STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	15G442	A. BUILDING 00 B. WING	06/10/2024

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RES CARE COMMUNITY ALTERNATIVES SE IN	402 EWING LN JEFFERSONVILLE, IN 47130

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W 0000 Bldg. 00	This visit was for a Post Certification Revisit (PCR) to the PCR completed 1/19/24 to the pre-determined full annual recertification and state licensure survey and the investigation of complaint #IN00407148 conducted on 12/4/23. Complaint #IN00407148: Corrected. This survey was in conjunction with a PCR to the investigation of complaint #IN00426049. This survey was in conjunction with a PCR to the investigation of complaint #IN00426636. Survey dates: 6/5/24, 6/6/24, 6/7/24 and 6/10/24. Facility Number: 000956 Provider Number: 15G442 AIM Number: 100244760 These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review of this report completed by #15068 and #27547 on 6/19/24.	W 0000		
W 0149 Bldg. 00	483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. Based on observation, record review and interview for 2 of 3 sampled clients (A and B), the facility failed to implement the Abuse, Neglect, Exploitation, Mistreatment and/or Violation of Individual's Rights policy to prevent: 1) a pattern of falls resulting in injury to client A, and 2) a pattern of falls and unknown injuries to client B.	W 0149	The Facility will ensure that the Nurse will review all HRPs, with focus on Client A's fall HRP. Syncope will be added to the fall risk plan and then nurse will retrain the staff on all HRPs. The Facility will add nonslip	07/01/2024

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Tracy Callahan	Program Manager	07/01/2024

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 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 disclo 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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	Findings include: 1) An observation was conducted on 6/5/24 from 3:32 PM to 4:43 PM. During the observation, client A wore a hard plastic boot on her right foot. Upon entering the home, client A was seated at the dining room table with her leg elevated in a chair while wearing the boot around her ankle. At 4:23 PM, client A participated in the evening meal and continued to wear the boot on her right foot. Client A wore the hard plastic boot throughout the observation period. During this observation, new flooring was observed throughout the kitchen and dining room. On 6/6/24 at 10:21 AM, a review of the facility's Bureau of Disabilities Services (BDS) reports was conducted. The review indicated the following affecting client A: -BDS incident report dated 3/24/24 indicated, "It was reported [client A] went to sit down in a chair at the kitchen table and missed the chair causing her to fall onto her bottom. [Client A] was able to get up on her own. [client A] then went to get her bread and condiments and fell a second time onto her bottom. [Client A] again was able to get up on her own. Staff notified the nurse and assessed [client A] for injuries noting no visible signs of redness or injuries, but [client A] stated her buttock was sore. A couple of hours later in the day, [client A] fell and immediately got herself back up when called to come take her medicine. [Client A] had no complaints of pain or discomfort. Staff notified the nurse who requested [client A] be transported to the ER (emergency room) for evaluation. Plan to Resolve: [Client A] was evaluated in the ER and discharged to her home. Discharge diagnosis: Lisfranc (bones in		treads to the van steps and the interior floor of the van to help with client stability. The Facility staff will be retrained on assisting clients 1 by 1 especially those at risk for falls when entering and exiting the van. The Facility will ensure that staff are retrained on giving verbal prompts to Client A on ensuring she has gained her balance before trying to ambulate. The Facility will ensure follow up appointment with a Neurologist to rule out seizure activity. The Facility will ensure that the staff are trained on notifying the nurse immediately of all incidents regarding falls. The Facility will ensure that the Nurse will review all HRPs, with focus on Client A's fall HRP. Syncope will be added to the fall risk plan and then nurse will retrain the staff on all HRPs. The Facility will add nonslip treads to the van steps and the interior floor of the van to help with client stability. The Facility staff will be retrained on assisting clients 1 by 1 especially those at risk for falls when entering and exiting the van. The Facility will ensure that staff are retrained on giving verbal prompts to Client A on ensuring she has gained her balance before trying to ambulate. The Facility will ensure	

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	midfoot) fracture right foot ... Discharge instructions: Referral to [Medical Provider Name] within 1 week. Non-weight bearing in boot and wheelchair. Follow-up primary care upon discharge for visit today. Staff have been trained on discharge instructions. Staff will continue to monitor [client A], ensure she follows all instructions, attends all follow-up appointments, and will notify the nurse of any changes". -BDS incident report dated 5/17/24 indicated, "It was reported [client A] had her head down and was not responding to staff when they called her name. Staff called 911 and [client A] was transported to the ER (emergency room) for evaluation. The nurse was notified. Plan to Resolve: [Client A] was evaluated in the ER and discharged to her home. Discharge diagnosis: Syncope (loss of consciousness), lightheadedness. Labs completed ... Discharge Instructions: Continue taking previously prescribed medications as directed. Change positions slowly and call for help if you begin feeling dizzy. Use ambulatory aid such as cane or walker. Get plenty of fluids. Follow-up with neurologist for further evaluation and management of lightheadedness and near syncope. Follow-up with PCP (primary care physician) as needed. Return to the ER for new or worsening symptoms. Staff have been trained on the discharge instructions. Staff will continue to monitor [client A], follow her plans in place, and notify the nurse of any changes. No further incidents have been reported". -BDS incident report dated 5/24/24 indicated, "It was reported [client A] wheeled herself into the kitchen and reported to staff she fell while in the restroom. Staff noted a knot on [client A's] forehead between her eyes at the top of her nose.		follow up appointment with a Neurologist to rule out seizure activity. The Facility will ensure that the staff are trained on notifying the nurse immediately of all incidents regarding falls. **PERSONS RESPONSIBLE:** AED, Nurse, Director of Nursing, Quality Assurance Manager, QA Coordinator/QIDP Manager, Program Manager, Area Supervisor, QIDP, Direct Support Lead, DSP	

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	Staff called 911 and [client A] was transported to the ER for evaluation. The nurse was notified. Plan to Resolve: [Client A] was evaluated in the ER and discharged to her home. Discharge diagnosis: Head injury, adult. No signs of fractures noted. Head injury information sheets were provided. Discharge instructions: Follow-up with PCP (primary care physician) in 2 to 3 days. Staff have been trained on the head injury information sheets and discharge instructions. Staff will continue to monitor [client A] and notify the nurse of any changes. The ID (interdisciplinary) team will meet to discuss additional measures needed to better assist [client A]. No further incidents have been reported". No investigation was available for review. On 6/6/24 at 11:49 AM, a focused review of client A's record was conducted. The review indicated the following: Fall Risk Plan dated 6/5/24 indicated, "Problem Risk of Falls ... Goal: Will have no injury related to falls through June 2025 ... Approach: 1. Staff will provide stand-by assistance with helping [client A] onto the van. 2. Staff will keep the environment free of any obstacles to prevent falls. 3. Staff will encourage client to wear shoes while ambulating/transferring. 4. Staff will ensure that [client A] wears walking boot while ambulating as prescribed by Orthopedic specialist. 5. Staff will notify nurse of any falls...". -No syncope health risk plan was available for review. On 6/6/24 at 12:18 PM, the Quality Assurance Manager (QAM) was interviewed. The QAM was asked about client A's falls with injuries. The			

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	QAM stated, "We met and did a trend analysis. We've seen what you're seeing. [Qualified Intellectual Disabilities Professional/QIDP] did additional training with staff. [Nurse] is doing more follow-up with OT/PT (Occupational Therapy/Physical Therapy)...". The QAM indicated the team did not find any one particular contributing factor to the falls. The QAM indicated she would provide additional follow-up for: A) investigations for client A's falls, B) medical discharge paperwork for the diagnosis of syncope and C) the interdisciplinary teams (IDTs) meeting minutes. On 6/6/24 at 1:52 PM, the QAM provided additional follow-up documentation for review. The QAM indicated more follow-up was being pursued with the QIDP to obtain the investigation for the 5/24/24 incident of client A reporting a fall with a head injury. The QAM indicated the QIDP was out of office for the week but would provide requested information once obtained for review. On 6/6/24 at 1:55 PM, a review was conducted of A) the investigation for client A's 3/24/24 fall with fracture, B) medical discharge paperwork for the diagnosis of syncope and C) the interdisciplinary teams (IDTs) meeting minutes for the trend of falls and accident at the group home. The review indicated the following: A) Investigation Summary dated 3/29/24 indicated, "Introduction: On 3/23/24, [client A] went to sit down in a chair at the kitchen table and missed the chair causing her to fall onto her bottom. [Client A] was able to get up on her own. [Client A] then went to get her bread and condiments and fell a second time onto her bottom. [Client A] again was able to get up on her own. Staff notified the nurse and assessed [client			

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	A] for injuries noting no visible signs of redness or injuries, but [client A] stated her buttock was sore. A couple of hours later in the day, [client A] fell and immediately got herself back up when called to come take her medicine. [Client A] had no complaints of pain or discomfort... Factual Findings: The first fall occurred when [client A] went to sit down in a chair at the kitchen table and missed the chair causing her to fall onto her bottom. [Client A] was able to get up on her own. The second fall occurred when [client A] went to get her bread and condiments and onto her bottom. [Client A] again was able to get up on her own. Staff notified the nurse and assessed [client A] for injuries noting no visible signs of redness or injuries, but [client A] stated her buttock was sore. A couple of hours later in the day, [client A] fell and immediately got herself back up when called to come take her medicine. [Client A] had no complaints of pain or discomfort. No staff reported assisting [client A] prior to the falls... [Staff #5] stated she was in the med (medication administration) room each time [client A] fell. [Staff #6] stated she was (sic) the restroom when [client A] fell the first two times and had just came in the kitchen when [client A] fell the third time. [Staff #5] and [staff #6] both stated they assisted her after the falls and checked her for injuries... [Client A's] 12/2023 fall risk plan has the following approach: 'Staff will provide stand-by assistance with helping [client A] onto the van... Staff will keep the environment free of any obstacles to prevent falls... Staff will encourage client to wear shoes while ambulating/transferring...			

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	Staff will ensure that [client A] wears walking boot while ambulating as prescribed by Orthopedic specialist'... [Client A] attended her follow-up appointment on 3/28/24. Physician/Consultant Orders: Right 2nd/3rd Metatarsal (bones in foot) base fractures - boney Lisfranc (broken foot) injury. Can be weight bearing in boot for short distances only - cannot walk without boot. Recheck in 2 weeks for repeat x-rays. If stable, then no surgery. If fractures move, will need surgery for fractures... Staff need to monitor [client A] when she is ambulating and give verbal prompts to ensure she stands and gains her balance before ambulating... Conclusion: It is substantiated [client A] fell and there are risk plans in place which appropriately address falls and metatarsal fractures. It is substantiated [client A's] fall risk plans were being implemented at the time of each fall... Recommendation: Staff to monitor [client A] when she is ambulating and give verbal prompts to ensure she stands and gains her balance before ambulating". Based on review of the factual findings, the investigation indicated staff members were not in close proximity to client A when she attempted to ambulate prior to her falls. The investigation indicated staff #5 was in the medication administration room each time client A fell and staff #6 stated she was in the restroom when client A fell the first two times and had just come back into the kitchen when client A fell the third time. Both staff #5 and staff #6 stated they assisted client A after each of the falls had occurred.			

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B) Medical Discharge dated 5/16/24 indicated, "Instructions:... Change positions slowly and call for help if you begin feeling dizzy. Use ambulatory aids such as cane or walker. Get plenty of fluids. Follow-up with neurologist for further evaluation and management of lightheadedness and near syncope. Follow-up with primary care provider as needed...".

C) IDT dated 5/31/24 indicated, "Meeting Minutes: IDT met to discuss falls and a potential trend as it relates to the [group home], for falls/injuries. Incident reports reviewed showed: [Client A] fell on 3/23 (2024) resulting in a fracture. She was discharged with follow up recommended, was non weight bearing in a boot and wheelchair. She had (sic) since been cleared to ambulate, w/ (with) boot. PT/OT was discussed, she will not be able to attend until she is released from Ortho (Orthopedic Doctor). [Client A] had another fall on 5/24 (2024) in which she was wheeling herself, in her wheelchair, to the kitchen and told staff she fell while in the restroom. She was transported to the ER...

Plan of Action:... Staff will have a refresher on HRPs (health risk plans), specifically as it relates to falls risk plans and assisting clients when needed, being mindful of environment, such as slick surfaces if raining, steps on vans/uneven surfaces, keeping walkways cleared, etc...

The flooring in the home was in the process of repair, PM (Program Manager) to follow up and ensure there are no areas of the floor that could pose as a potential trip hazard...

Neuro (Neurological) consult is set up to check [client A's] neurological status due to periods of

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	not responding to staff... Ortho was consulted regarding Dexa Scans (bone density) and they stated they didn't feel it was warranted at this time... The team agrees to continue OT/PT once released for [client A]... AS (Area Supervisor) is checking to ensure all clients have proper fitting shoes and staff are checking shoes to ensure they are being worn properly... Nonslip tape/surface will be purchased and placed on the van steps in order to provide extra grip if it's raining or slick. Staff will attempt to get clients off the van 1 by 1, assisting individuals who are a falls risk first...". On 6/6/24 at 3:28 PM, the Nurse was interviewed. The Nurse was asked about client A's incident history for falls with injury and her diagnosis of syncope. The Nurse indicated client A was currently in a walking boot and a hard cast had been removed the week prior. The Nurse stated, "They're in hope to put her in a normal shoe. She will not start PT until released. [Primary Care Physician] did not order a report on the Dexa Scan". The Nurse indicated a Dexa Scan to review for bone health and to rule out Osteoporosis (weak bones) had been completed previously in the year with negative findings to indicate client A had Osteoporosis. The Nurse was asked about client A's diagnosis of syncope. The Nurse indicated a referral from client A's primary care physician to a neurologist had been made and in process. The Nurse stated, "I just want to rule out neuro (neurological) or seizure activity. Once processed, the primary care will send it to us to go			

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	to the [Neurologist]". The Nurse was asked about client A's fall risk plan not indicating a risk of syncope to contribute to falls or a syncope risk plan available for review. The Nurse indicated a syncope risk plan had been developed and would provide a copy for review. The Nurse was asked how the hospital discharge instructions from a syncope diagnosis had been incorporated into client A's fall risk plan. The Nurse stated, "The only difference with (sic) syncope and fall risk is complaints of light headedness or dizzy (sic). I could combine them. It really could have been combined with that. The only thing I see different is the client could report if she feels dizzy or lightheaded". The Nurse was asked if client A used ambulatory aids. The Nurse stated, "She does not". The Nurse was asked if other discharge instructions needed incorporated into client A's fall risk plan beside client A's reporting of feeling dizzy or lightheaded and need for staff assistance. The Nurse stated, "Getting plenty of fluids, yeah that's on here (syncope risk plan). Encourage water intake. I guess that should be more daily. I guess I should split that (fluid intake), encourage water daily and encourage her to consume at least 4 ounces of water at med (medication) administration. I may need to have both (risk plans). The Fall Risk plan is more along the line of assisting, wearing the boot, assistance on and off the van. I could incorporate more of the syncope for dizzy or lightheadedness (requesting staff assistance) into the falls plan". On 6/6/24 at 4:30 PM, a focused review of client A's 5/17/24 syncope risk plan was conducted. The review indicated, "Triggers to Notify Nurse: Complaints of dizziness or lightheaded... Expected Outcome: [Client A] will have no injuries related to falls from Syncope thru May 2025... Actions: 1)			

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	Medications as ordered, 2) Encourage water intake daily and at medication administration, 3) Change positions slowly, 4) Staff will encourage [client A] to report if she is feeling dizzy or lightheaded, 5) Staff will assist as needed when getting on and off the van, 6) Staff will keep environment free of obstacles that may cause a fall...". Based on review of client A's fall risk plan, syncope risk plan and interview with the Nurse, client A's risk plan for the prevention of falls did not indicate elements of the medical discharge instruction for client A to ask for help when feeling dizzy or lightheaded. The Nurse indicated further review of client A's fall risk plan and syncope risk plan to determine if fall prevention should be incorporated as one plan or maintained as two separate plans was needed. The Nurse indicated more detail could be developed and added to client A's risk plan for the prevention of syncope and falls. The Nurse indicated more follow-up was being pursued to obtain a neurological consult to rule out the potential for seizure activity and any neurological factors that might contribute to falls and if necessary, revision would be made for client A's health risk plans. 2) On 6/6/24 at 10:21 AM, a review of the facility's Bureau of Disabilities Services (BDS) reports was conducted. The review indicated the following affecting client B: -BDS incident report dated 4/12/24 indicated, "Staff reported while she was preparing meds, another client came and reported [client B] had fallen out of bed. Staff went to check on [client B] and found her on the floor trying to get up. Staff told [client B] to stay where she was while staff went and got the phone. When staff returned to			

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	[client B] with the phone, [client B] was sitting on her bed. Staff notified the nurse and requested she be transported to the urgent care. Plan to Resolve: [Client B] was evaluated at the urgent care and discharged to her home. Discharge diagnosis: status post fall normal exam. Discharge instructions: Fall prevention in the home. [Client B] has a fall risk plan in place that staff are trained on. Staff will remind and encourage [client B] to utilize her call button when she is ready to get up so staff may assist. [Client B] denies complaints of pain or discomfort. Staff will continue to monitor [client B] and notify the nurse of any changes". No investigation was available for review. -BDS incident report dated 4/23/24 indicated, "It was reported on 4/21/24, [client B's] left hand appeared red. When [client B] awoke on 4/22/24, her left hand appeared swollen, and the redness developed into a bruise. [Client B] could not say how she injured her hand. The nurse was notified and requested [client B] be transported to the urgent care for evaluation. Plan to Resolve: [Client B] was evaluated at urgent care and discharged to her home. Discharge diagnosis: Contusion (bruise) of left hand, initial encounter, localized swelling on left hand, contusion of wrist... x-rays negative for fracture. Discharge instructions: Ace wrap to hand/wrist on and off to help with pain and swelling. Tylenol as needed for pain, swelling. Follow-up with PCP (primary care physician) in 1 week. Staff have been trained on the discharge instructions. [Client B] denies complaints of pain or discomfort. Staff will continue to monitor [client B] and notify the nurse of any changes". No investigation was available for review. -BDS incident report dated 5/15/24 indicated, "It			

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	was reported the inside of [client B's] left ankle and foot appeared bruised. [Client B] had not reported falls or incidents that could result in injuries. The nurse was notified and requested [client B] be transported to the urgent care for evaluation. Plan to Resolve: [Client B] was evaluated in the urgent care and discharged to her home. Discharge diagnosis: left foot pain. Imaging test completed... no findings. Discharge instructions: Follow-up with PCP for further evaluation and treatment as needed. Tylenol/Motrin as needed for pain/fevers. Make sure patient is drinking plenty of fluids. Return for any new or worsening symptoms. Staff have been trained on the discharge instructions. [Client B] denies complaints of pain or discomfort. Staff will continue to monitor [client B], follow her plans in place, and notify the nurse of any changes". No investigation was available for review. -BDS incident report dated 5/16/24 indicated, "It was reported staff heard a noise from [client B's] room and went to check and found [client B] on the floor. Staff assisted [client B] up and into her chair. [Client B] stated she was not sure why she got up without requesting staff assistance. Staff assessed [client B] for signs of injury noting a small scratch on her left knee. The nurse was notified. Plan to Resolve: Staff assisted [client B] with cleaning the scratch with an alcohol pad and applying a band-aid. [Client B] denied complaints of pain or discomfort. Staff will continue to monitor [client B], follow her plans in place, and notify the nurse of any changes". No investigation was available for review. On 6/6/24 at 11:57 AM, a focused review of client B's record was conducted. The review indicated			

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	the following: Fall Risk Plan dated 5/14/24 indicated, "Problem: Falls risk... Goal: Will have no injuries r/t (related to) falls thru (through) May 2025... Approach: 1. Staff will remain within arm's reach of [client B] with ambulation to ensure safety and help prevent falls. 2. Staff will ensure [client B] wears appropriate shoes, tennis shoes, soled shoes or non-skid socks. 3. Staff will ensure [client B] uses a shower chair and staff will remain in the bathroom in case assistance is needed/requested. 4. Staff will keep the environment free of any obstacles to prevent falls...". On 6/6/24 at 12:18 PM, the Quality Assurance Manager (QAM) was interviewed. The QAM was asked about client B's falls and injuries of unknown origin. The QAM stated, "We met and did a trend analysis. We've seen what you're seeing. [Qualified Intellectual Disabilities Professional/QIDP] did additional training with staff. [Nurse] is doing more follow-up with OT/PT (Occupational Therapy/Physical Therapy)...". The QAM indicated the team did not find any one particular contributing factor for the falls or injuries of unknown origin. The QAM indicated she would provide the interdisciplinary team (IDT) meeting minutes and the investigations into client B's incidents for falls and injuries of unknown origin. On 6/6/24 at 1:52 PM, the QAM provided additional follow-up documentation for review. The QAM indicated more follow-up was being pursued with the QIDP to obtain the investigations into client B's falls and injuries of unknown origin. The QAM indicated the QIDP was out of office for the week and would provide for review once obtained.			

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	On 6/6/24 at 1:55 PM, a review of the interdisciplinary teams (IDTs) meeting minutes for the trend of falls and injuries of unknown origin at the group home was conducted. The review indicated the following: IDT dated 5/31/24 indicated, "Meeting Minutes: IDT met to discuss falls and a potential trend as it relates to the [group home], for falls/injuries. Incident reports reviewed showed:... [Client B] had a fall w/o (without) injury on 4/12 (2024), she is sliding from her seat, another slide from the chair to the floor onto staff foot on 4/19 (2024) w/o injury, 5/16 (2024) she fell getting up from her bed. Plans were being followed at the time, [client B] remains stand-by assist when ambulating and she has alarms in place which are checked and confirmed to be in working order ... Plan of Action:... The team identified that [client B] is using a plastic mattress protector, due to incontinence issues, which may cause the surface to be slick when attempting to stand from a seated position. A new protector will be purchased, of a cloth material, in attempt to prevent falls/stumbles/slides... Staff will have a refresher on HRPs (health risk plans), specifically as it relates to falls risk plans and assisting clients when needed, being mindful of environment, such as slick surfaces if raining, steps on vans/uneven surfaces, keeping walkways cleared, etc... The flooring in the home was in the process of repair, PM (Program Manager) to follow up and ensure there are no areas of the floor that could pose as a potential trip hazard...			

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	[Client B] has OT/PT and call out to [Physical Therapy Provider] to set up going forward ... AS (Area Supervisor) is checking to ensure all clients have proper fitting shoes and staff are checking shoes to ensure they are being worn properly... Nonslip tape/surface will be purchased and placed on the van steps in order to provide extra grip if it's raining or slick. Staff will attempt to get clients off the van 1 by 1, assisting individuals who are a falls risk first...". On 6/6/24 at 3:28 PM, the Nurse was interviewed. The Nurse was asked about client B's incident of falls and injury of unknown origin. The Nurse stated, "She remains a stand-by assist with ambulation. [Staff #5] said [Physical Therapy Provider] is coming in the morning to do their initial assessment for both [client B] and...". The Nurse was asked if client B was utilizing an alarm to alert staff when attempting to ambulate. The Nurse stated, "She is. She uses it in the bed and they (staff) transfer it to the chair. She (client B) has a pager button where she can alert they're needed". Based on review of the incident history, client B's falls were heard by staff or reported by another client to staff. This indicates implementation of a stand-by assist with client B during ambulation did not occur. The pattern of falls and injuries of unknown origin indicated the audible alarm/call button to request assistance were not effective intervention strategies to prevent fall/injuries. On 6/6/24 at 12:27 PM, the QAM was asked about implementation of the abuse, neglect, exploitation, mistreatment and/or violation of an individual's			

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	rights (ANE) policy as it related to the pattern of falls and injuries of unknown origin for both clients A and B. The QAM indicated the pattern of falls and/or injuries had been identified as a trend at the group home and the purpose for the 5/31/24 IDT meeting to establish a plan of action. The QAM indicated the ANE policy should be implemented at all times and stated, "Yes". On 6/10/24 at 10:53 AM, the Quality Assurance Manager (QAM) was interviewed. The QAM was asked about the investigations for client B's incidents of falls and/or injuries of unknown origin and if they were available for review. The QAM indicated no investigations could not be provided for review and stated, "[QIDP] could not find those". On 6/7/24 at 11:15 AM, a review of the 11/10/23 ANE policy was conducted. The review indicated the following: "ResCare staff actively advocate for the rights and safety of all individuals... ResCare strictly prohibits abuse, neglect, exploitation, mistreatment, or violation of an Individual's rights...". 9-3-2(a)			
W 0154 Bldg. 00	483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated. Based on observation, record review and interview for 2 of 3 sampled clients (A and B), the facility failed to thoroughly investigate incidents of falls and injuries of unknown origin for clients A and B. Findings include:	W 0154	The Facility will ensure that the QIDP is retrained on thorough completion of investigations and follow ups for all incidents. The Facility will ensure that the area supervisor will retrain all staff on the proper implementation of the ANE policy to	07/01/2024

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	1) An observation was conducted on 6/5/24 from 3:32 PM to 4:43 PM. During the observation, client A wore a hard plastic boot on her right foot. Upon entering the home, client A was seated at the dining room table with her leg elevated in a chair while wearing the boot around her ankle. At 4:23 PM, client A participated in the evening meal and continued to wear the boot on her right foot. Client A wore the hard plastic boot throughout the observation period. During this observation, new flooring was observed throughout the kitchen and dining room. On 6/6/24 at 10:21 AM, a review of the facility's Bureau of Disabilities Services (BDS) reports was conducted. The review indicated the following affecting clients A: -BDS incident report dated 5/24/24 indicated, "It was reported [client A] wheeled herself into the kitchen and reported to staff she fell while in the restroom. Staff noted a knot on [client A's] forehead between her eyes at the top of her nose. Staff called 911 and [client A] was transported to the ER (emergency room) for evaluation. The nurse was notified. Plan to Resolve: [Client A] was evaluated in the ER and discharged to her home. Discharge diagnosis: Head injury, adult. No signs of fractures noted. Head injury information sheets were provided. Discharge instructions: Follow-up with PCP (primary care physician) in 2 to 3 days. Staff have been trained on the head injury information sheets and discharge instructions. Staff will continue to monitor [client A] and notify the nurse of any changes. The ID (interdisciplinary) team will meet to discuss additional measures needed to better assist [client A]. No further incidents have been reported". No investigation was available for review.		prevent/address the reoccurring patterns of trends. The Facility will ensure that the Nurse will review all HRPs, with focus on Client A's fall HRP. Syncope will be added to the fall risk plan and then nurse will retrain the staff on all HRPs. The Facility will add nonslip treads to the van steps and the interior floor of the van to help with client stability. The Facility staff will be retrained on assisting clients 1 by 1 especially those at risk for falls when entering and exiting the van. The Facility will ensure that staff are retrained on giving verbal prompts to Client A on ensuring she has gained her balance before trying to ambulate. The Facility will ensure follow up appointment with a Neurologist to rule out seizure activity. The Facility will ensure that the staff are trained on notifying the nurse immediately of all incidents regarding falls. **PERSONS RESPONSIBLE:** AED, Nurse, Director of Nursing, Quality Assurance Manager, QA Coordinator/QIDP Manager, Program Manager, Area Supervisor, QIDP, Direct Support Lead, DSP	

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On 6/6/24 at 11:49 AM, a focused review of client A's record was conducted. The review indicated the following:

Fall Risk Plan dated 6/5/24 indicated, "Problem Risk of Falls ... Goal: Will have no injury related to falls through June 2025 ... Approach: 1. Staff will provide stand-by assistance with helping [client A] onto the van. 2. Staff will keep the environment free of any obstacles to prevent falls. 3. Staff will encourage the client to wear shoes while ambulating/transferring. 4. Staff will ensure that [client A] wears walking boot while ambulating as prescribed by Orthopedic specialist. 5. Staff will notify the nurse of any falls...".

On 6/6/24 at 12:18 PM, the Quality Assurance Manager (QAM) was interviewed. The QAM was asked if an investigation into client A's fall with head injury was available for review. The QAM indicated she would need to follow up with the Qualified Intellectual Disabilities Professional (QIDP) who was out of the office for the week. The QAM indicated more follow up would be provided.

On 6/10/24 at 10:53 AM, the Quality Assurance Manager (QAM) was interviewed. The QAM was asked about the investigation for client A's fall with head injury. The QAM indicated an investigation could not be provided for review and stated, "[QIDP] could not find those".

2) On 6/6/24 at 10:21 AM, a review of the facility's Bureau of Disabilities Services (BDS) reports was conducted. The review indicated the following affecting clients B:

-BDS incident report dated 4/12/24 indicated,

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	"Staff reported while she was preparing meds, another client came and reported [client B] had fallen out of bed. Staff went to check on [client B] and found her on the floor trying to get up. Staff told [client B] to stay where she was while staff went and got the phone. When staff returned to [client B] with the phone, [client B] was sitting on her bed. Staff notified the nurse and requested she be transported to the urgent care. Plan to Resolve: [Client B] was evaluated at the urgent care and discharged to her home. Discharge diagnosis: status post fall normal exam. Discharge instructions: Fall prevention in the home. [Client B] has a fall risk plan in place that staff are trained on. Staff will remind and encourage [client B] to utilize her call button when she is ready to get up so staff may assist. [Client B] denies complaints of pain or discomfort. Staff will continue to monitor [client B] and notify the nurse of any changes". No investigation was available for review. -BDS incident report dated 4/23/24 indicated, "It was reported on 4/21/24, [client B's] left hand appeared red. When [client B] awoke on 4/22/24, her left hand appeared swollen, and the redness developed into a bruise. [Client B] could not say how she injured her hand. The nurse was notified and requested [client B] be transported to the urgent care for evaluation. Plan to Resolve: [Client B] was evaluated at urgent care and discharged to her home. Discharge diagnosis: Contusion (bruise) of left hand, initial encounter, localized swelling on left hand, contusion of wrist... x-rays negative for fracture. Discharge instructions: Ace wrap to hand/wrist on and off to help with pain and swelling. Tylenol as needed for pain, swelling. Follow-up with PCP (primary care physician) in 1 week. Staff have been trained on the discharge instructions. [Client B] denies complaints of pain			

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	or discomfort. Staff will continue to monitor [client B] and notify the nurse of any changes". No investigation was available for review. -BDS incident report dated 5/15/24 indicated, "It was reported the inside of [client B's] left ankle and foot appeared bruised. [Client B] had not reported falls or incidents that could result in injuries. The nurse was notified and requested [client B] be transported to the urgent care for evaluation. Plan to Resolve: [Client B] was evaluated in the urgent care and discharged to her home. Discharge diagnosis: left foot pain. Imaging test completed... no findings. Discharge instructions: Follow-up with PCP for further evaluation and treatment as needed. Tylenol/Motrin as needed for pain/fevers. Make sure patient is drinking plenty of fluids. Return for any new or worsening symptoms. Staff have been trained on the discharge instructions. [Client B] denies complaints of pain or discomfort. Staff will continue to monitor [client B], follow her plans in place, and notify the nurse of any changes". No investigation was available for review. -BDS incident report dated 5/16/24 indicated, "It was reported staff heard a noise from [client B's] room and went to check and found [client B] on the floor. Staff assisted [client B] up and into her chair. [Client B] stated she was not sure why she got up without requesting staff assistance. Staff assessed [client B] for signs of injury noting a small scratch on her left knee. The nurse was notified. Plan to Resolve: Staff assisted [client B] with cleaning the scratch with an alcohol pad and applying a band-aid. [Client B] denied complaints of pain or discomfort. Staff will continue to monitor [client B], follow her plans in place, and			

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	notify the nurse of any changes". No investigation was available for review. On 6/6/24 at 11:57 AM, a focused review of client B's record was conducted. The review indicated the following: Fall Risk Plan dated 5/14/24 indicated, "Problem: Falls risk... Goal: Will have no injuries r/t (related to) falls thru (through) May 2025... Approach: 1. Staff will remain within arm's reach of [client B] with ambulation to ensure safety and help prevent falls. 2. Staff will ensure [client B] wears appropriate shoes, tennis shoes, soled shoes or non-skid socks. 3. Staff will ensure [client B] uses a shower chair and staff will remain in the bathroom in case assistance is needed/requested. 4. Staff will keep the environment free of any obstacles to prevent falls...". On 6/6/24 at 12:18 PM, the Quality Assurance Manager (QAM) was interviewed. The QAM was asked if investigations for client B's incidents of falls and/or injuries of unknown origin were available for review. The QAM indicated she would need to follow up with the Qualified Intellectual Disabilities Professional (QIDP) who was out of the office for the week. The QAM indicated more follow up would be provided. On 6/10/24 at 10:53 AM, the Quality Assurance Manager (QAM) was interviewed. The QAM was asked about the investigations for client B's incidents of falls and/or injuries of unknown origin and if they were available for review. The QAM indicated no investigations could not be provided for review and stated, "[QIDP] could not find those".			

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W 0240 Bldg. 00	9-3-2(a) 483.440(c)(6)(i) INDIVIDUAL PROGRAM PLAN The individual program plan must describe relevant interventions to support the individual toward independence. Based on observation, record review and interview for 1 of 3 sampled clients (A), the facility failed to ensure client A's fall risk plan incorporated the risk of syncope (loss of consciousness) and medical discharge instructions. Findings include: An observation was conducted on 6/5/24 from 3:32 PM to 4:43 PM. During the observation, client A wore a hard plastic boot on her right foot. Upon entering the home, client A was seated at the dining room table with her leg elevated in a chair while wearing the boot around her ankle. At 4:23 PM, client A participated in the evening meal and continued to wear the boot on her right foot. Client A wore the hard plastic boot throughout the observation period. During this observation, new flooring was observed throughout the kitchen and dining room. On 6/6/24 at 10:21 AM, a review of the facility's Bureau of Disabilities Services (BDS) reports was conducted. The review indicated the following affecting client A: -BDS incident report dated 3/24/24 indicated, "It was reported [client A] went to sit down in a chair at the kitchen table and missed the chair causing her to fall onto her bottom. [Client A] was able to get up on her own. [client A] then went to get her bread and condiments and fell a second time onto	W 0240	The Facility will ensure that the Nurse will review all HRPs, with focus on Client A's fall HRP. Syncope will be added to the fall risk plan and then nurse will retrain the staff on all HRPs. The Facility will add nonslip treads to the van steps and the interior floor of the van to help with client stability. The Facility staff will be retrained on assisting clients 1 by 1 especially those at risk for falls when entering and exiting the van. The Facility will ensure that staff are retrained on giving verbal prompts to Client A on ensuring she has gained her balance before trying to ambulate. The Facility will ensure follow up appointment with a Neurologist to rule out seizure activity. The Facility will ensure that the staff are trained on notifying the nurse immediately of all incidents regarding falls. The Facility will ensure that the Nurse will review all HRPs, with focus on Client A's fall HRP. Syncope will be added to the fall risk plan and then nurse will retrain the staff on all HRPs.	07/01/2024

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	her bottom. [Client A] again was able to get up on her own. Staff notified the nurse and assessed [client A] for injuries noting no visible signs of redness or injuries, but [client A] stated her buttock was sore. A couple of hours later in the day, [client A] fell and immediately got herself back up when called to come take her medicine. [Client A] had no complaints of pain or discomfort. Staff notified the nurse who requested [client A] be transported to the ER (emergency room) for evaluation. Plan to Resolve: [Client A] was evaluated in the ER and discharged to her home. Discharge diagnosis: Lisfranc (bones in midfoot) fracture right foot ... Discharge instructions: Referral to [Medical Provider Name] within 1 week. Non-weight bearing in boot and wheelchair. Follow-up primary care upon discharge for visit today. Staff have been trained on discharge instructions. Staff will continue to monitor [client A], ensure she follows all instructions, attends all follow-up appointments, and will notify the nurse of any changes". -BDS incident report dated 5/17/24 indicated, "It was reported [client A] had her head down and was not responding to staff when they called her name. Staff called 911 and [client A] was transported to the ER (emergency room) for evaluation. The nurse was notified. Plan to Resolve: [Client A] was evaluated in the ER and discharged to her home. Discharge diagnosis: Syncope (loss of consciousness), lightheadedness. Labs completed ... Discharge Instructions: Continue taking previously prescribed medications as directed. Change positions slowly and call for help if you begin feeling dizzy. Use ambulatory aid such as cane or walker. Get plenty of fluids. Follow-up with neurologist for further evaluation and management of lightheadedness and near		The Facility will add nonslip treads to the van steps and the interior floor of the van to help with client stability. The Facility staff will be retrained on assisting clients 1 by 1 especially those at risk for falls when entering and exiting the van. The Facility will ensure that staff are retrained on giving verbal prompts to Client A on ensuring she has gained her balance before trying to ambulate. The Facility will ensure follow up appointment with a Neurologist to rule out seizure activity. The Facility will ensure that the staff are trained on notifying the nurse immediately of all incidents regarding falls. **PERSONS RESPONSIBLE:** AED, Nurse, Director of Nursing, Quality Assurance Manager, QA Coordinator/QIDP Manager, Program Manager, Area Supervisor, QIDP, Direct Support Lead, DSP	

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	15G442	A. BUILDING 00 B. WING	06/10/2024

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	syncope. Follow-up with PCP (primary care physician) as needed. Return to the ER for new or worsening symptoms. Staff have been trained on the discharge instructions. Staff will continue to monitor [client A], follow her plans in place, and notify the nurse of any changes. No further incidents have been reported". -BDS incident report dated 5/24/24 indicated, "It was reported [client A] wheeled herself into the kitchen and reported to staff she fell while in the restroom. Staff noted a knot on [client A's] forehead between her eyes at the top of her nose. Staff called 911 and [client A] was transported to the ER for evaluation. The nurse was notified. Plan to Resolve: [Client A] was evaluated in the ER and discharged to her home. Discharge diagnosis: Head injury, adult. No signs of fractures noted. Head injury information sheets were provided. Discharge instructions: Follow-up with PCP (primary care physician) in 2 to 3 days. Staff have been trained on the head injury information sheets and discharge instructions. Staff will continue to monitor [client A] and notify the nurse of any changes. The ID (interdisciplinary) team will meet to discuss additional measures needed to better assist [client A]. No further incidents have been reported". On 6/6/24 at 11:49 AM, a focused review of client A's record was conducted. The review indicated the following: Fall Risk Plan dated 6/5/24 indicated, "Problem Risk of Falls ... Goal: Will have no injury related to falls through June 2025... Approach: 1. Staff will provide stand-by assistance with helping [client A] onto the van. 2. Staff will keep the environment free of any obstacles to prevent falls. 3. Staff will encourage client to wear shoes while			

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ambulating/transferring. 4. Staff will ensure that [client A] wears walking boot while ambulating as prescribed by Orthopedic specialist. 5. Staff will notify nurse of any falls...".

-No syncope health risk plan was available for review.

On 6/6/24 at 12:18 PM, the Quality Assurance Manager (QAM) was interviewed. The QAM was asked about client A's falls with injuries. The QAM stated, "We met and did a trend analysis. We've seen what you're seeing. [Qualified Intellectual Disabilities Professional/QIDP] did additional training with staff. [Nurse] is doing more follow-up with OT/PT (Occupational Therapy/Physical Therapy)...". The QAM indicated the team did not find any one particular contributing factor to the falls. The QAM indicated she would provide additional follow-up for medical discharge paperwork for the diagnosis of syncope.

On 6/6/24 at 1:55 PM, a review was conducted of medical discharge paperwork for the diagnosis of syncope. The review indicated the following:

"[Client A's] 12/2023 fall risk plan has the following approach:
'Staff will provide stand-by assistance with helping [client A] onto the van...
Staff will keep the environment free of any obstacles to prevent falls...
Staff will encourage client to wear shoes while ambulating/transferring...
Staff will ensure that [client A] wears walking boot while ambulating as prescribed by Orthopedic specialist'...

[Client A] attended her follow-up appointment on

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	3/28/24. Physician/Consultant Orders: Right 2nd/3rd Metatarsal (bones in foot) base fractures - boney Lisfranc (broken foot) injury. Can weight bearing in boot for short distances only - cannot walk without boot. Recheck in 2 weeks for repeat x-rays. If stable, then no surgery. If fractures move, will need surgery for fractures... Staff need to monitor [client A] when she is ambulating and give verbal prompts to ensure she stands and gains her balance before ambulating... Conclusion: It is substantiated [client A] fell and there are risk plans in place which appropriately address falls and metatarsal fractures. It is substantiated [client A's] fall risk plans were being implemented at the time of each fall... Recommendation: Staff to monitor [client A] when she is ambulating and give verbal prompts to ensure she stands and gains her balance before ambulating". Medical Discharge dated 5/16/24 indicated, "Instructions:... Change positions slowly and call for help if you begin feeling dizzy. Use ambulatory aids such as cane or walker. Get plenty of fluids. Follow-up with neurologist for further evaluation and management of lightheadedness and near syncope. Follow-up with primary care provider as needed...". The recommendations for changing positions slowly and to call for help if feeling dizzy, the use of ambulatory aids, and drinking plenty of fluids were not incorporated into client A's fall risk plan. On 6/6/24 at 3:28 PM, the Nurse was interviewed. The Nurse was asked about client A's fall risk plan not indicating a risk of syncope to contribute to falls or a syncope risk plan available for review.			

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	The Nurse indicated a syncope risk plan had been developed and would provide a copy for review. The Nurse was asked how the hospital discharge instructions from a syncope diagnosis had been incorporated into client A's fall risk plan. The Nurse stated, "The only difference with (sic) syncope and fall risk is complaints of light headedness or dizzy. I could combine them. It really could have been combined with that. The only thing I see different is the client could report if she feels dizzy or lightheaded". The Nurse was asked if client A used ambulatory aids. The Nurse stated, "She does not". The Nurse was asked if other discharge instructions needed incorporated into client A's fall risk plan beside client A's reporting of feeling dizzy or lightheaded and need for staff assistance. The Nurse stated, "Getting plenty of fluids, yeah that's on here (syncope risk plan). Encourage water intake. I guess that should be more daily. I guess I should split that (fluid intake), encourage water daily and encourage her to consume at least 4 ounces of water at med (medication) administration. I may need to have both (risk plans). The Fall Risk plan is more along the line of assisting, wearing the boot, assistance on and off the van. I could incorporate more of the syncope for dizzy or lightheadedness (requesting staff assistance) into the falls plan". On 6/6/24 at 4:30 PM, a focused review of client A's 5/17/24 syncope risk plan was conducted. The review indicated, "Triggers to Notify Nurse: Complaints of dizziness or lightheaded... Expected Outcome: [Client A] will have no injuries related to falls from Syncope thru May 2025... Actions: 1) Medications as ordered, 2) Encourage water intake daily and at medication administration, 3) Change positions slowly, 4) Staff will encourage [client A] to report if she is feeling dizzy or			

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	lightheaded, 5) Staff will assist as needed when getting on and off the van, 6) Staff will keep environment free of obstacles that may cause a fall...". Based on review of client A's fall risk plan, syncope risk plan and interview with the Nurse, client A's risk plan for the prevention of falls did not indicate the medical discharge instruction for client A to ask for help when feeling dizzy or lightheaded. The Nurse indicated further review of client A's fall risk and syncope risk plans to determine if one plan or two was needed. The Nurse indicated more detail could be added to both the fall risk and syncope risk plan such as, asking for help when dizzy or lightheaded in the fall risk plan and 4 ounces of fluid intake during medication administration for the syncope risk plan. In addition, the Nurse indicated follow-up to obtain a neurological consult to rule out the potential for seizure activity and/or any neurological factors was being pursued and any necessary revision would be made for client A's health risk plans. This deficiency was cited on 1/19/24. The facility failed to implement a systemic plan of correction to prevent recurrence. 9-3-4(a)			
W 9999 Bldg. 00		W 9999	no response required	07/01/2024