

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G177	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  07/31/2013
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NAME OF PROVIDER OR SUPPLIER  TRADEWINDS SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 8416 CLINE AVE CROWN POINT, IN 46307
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W000000	<p>This visit was for an extended annual recertification and state licensure survey (Client Protections).</p> <p>Dates of survey: July 18, 19, 22, 23, 24, and 31, 2013.</p> <p>Facility number: 000711 Provider number: 15G177 AIM number: 100243200</p> <p>Surveyor: Amber Bloss, QIDP</p> <p>The following federal deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 8/1/13 by Ruth Shackelford, QIDP.</p>	W000000		

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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W000122	<p><b>483.420</b> <b>CLIENT PROTECTIONS</b> The facility must ensure that specific client protections requirements are met.</p> <p>Based on observation, interview and record review, the facility failed to meet the Condition of Participation: Client Protections for 1 additional client (Client #7). The facility neglected to implement its written policies and procedures to prevent neglect of Client #7 in regard to falls as the client had a history of falls. The facility neglected to address the client's health/medical needs in regards to occupational therapy when the client's needs changed. The facility neglected to implement, update and/or include specific risk plans which addressed safe strategies for Client #7 to conduct activities of daily living such as dressing and picking objects up. The facility neglected to prevent Client #7 from injuries to the head and face. The facility failed to take sufficient corrective measures to prevent recurrence of falls and to ensure the safety of Client #7. The facility failed to obtain an occupational therapy assessment based on client need. The facility failed to distinguish between intentional and unintentional falls in Client #7's Behavior Support Plan.</p> <p>Findings include:</p> <p>1. The facility neglected to implement its written policies and procedures to prevent neglect of Client #7 in regard to falls as the client had a history of falls. The facility neglected to address the client's health/medical needs in regards to occupational therapy when the client's needs changed. The facility neglected to implement, update and/or include specific risk plans which addressed safe strategies for client #7 to conduct activities of daily living such as dressing and</p>	W000122	<p><b>W122- Client Protections</b> For client #7, the Fall Risk Management Plan was revised on 8/8/13 &amp; all staff members working with client #7 have been re-trained on client #7's revised Fall Risk Management Plan. The Fall Risk Management Plan addresses falls while ambulating, getting dressed, on the toilet &amp; in the shower/bath. All staff is to follow right behind client #7 when she is ambulating. Client #7 is to have staff right in front of her when she is on the toilet, getting dressed &amp; bathing. (Please refer to revised Fall Risk Management Plan) All staff members have been trained on the revised Fall Risk Management Plan on 8/12/13. (Please see attached training documents for staff, which were trained on the Fall Risk Management Plan) The residential nurse is responsible for updating the Fall Risk Management Plan as need to meet the needs for client #7 &amp; all consumers who requires a Fall Risk Management Plan.</p> <p>On 7/31/13, client #7 saw her neurologist, Dr. Prasad, which suggested that client #7 remain on her current medications as prescribed. Dr. Prasad recommended that client #7 see a Hematologist, due to having a low</p>	08/12/2013			

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	<p>picking objects up. The facility neglected to prevent Client #7 from injuries to the head and face. Please see W149.</p> <p>2. The facility failed to take sufficient corrective measures to prevent falls and to ensure the safety of 1 additional client (#7). Please see W157.</p> <p>3. The facility failed to obtain an occupational therapy assessment based on client need. Please see W218.</p> <p>4. The facility failed to include in the fall risk plan strategies for activities of daily living for those activities which posed a fall risk such as dressing and picking objects up, failed to include measures to protect from head and face injury, and failed to distinguish between intentional and unintentional falls in the Behavior Support Plan. Please see W240.</p> <p>9-3-2(a)</p>		<p>platelet count. Client #7 saw the recommended Hematologist (Dr. Kurra) on 8/12/13. Labs were ordered &amp; will be completed on 8/16/13. A follow up appointment will take place in 2 weeks.</p> <p>An IDT meeting is scheduled for: Friday, August 16, 2013 at 1pm to address client #7's falls. The QDDP has spoken with the behaviorist about the need to distinguish on the Behavior Support Plan staff actions when the fall is intentional or unintentional.</p> <p>Client #7 met with an OT for an evaluation on 8/7/13. (Please see attached document) The residential nurse is waiting on a report in order to implement recommendations. There was a document faxed to the residential nurse from V-Care Home Health in regards of the OT, which states the start of care (8/7/13). (Please see attached document)</p> <p>Client #7 is meeting with her general practitioner (family physician/Dr. San Juan) on 8/13/13 &amp; during that visit it will be discussed if client #7 requires/is recommended a PT evaluation. Client #7 saw Dr. San Juan on 8/13/13 &amp; a gait belt was ordered during this visit. Dr. San Juan also ordered for client #7 to begin PT. Tradewinds will implement OT &amp; PT as ordered.</p>	

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			<p>On 8/13/13, client #7 was provided with a new walker with gliders installed on it. This was given to her for the purpose of being able to stand up straighter &amp; give her a steadier gait.</p> <p><i>Under W122-Protection requires</i> There is an attached document of the agency's policy on falls. Client #7's Fall Risk Management Plan was revised on: 8/8/13 &amp; all staff members working with client #7 were all trained on the Fall Risk Management Plan on: 8/12/13. There was an order obtained for an OT evaluation &amp; therapy from the family physician. There was a consultation with the Neurologist on current seizure medications. There was a consultation with the Hematologist on resulting anemia from seizure medications. There are ongoing PT evaluations with therapy &amp; home exercises. The Fall Risk Plans were also revised for client #7 in April 2013 &amp; July 2013. There was an inclusion of client #7's falls in the Behavior Support Plan. The revision made to the BSP to includes the falls of client #7. There is a rewards system in place in the BSP to decrease the intentional falls for attention.</p>		

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W000149	<p>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.</p> <p>Based on observation, record review and interview for 1 additional client (Client #7), the facility neglected to implement its written policies and procedures to prevent neglect of Client #7 in regard to falls as the client had a history of falls. The facility neglected to address the client's health/medical needs in regards to occupational therapy when the client's needs changed. The facility neglected to implement, update and/or include specific risk plans which addressed safe strategies for client #7 to conduct activities of daily living such as dressing and picking objects up. The facility neglected to prevent Client #7 from injuries to the head and face.</p> <p>Findings include:</p> <p>On 7/18/13 at 2:35 PM, the Bureau of Developmental Disabilities Services (BDDS) reports from 7/18/12 to 7/18/13 were reviewed. A BDDS report dated 8/3/12 indicated Client #7 fell while exiting the van. The BDDS report indicated Client #7 was "exiting the van (sic) she fell to her left side. She immediately got up and stated that she was not hurt." The report indicated Client #7's "hand slipped from the door handle and she could not be caught quickly enough." The report indicated Client #7's "Dilantin (seizure medication) was found to be slightly elevated." The report indicated Client #7's neurologist decreased her Dilantin by 50mg (milligrams) daily.</p> <p>A BDDS report dated 11/20/12 indicated Client #7 "was receiving her medications in the</p>	W000149	There is an agency policy for Fall Prevention & Management Provided in place. (Please see attached document) Client #7's Fall Risk Management Plan was revised on: 8/8/13 & all staff members working with client #7 were all trained on the Fall Risk Management Plan on: 8/12/13. (Please see attached documents) There was an order obtained for an OT evaluation & therapy from the family physician. There was a consultation with the Neurologist on current seizure medications. There was a consultation with the Hematologist on resulting anemia from seizure medications. There are ongoing PT evaluations with therapy & home exercises. The Fall Risk Plans were also revised for client #7 in April 2013 & July 2013. There was an inclusion of client #7's falls in the Behavior Support Plan. The revision made to the BSP to includes the falls of client #7. There is a rewards system in place in the BSP to decrease the intentional falls for attention.	08/12/2013			

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	<p>medication room. She was leaving the medication room on her way to her bedroom when she lost her balance and fell to the floor." The report indicated Client #7 sustained a scratch to her nose which was treated with antibiotic ointment. The BDDS report indicated Client #7 "does have cerebral palsy and walks with a wheeled walker." The report indicated Client #7 had a fall risk plan in place, she was in line of sight of staff, and there were no obstacles in her path. The BDDS report indicated Client #7 "was instructed to take her time when walking in the house and have secure hold of her walker. Walker was examined for any defects and none were found."</p> <p>A BDDS report dated 12/13/12 indicated Client #7 "had finished her bath and was sitting on the toilet attempting to put on her socks as she does each morning. She slipped from the toilet to the floor onto her left knee. In addition she bumped her forehead on the floor. Staff immediately evaluated her for injuries. There was no injury to the knee, although above her right eye it appeared red." The report indicated Client #7 had a fall risk plan but was reassessed and the plan was revised to include direct supervision by staff while Client #7 is dressing or undressing. The report indicated "staff will stand directly in front of her to support her from falling forward."</p> <p>A BDDS report dated 2/28/13 indicated Client #7 "was working on a puzzle in her area, staff was working with another consumer nearby." The report indicated Client #7 had "dropped a puzzle piece of the puzzle, staff was approaching [Client #7] to help her find the puzzle piece. Staff had told [Client #7] not to reach for the puzzle (piece) as staff was coming to help her." The report indicated Client #7 "reached for the piece and fell from the chair to the floor injuring her right eyebrow."</p>			

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	<p>-A follow up BDDS report dated 3/6/13 indicated Client #7 "has been exhibiting behaviors for attention." The report indicated "staff will keep her chair close to the table. It does have arms to prevent her from getting up on her own." The report indicated "[Client #7] has been spoken to regarding her participation in working with the staff when receiving instructions."</p> <p>-A follow up BDDS report dated 3/8/13 indicated Client #7 "takes medications to control her seizures. Lab work was completed and returned on 3-1-2013. [Client #7]'s levels were high. Her neurologist decreased her Dilantin by 50mg on 3-2-2013." The report indicated "this could have played a part in [Client #7] falling out of her chair to the floor when she leaned over to pick up the puzzle piece."</p> <p>A BDDS report dated 3/4/13 indicated Client #7 "was sitting in her bedroom in her rocker watching TV while staff drew her bath. She attempted to reach over for her bathrobe and slid down from the rocker hitting her lip. She had a small cut to the lip that was treated with first aid." The report indicated Client #7's "walker had been placed directly in front of her chair in which she was sitting. Staff will continue to follow her risk plan and instructed [Client #7] not to get up without their presence in the room in order for them to assist her if needed."</p> <p>-A follow up BDDS report dated 3/6/13 indicated Client #7 "appears to do this for attention and the behavioral specialist has been notified." The report indicated "her fall risk plan addresses her participation in conveying to staff her needs prior to her proceeding on her own." The report indicated staff continue to work with Client #7 in "setting time frames so [Client #7] knows what to</p>			

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	<p>expect and when she can complete her activities with assistance."</p> <p>A BDDS report dated 4/27/13 indicated Client #7 "fell while putting on her socks in the bathroom. [Client #7] suffered a small laceration to her eye from the fall." The report indicated supervision while dressing is in Client #7's fall plan. The report indicated there was uncertainty as to where staff were while Client #7 was attempting to dress. The report indicated a staff person was suspending pending an investigation of neglect.</p> <p>-A follow up BDDS report indicated the incident was fully investigated. The report indicated Client #7's "Fall Risk Plan as written was followed by staff, however to ensure the safety of the client, that client (sic) was removed from the schedule pending the investigation and retrained on the Fall Risk Plan by the residential nurse on 4/30/13 prior to being added back to the schedule."</p> <p>A BDDS report dated 5/16/13 indicated Client #7 "went on a community outing today at which time [Client #7] fell hitting the corner of her right eye. There was a small superficial cut approximately 3/4 inch to the right of the outside corner of her eye." The report indicated her risk plan was followed. The report indicated Client #7 went over to get her bowling ball and "she tripped on her own feet and fell towards the ball receiver hitting the right side of her head." The report indicated Client #7 "is very independent and will proceed with activities even when instructed to wait her turn. Staff is working closely with her so that she understands the importance of all safety items put in place for her and therefore can be an active participant in her daily activities."</p> <p>A BDDS report dated 6/11/13 indicated Client #7 was sitting at a table during day program when</p>			

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	<p>another individual became agitated. As the individual "began to go into behavior, staff was in the process of getting her peers out of arms reach. However, as her peer [Client #7] began to move and walk away from the table, she was then pushed from behind by [the individual]. [Client #7] then fell to the floor (face down) and landed on the right side of her face." The report indicated Client #7 "was assisted off floor and assessed by the day service nurse. [Client #7] developed a small (.3 cm) laceration on the nose, which began to bleed (small amount).</p> <p>A BDDS report dated 7/18/13 indicated Client #7 was approaching her table at day program when she fell to the floor. Client #7 had a 30 second seizure. Client #7 was evaluated and no injuries were found.</p> <p>On 7/18/13 between 4:45 PM and 6:30 PM group home observations were conducted. At 4:55 PM, Client #7 was observed to use her walker with a bent posture to ambulate from the couch to the table with her math book. Client #7 was observed to eat dinner at 5:31 PM. Client #7 was observed to sit in a chair with arms on both sides. At 6:09 PM, Client #7 was assisted with medication administration. Direct Support Professional (DSP) #1 was observed seated while prompting Client #7 to disinfect her hands with gel. Client #7 left her walker to turn around to use the gel. DSP #1 was observed to turn the walker around for Client #7 in case she needed to sit on the seated section. A picture of Client #7 in her MAR (Medication Administration Record) book indicated Client #7 wearing a helmet. When interviewed at 6:20 PM, Client #7 indicated the helmet was discontinued. DSP #1 also indicated Client #7 no longer wore the helmet. Client #7's right eye brow was largely swollen and drooping with a small scab in the center of the eye brow</p>			
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	<p>throughout the group home observations.</p> <p>On 7/19/13 between 5:59 AM and 7:00 AM, group home observations were conducted. At 6:19 AM, Client #7 proceeded from her room walking with her walker. DSP #2 positioned themselves behind Client #7 as she attempted to put on a sweater.</p> <p>On 7/23/13 at 1:58 PM, record review indicated Client #7 had a fall risk plan dated 12/11/12. Client #7's fall risk plan indicated Client #7 "is diagnosed with cerebral palsy and seizure disorder. She uses a wheeled walker. Over the last one year she has had two falls while attempting to dress herself, either in the bathroom or her bedroom. She will sit on her bed or the toilet and try to put on her socks, then lean forward and fall to the floor. Therefore it has become increasingly important to supervise [Client #7] during these times." The fall risk plan indicated staff would directly supervise Client #7 while she is dressing by standing directly in front of her to prevent "any fall from her leaning too far forward." The fall risk plan included proper footwear, lighting, safe environment, and assistance during showering. Client #7's fall risk plan neglected to include strategies to prevent her from falling while picking objects up or while ambulating during community outings or when getting in or out of the van during transportation. The fall risk plan did not include use of helmet. The fall risk plan neglected to indicate measures to protect Client #7 from head and face injury.</p> <p>Record review indicated Client #7 had a seizure risk plan dated 5/1/13. The seizure risk plan indicated staff should "be prepared to assist to the floor if client starts to fall."</p> <p>Record review indicated Client #7's diagnoses,</p>						

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	<p>included but were not limited to, intellectual disabilities, cerebral palsy, scoliosis, seizure disorder, and neurogenic bladder. Client #7's annual nursing evaluation dated 5/7/13 indicated Client #7 had PT (physical therapy) sessions in the home 6/2012 for complaints of fatigue and general weakness. The evaluation indicated Client #7 presented with scoliosis "with known osteoporosis." The evaluation indicated Client #7 had "several old lacerations from falls due to seizures."</p> <p>Review of Client #7's Behavior Support Plan (BSP) dated 11/9/12 (revised 3/1/13) indicated targeted behaviors of verbal aggression, toileting accidents, non-compliance, and inappropriate attention-seeking. The BSP defined inappropriate attention-seeking as "invading other's space, interrupting, intentionally falling, and any other behavior that elicits attention in a maladaptive manner." The BSP indicated "In September 2011, therapist spoke with [RN] who stated [Client #7] continues to fall. Her residential staff moved her bed against the wall to try to help prevent falls at night. [RN] said that last month, [Client #7]'s neurologist said that if she continues to have an increase in falls, he will have to order her to wear a helmet again."</p> <p>A revision to Client #7's BSP dated 3/1/13 indicated "in February 2013 it was reported [Client #7] had approximately 6 falls. After reviewing antecedents to these behaviors it appears the majority of falls are attention motivated. [Client #7] was informed that she would need to wear her helmet again if she kept falling because of safety reasons. Since she has been made aware her safety is of concern, she has not had any additional falls. Because this is a safety concern recommendations for falling will be added in antecedent interventions, as past reports</p>			

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	<p>indicate [Client #7] will sometimes fall to gain attention from others."</p> <p>The BSP indicated the "Procedure for Intentional Falling" which included the following:</p> <p>"a. Staff should check to ensure that [Client #7] has not injured herself. Staff should do this by looking at [Client #7] ensuring she is not bleeding or has no injuries and does not appear to be in pain. Staff should not speak to [Client #7] and should try not to make eye contact during this assessment.</p> <p>b. If [Client #7] is not injured, staff should ignore the behavior.</p> <p>c. Once [Client #7] gets up, staff should engage with her as normal and make no mention of the behavior.</p> <p>d. If the fall immediately follows a demand staff should immediately repeat the demand.</p> <p>e. If [Client #7] falls again, staff should repeat the procedure.</p> <p>f. If [Client #7] is standing, but engaging in noncompliance, staff should run the noncompliance procedure listed above.</p> <p>g. Staff should note the behavior on [Client #7]'s sheet and she should be told that she will not earn her sticker during the time period it occurred."</p> <p>On 7/23/13 at 2:20 PM, the Residential Nurse (RN) and the QIDP were interviewed. The RN stated Client #7 has "balance and hand dexterity" issues while dressing. The QIDP indicated they believed the rise in falls was a behavior and had Client #7's BSP (Behavior Support Plan) revised</p>			

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	<p>3/2013 to include new strategies. QIDP indicated they also added a button next to Client #7's bed so she may alert staff during the night if she needs assistance to the bathroom. QIDP indicated Client #7's chores have been adapted so she may sit during her chores. The RN indicated Client #7 had PT (Physical Therapy) services in the home in 2012. The RN indicated the facility had no O.T. (Occupational Therapy) assessment for Client #7. The RN indicated staff have Client #7 sit in a chair with arms in her bedroom to assist with balance but was unaware Client #7 was using the armed chair for dining and active treatment activities. The QIDP indicated Client #7's helmet was discontinued. The QIDP indicated the helmet caused injury to Client #7's eyebrow when she fell forward and it was discontinued. The RN indicated Client #7's right eyebrow always appears swollen as it has sustained numerous injuries from falls.</p> <p>On 7/23/13 at 4:00 PM, the facility's policy on "Abuse, Neglect, Exploitation, Mistreatment, Violation of an Individuals Rights, and Injuries of Unknown Origin" dated 2/1/2011 was reviewed and indicated "Abuse and or neglect or any mistreatment of any consumer who participates in a Tradewinds program is strictly prohibited....".</p> <p>9-3-2(a)</p>			

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W000157	<p><b>483.420(d)(4)</b> <b>STAFF TREATMENT OF CLIENTS</b> If the alleged violation is verified, appropriate corrective action must be taken.</p> <p>Based on observation, interview and record review, the facility failed to take sufficient corrective measures to prevent falls and to ensure the safety of 1 additional client (#7).</p> <p>Findings include:</p> <p>On 7/18/13 at 2:35 PM, the Bureau of Developmental Disabilities Services (BDDS) reports from 7/18/12 to 7/18/13 were reviewed. A BDDS report dated 8/3/12 indicated Client #7 fell while exiting the van. The BDDS report indicated Client #7 was "exiting the van (sic) she fell to her left side. She immediately got up and stated that she was not hurt." The report indicated Client #7's "hand slipped from the door handle and she could not be caught quickly enough." The report indicated Client #7's "Dilantin (seizure medication) was found to be slightly elevated." The report indicated Client #7's neurologist decreased her Dilantin by 50mg (milligrams) daily.</p> <p>A BDDS report dated 11/20/12 indicated Client #7 "was receiving her medications in the medication room. She was leaving the medication room on her way to her bedroom when she lost her balance and fell to the floor." The report indicated Client #7 sustained a scratch to her nose which was treated with antibiotic ointment. The BDDS report indicated Client #7 "does have cerebral palsy and walks with a wheeled walker." The report indicated Client #7 had a fall risk plan in place, she was in line of sight of staff, and there were no obstacles in her path. The BDDS report indicated Client #7 "was instructed to take her</p>	W000157	<p>Client #7's Fall Risk Management Plan was revised on 8/8/13 &amp; all staff members working with client #7 were trained on revised Fall Risk Management Plan 8/12/13. The QDDP is responsible for developing the ISP &amp; including all necessary information in the plan &amp; ensuring that once the ISP is developed that all staff members are trained on the ISP.</p> <p>The Group Home Manager is responsible for making sure that all new staff members are trained on the ISP &amp; ensuring that the ISP is followed in accordance.</p> <p>There is an agency policy for Fall Prevention &amp; Management Provided in place. (Please see attached document. There was an order obtained for an OT evaluation &amp; therapy from the family physician. There was a consultation with the Neurologist on current seizure medications. There was a consultation with the Hematologist on resulting anemia from seizure medications. There are ongoing PT evaluations with therapy &amp; home exercises. The Fall Risk Plans were also revised for client #7 in April 2013 &amp; July 2013. There was an inclusion of client #7's falls in the Behavior Support Plan. The revision made to the BSP to includes the falls of client #7. There is a rewards</p>	08/12/2013			

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	<p>time when walking in the house and have secure hold of her walker. Walker was examined for any defects and none were found."</p> <p>A BDDS report dated 12/13/12 indicated Client #7 "had finished her bath and was sitting on the toilet attempting to put on her socks as she does each morning. She slipped from the toilet to the floor onto her left knee. In addition she bumped her forehead on the floor. Staff immediately evaluated her for injuries. There was no injury to the knee, although above her right eye it appeared red." The report indicated Client #7 had a fall risk plan but was reassessed and the plan was revised to include direct supervision by staff while Client #7 is dressing or undressing. The report indicated "staff will stand directly in front of her to support her from falling forward."</p> <p>A BDDS report dated 2/28/13 indicated Client #7 "was working on a puzzle in her area, staff was working with another consumer nearby." The report indicated Client #7 had "dropped a puzzle piece of the puzzle, staff was approaching [Client #7] to help her find the puzzle piece. Staff had told [Client #7] not to reach for the puzzle (piece) as staff was coming to help her." The report indicated Client #7 "reached for the piece and fell from the chair to the floor injuring her right eyebrow."</p> <p>-A follow up BDDS report dated 3/6/13 indicated Client #7 "has been exhibiting behaviors for attention." The report indicated "staff will keep her chair close to the table. It does have arms to prevent her from getting up on her own." The report indicated "[Client #7] has been spoken to regarding her participation in working with the staff when receiving instructions."</p> <p>-A follow up BDDS report dated 3/8/13 indicated</p>		<p>system in place in the BSP to decrease the intentional falls for attention.</p>	

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	<p>Client #7 "takes medications to control her seizures. Lab work was completed and returned on 3-1-2013. [Client #7]'s levels were high. Her neurologist decreased her Dilantin by 50mg on 3-2-2013." The report indicated "this could have played a part in [Client #7] falling out of her chair to the floor when she leaned over to pick up the puzzle piece."</p> <p>A BDDS report dated 3/4/13 indicated Client #7 "was sitting in her bedroom in her rocker watching TV while staff drew her bath. She attempted to reach over for her bathrobe and slid down from the rocker hitting her lip. She had a small cut to the lip that was treated with first aid." The report indicated Client #7's "walker had been placed directly in front of her chair in which she was sitting. Staff will continue to follow her risk plan and instructed [Client #7] not to get up without their presence in the room in order for them to assist her if needed."</p> <p>-A follow up BDDS report dated 3/6/13 indicated Client #7 "appears to do this for attention and the behavioral specialist has been notified." The report indicated "her fall risk plan addresses her participation in conveying to staff her needs prior to her proceeding on her own." The report indicated staff continue to work with Client #7 in "setting time frames so [Client #7] knows what to expect and when she can complete her activities with assistance."</p> <p>A BDDS report dated 4/27/13 indicated Client #7 "fell while putting on her socks in the bathroom. [Client #7] suffered a small laceration to her eye from the fall." The report indicated supervision while dressing is in Client #7's fall plan. The report indicated there was uncertainty as to where staff were while Client #7 was attempting to dress. The report indicated a staff person was suspending</p>						

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	<p>pending an investigation of neglect.</p> <p>-A follow up BDDS report indicated the incident was fully investigated. The report indicated Client #7's "Fall Risk Plan as written was followed by staff, however to ensure the safety of the client, that client (sic) was removed from the schedule pending the investigation and retrained on the Fall Risk Plan by the residential nurse on 4/30/13 prior to being added back to the schedule."</p> <p>A BDDS report dated 5/16/13 indicated Client #7 "went on a community outing today at which time [Client #7] fell hitting the corner of her right eye. There was a small superficial cut approximately 3/4 inch to the right of the outside corner of her eye." The report indicated her risk plan was followed. The report indicated Client #7 went over to get her bowling ball and "she tripped on her own feet and fell towards the ball receiver hitting the right side of her head." The report indicated Client #7 "is very independent and will proceed with activities even when instructed to wait her turn. Staff is working closely with her so that she understands the importance of all safety items put in place for her and therefore can be an active participant in her daily activities."</p> <p>A BDDS report dated 6/11/13 indicated Client #7 was sitting at a table during day program when another individual became agitated. As the individual "began to go into behavior, staff was in the process of getting her peers out of arms reach. However, as her peer [Client #7] began to move and walk away from the table, she was then pushed from behind by [the individual]. [Client #7] then fell to the floor (face down) and landed on the right side of her face." The report indicated Client #7 "was assisted off floor and assessed by the day service nurse." [Client #7] developed a small (.3 cm) laceration on the nose, which began</p>			

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	<p>to bleed (small amount).</p> <p>A BDDS report dated 7/18/13 indicated Client #7 was approaching her table at day program when she fell to the floor. Client #7 had a 30 second seizure. Client #7 was evaluated and no injuries were found.</p> <p>On 7/18/13 between 4:45 PM and 6:30 PM group home observations were conducted. At 4:55 PM, Client #7 was observed to use her walker with a bent posture to ambulate from the couch to the table with her math book. Client #7 was observed to eat dinner at 5:31 PM. Client #7 was observed to sit in a chair with arms on both sides. At 6:09 PM, Client #7 was assisted with medication administration. Direct Support Professional (DSP) #1 was observed seated while prompting Client #7 to disinfect her hands with gel. Client #7 left her walker to turn around to use the gel. DSP #1 was observed to turn the walker around for Client #7 in case she needed to sit on the seated section. A picture of Client #7 in her MAR (Medication Administration Record) book indicated Client #7 wearing a helmet. When interviewed at 6:20 PM, Client #7 indicated the helmet was discontinued. DSP #1 also indicated Client #7 no longer wore the helmet. Client #7's right eye brow was largely swollen and drooping with a small scab in the center of the eye brow throughout the group home observations.</p> <p>On 7/19/13 between 5:59 AM and 7:00 AM, group home observations were conducted. At 6:19 AM, Client #7 proceeded from her room walking with her walker. DSP #2 positioned themselves behind Client #7 as she attempted to put on a sweater.</p> <p>On 7/23/13 at 1:58 PM, record review indicated Client #7 had a fall risk plan dated 12/11/12.</p>						

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	<p>Client #7's fall risk plan indicated Client #7 "is diagnosed with cerebral palsy and seizure disorder. She uses a wheeled walker. Over the last one year she has had two falls while attempting to dress herself, either in the bathroom or her bedroom. She will sit on her bed or the toilet and try to put on her socks, then lean forward and fall to the floor. Therefore it has become increasingly important to supervise [Client #7] during these times." The fall risk plan indicated staff would directly supervise Client #7 while she is dressing by standing directly in front of her to prevent "any fall from her leaning too far forward." The fall risk plan included proper footwear, lighting, safe environment, and assistance during showering. Client #7's fall risk plan neglected to include strategies to prevent her from falling while picking objects up or while ambulating during community outings or when getting in or out of the van during transportation. The fall risk plan did not include use of helmet. The fall risk plan neglected to indicate measures to protect Client #7 from head and face injury.</p> <p>Record review indicated Client #7 had a seizure risk plan dated 5/1/13. The seizure risk plan indicated staff should "be prepared to assist to the floor if client starts to fall."</p> <p>Record review indicated Client #7's diagnoses, included but were not limited to, intellectual disabilities, cerebral palsy, scoliosis, seizure disorder, and neurogenic bladder. Client #7's annual nursing evaluation dated 5/7/13 indicated Client #7 had PT (physical therapy) sessions in the home 6/2012 for complaints of fatigue and general weakness. The evaluation indicated Client #7 presented with scoliosis "with known osteoporosis." The evaluation indicated Client #7 had "several old lacerations from falls due to seizures." Record review indicated no</p>						

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	<p>occupational therapy assessment for Client #7.</p> <p>Review of Client #7's Behavior Support Plan (BSP) dated 11/9/12 (revised 3/1/13) indicated targeted behaviors of verbal aggression, toileting accidents, non-compliance, and inappropriate attention-seeking. The BSP defined inappropriate attention-seeking as "invading other's space, interrupting, intentionally falling, and any other behavior that elicits attention in a maladaptive manner." The BSP indicated "In September 2011, therapist spoke with [RN] who stated [Client #7] continues to fall. Her residential staff moved her bed against the wall to try to help prevent falls at night. [RN] said that last month, [Client #7]'s neurologist said that if she continues to have an increase in falls, he will have to order her to wear a helmet again."</p> <p>A revision to Client #7's BSP dated 3/1/13 indicated "in February 2013 it was reported [Client #7] had approximately 6 falls. After reviewing antecedents to these behaviors it appears the majority of falls are attention motivated. [Client #7] was informed that she would need to wear her helmet again if she kept falling because of safety reasons. Since she has been made aware her safety is of concern, she has not had any additional falls. Because this is a safety concern recommendations for falling will be added in antecedent interventions, as past reports indicate [Client #7] will sometimes fall to gain attention from others."</p> <p>The BSP indicated the "Procedure for Intentional Falling" which included the following:</p> <p>"a. Staff should check to ensure that [Client #7] has not injured herself. Staff should do this by looking at [Client #7] ensuring she is not bleeding or has no injuries and does not appear to be in</p>			

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	<p>pain. Staff should not speak to [Client #7] and should try not to make eye contact during this assessment.</p> <p>b. If [Client #7] is not injured, staff should ignore the behavior.</p> <p>c. Once [Client #7] gets up, staff should engage with her as normal and make no mention of the behavior.</p> <p>d. If the fall immediately follows a demand staff should immediately repeat the demand.</p> <p>e. If [Client #7] falls again, staff should repeat the procedure.</p> <p>f. If [Client #7] is standing, but engaging in noncompliance, staff should run the noncompliance procedure listed above.</p> <p>g. Staff should note the behavior on [Client #7]'s sheet and she should be told that she will not earn her sticker during the time period it occurred."</p> <p>On 7/23/13 at 2:20 PM, the Residential Nurse (RN) and the QIDP were interviewed. The RN indicated Client #7 has "balance and hand dexterity" issues while dressing. The QIDP indicated they believed the rise in falls was a behavior and had Client #7's BSP (Behavior Support Plan) revised 3/2013 to include new strategies. QIDP indicated they also added a button next to Client #7's bed so she may alert staff during the night if she needs assistance to the bathroom. QIDP indicated Client #7's chores have been adapted so she may sit during her chores. The RN indicated Client #7 had PT (Physical Therapy) services in the home in 2012. The RN indicated the facility had no O.T. (Occupational Therapy) assessment for Client #7. The RN</p>						

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	<p>indicated staff have Client #7 sit in a chair with arms in her bedroom to assist with balance but was unaware Client #7 was using the armed chair for dining and active treatment activities. The QIDP indicated Client #7's helmet was discontinued. The QIDP indicated the helmet caused injury to Client #7's eyebrow when she fell forward and it was discontinued. The RN indicated Client #7's right eyebrow usually appears swollen as it has sustained numerous injuries from falls.</p> <p>9-3-2(a)</p>			

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W000218	<p><b>483.440(c)(3)(v)</b> <b>INDIVIDUAL PROGRAM PLAN</b> The comprehensive functional assessment must include sensorimotor development.</p> <p>Based on observation, interview and record review for 1 additional client (#7), the facility failed to obtain an occupational therapy assessment based on client need.</p> <p>Findings include:</p> <p>On 7/18/13 at 2:35 PM, the Bureau of Developmental Disabilities Services (BDDS) reports from 7/18/12 to 7/18/13 were reviewed. A BDDS report dated 8/3/12 indicated Client #7 fell while exiting the van. The BDDS report indicated Client #7 was "exiting the van (sic) she fell to her left side. She immediately got up and stated that she was not hurt." The report indicated Client #7's "hand slipped from the door handle and she could not be caught quickly enough." The report indicated Client #7's "Dilantin (seizure medication) was found to be slightly elevated." The report indicated Client #7's neurologist decreased her Dilantin by 50mg (milligrams) daily.</p> <p>A BDDS report dated 11/20/12 indicated Client #7 "was receiving her medications in the medication room. She was leaving the medication room on her way to her bedroom when she lost her balance and fell to the floor." The report indicated Client #7 sustained a scratch to her nose which was treated with antibiotic ointment. The BDDS report indicated Client #7 "does have cerebral palsy and walks with a wheeled walker." The report indicated Client #7 had a fall risk plan in place, she was in line of sight of staff, and there were no obstacles in her path. The BDDS report indicated Client #7 "was instructed to take her</p>	W000218	<p>Client #7's Fall Risk Management Plan was revised on: 8/8/13 &amp; all staff members working with client #7 were all trained on the Fall Risk Management Plan on: 8/12/13.</p> <p>There was an order obtained for an OT evaluation &amp; therapy from the family physician. There was a consultation with the Neurologist on current seizure medications. There was a consultation with the Hematologist on resulting anemia from seizure medications. There are ongoing PT evaluations with therapy &amp; home exercises. The Fall Risk Plans were also revised for client #7 in April 2013 &amp; July 2013. There was an inclusion of client #7's falls in the Behavior Support Plan. The revision made to the BSP to includes the falls of client #7. There is a rewards system in place in the BSP to decrease the intentional falls for attention.</p> <p>The QDDP is responsible for developing goals/objectives that indicates the time frames; the various prompt levels &amp; the percentage of goal in which the goal is completed. The QDDP is responsible for making sure the goals for all consumers are measurable of the consumer(s) performance. When the ISP is completed by the QDDP, it will be</p>	08/12/2013

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	<p>time when walking in the house and have secure hold of her walker. Walker was examined for any defects and none were found."</p> <p>A BDDS report dated 12/13/12 indicated Client #7 "had finished her bath and was sitting on the toilet attempting to put on her socks as she does each morning. She slipped from the toilet to the floor onto her left knee. In addition she bumped her forehead on the floor. Staff immediately evaluated her for injuries. There was no injury to the knee, although above her right eye it appeared red." The report indicated Client #7 had a fall risk plan but was reassessed and the plan was revised to include direct supervision by staff while Client #7 is dressing or undressing. The report indicated "staff will stand directly in front of her to support her from falling forward."</p> <p>A BDDS report dated 2/28/13 indicated Client #7 "was working on a puzzle in her area, staff was working with another consumer nearby." The report indicated Client #7 had "dropped a puzzle piece of the puzzle, staff was approaching [Client #7] to help her find the puzzle piece. Staff had told [Client #7] not to reach for the puzzle as staff was coming to help her." The report indicated Client #7 "reached for the piece and fell from the chair to the floor injuring her right eyebrow."</p> <p>A BDDS report dated 3/4/13 indicated Client #7 "was sitting in her bedroom in her rocker watching TV while staff drew her bath. She attempted to reach over for her bathrobe and slide down from the rocker hitting her lip. She had a small cut to the lip that was treated with first aid." The report indicated Client #7's "walker had been placed directly in front of her chair in which she was sitting. Staff will continue to follow her risk plan and instructed [Client #7] not to get up without their presence in the room in order for them to</p>		<p>reviewed by the Residential Coordinator for quality control &amp; to ensure that all goals are measurable. The group home manager is responsible for monitoring staff &amp; ensuring that the consumer(s) goals are being implemented accordingly to the ISPs.</p> <p>The QDDP is responsible for ensuring that all updated documents are in place &amp; that if a consumer has reached his/her goal that a new goal has been written, in place &amp; being implemented. The QDDP is also responsible for ensuring that the new goals/objectives are measurable &amp; indicates the time frames, various prompt levels &amp; the percentage of completion of the goal.</p>				

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	<p>assist her if needed."</p> <p>A BDDS report dated 4/27/13 indicated Client #7 "fell while putting on her socks in the bathroom. [Client #7] suffered a small laceration to her eye from the fall." The report indicated supervision while dressing is in Client #7's fall plan. The report indicated there was uncertainty as to where staff were while Client #7 was attempting to dress. The report indicated a staff person was suspending pending an investigation of neglect.</p> <p>A BDDS report dated 5/16/13 indicated Client #7 "went on a community outing today at which time [Client #7] fell hitting the corner of her right eye. There was a small superficial cut approximately 3/4 inch to the right of the outside corner of there eye." The report indicated her risk plan was followed. The report indicated Client #7 went over to get her bowling ball and "she tripped on her own feet and fell towards the ball receiver hitting the right side of her head." The report indicated Client #7 "is very independent and will proceed with activities even when instructed to wait her turn. Staff is working closely with her so that she understands the importance of all safety items put in place for her and therefore can be an active participant in her daily activities."</p> <p>On 7/18/13 between 4:45 PM and 6:30 PM group home observations were conducted. At 4:55 PM, Client #7 was observed to use her walker with a bent posture to ambulate from the couch to the table with her math book. Client #7 was observed to eat dinner at 5:31 PM. Client #7 was observed to sit in a chair with arms on both sides. At 6:09 PM, Client #7 was assisted with medication administration. Direct Support Professional (DSP) #1 was observed seated while prompting Client #7 to disinfect her hands with gel. Client #7 left her walker to turn around to use the gel.</p>						

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	<p>DSP #1 was observed to turn the walker around for Client #7 in case she needed to sit on the seated section. A picture of Client #7 in her MAR (Medication Administration Record) book indicated Client #7 wearing a helmet. When interviewed at 6:20 PM, Client #7 indicated the helmet was discontinued. DSP #1 also indicated Client #7 no longer used the helmet. Client #7's right eye brow was largely swollen and drooping with a small scab in the center of the eye brow throughout the group home observations.</p> <p>On 7/19/13 between 5:59 AM and 7:00 AM, group home observations were conducted. At 6:19 AM, Client #7 proceeded from her room walking with her walker. DSP #2 positioned themselves behind Client #7 as she attempted to put on a sweater.</p> <p>On 7/23/13 at 1:58 PM, record review indicated Client #7 had a fall risk plan dated 12/11/12. Client #7's fall risk plan indicated Client #7 "is diagnosed with cerebral palsy and seizure disorder. She uses a wheeled walker. Over the last one year she has had two falls while attempting to dress herself, either in the bathroom or her bedroom. She will sit on her bed or the toilet and try to put on her socks, then lean forward and fall to the floor. Therefore it has become increasingly important to supervise [Client #7] during these times." The fall risk plan indicated staff would directly supervise Client #7 while she is dressing by standing directly in front of her to prevent "any fall from her leaning too far forward."</p> <p>Record review indicated Client #7 had a seizure risk plan dated 5/1/13. The seizure risk plan indicated staff should "be prepared to assist to the floor if client starts to fall."</p> <p>Record review indicated Client #7's diagnoses,</p>			

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	<p>included but were not limited to, intellectual disabilities, cerebral palsy, scoliosis, seizure disorder, and neurogenic bladder. Client #7's annual nursing evaluation dated 5/7/13 indicated Client #7 had PT (physical therapy) sessions in the home 6/2012 for complaint of fatigue and general weakness. The evaluation indicated Client #7 presented with scoliosis "with known osteoporosis." The evaluation indicated Client #7 had "several old lacerations from falls due to seizures." Record review indicated no occupational assessment for Client #7.</p> <p>On 7/23/13 at 2:20 PM, the Residential Nurse (RN) and the QIDP were interviewed. The RN stated Client #7 has "balance and hand dexterity" issues while dressing. The QIDP indicated they believed the rise in falls was a behavior and had Client #7's BSP (Behavior Support Plan) revised 3/2013 to include new strategies. The RN indicated the facility had no initial O.T. (Occupational Therapy) assessment for Client #7.</p> <p>9-3-4(a)</p>			

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W000231	<p>483.440(c)(4)(iii) INDIVIDUAL PROGRAM PLAN The objectives of the individual program plan must be expressed in behavioral terms that provide measurable indices of performance.</p> <p>Based on record review and interview, the facility failed to develop client individual program plan objectives in measurable terms in regards to time frames, prompt levels, and percentage necessary for achievement for 4 of 4 sampled clients (#1, #2, #3, and #4).</p> <p>Findings include:</p> <p>1) On 7/23/13 at 11:31 AM, record review was conducted. The QIDP (Qualified Intellectual Disabilities Professional) monthlies for April 2013 were reviewed and indicated Client #1 had an ISP (Individual Support Plan) dated 12/18/12 with goals in the areas of self care, daily living skills, communication, medication administration, leisure skills, health, money management, and community safety. The goals did not indicate the time frames, prompt levels, and percentage necessary for Client #1 to achieve the following goals:</p> <ul style="list-style-type: none"> <li>-Client #1 had a goal to "learn to bathe herself."</li> <li>-Client #1 had a goal to "learn to set the table."</li> <li>-Client #1 had a goal to "learn to complete household chores."</li> <li>-Client #1 had a goal to "learn to identify her own medication box."</li> <li>-Client #1 had a goal to "participate in a leisure activity daily."</li> </ul>	W000231	<p>Client #7's Fall Risk Management Plan was revised on: 8/8/13 &amp; all staff members working with client #7 were all trained on the Fall Risk Management Plan on: 8/12/13. There was an order obtained for an OT evaluation &amp; therapy from the family physician. There was a consultation with the Neurologist on current seizure medications. There was a consultation with the Hematologist on resulting anemia from seizure medications. There are ongoing PT evaluations with therapy &amp; home exercises. The Fall Risk Plans were also revised for client #7 in April 2013 &amp; July 2013. There was an inclusion of client #7's falls in the Behavior Support Plan. The revision made to the BSP to includes the falls of client #7. There is a rewards system in place in the BSP to decrease the intentional falls for attention.</p> <p>The QDDP is responsible for developing goals/objectives that indicates the time frames; the various prompt levels &amp; the percentage of goal in which the goal is completed. The QDDP is responsible for making sure the goals for all consumers are measurable of the consumer(s)</p>	08/12/2013	

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	<p>-Client #1 had a goal to "exercise."</p> <p>-Client #1 had a good to "learn to identify coins."</p> <p>-Client #1 had a goal to "learn to be safe in the community."</p> <p>2) On 7/23/13 at 11:31 AM, record review was conducted. The QIDP (Qualified Intellectual Disabilities Professional) monthlies for April 2013 were reviewed and indicated Client #2 had an ISP dated 10/9/12 with goals in the areas of cell phone etiquette, health, and money management. The goals did not indicate the time frames, prompt levels, and percentage necessary for Client #2 to achieve the following goals:</p> <p>-Client #2 had a goal to "learn cell phone etiquette."</p> <p>-Client #2 had a goal to "exercise at least 5 times a week."</p> <p>-Client #2 had a goal "to balance her checkbook."</p> <p>3) On 7/23/13 at 11:31 AM, record review was conducted. The QIDP (Qualified Intellectual Disabilities Professional) monthlies for April 2013 were reviewed and indicated Client #3 had an ISP dated 3/20/13 with goals in the areas of daily living skills, medication management, functional living skill, and health. The goals did not indicate the time frames, prompt levels, and percentage necessary for Client #3 to achieve the following goals:</p> <p>-Client #3 had a goal to "learn to use the oven to bake cookies or brownies."</p> <p>-Client #3 had a goal to "learn to administer her own medications."</p>		<p>performance. When the ISP is completed by the QDDP, it will be reviewed by the Residential Coordinator for quality control &amp; to ensure that all goals are measurable. The group home manager is responsible for monitoring staff &amp; ensuring that the consumer(s) goals are being implemented accordingly to the ISPs.</p> <p>The QDDP is responsible for ensuring that all updated documents are in place &amp; that if a consumer has reached his/her goal that a new goal has been written, in place &amp; being implemented. The QDDP is also responsible for ensuring that the new goals/objectives are measurable &amp; indicates the time frames, various prompt levels &amp; the percentage of completion of the goal.</p>		

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	<p>-Client #3 had a goal to "learn to write her address and sign her name to a card."</p> <p>-Client #3 had a goal to brush her teeth "completely and thoroughly."</p> <p>-Client #3 had a goal to "learn to identify coins."</p> <p>4) On 7/23/13 at 11:31 AM, record review was conducted. The QIDP (Qualified Intellectual Disabilities Professional) monthlies for April 2013 were reviewed and indicated Client #4 had an ISP dated 11/13/12 with goals in the areas of daily living skills, health, functional living skills, money management, and grooming. The goals did not indicate the time frames, prompt levels, and percentage necessary for Client #4 to achieve the following goals:</p> <p>-Client #4 had a goal to "organize the clothes in her dresser drawer each week."</p> <p>-Client #4 had a goal to "self administer Fosamax which is prescribed once a week."</p> <p>-Client #4 had a goal to "learn to count change."</p> <p>-Client #4 had a goal to "shave the hair on her chin."</p> <p>Interview with the QIDP #1 on 7/23/13 at 4:00 PM indicated she didn't develop all the client goals to include measurable and achievable objectives.</p> <p>9-3-4(a)</p>						

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W000240	<p>483.440(c)(6)(i) INDIVIDUAL PROGRAM PLAN The individual program plan must describe relevant interventions to support the individual toward independence.</p> <p>Based on observation, interview and record review for 1 additional client (#7), the facility failed to include in the fall risk plan strategies for activities of daily living for those activities which posed a fall risk such as dressing and picking objects up, failed to include measures to protect from head and face injury, and failed to distinguish between intentional and unintentional falls in the Behavior Support Plan.</p> <p>Findings include:</p> <p>On 7/18/13 at 2:35 PM, the Bureau of Developmental Disabilities Services (BDDS) reports from 7/18/12 to 7/18/13 were reviewed. A BDDS report dated 8/3/12 indicated Client #7 fell while exiting the van. The BDDS report indicated Client #7 was "exiting the van (sic) she fell to her left side. She immediately got up and stated that she was not hurt." The report indicated Client #7's "hand slipped from the door handle and she could not be caught quickly enough." The report indicated Client #7's "Dilantin (seizure medication) was found to be slightly elevated." The report indicated Client #7's neurologist decreased her Dilantin by 50mg (milligrams) daily.</p> <p>A BDDS report dated 11/20/12 indicated Client #7 "was receiving her medications in the medication room. She was leaving the medication room on her way to her bedroom when she lost her balance and fell to the floor." The report indicated Client #7 sustained a scratch to her nose which was treated with antibiotic ointment. The BDDS</p>	W000240	<p>Client #7's Fall Risk Management Plan was revised on: 8/8/13 &amp; all staff members working with client #7 were all trained on the Fall Risk Management Plan on: 8/12/13. There was an order obtained for an OT evaluation &amp; therapy from the family physician. There was a consultation with the Neurologist on current seizure medications. There was a consultation with the Hematologist on resulting anemia from seizure medications. There are ongoing PT evaluations with therapy &amp; home exercises. The Fall Risk Plans were also revised for client #7 in April 2013 &amp; July 2013. There was an inclusion of client #7's falls in the Behavior Support Plan. The revision made to the BSP to includes the falls of client #7. There is a rewards system in place in the BSP to decrease the intentional falls for attention.</p> <p>The QDDP is responsible for developing goals/objectives that indicates the time frames; the various prompt levels &amp; the percentage of goal in which the goal is completed. The QDDP is responsible for making sure the goals for all consumers are measurable of the consumer(s) performance. When the ISP is</p>	08/12/2013			

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	<p>report indicated Client #7 "does have cerebral palsy and walks with a wheeled walker." The report indicated Client #7 had a fall risk plan in place, she was in line of sight of staff, and there were no obstacles in her path. The BDDS report indicated Client #7 "was instructed to take her time when walking in the house and have secure hold of her walker. Walker was examined for any defects and none were found."</p> <p>A BDDS report dated 12/13/12 indicated Client #7 "had finished her bath and was sitting on the toilet attempting to put on her socks as she does each morning. She slipped from the toilet to the floor onto her left knee. In addition she bumped her forehead on the floor. Staff immediately evaluated her for injuries. There was no injury to the knee, although above her right eye it appeared red." The report indicated Client #7 had a fall risk plan but was reassessed and the plan was revised to include direct supervision by staff while Client #7 is dressing or undressing. The report indicated "staff will stand directly in front of her to support her from falling forward."</p> <p>A BDDS report dated 2/28/13 indicated Client #7 "was working on a puzzle in her area, staff was working with another consumer nearby." The report indicated Client #7 had "dropped a puzzle piece of the puzzle, staff was approaching [Client #7] to help her find the puzzle piece. Staff had told [Client #7] not to reach for the puzzle as staff was coming to help her." The report indicated Client #7 "reached for the piece and fell from the chair to the floor injuring her right eyebrow."</p> <p>A BDDS report dated 3/4/13 indicated Client #7 "was sitting in her bedroom in her rocker watching TV while staff drew her bath. She attempted to reach over for her bathrobe and slide down from the rocker hitting her lip. She had a small cut to</p>		<p>completed by the QDDP, it will be reviewed by the Residential Coordinator for quality control &amp; to ensure that all goals are measurable. The group home manager is responsible for monitoring staff &amp; ensuring that the consumer(s) goals are being implemented accordingly to the ISPs.</p> <p>The QDDP is responsible for ensuring that all updated documents are in place &amp; that if a consumer has reached his/her goal that a new goal has been written, in place &amp; being implemented. The QDDP is also responsible for ensuring that the new goals/objectives are measurable &amp; indicates the time frames, various prompt levels &amp; the percentage of completion of the goal.</p> <p>Correction Measures for the Future: (Please see attached document)</p> <p>The Residential Nursing Department will perform a quarterly motor assessment (Please see attached document) of those consumers know to be a fall risk as part of their 90 day nursing evaluation. This will be completed earlier upon a change or condition in a client's functional motor abilities. All new consumers admitted to the Residential Program will have an initial Gross Motor Skill Assessment &amp; quarterly thereafter if deemed necessary by the IDT. Input will be obtained from the IDT as part of this assessment.</p>				

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	<p>the lip that was treated with first aid." The report indicated Client #7's "walker had been placed directly in front of her chair in which she was sitting. Staff will continue to follow her risk plan and instructed [Client #7] not to get up without their presence in the room in order for them to assist her if needed."</p> <p>A BDDS report dated 4/27/13 indicated Client #7 "fell while putting on her socks in the bathroom. [Client #7] suffered a small laceration to her eye from the fall." The report indicated supervision while dressing is in Client #7's fall plan. The report indicated there was uncertainty as to where staff were while Client #7 was attempting to dress. The report indicated a staff person was suspending pending an investigation of neglect.</p> <p>A BDDS report dated 5/16/13 indicated Client #7 "went on a community outing today at which time [Client #7] fell hitting the corner of her right eye. There was a small superficial cut approximately 3/4 inch to the right of the outside corner of there eye." The report indicated her risk plan was followed. The report indicated Client #7 went over to get her bowling ball and "she tripped on her own feet and fell towards the ball receiver hitting the right side of her head." The report indicated Client #7 "is very independent and will proceed with activities even when instructed to wait her turn. Staff is working closely with her so that she understands the importance of all safety items put in place for her and therefore can be an active participant in her daily activities."</p> <p>On 7/18/13 between 4:45 PM and 6:30 PM group home observations were conducted. At 4:55 PM, Client #7 was observed to use her walker with a bent posture to ambulate from the couch to the table with her math book. Client #7 was observed to eat dinner at 5:31 PM. Client #7 was observed</p>		<p><i>Fall risk plans</i> will be updated on annual bases &amp; revised earlier if the need arises. These plans will be maintained in the Residential Nursing Department, the QDDP office, the Day Services Program &amp; the Residential Group Home. All staff will be trained on any new fall risk plans or revisions. Annual Fall Risk Plans will be included in the Residential Nursing Annual Evaluation &amp; distributed at the consumer's annual case conference. All consumers admitted to the Residential Group Home program will have an initial fall risk management performed by the residential nursing department. Those consumers using adaptive equipment, have gait &amp; or mobility disturbances or may benefit from PT or OT services as deemed beneficial by the IDT will be referred to their family physicians for recommendation of PT &amp; or OT evaluation &amp; therapy. Those consumers considered at risk for falls due to medical conditions as seizure disorders or use of psychotropic medications will have a fall risk plan implemented if deemed necessary by the IDT.</p> <p>The Residential Nursing Department will develop a program for all consumers with a fall risk plans to accurately track all falls &amp; the cause of falls. These tracking sheets will</p>				

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	<p>to sit in a chair with arms on both sides. At 6:09 PM, Client #7 was assisted with medication administration. Direct Support Professional (DSP) #1 was observed seated while prompting Client #7 to disinfect her hands with gel. Client #7 left her walker to turn around to use the gel. DSP #1 was observed to turn the walker around for Client #7 in case she needed to sit on the seated section. A picture of Client #7 in her MAR (Medication Administration Record) book indicated Client #7 wearing a helmet. When interviewed at 6:20 PM, Client #7 indicated the helmet was discontinued. DSP #1 also indicated Client #7 no longer used the helmet. Client #7's right eye brow was largely swollen and drooping with a small scab in the center of the eye brow throughout the group home observations.</p> <p>On 7/19/13 between 5:59 AM and 7:00 AM, group home observations were conducted. At 6:19 AM, Client #7 proceeded from her room walking with her walker. DSP #2 positioned themselves behind Client #7 as she attempted to put on a sweater.</p> <p>On 7/23/13 at 1:58 PM, record review indicated Client #7 had a fall risk plan dated 12/11/12. Client #7's fall risk plan indicated Client #7 "is diagnosed with cerebral palsy and seizure disorder. She uses a wheeled walker. Over the last one year she has had two falls while attempting to dress herself, either in the bathroom or her bedroom. She will sit on her bed or the toilet and try to put on her socks, then lean forward and fall to the floor. Therefore it has become increasingly important to supervise [Client #7] during these times." The fall risk plan indicated staff would directly supervise Client #7 while she is dressing by standing directly in front of her to prevent "any fall from her leaning too far forward." The fall risk plan included proper</p>		provide the consumer's QDDP on a quarterly basis or earlier if necessary for any further recommendations.	

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	<p>footwear, lighting, safe environment, and assistance during showering. Client #7's fall risk plan neglected to include strategies to prevent her from falling while picking objects up or while ambulating during community outings or when getting in or out of the van during transportation. The fall risk plan did not include use of helmet. The fall risk plan neglected to indicate measures to protect Client #7 from head and face injury.</p> <p>Record review indicated Client #7 had a seizure risk plan dated 5/1/13. The seizure risk plan indicated staff should "be prepared to assist to the floor if client starts to fall."</p> <p>Record review indicated Client #7's diagnoses, included but were not limited to, intellectual disabilities, cerebral palsy, scoliosis, seizure disorder, and neurogenic bladder. Client #7's annual nursing evaluation dated 5/7/13 indicated Client #7 had PT (physical therapy) sessions in the home 6/2012 for complaint of fatigue and general weakness. The evaluation indicated Client #7 presented with scoliosis "with known osteoporosis." The evaluation indicated Client #7 had "several old lacerations from falls due to seizures."</p> <p>On 7/23/13 at 2:20 PM, the Residential Nurse (RN) and the QIDP were interviewed. The RN stated Client #7 has "balance and hand dexterity" issues while dressing. The QIDP indicated they believed the rise in falls was a behavior and had Client #7's BSP (Behavior Support Plan) revised 3/2013 to include new strategies. The RN indicated the facility had not revised Client #7's fall risk plan to include safe strategies for dressing, picking up objects independently, or other activities of daily living which posed a fall risk.</p> <p>9-3-4(a)</p>			

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