurse will review and update all consumers fall protocols following any falls that occur. The Program Nurse will work with the Program Director to ensure that all staff are trained on any updates to the fall protocol as needed. The Area Director will review any investigations and recommendations after a fall to ensure that all recommendations have been completed, fall protocols have been updated and training has been provided to staff as needed.</p> <p>All consumers' wheelchairs were professionally evaluated and repairs have been made as recommended by the evaluations. In addition, all missing components were replaced as needed. The Program Nurse was retrained on the need to ensure follow up is completed on all recommendations for repairs for all consumers' wheelchairs and that all components such as seat cushions, leg rests, arm rests, etc. are in good repair and are present on the wheelchair as needed.</p> <p>Staff were trained on the need to ensure any issues regarding consumers wheelchairs needing</p>		

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	instructions for staff to report back to the nurse if client F exhibited bruising or redness. On 12/6/12 at 7:00 AM, staff (unidentified) called. Client F was unable to lift her left arm. Client F was taken to an urgent care center on 12/6/12 at 1:30 PM, was diagnosed with a dislocated shoulder and taken to the emergency room for outpatient shoulder adjustment. An entry dated 12/12/12 indicated a follow up visit to client F's physician in which PT/OT was ordered. An entry dated 12/16/12 indicated PT evaluated client F. "Spoke with PT about shoulder and need for training and/or exercises for shoulder and transfers." An entry dated 12/18/12 indicated OT was in the home, on 12/20/12 OT/PT in the home, on 12/24/12 PT was in the home, on 12/28/12 OT/PT was in the home. A 12/31/12 entry indicated the OT called and said she got an order for a new wheelchair, and the OT said she has done training with "most of the staff" on transferring safely and client F's exercises. There was no evidence in client F's records provided of the documentation of OT and PT assessment of client F's needs for staff assistance during transfer, of the OT and PT visits with client F, an updated fall risk protocol, or evidence of competency based staff training for all staff working in the group home.		repairs are reported immediately the Home Manager and Program Nurse so that repairs can be completed in a timely manner. Ongoing, the Home Manager will look over all consumers wheelchairs at least weekly to determine if they are in good working order and if any repairs need to be made. The Program Nurse will look over all of the consumers wheelchairs at least monthly to ensure that they are in good working order and determine if any repairs need to be made. The Program Nurse will document this on the monthly nursing notes. The Area Director and/or Nursing Supervisor will review the nursing notes a minimum of quarterly to ensure that documentation of the Program Nurse reviewing the status of all consumers wheelchairs is being documented. The Program Nurse will get all consumers wheelchairs professionally evaluated a minimum of annually to ensure they are in good working order.  Responsible Party: Home Manager, Program Director, Area Director, Program Nurse, Nursing Supervisor				

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	<p>The Area Director #2 and Program Director were interviewed on 1/3/13 at 1:35 PM and indicated they had overlooked providing the reported possible fall with injury to client F and a BDDS report had been made of the incident. They indicated interventions had been put in place for 2 staff to transfer client F, or to use a Hoyer lift to assist client F during transfer. They indicated the physician who treated client F indicated she was at risk for dislocation due to the structure of her shoulder and her condition was not previously known. They indicated the fall risk protocol should be specific for client F's support needs for transfer, the fall protocol had not been updated and did not include the assessment recommendations from medical professionals including OT and PT. They indicated it was the nurse's responsibility to update the fall protocol and the nurse and the Program Director's responsibility to ensure the fall risk protocol was updated.</p> <p>The BDDS report dated 12/5/12 of the incident involving client F was reviewed on 1/3/13 at 1:45 PM. The BDDS report indicated client F reported to staff that her arm hurt and client F stated she fell, but indicated she fell in the bathroom, the living room, in the kitchen and at day program. There were no witnesses to a</p>						

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	<p>fall, and staff checked client F for injury and found no injuries or marks/bruising. Client F was taken to an urgent care center to be checked on 12/6/12 and the doctor stated she had dislocated her shoulder and he instructed staff to take her to the emergency room for evaluation and treatment. The report indicated an investigation was underway to determine the origin of her injury.</p> <p>The investigation dated 12/18/12 into the incident involving client F was reviewed on 1/3/13 at 1:45 PM. The investigation summary indicated the evidence did not support a fall as the cause of injury to client F's shoulder, and was "likely" dislocated the evening of 12/5/12 while completing personal hygiene. Recommendations included an assessment of client F's shoulder weakness, OT evaluation to develop transfer procedures and any other recommendations needed, develop a step-by step protocol for recommended transfers to include need for competency based assessment of staff before they may transfer clients A, B, E and F, develop a competency based assessment of transfers for clients A, B, E and F, retrain staff on transfer protocol and any other recommendations resulting from client F's OT evaluation, competency based assessment of transfers with current staff</p>						

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	<p>and ongoing, complete "frequent" observations of client transfers for 30 days following retraining.</p> <p>An Indiana Mentor Nursing Progress Note dated 1/2/13 was reviewed on 1/4/13 at 10:10 AM. The note indicated client F had been seen by an OT "to address left upper extremity range of motion and strength, safety with functional transfers and self care, safe positioning, prevention of pressure ulcer, caregiver education, and establishment of a home exercise program." The note indicated staff had been educated on "safe way to transfer patient with a gait belt as well as not to pull on shoulder joints when lifting to prevent injury. Staff verbalized understanding." There was no further evidence of competency based training provided for staff regarding safe transfer techniques for client F.</p> <p>Area Director #1 was interviewed on 1/8/13 at 3:35 PM. When asked if the follow up appointment dated 1/2/13 was timely to address client F's needs related to transfers and her dislocated shoulder, she indicated she would check with the nurse on the timing of client F's OT and PT assessment to follow up after her dislocated shoulder. She indicated sometimes a period of time was required because of the availability of therapies</p>						

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	<p>and stated, "We are at the mercy of of the availability," and "The sooner the better." She indicated she would investigate the status of the competency based staff training records that were recommended by the investigation into the incident involving client F's dislocated shoulder. She indicated it was the nurse and the Program Director's joint responsibility to ensure plans were updated as needed to meet client needs, and to ensure staff training was completed.</p> <p>2. The Area Director #2 and Program Director were interviewed on 1/2/13 at 2:55 PM. The Area Director #2 indicated wheelchair evaluations had been completed for clients who used wheelchairs in the home and 2 wheelchairs required repair and one had been replaced. They indicated the nurse would have the evaluations available in the client records located at the group home.</p> <p>During the observation at the group home on 1/2/13 from 4:35 PM until 6:25 PM, client A's wheelchair was missing the seat cushion, one arm pad on the left arm rest bar and was missing the left foot rest. Client B's wheelchair was missing a seat cushion, the foot rests and was missing an arm rest on the right side.</p>			

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	<p>Staff #1 was interviewed on 1/2/12 at 5:10 PM. Staff #1 indicated the nurse had indicated client A was to receive a new wheelchair and client B's wheelchair repair parts were on order.</p> <p>Client A was interviewed on 1/3/13 at 4:45 PM. He pointed to the wheelchair cushion propped up against the wall in his bedroom and indicated the use of the cushion made the seat too high. He indicated the foot rest was in the closet. Client A indicated he wanted the missing items restored and the arm rest repaired.</p> <p>Client B was interviewed on 1/3/13 at 4:55 PM. He indicated he would like to have a seat cushion, foot rests and an arm rest for his wheelchair and stated, "I don't know if they're going to fix it or get a new one. I don't have any idea when."</p> <p>Client A's records were reviewed at the group home on 1/2/13 at 5:16 PM. Client A's annual physical exam dated 8/15/12 indicated he was "wheelchair dependent." A physician's order dated 11/28/12 indicated a prescription for OT/PT (Occupational Therapy/Physical Therapy) wheelchair evaluation. A quarterly nursing note dated 12/12/12 indicated a new wheelchair recommendation was sent to client A's physician. A December 2012 Healthcare Coordination/Monthly Health</p>				

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	<p>Review included an entry dated 12/10/12 that indicated an appointment was made for client A to receive a wheelchair evaluation. "On 12/19/12 PT called. Said they recommend a new wheelchair and will send to MD (medical doctor)."</p> <p>Client B's records were reviewed at the agency's office on 1/3/13 at 12:55 PM. A Fall Protocol dated 8/10/12 indicated client B had unstable gait due to cerebral palsy and knee "problems... Currently using wheelchair but transfers to and from chair. Needs supervision during transfers and to and from chair." A December 2012 Healthcare Coordination/Monthly Health Review included an entry dated 12/6/12 which indicated the nurse spoke with the wheelchair evaluation company. "They lost w/c (wheelchair) evaluation for Nov 14th. Faxed them my copy. They will call to make repairs on chair." An entry dated 12/11/12 indicated the nurse had called the wheelchair evaluation company about client B's wheelchair. "They forgot to call back last week. They will order needed parts. Should be in in (sic) 1 1/2 weeks. Made an appt (appointment) for 12/28/12 for repairs." An entry dated 12/27/12 indicated the wheelchair company called and the parts were not in yet for client B's wheelchair and the appointment was rescheduled for 1/11/13.</p>						

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	<p>The Area Director #2 and the Program Director were interviewed on 1/3/13 at 1:35 PM and indicated it was not unusual to wait a month for parts to a wheelchair ,and the company was within usual timeframes to provide needed services for clients' wheelchair needs.</p> <p>This deficiency was cited on 11/26/12. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>9-3-3(a)</p>				

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W0189	<p>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.</p> <p>Based on observation, interview and record review, the facility failed to adequately train staff to demonstrate competency to prevent future injury resulting from transfers for 1 additional client (client F).</p> <p>Findings include:</p> <p>Staff training records were reviewed on 1/2/13 at 2:55 PM. Training records indicated staff had been trained on client support levels, documentation and use of a Hoyer lift on 12/17/12. There was no evidence of training on client F's fall risk protocol and transfer support needs.</p> <p>The group home's January, 2013 staff log was reviewed on 1/2/13 at 5:45 PM and indicated an entry dated 1/2/13 indicating OT had provided services to client F regarding her wheelchair.</p> <p>Client F's Fall Risk Plan and nurse's monthly notes were reviewed on 1/3/13 at 1:05 PM at the facility office. A fall risk protocol dated 8/10/12 indicated client F</p>	W0189	<p>Client F's fall protocol was updated and all staff were given competency based training on specific ways to transfer Client F to prevent any further injuries from transferring her. The Home Manager, Program Director and Program Nurse will completed observations at least 3 times weekly for 4 weeks to ensure that staff are completing transfers correctly. After the 4 weeks observations will be completed at least weekly to ensure that staff are completing transfers correctly.</p> <p>The Program Nurse was retrained by the Nursing Supervisor regarding timely assessment of any reported consumer injuries or incidents that could cause potential injuries. The Program Nurse was also retrained on ensuring that consumers fall protocols are reviewed and updated after any reported fall, ensuring staff are trained on updates and modifications to fall protocols. The Program Nurse was also retrained on ensuring documentation of all consumers medical appointments, evaluations, reports from</p>	02/08/2013			

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	was at risk for falls due to decreased mobility and strength in her arms and legs and required staff assistance during transfers to and from her wheelchair and the shower chair. The protocol did not specify the type of staff assistance client F required to transfer to her wheelchair or shower chair. A December, 2012 Healthcare Coordination/Monthly Health Review indicated Client F was taken to an urgent care center on 12/6/12 at 1:30 PM, was diagnosed with a dislocated shoulder and taken to the emergency room for outpatient shoulder adjustment. An entry dated 12/12/12 indicated a follow up visit to client F's physician in which PT/OT was ordered. An entry dated 12/16/12 indicated PT evaluated client F. "Spoke with PT about shoulder and need for training and/or exercises for shoulder and transfers." An entry dated 12/18/12 indicated OT was in the home, on 12/20/12 OT/PT in the home, on 12/24/12 PT was in the home, on 12/28/12 OT/PT was in the home. A 12/31/12 entry indicated the OT called and said she got an order for a new wheelchair, and the OT said she has done training with "most of the staff" on transferring safely and client F's exercises. There was no evidence in client F's records provided of the documentation of OT and PT assessment of client F's needs for staff assistance during transfer, an		therapies such as OT, PT, speech, etc. are all present in all consumers' files and are available for review.  Ongoing, the Program Nurse will review and update all consumers fall protocols following any falls that occur. The Program Nurse will work with the Program Director to ensure that all staff are trained on any updates to the fall protocol as needed. The Area Director will review any investigations and recommendations after a fall to ensure that all recommendations have been completed, fall protocols have been updated and training has been provided to staff as needed.  Responsible Party: Home Manager, Program Director, Area Director, Program Nurse, Nursing Supervisor				

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	<p>updated fall risk protocol, or evidence of competency based staff training for all staff working in the group home.</p> <p>The Area Director #2 and Program Director were interviewed on 1/3/13 at 1:35 PM and indicated they had overlooked providing the reported possible fall with injury to client F and a BDDS report had been made of the incident. They indicated interventions had been put in place for 2 staff to transfer client F, or to use a Hoyer lift to assist client F during transfer. They indicated the physician who treated client F indicated she was at risk for dislocation due to the structure of her shoulder and her condition was not previously known. They indicated client F's fall risk protocol should be specific for her needs, client F's fall protocol had not been updated and did not include the assessment recommendations from medical professionals including OT and PT. They indicated staff had been trained on the use of the Hoyer lift and had been trained to use 2 persons or the Hoyer lift to transfer client F.</p> <p>The BDDS report dated 12/5/12 of the incident involving client F was reviewed on 1/3/13 at 1:45 PM. The BDDS report indicated client F reported to staff that her arm hurt and client F stated she fell, but</p>			

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	<p>indicated she fell in the bathroom, the living room, in the kitchen and at day program. There were no witnesses to a fall, and staff checked client F for injury and found no injuries or marks/bruising. Client F was taken to an urgent care center to be checked on 12/6/12 and the doctor stated she had dislocated her shoulder and he instructed staff to take her to the emergency room for evaluation and treatment. The report indicated an investigation was underway to determine the origin of her injury.</p> <p>The investigation dated 12/18/12 into the incident involving client F was reviewed on 1/3/13 at 1:45 PM. The investigation summary indicated the evidence did not support a fall as the cause of injury to client F's shoulder, and was "likely" dislocated the evening of 12/5/12 while completing personal hygiene. Recommendations included an assessment of client F's shoulder weakness, OT evaluation to develop transfer procedures and any other recommendations needed, develop a step-by step protocol for recommended transfers to include need for competency based assessment of staff before they may transfer clients A, B, E and F, develop a competency based assessment of transfers for clients A, B, E and F, retrain staff on transfer protocol and any other</p>				

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	<p>recommendations resulting from client F's OT evaluation, competency based assessment of transfers with current staff and ongoing, complete "frequent" observations of client transfers for 30 days following retraining.</p> <p>An Indiana Mentor Nursing Progress Note dated 1/2/13 was reviewed on 1/4/13 at 10:10 AM. The note indicated client F had been seen by an OT "to address left upper extremity range of motion and strength, safety with functional transfers and self care, safe positioning, prevention of pressure ulcer, caregiver education, and establishment of a home exercise program. The note indicated staff had been educated on "safe way to transfer patient with a gait belt as well as not to pull on shoulder joints when lifting to prevent injury. Staff verbalized understanding." There was no further evidence of competency based training provided for staff regarding safe transfer techniques for client F.</p> <p>Area Director #1 was interviewed on 1/8/13 at 3:35 PM. She indicated she would investigate the status of the competency based staff training records that were recommended by the investigation into the incident involving client F's dislocated shoulder.</p>						

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	<p>The Area Director #1 was interviewed on 1/9/13 at 12:30 PM and indicated there was no record of the competency based training recommended by the investigation into client F's dislocated shoulder regarding client F's support needs.</p> <p>This deficiency was cited on 11/26/12. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>9-3-3(a)</p>			

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W0331	<p>483.460(c) NURSING SERVICES The facility must provide clients with nursing services in accordance with their needs.</p> <p>Based on observation, interview and record review, the facility's health care services failed for 1 additional client (client F) to ensure timely assessment of the client's transfer needs, failed to update the client's fall prevention protocol after a significant injury resulted from transfer, failed to ensure staff were trained to demonstrate competency to prevent future injury resulting from transfers for client F and failed to ensure wheelchairs were in good condition for 2 of 4 sampled clients who used wheelchairs (clients A and B).</p> <p>Findings include:</p> <p>1. The Area Director #2 and Program Director indicated on 1/2/13 at 2:55 PM there were no incidents of falls or of reportable incidents to the Bureau of Developmental Disabilities Services (BDDS) since the exit conference of the last visit to the facility on 11/26/12.</p> <p>Staff training records were reviewed on 1/2/13 at 2:55 PM. Training records indicated staff had been trained on client support levels, documentation and use of a Hoyer lift on 12/17/12. There was no evidence of training on client F's fall risk</p>	W0331	<p>Client F's fall protocol was updated and all staff were given competency based training on specific ways to transfer Client F to prevent any further injuries from transferring her. The Home Manager, Program Director and Program Nurse will completed observations at least 3 times weekly for 4 weeks to ensure that staff are completing transfers correctly. After the 4 weeks observations will be completed at least weekly to ensure that staff are completing transfers correctly.</p> <p>The Program Nurse was retrained by the Nursing Supervisor regarding timely assessment of any reported consumer injuries or incidents that could cause potential injuries. The Program Nurse was also retrained on ensuring that consumers fall protocols are reviewed and updated after any reported fall, ensuring staff are trained on updates and modifications to fall protocols. The Program Nurse was also retrained on ensuring documentation of all consumers medical appointments, evaluations, reports from therapies such as OT, PT, speech, etc. are all present in all consumers' files and are available</p>	02/08/2013			

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	<p>protocol and transfer support needs.</p> <p>Staff #1 and #2 were interviewed on 1/2/13 at 5:10 PM and indicated there had been no falls since 11/26/12. Staff #2 stated, "We would report it." Staff #1 indicated the nurse indicated client A was to receive a new wheelchair and client B's wheelchair repair parts were on order.</p> <p>The group home's January, 2013 staff log was reviewed on 1/2/13 at 5:45 PM and indicated an entry dated 1/2/13 indicating OT had provided services to client F regarding her wheelchair.</p> <p>Client F's Fall Risk Plan and nurse's monthly notes were reviewed on 1/3/13 at 1:05 PM at the facility office. A fall risk protocol dated 8/10/12 indicated client F was at risk for falls due to decreased mobility and strength in her arms and legs and required staff assistance during transfers to and from her wheelchair and the shower chair. The protocol did not specify the type of staff assistance client F required to transfer to her wheelchair or shower chair. A December, 2012 Healthcare Coordination/Monthly Health Review indicated staff #5 had called the nurse on 12/5/12 at 8:30 (AM or PM not indicated) to report client F had complained of arm pain. Client F had stated she fell, but there had been no</p>		<p>for review.</p> <p>Ongoing, the Program Nurse will review and update all consumers fall protocols following any falls that occur. The Program Nurse will work with the Program Director to ensure that all staff are trained on any updates to the fall protocol as needed. The Area Director will review any investigations and recommendations after a fall to ensure that all recommendations have been completed, fall protocols have been updated and training has been provided to staff as needed.</p> <p>All consumers' wheelchairs were professionally evaluated and repairs have been made as recommended by the evaluations. In addition, all missing components were replaced as needed. The Program Nurse was retrained on the need to ensure follow up is completed on all recommendations for repairs for all consumers' wheelchairs and that all components such as seat cushions, leg rests, arm rests, etc. are in good repair and are present on the wheelchair as needed.</p> <p>Staff were trained on the need to ensure any issues regarding consumers wheelchairs needing repairs are reported immediately the Home Manager and Program Nurse so that repairs can be</p>				

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	witnesses of a fall at home or a report of a fall at day services. The nurse gave instructions for staff to report back to the nurse if client F exhibited brushing or redness. On 12/6/12 at 7:00 AM, staff (unidentified) called. Client F was unable to lift her left arm. Client F was taken to an urgent care center on 12/6/12 at 1:30 PM, was diagnosed with a dislocated shoulder and taken to the emergency room for outpatient shoulder adjustment. An entry dated 12/12/12 indicated a follow up visit to client F's physician in which PT/OT was ordered. An entry dated 12/16/12 indicated PT evaluated client F. "Spoke with PT about shoulder and need for training and/or exercises for shoulder and transfers." An entry dated 12/18/12 indicated OT was in the home, on 12/20/12 OT/PT in the home, on 12/24/12 PT was in the home, on 12/28/12 OT/PT was in the home. A 12/31/12 entry indicated the OT called and said she got an order for a new wheelchair, and the OT said she has done training with "most of the staff" on transferring safely and client F's exercises. There was no evidence in client F's records provided of the documentation of OT and PT assessment of client F's needs for staff assistance during transfer, of the OT and PT visits with client F, an updated fall risk protocol, or evidence of competency based staff training for all		completed in a timely manner. Ongoing, the Home Manager will look over all consumers wheelchairs at least weekly to determine if they are in good working order and if any repairs need to be made. The Program Nurse will look over all of the consumers wheelchairs at least monthly to ensure that they are in good working order and determine if any repairs need to be made. The Program Nurse will document this on the monthly nursing notes. The Area Director and/or Nursing Supervisor will review the nursing notes a minimum of quarterly to ensure that documentation of the Program Nurse reviewing the status of all consumers wheelchairs is being documented. The Program Nurse will get all consumers wheelchairs professionally evaluated a minimum of annually to ensure they are in good working order.  Responsible Party: Home Manager, Program Director, Area Director, Program Nurse, Nursing Supervisor		

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	<p>staff working in the group home.</p> <p>The Area Director #2 and Program Director were interviewed on 1/3/13 at 1:35 PM and indicated they had overlooked providing the reported possible fall with injury to client F and a BDDS report had been made of the incident. They indicated interventions had been put in place for 2 staff to transfer client F, or to use a Hoyer lift to assist client F during transfer. They indicated the physician who treated client F indicated she was at risk for dislocation due to the structure of her shoulder and her condition was not previously known. They indicated the fall risk protocol should be specific for client F's support needs for transfer, the fall protocol had not been updated and did not include the assessment recommendations from medical professionals including OT and PT. They indicated it was the nurse's responsibility to update the fall protocol and the nurse and the Program Director's responsibility to ensure the fall risk protocol was updated.</p> <p>The BDDS report dated 12/5/12 of the incident involving client F was reviewed on 1/3/13 at 1:45 PM. The BDDS report indicated client F reported to staff that her arm hurt and client F stated she fell, but indicated she fell in the bathroom, the</p>						

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	<p>living room, in the kitchen and at day program. There were no witnesses to a fall, and staff checked client F for injury and found no injuries or marks/bruising. Client F was taken to an urgent care center to be checked on 12/6/12 and the doctor stated she had dislocated her shoulder and he instructed staff to take her to the emergency room for evaluation and treatment. The report indicated an investigation was underway to determine the origin of her injury.</p> <p>The investigation dated 12/18/12 into the incident involving client F was reviewed on 1/3/13 at 1:45 PM. The investigation summary indicated the evidence did not support a fall as the cause of injury to client F's shoulder, and was "likely" dislocated the evening of 12/5/12 while completing personal hygiene. Recommendations included an assessment of client F's shoulder weakness, OT evaluation to develop transfer procedures and any other recommendations needed, develop a step-by step protocol for recommended transfers to include need for competency based assessment of staff before they may transfer clients A, B, E and F, develop a competency based assessment of transfers for clients A, B, E and F, retrain staff on transfer protocol and any other recommendations resulting from client F's</p>						

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	<p>OT evaluation, competency based assessment of transfers with current staff and ongoing, complete "frequent" observations of client transfers for 30 days following retraining.</p> <p>An Indiana Mentor Nursing Progress Note dated 1/2/13 was reviewed on 1/4/13 at 10:10 AM. The note indicated client F had been seen by an OT "to address left upper extremity range of motion and strength, safety with functional transfers and self care, safe positioning, prevention of pressure ulcer, caregiver education, and establishment of a home exercise program." The note indicated staff had been educated on "safe way to transfer patient with a gait belt as well as not to pull on shoulder joints when lifting to prevent injury. Staff verbalized understanding." There was no further evidence of competency based training provided for staff regarding safe transfer techniques for client F.</p> <p>Area Director #1 was interviewed on 1/8/13 at 3:35 PM. When asked if the follow up appointment dated 1/2/13 was timely to address client F's needs related to transfers and her dislocated shoulder, she indicated she would check with the nurse on the timing of client F's OT and PT assessment to follow up after her dislocated shoulder. She indicated</p>			

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	<p>sometimes a period of time was required because of the availability of therapies and stated, "We are at the mercy of of the availability," and "The sooner the better." She indicated she would investigate the status of the competency based staff training records that were recommended by the investigation into the incident involving client F's dislocated shoulder.</p> <p>2. The Area Director #2 and Program Director were interviewed on 1/2/13 at 2:55 PM. The Area Director #2 indicated wheelchair evaluations had been completed for clients who used wheelchairs in the home and 2 wheelchairs required repair and one had been replaced. They indicated the nurse would have the evaluations available in the client records located at the group home.</p> <p>During the observation at the group home on 1/2/13 from 4:35 PM until 6:25 PM, client A's wheelchair was missing the seat cushion, one arm pad on the left arm rest bar and was missing the left foot rest. Client B's wheelchair was missing a seat cushion, the foot rests and was missing an arm rest on the right side.</p> <p>Staff #1 was interviewed on 1/2/13 at 5:10 PM. Staff #1 indicated the nurse had indicated client A was to receive a new</p>						

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	<p>wheelchair and client B's wheelchair repair parts were on order.</p> <p>Client A was interviewed on 1/3/13 at 4:45 PM. He pointed to the wheelchair cushion propped up against the wall in his bedroom and indicated the use of the cushion made the seat too high. He indicated the foot rest was in the closet. Client A indicated he wanted the missing items restored and the arm rest repaired.</p> <p>Client B was interviewed on 1/3/13 at 4:55 PM. He indicated he would like to have a seat cushion, foot rests and an arm rest for his wheelchair and stated, "I don't know if they're going to fix it or get a new one. I don't have any idea when."</p> <p>Client A's records were reviewed at the group home on 1/2/13 at 5:16 PM. Client A's annual physical exam dated 8/15/12 indicated he was "wheelchair dependent." A physician's order dated 11/28/12 indicated a prescription for OT/PT (Occupational Therapy/Physical Therapy) wheelchair evaluation. A quarterly nursing note dated 12/12/12 indicated a new wheelchair recommendation was sent to client A's physician. A December 2012 Healthcare Coordination/Monthly Health Review included an entry dated 12/10/12 that indicated an appointment was made for client A to receive a wheelchair</p>			

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	<p>evaluation. "On 12/19/12 PT called. Said they recommend a new wheelchair and will send to MD (medical doctor)."</p> <p>Client B's records were reviewed at the agency's office on 1/3/13 at 12:55 PM. A Fall Protocol dated 8/10/12 indicated client B had unstable gait due to cerebral palsy and knee "problems... Currently using wheelchair but transfers to and from chair. Needs supervision during transfers and to and from chair." A December 2012 Healthcare Coordination/Monthly Health Review included an entry dated 12/6/12 which indicated the nurse spoke with the wheelchair evaluation company. "They lost w/c (wheelchair) evaluation for Nov 14th. Faxed them my copy. They will call to make repairs on chair." An entry dated 12/11/12 indicated the nurse had called the wheelchair evaluation company about client B's wheelchair. "They forgot to call back last week. They will order needed parts. Should be in in (sic) 1 1/2 weeks. Made an appt (appointment) for 12/28/12 for repairs." An entry dated 12/27/12 indicated the wheelchair company called and the parts were not in yet for client B's wheelchair and the appointment was rescheduled for 1/11/13.</p> <p>The Area Director #2 and the Program Director were interviewed on 1/3/13 at 1:35 PM and indicated it was not unusual</p>						

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	<p>to wait a month for parts to a wheelchair, and the company was within usual timeframes to provide needed services for clients' wheelchair needs.</p> <p>This deficiency was cited on 11/26/12. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>9-3-6(a)</p>			

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W0436	<p>483.470(g)(2) SPACE AND EQUIPMENT</p> <p>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.</p> <p>Based on observation, interview and record review, the facility failed to ensure wheelchairs were in good condition for 2 of 4 clients who used wheelchairs (clients A and B).</p> <p>Findings include:</p> <p>The Area Director #2 and Program Director were interviewed on 1/2/13 at 2:55 PM. The Area Director #2 indicated wheelchair evaluations had been completed for clients who used wheelchairs in the home and 2 wheelchairs required repair and one had been replaced. They indicated the nurse would have the evaluations available in the client records located at the group home.</p> <p>During the observation at the group home on 1/2/13 from 4:35 PM until 6:25 PM, client A's wheelchair was missing the seat cushion, one arm pad on the left arm rest bar and was missing the left foot rest. Client B's wheelchair was missing a seat cushion, the foot rests and was missing an</p>	W0436	<p>All consumers' wheelchairs were professionally evaluated and repairs have been made as recommended by the evaluations. In addition, all missing components were replaced as needed. The Program Nurse was retrained on the need to ensure follow up is completed on all recommendations for repairs for all consumers' wheelchairs and that all components such as seat cushions, leg rests, arm rests, etc. are in good repair and are present on the wheelchair as needed.</p> <p>Staff were trained on the need to ensure any issues regarding consumers wheelchairs needing repairs are reported immediately the Home Manager and Program Nurse so that repairs can be completed in a timely manner. Ongoing, the Home Manager will look over all consumers wheelchairs at least weekly to determine if they are in good working order and if any repairs need to be made. The Program Nurse will look over all of the consumers wheelchairs at least monthly to ensure that they are in</p>	02/08/2013			

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	<p>arm rest on the right side.</p> <p>Staff #1 was interviewed on 1/2/13 at 5:10 PM. Staff #1 indicated the nurse had indicated client A was to receive a new wheelchair and client B's wheelchair repair parts were on order.</p> <p>Client A was interviewed on 1/3/13 at 4:45 PM. He pointed to the wheelchair cushion propped up against the wall in his bedroom and indicated the use of the cushion made the seat too high. He indicated the foot rest was in the closet. Client A indicated he wanted the missing items restored and the arm rest repaired.</p> <p>Client B was interviewed on 1/3/13 at 4:55 PM. He indicated he would like to have a seat cushion, foot rests and an arm rest for his wheelchair and stated, "I don't know if they're going to fix it or get a new one. I don't have any idea when."</p> <p>Client A's records were reviewed at the group home on 1/2/13 at 5:16 PM. Client A's annual physical exam dated 8/15/12 indicated he was "wheelchair dependent." A physician's order dated 11/28/12 indicated a prescription for OT/PT (Occupational Therapy/Physical Therapy) wheelchair evaluation. A quarterly nursing note dated 12/12/12 indicated a new wheelchair recommendation was sent</p>		<p>good working order and determine if any repairs need to be made. The Program Nurse will document this on the monthly nursing notes. The Area Director and/or Nursing Supervisor will review the nursing notes a minimum of quarterly to ensure that documentation of the Program Nurse reviewing the status of all consumers wheelchairs is being documented. The Program Nurse will get all consumers wheelchairs professionally evaluated a minimum of annually to ensure they are in good working order.</p> <p>Responsible Party: Home Manager, Program Director, Area Director, Program Nurse, Nursing Supervisor</p>				

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	<p>to client A's physician. A December 2012 Healthcare Coordination/Monthly Health Review included an entry dated 12/10/12 that indicated an appointment was made for client A to receive a wheelchair evaluation. "On 12/19/12 PT called. Said they recommend a new wheelchair and will send to MD (medical doctor)."</p> <p>Client B's records were reviewed at the agency's office on 1/3/13 at 12:55 PM. A Fall Protocol dated 8/10/12 indicated client B had unstable gait due to cerebral palsy and knee "problems... Currently using wheelchair but transfers to and from chair. Needs supervision during transfers and to and from chair." A December 2012 Healthcare Coordination/Monthly Health Review included an entry dated 12/6/12 which indicated the nurse spoke with the wheelchair evaluation company. "They lost w/c (wheelchair) evaluation for Nov 14th. Faxed them my copy. They will call to make repairs on chair." An entry dated 12/11/12 indicated the nurse had called the wheelchair evaluation company about client B's wheelchair. "They forgot to call back last week. They will order needed parts. Should be in in (sic) 1 1/2 weeks. Made an appt (appointment) for 12/28/12 for repairs." An entry dated 12/27/12 indicated the wheelchair company called and the parts were not in yet for client B's wheelchair and the</p>			

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  01/09/2013	
NAME OF PROVIDER OR SUPPLIER  REM-INDIANA INC				STREET ADDRESS, CITY, STATE, ZIP CODE 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			
	<p>appointment was rescheduled for 1/11/13.</p> <p>The Area Director #2 and the Program Director were interviewed on 1/3/13 at 1:35 PM and indicated it was not unusual to wait a month for parts to a wheelchair, and the company was within usual timeframes to provide needed services for clients' wheelchair needs.</p> <p>The Area Director #1 was interviewed on 1/9/13 at 12:30 PM and indicated wheelchairs should be maintained in good condition.</p> <p>This deficiency was cited on 11/26/12. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>9-3-7(a)</p>						