

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G450	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 04/24/2015
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NAME OF PROVIDER OR SUPPLIER RESIDENTIAL CRF INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1305 Q AVE NEW CASTLE, IN 47362
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W 000 Bldg. 00	<p>This visit was for an annual fundamental recertification and state licensure survey.</p> <p>Dates of Survey: April 21, 22, 23 and 24, 2015.</p> <p>Facility Number: 000964 Provider Number: 15G450 AIMS Number: 100249350</p> <p>These federal deficiencies also reflect state findings in accordance with 460 IAC 9.</p>	W 000		
W 104 Bldg. 00	<p>483.410(a)(1) GOVERNING BODY</p> <p>The governing body must exercise general policy, budget, and operating direction over the facility.</p> <p>Based on observation and interview for 4 of 4 sampled clients (#1, #2, #3 and #4) and 4 additional clients (#5, #6, #7 and #8), the governing body failed to exercise general policy, budget, and operating direction over the facility to ensure:</p> <p>___ The home was maintained and in good repair for all clients living in the home (clients #1, #2, #3, #4, #5, #6, #7 and #8).</p> <p>___ An awake staff on the overnight shift during sleeping hours to monitor and supervise client #4 and client #5 in regard</p>	W 104	W104 Residential CRF governingbody will provide, monitor, and revise, as necessary, policies and operating direction which insure the necessary staffing, training resources, equipment and environment to provide individuals with active treatment and to provide for their health and safety. Further, the governing body will ensure that the facility is in compliance with all applicable provisions of Federal, State and local laws, regulations and codes	05/24/2015

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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	<p>to identified behavioral and health needs.</p> <p>__ Client #4's bedroom had sufficient space to easily maneuver a walker in and about the room.</p> <p>Findings include:</p> <p>1. Observations were conducted at the group home of clients #1, #2, #3, #4, #5, #6, #7 and #8 on 4/21/15 between 3:45 PM and 6:45 PM. During this observation period the following was observed:</p> <p>__ The leather upholstery on the large brown recliner in the living room was torn and missing two large portions of upholstery, a large portion on the back of the chair and a large portion on the seat of the chair.</p> <p>__ The carpets throughout the home were brown in color and were worn, matted and/or stained in multiple places throughout both living rooms, both hallways and the clients' bedrooms.</p> <p>__ The carpet in the front living room and hallway was not padded and was firm to walk across like that of a hard wood floor or cement floor.</p> <p>__ The carpet in the front living room at the top of the step going toward the hallway was ripped, torn and frayed.</p> <p>__ The walls throughout the home had paint that was chipped and/or peeled from the walls.</p>		<p>pertaining to health, safety, and sanitation. In regard to those deficient practices as they relate to the governing body cited in the survey dated 4-24-2015, the following actions have been taken:</p> <p>1.HomeMaintenance. 1a) all house staff have been retrained in regard to the procedure for reporting needed repairs to the home. For any noted need for repair, a work order will be completed and forwarded to the maintenance department. The maintenance department will complete needed work and assign a completion date on the work order. The headof the maintenance department will keep a record of all work orders they receive for the governing body to review on a monthly basis or as needed. 1b) the home maintenance quality assurance checklist has been reviewed and revised to include a thorough reporting of needed repairs. The area supervisor will do a monthly inspectionof the home in order to complete this QA checklist. The checklist will beforwarded to the IDT and reviewed weekly. The IDT will review with the governing body monthly. In the event of an emergency repair, the governing body will be contacted immediately for proper approvals. Any needed repairswill be noted in a work order and the above mentioned</p>	

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	<p>__The bathroom off of the front sitting room had a large area on the wall behind the sink where the paint had been peeled off the walls. The light fixture in the center of the bathroom did not work and was missing a light bulb. The only light switch that worked in the bathroom was located across the bathroom and near the bathroom sink on the wall.</p> <p>__The base board heater in client #3's and client #4's bedroom was missing the front panel of the heater exposing sharp pieces of metal along with dust, dirt and cobwebs.</p> <p>__The paint on the closet doors in client #3's and client #4's bedroom was chipped and/or peeling in multiple places on the doors.</p> <p>__The paint on the walls of the bathroom off of the hallway had large spots of peeled and chipped paint. The two cabinet doors beneath the sink were completely peeled and/or stripped of paint and a large piece of paint/plaster was stripped from the wall by the shower.</p> <p>__The linoleum in the back bathroom had an area approximately two feet in diameter that was brownish black in color.</p> <p>__The linoleum in the laundry room was cracked and broken.</p> <p>__Pieces of the base board trim was missing in various places throughout the home.</p>		<p>procedure (1a) will be followed for completion of repairs. The governing body has reviewed the deficiency report in reference to the condition of 1305 Q Avenue, NewCastle. The following repairs/updates have been completed or will be completed by or prior to May 24, 2015. -Torn leather/upholstered recliner: The recliner has been replaced with a wooden rocking chair. -Carpets in home worn, matted and stained: Living room (LR) carpets, hallway and client bedroom carpets will be replaced. -Carpets not padded: Padding will be installed where appropriate. -Carpet in front LR was ripped and frayed: Carpet will be replaced. -Walls throughout home had paint chipped and peeled: Chipped paint has been removed and walls re-painted. -Bathroom off front sitting room had area behind the sink with paint peeled off, light fixture did not work, and switch for bathroom was in bathroom across room: chipped paint has been removed and walls repainted, light fixture has been repaired and light switch has been relocated. -Baseboard heater in #3 and #4 bedroom was dirty and missing front panel: Heater has been cleaned and front panel replaced. -Paint on closet doors in #3 and #4 bedroom was chipped/peeling: Chipped paint has been removed and doors repainted. -Walls in</p>	

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	<p>__The missing base board trim in the laundry room left an exposed area and a hole in the wall by the floor.</p> <p>__Client #1's ceiling fan and light fixtures did not work.</p> <p>__One of the dining room chairs was missing a corner of the upholstery and the padding was exposed.</p> <p>__The front entrance door sill around the inside bottom of the door was covered in a black moist substance and the carpet was coming up from around the door frame. A matching piece of carpet that was frayed around the edges lay at the front door over the existing carpet.</p> <p>During interview with staff #1 on 4/21/15 at 4:30 PM, staff #1:</p> <p>__Stated "We (all of the staff) think [client #5] is the one that is picking at the walls and the furniture. I have seen him do it a couple of times but he's hard to catch. We have reported it to [the behavior specialist]. We think he's the one that picked the upholstery off the chair but we don't know for sure."</p> <p>__Indicated maintenance requests were completed by the staff and then taken to the main office.</p> <p>__Indicated some of the repairs had been reported and stated, "But I don't know if all of them have."</p> <p>During interview with the QIDP</p>		<p>bathroom off of the hallway had spots of peeled and chipped paint, cabinet doors were bare, and a large piece of paint was stripped from the wall by the shower: Walls and cabinet doors were repainted, and wall area was repaired. -Linoleum in back bathroom had 2ft. diameter area that was brownish black: Linoleum will be replaced. -Linoleum in laundry room was cracked/broken: Linoleum will bereplaced. -Pieces of baseboard trim wasmissing throughout the house: Trim willbe added after flooring completed. -Missing baseboard trim in laundryroom exposed a hole in wall: Hole willbe repaired and trim will be added after flooring completed. -Client #1 ceiling fan and lightfixture did not work: Defective fan/light has been removed. -One dining room chair had torn upholstery/padding showing: Chair will be replaced/repaired. -Front door entrance door sill was dirty and carpet was coming loose from the frame: Door sill was cleaned and re-painted and carpet will be replaced. This corrective action will address all of the affected residents in the 1305 Q Avenue home. This would also apply to any new consumerswho may be admitted to the home in the future with any vacancies that may occur. The use of the QA review will assist in assuring that this home and other homes in the</p>	

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	<p>(Qualified Intellectual Disabilities Professional) on 4/21/15 at 5 PM, the QIDP:</p> <p>__ Indicated she was not aware of the extent of damage to the home in regard to the hallway bathroom, the paint and the recliner in the living room.</p> <p>__ Indicated the maintenance requests were filled out by the staff and routed to the maintenance department for repairs.</p> <p>__ Indicated she was in the home on a regular basis.</p> <p>During interview with Adm (Administrative) staff #1 on 4/23/15 at 10:30 AM, Adm staff #1:</p> <p>__ Indicated she was not aware of the maintenance issues and/or needs of the home.</p> <p>__ Indicated the staff were to report any needed repairs immediately.</p> <p>__ Indicated the home was to be in good repair and maintained at all times.</p> <p>__ Indicated the maintenance staff was in the home and the repairs would be addressed immediately.</p> <p>During interview with Adm staff #2 on 4/23/15 at 1:30 PM, Adm staff #2</p> <p>__ Indicated the requests were given to the maintenance department and copies were not maintained in the office.</p> <p>__ Indicated she was not able to locate any maintenance requests.</p>		<p>Residential CRF system will be maintained and routine and emergency repairs will be completed in a more timely manner. This will enhance the quality of life of the clients as well as preserve the integrity and value of the home. The QA procedure will be monitored weekly, monthly and as needed to assure that maintenance work is completed as directed in a timely manner.</p> <p>2.FacilityStaffing: The governing body will ensure that responsible direct care staff will be on duty and awake on a 24 –hour basis, when clients are present, totake prompt, appropriate action in case of injury, illness, fire or other emergency. This pertains to client #4 and #5. An awake night staff has been hired to monitor and supervise Client #4 and #5 during sleeping hours. In addition, awake night staff will assist all other residents in the home during sleeping hours with any issues that may occur. The IDT will review residents' records to identify other residents who display similar issues and will determine if changes need to be made to facilitate their needs. If so, the IDT will make recommendations to the governing body for evaluation and review of changes to support their care. The QA reviews will also be used to support any needed changes. Awake staff will be providing documentation of</p>		

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W 183 Bldg. 00	<p>2. The governing body failed to exercise general policy, budget, and operating direction over the facility to ensure an awake staff on the overnight shift during sleeping hours to monitor and supervise clients #4 and #5. Please see W183.</p> <p>3. The governing body failed to exercise general policy, budget, and operating direction over the facility to ensure client #4 was provided a bedroom with sufficient space to easily maneuver a walker in and about the room. Please see W422.</p> <p>9-3-1(a)</p> <p>483.430(c)(2) FACILITY STAFFING There must be responsible direct care staff on duty and awake on a 24-hour basis, when clients are present, to take prompt, appropriate action in case of injury, illness, fire or other emergency, in each defined residential living unit housing:</p>		<p>occurrences during the night sleep period, and the IDT will review weekly to assure that all client needs are identified and program planning is put in place to meet these needs. Continuous QA review will assist in this process by assuring that a thorough review process will prevent any deficient practices in the future.</p> <p>3. ResidentialCRF governing body will ensure that all clients being served will have sufficient space to easily maneuver any adaptive equipment in and about the home. Client#4 was moved to a single bedroom in the home which provides space for him to maneuver in and about the room with his walker. As client needs change, the facility governing body will be notified of issues and assist the IDT with an appropriate action or accommodation. The QA process will help assure that client needs are identified in a timely manner and addressed by the IDT, HRC and governing body. Responsible- Governing body, QIDP, Supervisor, Maintenance, House staff</p>		

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	<p>(i) Clients for whom a physician has ordered a medical care plan;</p> <p>(ii) Clients who are aggressive, assaultive or security risks;</p> <p>(iii) More than 16 clients; or</p> <p>(iv) Fewer than 16 clients within a multi-unit building.</p> <p>Based on observation, interview and record review for 1 of 4 sampled clients (#4) and 1 additional client (#5) with behavioral and health needs, the facility failed to provide overnight awake staff to ensure staff supervision for client #4's and client #5's identified needs.</p> <p>Findings include:</p> <p>1. The facility's reportable records were reviewed on 4/21/15 at 1 PM. ___ The 4/4/15 BDDS (Bureau of Developmental Disabilities Services) report indicated on 4/3/15 at 8:50 PM while client #4 was running the sweeper the client went into a seizure lasting over three minutes. The staff called an ambulance and the client was taken to the ER (Emergency Room) for evaluation. The report indicated client #4 was treated and released "around 10:05 PM" to return home to the group home. ___ The 12/26/14 BDDS report indicated on 12/25/14 at 8:05 PM client #4 had a seizure "around 8:05 PM in his bedroom while taking off his shoes." The report indicated client #4 came out of his</p>	W 183	W 183-1 The facility will provide appropriate staffing to accommodate the needs of client #4 in light of health issues. The IDT will consider all possible options in the future concerning client #4's health needs. The IDT will continue to evaluate #4's health status to assure that his health and mobility needs can be addressed in the group home setting. Monthly nursing reviews, QIDP reviews, Quarterly reviews and IDT meeting reports will assist the staff in developing a plan which best meets his needs. The IDT has discussed the usage of door alarms in the home for #4 vs. awake night staff. The BSP and ISP have been modified to reflect changes in the plan for #4. The IDT and HRC will continue to evaluate #4's progress and needs. In addition, the medical needs of the other clients who reside in this group home will be followed by nursing personnel and the QIDP. If other clients display health or other issues requiring awake night staff, the IDT will address these needs and staffing will be available. W183-2 The facility will provide appropriate staffing to accommodate the needs of client	05/24/2015	

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	<p>seizure "about 10 minutes later." An ambulance was called and client #4 was taken to the hospital "where it was noted he had difficulty coming out of the seizure. It was decided that he be transported to [name of hospital] at 3 AM." Client #4 was admitted to the hospital for observation. The report indicated client #4 was released from the hospital on 12/27/14 to return to the group home.</p> <p>__The 9/9/14 BDDS report indicated on 9/8/14 at 4:50 PM client #4 was sitting in the recliner watching television when he had a seizure. The report indicated the staff called an ambulance and client #4 was transported to the hospital where he was treated and released to return to the group home at 8 PM.</p> <p>Observations were conducted at the group home on 4/21/15 between 3:45 PM and 6:45 PM.</p> <p>__Alarms were noted on every egress door in the home; the front door, the side door, the outside door in client #1's bedroom, the outside door in client #7's bedroom and the outside door in the staff bed room.</p> <p>__Client #4 was a tall elderly male with a forward stance and a slight hunch back.</p> <p>__Client #4 wore a helmet and walked with an unsteady gait while using a four wheeled walker.</p>		<p>#5 in light of behavioral issues. The IDT will continue to evaluate the behavioral issues of client #5 in relation to picking/propertydestruction. A data collection systemhas been put in place in his BSP to record incidents of picking. All other consumers will also be monitored using an informal picking tracking sheet which will be used to document incidents of known incidents for the next 3 months. This will help to assure that the individual causing picking damage is 100% identified. BSP and ISP programming would changeaccordingly. Along with this, the facility will use data obtained in routine QA checks to determine if damages are recurring . The IDT and HRC will review any further plans/ revision as needed. Responsible-Behavior Consultant, QIDP, Nursing, House staff</p>		

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	<p>__ Client #4's conversation was difficult to understand and follow.</p> <p>__ During the evening meal while the staff and clients were sitting at the dining room table, the staff called client #4's name several times to try to gain client #4's attention. Client #4 did not respond until the 4th call of his name and then was confused as to what the staff wanted of him. After client #4 had eaten his evening meal, staff #1 prompted client #4 to brush his teeth. Client #4 got up from the table and walked into the living room, placed his walker behind the recliner, walked away from his walker and headed down the hallway in the opposite direction of his bedroom. Staff #1 called after client #4 and stated, "[Client #4] where are you going? Your room is this way." Staff #1 prompted client #4 to get his walker and go to his bedroom in the opposite part of the home to retrieve his toothbrush to brush his teeth.</p> <p>Observations were conducted at the group home on 4/22/15 between 6:30 AM and 9 AM.</p> <p>__ At 6:35 AM client #4 was in his bedroom dressing himself and trying to zip his pants while still wearing his pajamas under his clothing. When client #4 was asked if he still had his pajamas on, client #4 stared forward and did not answer. Client #4's walker was not in his</p>			

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	<p>bedroom. Staff #2 entered the room and assisted client #4 to remove his pants, take off his pajamas and to get redressed. While assisting client #4 to dress, staff #2 asked client #4, "Where is your walker." Client #4 indicated his walker was in the closet. Staff #2 stated, "It (client #4's walker) was in his bedroom last night when I checked on him before going to bed. I have no idea what he's done with it."</p> <p>__At 6:40 AM staff #1 was asked if she knew the location of client #4's walker. After looking through the home, staff #1 found client #4's walker in the living room behind the recliner. Staff #1 stated, "He must have gotten up sometime during the night and put it there."</p> <p>__Staff #1 and staff #2 indicated they did not hear client #4 get up during the night and did not know how client #4's walker had gotten into the living room.</p> <p>Client #4's record was reviewed on 4/23/15 at 2 PM.</p> <p>__Client #4's record indicated diagnoses of, but not limited to, Seizure Disorder and Dementia (memory loss).</p> <p>__Client #4's ISP (Individualized Support Plan) dated 1/22/15 indicated client #4 was at risk of falls, had an unsteady gait, was to use a four wheeled rolling walker while ambulating to prevent falls and was to wear a helmet to prevent head injury</p>			

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	<p>due to seizures and/or falls.</p> <p>__ Client #4's IDT (Interdisciplinary Team) note dated 2/23/15 indicated client #4 had a history of not sleeping at night and "acting very confused and incoherent." The note indicated the IDT was concerned with client #4's safety "given the possibility that he could leave the house unsupervised during one of these episodes." The IDT note indicated alarms would be installed on all exterior doors to alert staff if a door was opened at night. The note indicated the alarms would be activated during sleep hours only and deactivated during normal waking hours.</p> <p>During interview with staff #1 on 4/22/15 at 6:45 AM, staff #1:</p> <p>__ Indicated two staff were in the home throughout the night and each staff had their own bedroom and slept through the night.</p> <p>__ Indicated client #4 had an unsteady gait and a history of seizures.</p> <p>__ Indicated client #4 was to wear his helmet and use his walker whenever out of bed and ambulating.</p> <p>__ Indicated client #4 often would get up at night and the staff would not know that he was up.</p> <p>__ Indicated all staff were concerned for client #4's safety due to client #4's worsening dementia.</p>			

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NAME OF PROVIDER OR SUPPLIER RESIDENTIAL CRF INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1305 Q AVE NEW CASTLE, IN 47362
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	<p>__ Indicated a concern that client #4 would get up during the night and exit the home and the staff would not know and stated "I have caught him once when he had his hand on the door to open it (the door). I don't know what would have happened if he had actually gotten out."</p> <p>__ Indicated the alarms had recently been put on all doors to alert the staff during the night if any of the exit doors were opened.</p> <p>__ Indicated no awake staff in the home at night.</p> <p>__ Indicated she was a light sleeper but did not always hear the clients when they were up.</p> <p>During interview with the BC (Behavior Consultant) on 4/23/15 at 11 AM, the BC:</p> <p>__ Indicated the staff had reported client #4 was not sleeping at night and getting up more frequently during the night.</p> <p>__ Indicated the staff voiced a concern client #4 might exit the home at night while the staff were sleeping.</p> <p>__ Indicated the alarms were placed on all of the doors because of client #4's increasing dementia and concern of exiting the home without staff knowledge.</p> <p>__ Indicated the IDT had not discussed adding an awake staff in the home in lieu of and/or in addition to the alarms.</p>			

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	<p>__ When asked what if client #4 would turn on the stove at night and/or fall while he is up, the BC stated, "We wanted to take the least restrictive route and was focused more on his not sleeping at night and the concern of his exiting the home. We can certainly put an awake staff in the home if needed."</p> <p>During interview with the QIDP (Qualified Intellectual Disabilities Professional) on 4/23/15 at 2 PM, the QIDP:</p> <p>__ Indicated when client #4 had a seizure he was slow in recovering and always required treatment at the hospital.</p> <p>__ Indicated client #4's dementia was worsening.</p> <p>__ Indicated client #4 had a history of getting up at night.</p> <p>__ Indicated the IDT had met and decided to put alarms on all of the exit doors due to client #4's increasing dementia and the concern client #4 would exit the home without staff knowledge.</p> <p>__ Indicated the alarms were used only at night.</p> <p>__ Indicated the IDT had not discussed adding an awake staff in the home in lieu of and/or in addition to the alarms.</p> <p>__ When asked the question due to client #4's increasing dementia, what if client #4 would turn on the stove at night and/or fall while up, the QIDP stated, "I</p>			

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	<p>see your point. We were thinking more in terms of him leaving the home and the alarms would alert the staff."</p> <p>2. Observations were conducted at the group home on 4/21/15 between 3:45 PM and 6:45 PM. The following was observed:</p> <p>__ The leather upholstery on the large brown recliner in the living room was missing two large portions of the upholstery, a large portion on the back of the chair and a large portion on the seat of the chair.</p> <p>__ The walls throughout the home had paint that was chipped and/or peeled from the walls.</p> <p>__ The bathroom off of the front sitting room had a large area of paint missing on the wall behind the sink.</p> <p>__ The bathroom off of the hallway had several large areas of peeled missing paint and the cabinet doors beneath the sink were completely stripped of paint.</p> <p>__ The linoleum in the laundry room was cracked and broken.</p> <p>__ One of the dining room chairs was missing a corner of the upholstery and the padding was exposed.</p> <p>Client #5's record was reviewed on 4/23/15 at 3 PM. Client #5's BSP (Behavior Support Plan) dated 1/22/15 indicated client #5 had targeted behaviors</p>			

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	<p>of "stealing, emotional outbursts, inappropriate sexual conduct/touching and picking (informal)." Client #5's record indicated no documented data of client #5's targeted behavior of picking.</p> <p>Staff #1 and staff #2 were interviewed on 4/22/15 at 6:30 AM.</p> <p>__Staff #1 and staff #2 stated, "We think" client #5 was responsible for the peeled paint on the walls, the cabinet doors in both bathrooms and for the damage to the recliner.</p> <p>__Staff #1 indicated client #5 does not like to be disturbed when he was in the bathroom and would stay in the bathroom for long periods of time.</p> <p>__Staff #2 stated, "We (staff #1 and #2) think that's when he is doing all of this picking."</p> <p>__Staff #2 indicated she had found pieces of the chair upholstery on the floor beside the chair when client #5 was the last one to have sat in the chair.</p> <p>__Staff #1 stated client #1 "is sneaky, and we don't see him do it, but we know he's the one doing it."</p> <p>__Staff #1 indicated she had caught client #5 picking at the linoleum in the laundry room.</p> <p>__Staff #2 stated, "[Client #5] is probably the one that picked at the dining room chair too."</p> <p>__Staff #1 indicated the staff had</p>			

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	<p>requested picking be added to client #5's BSP.</p> <p>__Staff #2 indicated she would often get up during the night to go to the bathroom and would find client #5 up and sitting in the living room alone.</p> <p>__Staff #2 indicated client #5 would often get up during the night and the staff would not hear him.</p> <p>__Staff #1 indicated the night shift staff was a sleep shift and there were no awake staff in the home at night.</p> <p>During interview with the BC on 4/23/15 at 11 AM, the BC indicated the staff had voiced a concern about client #5's behavior of picking and had asked it be included in client #5's BSP. The BC stated he did not see it as a big concern and added the behavior as an informal target behavior and "assumed they (the staff) would address it informally with redirection." The BC indicated he did not realize the extent of the damage done to the home supposedly by client #5's behavior.</p> <p>Telephone interview with staff #3 on 4/24/15 at 9 AM indicated it was not unusual for the staff to get up and find client #5 up and sitting in the living room. Staff #3 indicated all staff that worked in the home thought client #5 was responsible for the damage being</p>						

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W 210 Bldg. 00	<p>done to the home from client #5's behavior of picking but no one had actually seen client #5 picking. Staff #3 stated, "He (client #5) is really sneaky. We (the staff) think he's doing it (picking) at night when everyone's sleeping. He (client #5) also likes to shut himself in the bathroom and doesn't like to be disturbed and he will stay in there for a long time."</p> <p>During interview with the QIDP on 4/23/15 at 2 PM, the QIDP indicated two staff were in the home at night and each staff had their own bedroom. The QIDP indicated no awake staff at night. The QIDP indicated she was not aware of the extent of client #5's picking behaviors.</p> <p>9-3-3(a)</p> <p>483.440(c)(3) INDIVIDUAL PROGRAM PLAN Within 30 days after admission, the interdisciplinary team must perform accurate assessments or reassessments as needed to supplement the preliminary evaluation conducted prior to admission. Based on observation, interview and record review for 1 of 4 sampled clients (#4), the facility failed to ensure the IDT (Interdisciplinary Team) assessed and/or reassessed client #4's increasing dementia</p>	W 210	W 210-1 The IDT will continue to review client #4's night time supervision needs Re: Dementia and level of supervision. Awake night staff has been added to the home. The IDT has assessed	05/24/2015

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	<p>in regard to the level of supervision needed during the night time hours and the use of alarms on all egress doors within the home in lieu of and/or in addition to an awake staff at night.</p> <p>The facility failed to ensure the IDT assessed and/or reassessed client #4's mobility needs in regard to going up and down steps while using a rolling walker.</p> <p>Findings include:</p> <p>Observations were conducted at the group home on 4/21/15 between 3:45 PM and 6:45 PM.</p> <p>__ Alarms were noted on every egress door in the home; the front door, the side door, the outside door in client #1's bedroom, the outside door in client #7's bedroom and the outside door in the staff bed room.</p> <p>__ Client #4 was a tall elderly male with a forward lean and a slight hunch back.</p> <p>__ Client #4 wore a helmet and walked with an unsteady gait while using a four wheeled walker.</p> <p>__ There were two steps off of the sitting room, one step leading to the kitchen and one step leading to client #4's bedroom. Client #4 had to maneuver both steps to enter and to exit the dining room area from his bedroom. When going up and/or down the steps client #4 would pick up</p>		<p>the use of door alarms and have determined that they are no longer needed. Dementia data is tracked on a daily basis and recorded on a monthly form. Data will be reviewed by the IDT at least monthly. The team will address any needs discovered and will assure that the governing body is notified of any changes needed. Nursing will continue to monitor the medical needs of all of the clients in this home, and the IDT will discuss any changes which may be made to the ISP of these individuals. The QA review will also help the IDT to identify needs and to help put a monitoring system in place to better meet the individual needs of each client. W210-2 The IDT reviewed #4's use of rolling walker and was referred for an updated PT evaluation to assess this. The evaluation was completed on 5-7-15. Risk plans and training will be updated to reflect use of walker and level of supervision needed. The staff will be retrained on the PT findings as needed. The IDT will assure that future updates will be completed if any decline of client#4 condition occurs. The ISP will be updated to reflect this information. In addition the mobility needs of the other clients in the home will be reviewed as needed to assure that the appropriate level of supervision and mobility supports is in place to meet their needs. Responsible- Nursing, QIDP,</p>		

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	<p>his walker and step up and/or step down while holding his walker off the floor.</p> <p>__ During the evening meal while the staff and clients were sitting at the dining room table, staff #2 called client #4's name several times to try to gain client #4's attention. Client #4 did not respond until the 4th call of his name and then was confused as to what the staff wanted of him. After client #4 had eaten his evening meal, staff #1 prompted client #4 to brush his teeth. Client #4 got up from the table and walked into the main living room, placed his walker behind the recliner, walked away from his walker and headed down the hallway in the opposite direction of his bedroom. Staff #1 called after client #4 and stated, "[Client #4] where are you going? Your room is this way." Staff #1 prompted client #4 to get his walker and go to his bedroom in the opposite part of the home to retrieve his toothbrush to brush his teeth.</p> <p>Observations were conducted at the group home on 4/22/15 between 6:30 AM and 9 AM.</p> <p>__ At 6:35 AM client #4 was in his bedroom dressing himself and trying to zip his pants while still wearing his pajamas under his clothing. When client #4 was asked if he still had his pajamas on, client #4 stared forward and did not</p>		House staff	

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	<p>answer. Client #4's walker was not in his bedroom. Staff #2 entered the room and assisted client #4 to remove his pants, take off his pajamas and to get redressed. While assisting client #4 to dress, staff #2 asked client #4, "Where is your walker?" Client #4 indicated his walker was in the closet. Staff #2 stated, "It (client #4's walker) was in his bedroom last night when I checked on him before going to bed. I have no idea what he's done with it."</p> <p>__At 6:40 AM staff #1 was asked if she knew the location of client #4's walker. After looking through the home, staff #1 found client #4's walker in the living room behind the recliner. Staff #1 stated, "He must have gotten up sometime during the night and put it there."</p> <p>__Staff #1 and staff #2 indicated they did not hear client #4 get up during the night and did not know how client #4's walker had gotten into the living room that morning.</p> <p>Client #4's record was reviewed on 4/23/15 at 2 PM. Client #4's record indicated diagnoses of, but not limited to, Seizure Disorder and Dementia (memory loss).</p> <p>Client #4's ISP (Individualized Support Plan) dated 1/22/15 indicated client #4 was at risk of falls, had an unsteady gait,</p>			

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	<p>was to use a four wheeled rolling walker while ambulating to prevent falls and was to wear a helmet to prevent head injury due to seizures and/or falls.</p> <p>Client #4's Fall Risk Management Plan dated 1/22/15 indicated, not all inclusive: ___ "[Client #4] was to use his walker to assist with ambulation and balance." ___ "[Client #4] will be seen as needed to evaluate his safety when ambulating." ___ "Staff will be sure stairs are well lit and encourage [client #4] to use hand rails."</p> <p>Client #4's PT (Physical Therapy) evaluation dated 4/29/14 indicated "Summary: Pt (patient) does not appear to need a HEP (Home Exercise Program) at this time and does not need additional PT. Evaluation completed for annual physical. Gait abnormal. Ambulates with a four wheeled walker with moderate intervention. Safe with changing directions, no loss of balance."</p> <p>Client #4's annual nursing report dated 1/22/15 indicated "4/29/14 [Client #4] is independent in his gross motor skills and is independently ambulatory. He is noted to have decreased strength BIL (bilateral). He was issued a 4 wheel roller walker. He was also give (sic) a HEP to maximize his functional ability....</p>			

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	<p>Recommend standby assistance when ascending and descending stairs and when performing transfers in and out of car."</p> <p>Client #4's IDT note dated 2/23/15 indicated "[Client #4] has a history of not sleeping at night. He was started on Amyltriptyline (an antidepressant) December 9th, 2014 for sleeplessness. He is sleeping more now however since then it has been reported that starting early in January, [client #4] has been up at night and acting very confused and incoherent. The IDT is concerned with his safety given the possibility that he could leave the house unsupervised during one of these episodes. The IDT would make the following recommendations:</p> <ol style="list-style-type: none"> 1. Review all medications he is currently taking for potential side effects (especially those medications that may cause sleeplessness). 2. Review the efficacy of those medications he is taking or may take that would help him sleep better at night. 3. Continue supervision during sleep time hours. 4. Install an alarm on all exterior doors to alert staff if a door is opened at night. 5. The door alarms are to be activated during sleep hours only and deactivated during normal waking hours." 			

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	<p>Client #4's Dementia/Memory Loss Care Plan data sheets for 2/2015 through 9/2014 indicated client #4 was up during the night on 43 nights out of 242 nights.</p> <p>During interview with staff #1 on 4/22/15 at 6:45 AM, staff #1:</p> <p>__ Indicated client #4 had an unsteady gait and a history of seizures.</p> <p>__ Indicated client #4 was to wear his helmet and use his walker whenever out of bed and ambulating.</p> <p>__ Stated client #4 "always goes up and down the steps (in the home) that way."</p> <p>__ Indicated client #4 holds onto his walker and leans over to set his walker down and then steps down and/or up while holding onto the rolling walker.</p> <p>__ Indicated two staff were in the home throughout the night and each staff had their own bedroom and slept through the night.</p> <p>__ Indicated client #4 would often get up frequently at night.</p> <p>__ Indicated staff got up if and when the staff heard a client up.</p> <p>__ Indicated she was a light sleeper but did not always hear the clients when they were up.</p> <p>__ Indicated she (staff #1) had gotten up on occasion to go to the bathroom during the night and found client #4 awake and/or up.</p> <p>__ Indicated all staff were concerned for</p>			

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	<p>client #4's safety due to client #4's worsening dementia.</p> <p>__ Indicated a concern that client #4 would get up during the night and exit the home and the staff would not know and stated "I have caught him once when he had his hand on the door to open it. I don't know what would have happened if he had actually gotten out."</p> <p>__ Indicated the alarms had recently been put on all doors to alert the staff during the night if any of the exit doors were opened.</p> <p>__ Indicated no awake staff in the home at night.</p> <p>Telephone interview with staff #3 on 4/24/15 at 9 AM indicated client #4 would frequently get up during the night and stated she (staff #3) would get up if a client was heard but did not always hear every client because she (staff #3) had gotten up "on a few occasions" and found clients up and did not hear the clients getting out of bed.</p> <p>During interview with the BC (Behavior Consultant) on 4/23/15 at 11 AM, the BC:</p> <p>__ Indicated the staff had reported client #4 was not sleeping at night and was getting up more frequently during the night.</p> <p>__ Indicated the staff voiced a concern</p>			

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	<p>client #4 might exit the home at night while the staff were sleeping.</p> <p>__ Indicated the alarms were placed on all of the doors because of client #4's increasing dementia and the staffs' concern of exiting the home without staff knowledge.</p> <p>__ Indicated the IDT had not discussed adding an awake staff in the home in lieu of and/or in addition to the alarms.</p> <p>__ When asked what if client #4 would turn on the stove at night and/or fall while he was up the BC stated, "We wanted to take the least restrictive route and was focused more on his (client #4's) not sleeping at night and the concern of his exiting the home. We can certainly put an awake staff in the home if needed."</p> <p>__ Indicated the IDT did not assess client #4's night time supervision needs in regard to client #4's dementia and had mainly looked at the concern of client #4 exiting the home without supervision.</p> <p>During interview with the QIDP (Qualified Intellectual Disabilities Professional) on 4/23/15 at 2 PM, the QIDP:</p> <p>__ Indicated client #4's dementia was worsening.</p> <p>__ Indicated client #4 had a history of getting up at night.</p> <p>__ Indicated the IDT had met and decided</p>			

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W 240 Bldg. 00	<p>to put alarms on all of the exit doors due to the concern of client #4 exiting the home without staff knowledge.</p> <p>__ Indicated the alarms were used only at night to alert the sleeping staff.</p> <p>__ Indicated the IDT had not discussed adding an awake staff in the home in lieu of and/or in addition to the alarms.</p> <p>__ When asked what if client #4 would turn on the stove at night and/or fall while up, the QIDP stated, "I see your point. We were thinking more in terms of him (client #4) leaving the home and the alarms would alert the staff."</p> <p>__ Indicated client #4 would be reassessed for the use of the alarms and his night time supervision needs in regard to his dementia.</p> <p>__ Indicated client #4 would need to be assessed and/or reassessed in regard to going up and down steps while using his walker.</p> <p>9-3-4(a)</p> <p>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 additional client (client</p>	W 240	W240 The ISP for client #5 will address picking and his BSP will address how staff monitor #5 for	05/24/2015

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	<p>#5), the client's BSP (Behavior Support Plan) failed to address how the staff were to monitor client #5 for picking and/or property destruction and what the staff were to do when client #5 was found picking.</p> <p>Findings include:</p> <p>Observations were conducted at the group home on 4/21/15 between 3:45 PM and 6:45 PM. The following was observed:</p> <p>__ The large dark brown recliner in the living room was missing upholstery, a large portion on the back of the chair and a large portion on the seat of the chair.</p> <p>__ The walls throughout the home had paint that was chipped and/or peeled.</p> <p>__ The bathroom off of the front sitting room had a large area of missing paint on the wall behind the sink.</p> <p>__ The bathroom off of the hallway had several large areas of peeled missing paint and the cabinet doors beneath the sink were completely stripped of paint.</p> <p>__ The linoleum in the laundry room was broken and cracked.</p> <p>__ One of the dining room chairs was missing a corner of the upholstery and the padding was exposed.</p> <p>Client #5's record was reviewed on 4/23/15 at 3 PM. Client #5's BSP dated</p>		<p>picking (property destruction) and outline the intervention. Staff will be trained on the new BSP. Review will be done of the data sheets monthly by the BC and the QIDP and quarterly by the IDT or as needed. Approval will be obtained as needed by the IDT and HRC. In addition, all other consumers will also be monitored using an informal picking tracking sheet which will be used to document incidents of known incidents for the next 3 months. This will help to assure that the individual causing picking damage is 100% identified. In the event that another individual is identified, the BSP and ISP programming would change accordingly.</p> <p>Responsible- Nursing, Behavior Clinician, QIDP, House staff</p>		

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	<p>1/22/15 indicated client #5 had a targeted behavior of "picking (informal)." Client #5's BSP did not include how the staff were to monitor client #5 for picking and/or property destruction and/or include what the staff were to do when client #5 was found picking.</p> <p>Staff #1 and staff #2 were interviewed on 4/22/15 at 6:30 AM.</p> <p>__Staff #1 and staff #2 stated, "We think [client #5] is responsible" for the peeled and/or missing paint in both bathrooms and throughout the house and for the damage to the recliner.</p> <p>__Staff #1 indicated client #5 does not like to be disturbed when he was in the bathroom and would stay in the bathroom for long periods of time.</p> <p>__Staff #2 stated, "We (staff #1 and #2) think that's when he's doing some of it (the picking)."</p> <p>__Staff #2 indicated she had found some of the upholstery from the chair lying on the floor beside the chair and client #5 was the last one to have sat in the chair.</p> <p>__Staff #1 stated client #1 "is sneaky, and we don't see him picking but we know he's the one doing it."</p> <p>__Staff #1 indicated she had caught client #5 picking at the linoleum in the laundry room on one occasion.</p> <p>__Staff #2 stated, "[Client #5] is probably the one that damaged the dining room</p>			

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	<p>chair too."</p> <p>__Staff #1 indicated the staff had requested picking be added to client #5's BSP.</p> <p>__Staff #2 indicated she would often get up during the night to go to the bathroom and would find client #5 up and sitting in the living room and stated, "He could be doing it at night."</p> <p>Telephone interview with staff #3 on 4/24/15 at 9 AM indicated it was not unusual for the staff to get up and find client #5 up and sitting in the living room alone. Staff #3 indicated all staff that worked in the home thought client #5 was responsible for the damage being done to the home but no one had actually seen client #5 picking. Staff #3 stated, "He (client #5) is really sneaky. We (the staff) think he's doing it (picking) at night when everyone's sleeping. He (client #5) also likes to shut himself in the bathroom and doesn't like to be disturbed and he will stay in there for a long time."</p> <p>During interview with the BC (Behavior Consultant) on 4/23/15 at 11 AM, the BC:</p> <p>__Indicated the staff had voiced a concern about client #5's behavior of picking and had asked for the behavior to be included in client #5's BSP.</p> <p>__Stated he did not see it as a big</p>			

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W 331 Bldg. 00	<p>concern and added the behavior as an informal target behavior and "assumed they (the staff) would address it informally with redirection." ___ Indicated he did not realize the extent of the damage done to the home supposedly by client #5's behavior. ___ Indicated the behavior of picking was not added to client #5's monthly behavior records for the staff to track and/or document the behavior. ___ Indicated client #5's BSP did not include how the staff were to monitor client #5 for picking and did not include reactive strategies to address client #5's identified behavior of picking.</p> <p>9-3-4(a)</p> <p>483.460(c) NURSING SERVICES</p> <p>The facility must provide clients with nursing services in accordance with their needs. Based on record review and interview for 2 of 4 sampled clients (#2 and #4), the facility nursing services failed to clarify the clients' medication orders with the clients' physicians and with pharmacy services and to ensure the staff immediately reported all discrepancies found on the clients' MARs (Medication Administration Records) to nursing services.</p>	W 331	<p>W331 The MAR's for client #2 and #4, identified in error at the survey, have been corrected per physician orders. Staff have been retrained on procedures to report MAR discrepancies. Nursing staff will review all MAR's and make all necessary corrections/ changes prior to distribution to the homes. Supervisor and the QIDP will check the MAR upon monthly home visits to assure that</p>	05/24/2015

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	<p>Findings include:</p> <p>Observations were conducted at the group home of the medication pass on 4/21/15 between 8:05 AM and 8:55 AM. During this observation period client #2 and client #4 received their 8 AM medications. Client #2 and client #4 did not receive Milk of Magnesia.</p> <p>Review of client #2's and client #4's MARs (Medication Administration Records) for April 2015 on 4/21/15 at 9 AM indicated client #2 and client #4 were to receive 30 ml (milliliters) of Milk of Magnesia every AM at 8 AM. The MARs indicated client #2 and client #4 did not receive Milk of Magnesia at 8 AM from 4/1/15 through 4/21/15.</p> <p>During interview with staff #1 on 4/21/15 at 9 AM, staff #1: ___ Indicated client #1's and client #4's order for Milk of Magnesia was to be given PRN (as needed). ___ Indicated the MAR was not correct and stated nursing services "should have been" notified of the discrepancy so it could have been corrected.</p> <p>During interview with the facility's LPN on 4/21/15 at 1 PM, the LPN: ___ Indicated the facility's RN was</p>		<p>paperwork is accurate and medications are being given per protocol. Any discrepancies will be immediately brought to the attention of the nursing staff. Responsible- Nursing, QIDP, House staff, Supervisor</p>	

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W 422 Bldg. 00	<p>responsible for checking the clients' MARS against each client's physician's orders to ensure they were the same prior to the MARs being used.</p> <p>__ Indicated client #2's and client #4's orders for Milk of Magnesia were to be PRN and not daily at 8 AM.</p> <p>__ Stated, "We have been having problems with our pharmacy changing and/or leaving off some of the physician's orders when printing the monthly MARs for us."</p> <p>__ Stated the staff "should have" notified the facility's RN of the error when the staff first noticed the error on 4/1/15.</p> <p>9-3-6(a)</p> <p>483.470(c)(1) STORAGE SPACE IN BEDROOMS The facility must provide space for equipment for daily out-of-bed activity for all clients who are not yet mobile, except those who have a short-term illness or those few clients for whom out-of-bed activity is a threat to health and safety.</p> <p>Based on observation, record review and interview for 1 of 4 sampled clients (#4), the facility failed to provide client #4 a bedroom with sufficient space to easily maneuver a walker in and about the room.</p>	W 422	W 422 Client #4 was moved to a larger single room to accommodate his need for increased space with use of his walker. An updated PT evaluation was completed on 5-7-2015 to address usage of the walker. This will be updated in the client ISP and staff training	05/09/2015

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	<p>Findings include:</p> <p>Observations were conducted at the group home on 4/21/15 between 3:45 PM and 6:45 PM. During this observation period the following was observed:</p> <p>__ Client #4 was a tall elderly male with a forward stance and a slight hunch back.</p> <p>__ Client #4 wore a helmet and walked with an unsteady gait while using a four wheeled walker.</p> <p>__ Client #4 shared a small bedroom with client #3.</p> <p>__ Client #4's bedroom measured 10.2 feet by 12.2 feet and contained two twin beds, two tall dressers and a night stand.</p> <p>__ To enter and exit the bedroom client #4 picked up his walker and lifted it up and over the end of client #3's bed.</p> <p>__ Client #4 could not get his walker between client #3's dresser and the end of client #3's bed to enter or to exit his bedroom.</p> <p>__ Client #3's and client #4's beds were against separate walls of the bedroom.</p> <p>__ Client #4 could not walk around his bed with his walker to make his own bed due to lack of space in client #4's room.</p> <p>Client #4's record was reviewed on 4/23/15 at 2 PM. Client #4's record indicated diagnoses of, but not limited to, Seizure Disorder and Dementia (memory loss). Client #4's ISP (Individualized</p>		<p>will be completed. The QIDP will review the status of client #4 monthly and report any changes of status to the IDT for review. Based on observation and any other evaluation the team will implement mobility programs as needed. By observation and continuous record review, the IDT will determine if any other clients have specialized mobility needs, either permanently or temporarily and accommodate these needs. Review will be on-going. Responsible- QIDP, Supervisor, Nursing, House staff</p>				

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	<p>Support Plan) dated 1/22/15 indicated client #4 had an unsteady gait and was to use a four wheeled rolling walker while ambulating.</p> <p>During interview with staff #1 on 4/21/15 at 4:30 PM, staff #1: ___ Indicated client #4 had an unsteady gait and was to use his walker at all times. ___ Indicated client #3's and client #4's bedroom was small. ___ Indicated client #4 could not enter and/or exit his (client #4's) bedroom without lifting his walker up and over the end of client #3's bed. ___ Stated, "There's not enough space for him (client #4) to get his walker through there (the space between the end of client #3's bed and client #3's dresser)." ___ Indicated insufficient space in the bedroom for client #4 to walk around his bed to be able to make his own bed and stated, "To be honest, we have to do it for him because there's no way there's enough room back there for him to get his walker in and to be able to make his bed."</p> <p>During interview with the QIDP (Qualified Intellectual Disabilities Professional) on 4/21/15 at 5 PM, the QIDP: ___ Indicated she was not aware client #4</p>			

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	<p>was not able to freely go in and out of his bedroom while still using his walker.</p> <p>___ Stated, "Maybe the beds can be turned around or something. I'm not sure, but we'll fix it."</p> <p>9-3-7(a)</p>				