

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G299	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/28/2016
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NAME OF PROVIDER OR SUPPLIER OPPORTUNITY ENTERPRISES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1807 W PORTER AVE CHESTERTON, IN 46304
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W 0000 Bldg. 00	<p>This visit was for a recertification and state licensure survey.</p> <p>Dates of Survey: 4/19, 4/20, 4/21 and 4/28/16.</p> <p>Facility number: 000818 Provider number: 15G299 AIM number: 100234990</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review of this report completed by #15068 on 5/5/16.</p>	W 0000		
W 0104 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, interview and record review for 3 of 3 sampled clients (#1, #2, #3) and for 1 additional client (#4), the governing body failed to exercise general policy, budget and operating direction over the facility to ensure the facility maintained a dining room chair which was being used. The governing body failed to exercise general policy, budget and operating direction over the facility to ensure the bi-level group home was appropriate and/or accessible for clients who had difficulty maneuvering steps/stairs due to the</p>	W 0104	<p>The facility inspected the other dining room chairs and furniture to ensure that no other clients have been affected by this deficient practice; findings conclude that no other equipment was found to be defective. The table has been repaired to working order by the facilities maintenance team. The table is going to be replaced during the transition into a new group home. To ensure this deficient practice does not reoccur, the QDDP and or Group Home Director will inspect agency furniture during monthly visits. Documentation of these inspections will be</p>	05/30/2016

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>clients' chronic physical conditions and risks of falls.</p> <p>Findings include:</p> <p>1. During the 4/19/16 observation period between 4:05 PM and 5:15 PM at the group home, a dining room chair was missing an arm on the chair. The top part of the arm fell off when sitting in the chair. The top part of the chair arm was just sitting on top of the bottom piece. During the 4/19/16 observation period and the 4/20/16 observation period between 5:25 AM and 8:00 AM at the group home, client #2 sat in the chair where the arm was missing and the second arm was broken.</p> <p>Client #2's record was reviewed on 4/20/16 at 11:55 AM. Client #2's 2/17/16 ISP indicated client #2's diagnoses included, but were not limited to, Arthritis in left shoulder, Arthritis in knee, Osteoporosis and Macular Degeneration.</p> <p>Client #2's 2/17/16 Fall Protocol indicated "[Client #2] is at high risk for falling...."</p> <p>Interview with staff #3 on 4/20/16 at 7:30 AM indicated she knew client #2's chair was missing an arm, but she was not</p>		<p>maintained by the Group Home Director and QDDP. To address the issue of client accessibility, in this split level home, the agency has purchased another home on 5.16.16, with a 45-day closing expectation. The agency will transition all clients to the new group home, which will fully meet the accessibility needs of the clients.</p>	

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	<p>aware the second arm was broken. Staff #3 stated the facility needed to replace the dining room chairs as they were "mixed matched."</p> <p>Interview with administrative staff #1 on 4/21/16 at 11:30 AM indicated he was aware the dining room table and chairs needed to be replaced at the group home. Administrative staff #1 indicated he was not aware one of the chairs was broken. Administrative staff #1 stated "It is on budget for tables and chairs this year."</p> <p>2. During the 4/19/16 observation period between 4:05 PM and 5:15 PM at the group home, clients #1, #2, #3, #4, #5 and #6 arrived at the group home at 4:05 PM from the day program. The group home was bi-level in that the group home had 2 flights of stairs/steps that led into the group home from the front door 8 to 10 steps/stairs went down into the basement area of the group home where the medication room, staff office area, sitting area/family room, laundry room and clients #2 and #6's bedroom were located. The second flight of steps/stairs (8 to 10 stairs) led up to the main floor of the group home where the living room, kitchen, bathrooms and clients #1, #3, #4 and #5's bedrooms were located. Clients #4 and #6 were able to get off the van without assistance and go into the group</p>			

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	<p>home. Clients #1, #3 and #5 required staff physical assistance to unload from the van using the van lift as the clients utilized roller walkers and client #2 required physical assistance to get off the van via the side door and to walk into the group home. Clients #1 and #2 wore helmets. Clients #2, #3 and #5 required one on one staff assistance to maneuver/walk up the steps into the group home. Client #1 required 2 staff to physically assist client #1 to get up the steps into the group home as client #1 had difficulty lifting/bending her left leg to get on each step. Client #2 required staff assistance to maneuver the steps/stairs to get down to her bedroom. At 5:15 PM, clients #1, #2, #3 and #5 had to go back down the steps/stairs to exit the group home to go out to dinner to eat. Each client required staff physical assistance to get down the steps and out the front door of the group home.</p> <p>During the 4/20/16 observation period between 5:25 AM and 8:00 AM at the group home, 2 facility staff worked in the group home with clients #1, #2, #3, #4, #5 and #6 from 5:46 AM until 7:45 AM when the clients got ready to leave out of the group home. Clients #1, #3 and #5 utilized roller walkers in the bi-level group home. Client #2 wore a helmet and required staff physical assistance to</p>			

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	maneuver the flight of stairs in the group home. During the morning medication pass, staff #2 took client #1 her morning medications into the client's bedroom to administer. Interview with staff #2 on 4/19/16 at 6:30 AM indicated client #1 did not come down to the basement to get her medications as the client was not able to get down the steps. Staff #2 stated client #2 was a "fall risk" and they had to administer the client's medication in her bedroom. During the 4/20/16 observation period, clients #1, #3 and #5 did not go down the 2 flights of steps/stairs to the basement area. They stayed on the main floor of the group home. At 7:45 AM, staff #3 went to warm up the van as staff #2 assisted clients to walk down 1 flight of steps to get to the front door. Staff #2 assisted client #1 to walk down the steps first after taking the client's walker to the bottom of the steps and then physically holding onto client #1's gait belt to walk/ambulate 1 step at a time down the steps/stairs. Staff #2 got client #1 at the bottom of the steps and then staff #3 came to physically assist the client to walk down 2 different steps to get out the door with a roller walker and to the van lift. Clients #4 and #6 walked down the steps independently and got on the van. Staff #3 then assisted client #5 to walk down the steps once the staff person sat			

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	<p>the client's walker at the bottom of the steps. Client #5 required one on one staff assistance to maneuver and get down the steps to the landing. Client #2 who was standing at the top of the steps, started to walk down the steps without staff. Staff #3 turned around and ran up the steps to physically assist client #2 to walk down the steps as staff #3 was still assisting client #1 to get on the van, and client #5 stood at the front door waiting for staff #3 to come and assist her. Client #3 stood at the top of the steps with her roller walker waiting to be assisted down the stairs/steps. Once staff #3 assisted client #5 to walk to the van and client #2, staff #3 returned to the group home to assist staff #2 with client #3. One staff stood in front of client #3 and one staff behind client #3 to physically assist the client to walk down the stairs/steps. Client #3's left knee would not bend as they were going down the steps. The client had to try and go down one step at a time while holding on to both rails. Client #3 would step down with her right foot/leg and then swing her left leg down to the same step and then repeat the process. Staff #2 and #3 had to physically assist the client to maneuver the steps. Once at the bottom, client #3 held onto the rails and walked side ways to get to the step to get out the front the door. Staff #2 encouraged client #3 by</p>			

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	<p>telling the client she could do it. Client #3 held onto the front door frame to try and step down onto the small porch/step to the outside. Interview with staff #2 on 4/19/16 at 7:55 AM stated client #3 had to get out of the house "sideways" as they could not give the client her walker "as it may fall over."</p> <p>Client #1's record was reviewed on 4/20/16 at 10:30 AM. Client #1's 8/5/15 Individual Support Plan (ISP) indicated client #1's diagnoses included, but were not limited to, Epilepsy and Right Sided Hemiplegia. Client #1's ISP indicated client #1 was seen by her doctor on 4/7/16 for "frequent falls." The ISP indicated "...Dr. (doctor) thinks it's not medical, needs to slow down and be careful...."</p> <p>Client #1's 3/21/16 Consultation Form for Physical Therapy (PT) indicated client #1 had "Weakness (R) U (right upper) & (and) LE (lower extremity). Forward posture (with) stress through lumbar spine causing pain. (R) foot (with) Arizona brace...decreased balance (static and dynamic)...Unable to maintain upright position without external support (walker or caregiver)...."</p> <p>Client #1's 4/5/16 Fall Protocol indicated "[Client #1] is at high risk for falling; due</p>			

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	<p>to the use of a wheeled walker and unsteady gait. [Client #1] will use a HRC (Human Rights Committee) approved gait belt during ambulation, (sic) Staff is to walk along side of [client #1] while ambulating, using the gait belt as instructed. [Client #1] will wear non-skid foot wear when up to decrease fall risk and increase safety. Staff will encourage [client #1] to walk slowly if she begins to move at a faster rate than safety allows...[Client #1] will have gait belt in place when transferring/ambulating...."</p> <p>Client #2's record was reviewed on 4/20/16 at 11:55 AM. Client #2's 2/17/16 ISP indicated client #2's diagnoses included, but were not limited to, Arthritis in left shoulder, Arthritis in knee, Osteoporosis and Macular Degeneration. Client #2's 2/17/16 ISP indicated "...[Client #2] has fallen 5 times and these have occurred both at ADC (facility owned day program) and at home. In two of the incidences [client #2] has had a UTI (Urinary Tract Infection)...[Client #2] has been diagnosed with Macular degeneration (sic) in her right eye and this could be part of the issue with her depth perception. The PT (Physical Therapy) instructor said that he did not feel that it was an physical therapy issue but more</p>			

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	<p>depth perception...."</p> <p>Client #2's 3/8/16 Consultation Form indicated "Bone Density 3/2016 shows worsening osteoporosis...."</p> <p>Client #2's 2/17/16 Fall Protocol indicated "[Client #2] is at high risk for falling. [Client #2] should be walked to and from vehicles. Staff will hold her arm while walking to and from vehicle...."</p> <p>Client #3's record was reviewed on 4/20/16 at 12:38 PM. Client #3's 11/1/15 ISP indicated client #3's diagnoses included, but were not limited to, Degenerative knees, Left knee Replacement, Slipped Vertebrae and Arthritis in back. Client #3's ISP indicated client #3 wore a knee brace.</p> <p>Client #3's 11/11/15 Fall Protocol indicated "[Client #3] is at high risk for falling; due to arthritis in of the knee (sic). [Client #3] ambulates with the assistance of a wheeled walker. [Client #3] may complain of hip or knee pain which may add to fall risk...."</p> <p>Client #5's record was reviewed on 4/20/16 at 1:15 PM. Client #5's 5/14/15 ISP indicated client #5's diagnoses included, but were not limited to,</p>			

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	<p>Macular Degeneration and Osteoporosis. Client #5's ISP indicated the client utilized a wheeled walker and used a wheelchair for long distances. Client #5's ISP indicated client #5 was at risk for falls.</p> <p>Interview with staff #1 on 4/19/16 at 4:10 PM in regard to why clients #1, #2, #3, and #5 lived in a bi-level group home, staff #1 stated "We ask that all the time." Staff #1 indicated clients #1, #2, #3 and #5 had a difficult time going up and down the stairs to get out of the group home. Staff #1 indicated the facility was aware the clients had a hard time with the stairs/steps at the group home. Staff #1 indicated the facility was in the process of looking for an alternate house for the group home.</p> <p>Interview with staff #2 and #3 on 4/20/16 at 7:40 AM indicated client #1 required 2 staff to assist the client to come down the stairs due to the client's knees.</p> <p>Interview with administrative staff #1 and the Qualified Intellectual Disabilities Professional (QIDP) on 4/21/16 at 11:30 AM indicated they were aware clients #1, #2, #3 and #5 had difficulty with the steps/stairs at the group home. Administrative staff #1 indicated due to client #3's difficulty with the steps, they</p>			

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W 0125 Bldg. 00	<p>had been looking for another group home to purchase which was one story. The QIDP and administrative staff #1 indicated as the clients had aged at the group home, they had difficulty maneuvering the steps/stairs in the bi-level group home. The QIDP and administrative staff #1 indicated they realized it was difficult for staff to get the clients out of the group home due to the steps/stairs. Administrative staff #1 indicated they were having trouble finding a home which had at least 4 bedrooms which was one story.</p> <p>9-3-1(a)</p> <p>483.420(a)(3) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must allow and encourage individual clients to exercise their rights as clients of the facility, and as citizens of the United States, including the right to file complaints, and the right to due process.</p> <p>Based on record review and interview for 1 of 3 sampled clients (#2), the facility failed to obtain a surrogate and/or a legal representative for a client who was not able to make informed decisions for herself in regards to her health and/or finances.</p> <p>Findings include:</p>	W 0125	An audit has been conducted, to ensure that no other clients have been affected by this deficient practice. Findings conclude that no other clients are in need of a guardian or health care representative. Client #2 has no relatives or known associates that wish to serve as a guardian or advocate. The agency will contact a private advocacy group,	05/30/2016

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	<p>Client #2's record was reviewed on 4/20/16 at 11:55 AM. Client #2's 3/8/16 Consultation Form indicated "Bone Density 3/2016 shows worsening osteoporosis...."</p> <p>Client #2's April 2016 physician's orders indicated client #2 received the following routine medications:</p> <ul style="list-style-type: none"> -Artificial Tears ointment and solution for dry eyes -Aspirin 81 mg (milligrams) for Arthritis -Calcitonin daily for Osteoporosis -Calcium with vitamin D two times daily for supplement -Carnation Instant breakfast three times a day for weight loss -Fish oil for Cholesterol -Lactulose daily for Constipation -Loratadine daily for allergies -Naproxen 500 milligrams daily for Arthritis -Omeprazole for GERD (Gastroesophageal Disorder) -Thera tab for supplement <p>Client #2's 2/17/16 Fall Protocol indicated "[Client #2] is at high risk for falling...."</p> <p>Client #2's 1/5/16 Community and Home Life Assessment indicated the following</p>		<p>to enlist the services of a guardian for Client #2. To ensure this deficient practice does not reoccur, the QDDP is now tasked with ensuring that the client's comprehensive functional assessment (CFA) conclusively determines the need for a guardian or advocate. To ensure this process is implemented correctly, a quality assurance audit, of client's CFA, will occur quarterly, by the Group Home Director or designee. The audit will examine all client records and seek to find that each client CFA has accurate information and a determination of a recommendation for a guardian or advocate.</p>	

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	<p>(not all inclusive):</p> <p>Personal Care: "[Client #2] requires assistance to use proper hygiene when toileting, observe privacy when toileting, adjust water temperature and flow when bathing, brush/comb/style her hair, wash her hands...She is dependent upon staff to go to the beautician, shave, maintain an appropriate length of fingernails, wear most make-up and jewelry, and make plans a week in advance."</p> <p>Home Activities: "...She is dependent upon staff purchase clothing items when needed, know her clothing size, sort laundry, use a dryer, wash clothing items by hand as needed, use the dry cleaners;Laundromat, move furniture as needed to clean the floors, take out the trash, carry out most meal preparation skills, use a stove/oven, use the telephone, and engage in yard work."</p> <p>Health Care: Client #2 required staff assistance to follow doctor's orders. Client #2 is "dependent upon others" to know the side effects of the client's medications, to administer the client's medications, to apply first aid, and to know about the client's healthcare.</p> <p>Safety: Client #2 is "dependent upon staff to protect her", to respond to</p>			

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	<p>emergencies, to evacuate during fire drills, to recognize hazardous material and to adjust hot water.</p> <p>Community Activities/Skills: "...She is dependent upon staff to carry out community mobility skills, carry out most shopping skills, make purchases from a vending machine, carry out community integration skills, manage her personal money, and purchase personal items."</p> <p>Client #2's 1/5/16 Aging Assessment indicated "[Client #2] cannot write her first name. She does not know her age, when her birthday is, the time period of the day, the day of the week, the month of the year, the name of her group home, or know the address of her group home...moderate changes have been noted in her overall physical ability and in her ability to take care of herself...."</p> <p>Client #2's 2/17/16 Individual Support Plan (ISP) indicated client #2's diagnoses included, but were not limited to, Severe Intellectual Disability, Arthritis in left shoulder, Arthritis in knee, Osteoporosis, Gastroesophageal Reflux Disorder (GERD), Myopia with Astigmatism and Macular Degeneration. Client #2's ISP indicated client #2 had an operation on her neck on 11/19/14 for Spinal Stenosis</p>			

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	<p>in the cervical region, and had decreased hearing in the client's left ear. Client #2's ISP and/or record indicated client #2 was older in age.</p> <p>Client #2's ISP indicated the client did not sign her ISP as the space for the client's signature was blank. Client #2's ISP indicated client #2 was her own guardian and did not have any family involvement, health care representative and/or guardian to assist the client with her money and/or healthcare needs/decisions.</p> <p>Interview with the Qualified Intellectual Disabilities Professional (QIDP), Registered Nurse (RN) #1 and administrative staff #1 on 4/21/16 at 11:30 AM indicated client #2 was her own guardian. When asked if client #2 could make informed decisions in regard to her health, administrative staff #1 and RN #1 indicated client #2 recently had neck surgery. RN #1 and administrative staff #1 indicated client #2's doctor was ok with performing the surgery with client #2's consent/signature. RN #1 and administrative staff #1 indicated the nurses at the hospital questioned whether or not client #2 was able to understand and/or give consent for the surgery. Administrative staff #1 indicated they finally accepted the client's consent. The QIDP indicated they had started to look</p>			

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W 0149 Bldg. 00	<p>for a guardian for the client. The QIDP indicated she did not have any documentation the facility had been looking for a guardian for client #2.</p> <p>9-3-2(a)</p> <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. Based on observation, interview and record review for 1 of 3 sampled clients (#1), the facility failed to implement its written policy and procedures to prevent neglect of a client in regard to falls in her bedroom.</p> <p>Findings include:</p> <p>During the 4/19/16 observation period between 4:05 PM and 5:15 PM and the 4/20/16 observation period between 5:25 AM and 8:00 AM, at the group home, client #1 required staff physical assistance to ambulate with a roller walker. Facility staff would hold client #1's gait belt to assist client #1 to ambulate with her walker while wearing a helmet. Specifically, during the 4/20/16 observation period, client #1 sat on her bed in her bedroom while staff #2 went downstairs to prepare the client's</p>	W 0149	The agency looked at all other clients, and their fall risk, to ensure that no other clients have been affected by this deficient practice. Findings conclude that no other clients are affected by this deficient practice. Analysis of falls found that client #1 had a tendency to reach for items, which often resulted in falls. The agency purchased a grab assister and has implemented an IPP goal to teach the client how to properly use the grabber. The grabber will help prevent the client from reaching for items that are out of reach. To ensure this deficient practice does not reoccur, the QDDP will assess the use of the grabber through IPP data; the team will discuss IPP progress monthly. To ensure the client understood the initial use of the grabber, the Group Home Manager and Assistant Manager evaluated its use for the first three days. The client showed competency with the grabber and	05/09/2016

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	<p>morning medications. Client #1 sat near the bottom of her bed away from her side bedrails. Client #1's side bedrails were covered with the client's bedspread. Client #1's walker was at the foot of the bed away from the client. Client #1 would bend her head forward as she sat on the bed waiting for staff #2 to pass her medications. Client #1 had a baby monitor sitting on the floor of her bedroom which was on.</p> <p>The facility's Generated Events Reports (GERs), reportable incident reports and/or investigations were reviewed on 4/19/16 at 1:16 PM. The facility's GERs, reportable incident reports and/or investigations indicated the following (not all inclusive):</p> <p>-3/30/16 "Staff woke [client #1] up to use the bathroom this morning. Once she was done we headed back to her room so she can change into her work clothes. Before sitting [client #1] down on her bed staff help (sic) pull her pants down. [Client #1] was then seated and staff took off her gate (sic) belt and helmet. Staff then got her clothing and and (sic) everything she needed and sat it beside her and told [client #1] to call for staff once she slips her pants on so that staff can help her stand up and pull them all the way up and put on her belt (sic).</p>		indicated she understood its use.	

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	<p>[Client #1] replied with 'ok. I will let you know' and staff left the room to start breakfast. Once staff made it to the kitchen and sat the bowls out staff heard [client #1] calling for help through the monitor. Staff then stopped and made it to her as quickly as possible. When staff entered [client #1's] room [client #1] was sitting up with her legs on the mat and her bottom on the floor and her underwear pulled halfway (sic) right about (sic) her knees...Once staff sat [client #1] on her bed staff asked why was she walking without staff after I told her seconds ago to call for staff and she said 'my socks were on the floor and I was trying to get them.'...." The GER indicated client #1 was checked and not injured.</p> <p>-12/12/15 "Staff was in the kitchen getting plates ready for dinner when they heard a loud crash. They went down the hallway to see what had caused the noise and found [client #1] in her room on the floor, lying on her back...." The note indicated client #1 was trying to get something out of her closet when she fell. The GER indicated client #1 did not know why she did not call staff for help. The GER indicated client #1 was not injured.</p> <p>-11/1/15 "Staff was in the kitchen helping</p>			

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	<p>other clients with breakfast when they heard [client #1] yelling from her bedroom that she had fallen down. Staff entered [client #1's] bedroom to find [client #1] on the floor. [Client #1] had gotten out of bed without calling for staff and was walking around her bedroom... [Client #1] was using her walker, wearing her helmet, and wearing her gym shoes at the time of the fall."</p> <p>-10/29/15 "[Client #1] was standing at the foot of her bed working with staff to make her bed. Her legs suddenly let (sic) out beneath her and she fell. She fell against her dresser. She was wearing her helmet and did not have any injuries or bruises. She was holding onto her walker as well." The GER indicated client #1 was in the process of getting a bone density test done and her labs had been drawn which were all in "normal limits."</p> <p>-10/22/15 "[Client #1] was yelling from her bedroom for staff. When staff walked in there [client #1] was on the floor laying on her right side in a fetal position. [Client #1] stated she fell down...[Client #1's] walker was next to her standing upright. [Client #1] had her tennis shoes on and her helmet...." The GER indicated client #1 was not injured.</p> <p>-10/22/15 "[Client #1] was in room</p>			

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	<p>sleeping. She was prompted earlier to let staff know when she needed to get up to use the bathroom. [Client #1] did not notify staff this time that she needed to get up. She yelled out stating that she fell. She was wearing her helmet and did not have any injuries...." Client #1's 10/22/15 GER indicated "...QDDP (Qualified Developmental Disabilities Professional) and the team will continue to monitor [client #1] and track all her falls that occur."</p> <p>-10/15/15 "[Client #1] yelled out for help, stating that she fell. Staff came upstairs immediately and checked her for injuries or new bruises. None were found. It was discovered that she had soiled herself a little. She was wearing her helmet. She was helped up off the floor. [Client #1] stated that she needed to use the bathroom very badly still..[Client #1] was prompted to next time call out to staff when she needed to use the bathroom really bad. It was explained to her that staff could help her when she needs to rush to the bathroom." The GER indicated "...At a previous IDT (interdisciplinary team) the team agreed [client #1] should keep her shoes on at all times to prevent her from slipping on the hard wood floor. We also discussed [client #1's] getting labs and testing done to ensure nothing medically is causing</p>			

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	<p>these falls. At this time we have gotten normal ranges on her labs and Depakote (seizure) levels. We are still awaiting to check her bone density test. Staff will continue to monitor [client #1] while she is in her room."</p> <p>-10/11/15 "Staff was downstairs helping another client when they heard a bang from upstairs. Staff went into [client #1's] bedroom to discover [client #1] sitting in her roommate's clothes basket. [Client #1] said she had fallen back into the basket. [Client #1] had her helmet on her head and her walker was directly in front of her...." The GER indicated client #1 was not injured. The 10/11/15 GER indicated "...We continue to monitor all of [client #1's] falls. [Client #1's] labs have been checked and she has been seen by her primary physician has seen (sic) [client #1] due to these falls and he couldn't find anything physically wrong with [client #1]. At a recent IDT we decided that [client #1] will always wear her gym shoes and will have her helmet on at all times. We also stated that [client #1] will notify staff when she is moving around in room so they can assist if she needs it. Staff will continue to monitor [client #1]."</p> <p>-10/1/15 "[Client #1] was exiting her room to use the restroom. She fell onto</p>			

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	<p>the floor as she was coming out of room. She was helped up and into the bathroom...She later stated that she was dizzy before she fell."</p> <p>-9/22/15 "Staff was in the kitchen helping other clients when they heard a bang coming from [client #1's] bedroom. Staff entered [client #1's] bedroom to find [client #1] sitting on the floor and her walker on the other side of her bedroom. [Client #1] told staff she fell while getting her things ready. [Client #1] said she hit her head while she fell...." The GER indicated client #1 was not injured.</p> <p>-9/6/15 "[Client #1] told staff that while she was getting her nail polish case off the shelf in her closet, she fell on her bottom. Staff knocked on her door when they heard an odd noise from the monitor. That was when they found her on the floor in front of her closet....Staff will continue to monitor...."</p> <p>Client #1's record was reviewed on 4/20/16 at 10:30 AM. Client #1's 4/18/16 Health Care Report (HCR) indicated client #1 had seizures. The HCR indicated 5 seizures in January, February, March 2016 and 3 seizures in April 2016 thus far. The 4/18/16 HCR indicated client #1 fell to the floor on 3/23/16 when she had a seizure at the day program.</p>			

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	<p>The 4/18/16 HCR indicated client #1 was also being seen by a physical therapist to work on "...gait strengthening, and balancing. Including leg strength, core strengthening and ambulation with and without walker."</p> <p>Client #1's 8/5/15 Individual Support Plan (ISP) indicated client #1's diagnoses included, but were not limited to, Epilepsy and Right Sided Hemiplegia. Client #1's ISP indicated client #1 was seen by her doctor on 4/7/16 for "frequent falls." The ISP indicated "...Dr. (doctor) thinks it's not medical, needs to slow down and be careful...."</p> <p>Client #1's 3/7/16 Bedrail/Siderail Safety protocol indicated "Bedrails are used as a safety device to protect [client #1] from falls that may result in injury. These rails are padded for [client #1's] safety to prevent injury in the event of a nighttime (sic) seizure."</p> <p>Client #1's 3/7/16 Seizure Management Plan indicated client #1 was to wear her helmet when she was not in bed due to the client's seizures. The seizure protocol also indicated "...Fall mats will be placed on client's bedroom floor when she is in bed for client safety...."</p> <p>Client #1's 4/5/16 Fall Protocol indicated</p>			

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	<p>"[Client #1] is at high risk for falling; due to the use of a wheeled walker and unsteady gait. [Client #1] will use a HRC (Human Rights Committee) approved gait belt during ambulation, (sic) Staff is to walk along side of [client #1] while ambulating, using the gait belt as instructed. [Client #1] will wear non-skid foot wear when up to decrease fall risk and increase safety. Staff will encourage [client #1] to walk slowly if she begins to move at a faster rate than safety allows. Staff will stay with [client #1] at all times when showering, and will assist [client #1] in and out of the bathtub to prevent falls. Shower curtain will be clear for constant observation and improved safety. [Client #1] will have gait belt in place when transferring/ambulating...." Client #1's fall protocol also indicated "...Staff will be trained on fall precautions.</p> <ol style="list-style-type: none"> 1. No throw rugs in the home. 2. Hallways should remain clear of all obstacles. 3. Staff will be trained on use of gait belt. 4. [Client #1] will have gait belt in place at all times while ambulating with staff assist. 5. Fall mat will be placed on floor when [client #1] is in bed. 6. [Client #1] will be encouraged to wear safety helmet when out of bed. 			

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	<p>Staff should be aware of uneven surfaces that may pose a hazard for [client #1] when in the community." Client #1's monitor in the client's bedroom was not part of the client's seizure and/or fall protocols.</p> <p>Client #1's Residential Monthly Summaries indicated the following (not all inclusive):</p> <p>-September 2015 "Has been having issues with not being able to keep her weight on her feet...Discussed her falls and will try and see if she can switch rooms to a bigger room...."</p> <p>-October 2015 "Continues to fall. Goes to [name of doctor] 11/19/15 to discuss her falls. GHM (Group Home Manager) will update team once she goes...."</p> <p>-November 2015 "[Client #1] did fall last month but no injuries at the time. Staff will continue to monitor [client #1] and her falls."</p> <p>-December 2015 "New safety goal- Call for staff when she needs to get up...."</p> <p>-January 2016 "...Get test results back to help determine why she (sic) falling and her seizures." Client #1's monthly IDT summaries, fall protocol and/or record</p>			

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	<p>did not specifically indicate how the facility addressed/prevented client #1's falls in her bedroom. Even though, client #1 had a monitor in the client's bedroom and a fall mat, client #1 continued to have falls in her bedroom.</p> <p>Interview with staff #2 and #3 on 4/20/16 at 7:40 AM indicated client #1 was monitored by staff to prevent her from falling. Staff #2 and #3 indicated they utilized a gait belt with client #1 when ambulating, and did not leave client #1 unattended in the bathroom. Staff #2 indicated client #1 had falls in the bathroom. Staff #2 indicated facility staff had to stay with client #2 in the bathroom when she showered. Staff #3 indicated client #1 was able to stay in her bedroom by herself to start dressing and then staff would join her to assist in finishing dressing. When asked when was client #1's last fall, staff #3 indicated she thought it was about 3 weeks ago. Staff #3 stated client #1 "slipped off the bed."</p> <p>Interview with Registered Nurse (RN) #1, administrative staff #1 and the Qualified Intellectual Disabilities Professional (QIDP) on 4/21/16 at 11:30 AM indicated client #1 was a fall risk. The QIDP stated client #1's monitor "worked both ways." Facility staff could hear client #1 when the client was in her</p>			

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	<p>room and could hear in the living room when facility staff was in the room with client #1. The QIDP and RN #1 indicated the use of the monitor had not been incorporated into client #1's fall and/or seizure protocols. The QIDP, administrative staff #1 and RN #1 indicated client #1 had several falls in the bathroom. The QIDP, administrative staff #1 and RN #1 indicated facility staff now had to be with the client when she was in the bathroom due to the falls. When asked how the facility was addressing and/or preventing the falls in client #1's bedroom, client #1 was to call staff for help when she wanted to get up to ambulate in her bedroom. The QIDP indicated client #1 had a floor mat in her bedroom and the monitor. The QIDP stated client #1 "wants privacy and wants to be independent. We will have to address."</p> <p>The facility's policy and procedures were reviewed on 4/19/16 at 1:17 PM. The facility's 3/17/16 policy entitled Abuse and Neglect indicated "...Neglect: Includes the refusal or failure to provide appropriate care, food, medical care, training or supervision. It may also include: Knowingly placing a individual in a situation that may endanger his/her health or life...failure to provide a safe, clean and sanitary environment...."</p>			

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W 0186 Bldg. 00	<p>9-3-2(a)</p> <p>483.430(d)(1-2) DIRECT CARE STAFF The facility must provide sufficient direct care staff to manage and supervise clients in accordance with their individual program plans.</p> <p>Direct care staff are defined as the present on-duty staff calculated over all shifts in a 24-hour period for each defined residential living unit.</p> <p>Based on observation, interview and record review for 3 of 3 sampled clients (#1, #2 and #3) and for 3 additional clients (#4, #5 and #6), the facility failed to ensure there were sufficient staff to meet the needs of the client's when they woke up in the morning.</p> <p>Findings include:</p> <p>During the 4/20/16 observation period between 5:25 AM and 8:00 AM, at the group home, there was facility staff (staff #3) with clients #1, #2, #3, #4, #5 and #6 upon arrival to the group home. Facility staff #3 was assisting client #2 to walk up 2 flights of stairs to the living room area where client #6 was placing cereal boxes, bowls and saucers on the counter for breakfast. Client #4 was dressed for the day and sitting on the couch. Staff #3</p>	W 0186	<p>Upon closing of the survey, the group home schedule was adjusted to ensure that two staff were present every morning, beginning at 5:30am. To ensure this deficient practice does not reoccur, the QDDP and/or Group Home Director will examine weekly schedules, set forth by the Group Home Manager. The inspections will seek to determine that the appropriate number of staff are on duty at all times. The inspections will occur for four weeks; if after four weeks no errors or gaps in coverage occur, the inspections will cease.</p>	05/16/2016

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	<p>assisted client #2 to sit down on the couch to wait for her shower as client #5 was in the shower. Staff #3 told client #2 to stay seated on the couch while she went to assist client #1 who was sitting on her bed attempting to get dressed. Client #3 came out of her bedroom dressed for the day using her roller walker to ambulate to the kitchen. At 5:30 AM, staff #3 could be heard through the monitor saying to clients #2, #3 and #6 "I will be out there soon." Client #3 went to sit at the counter and client #6 helped the client get her breakfast. At 5:34 AM, client #2 stood up off the couch and began walking in the kitchen area. Staff #3 stated through the baby monitor "[Client #2] are you off the couch?" Client #2 turned back around and walked back to the living room area and sat back down on the couch. Staff #3 stated to clients #2, #3 and #6 through the monitor, "I will be right there." Staff #3 was assisting client #1 to get dressed in the client's bedroom. At which time, client #6 assisted client #4 to get her breakfast a bowl of Cheerios and a cup of milk. Client #4 did not pour the milk on her cereal. Client #4 ate her cereal dry. At 5:42 AM, staff #3 came out of client #1's bedroom with client #1 and went into the bathroom with client #1 as client #2 sat on the couch in her robe waiting to get a shower. Clients #3 and #6 were</p>			

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	<p>eating their breakfast at the kitchen counter and client #4 was eating at the dining room table. At 5:43 AM, staff #3 walked client #1 to the dining room table utilizing the client's gait belt as the client ambulated with her roller walker. Staff #3 physically assisted client #1 to sit at the dining room table. Staff #3 told client #6 she was doing a good job with breakfast and then told client #1 she would not be allowed to eat until after she (staff #3) gave client #2 a shower. Staff #3 stated "You cannot eat or drink, until I give [client #2] a shower. You have to be monitored so you won't choke." Staff #3 then told client #2 to wait as staff #3 had to go downstairs and get the client #2's towel. Staff #3 left clients #1, #2, #3, #4 and #6 upstairs as she went downstairs of the bi-level home. Client #5 was still in her room getting dressed from her shower. At 5:45 AM, staff #3 took client #2 to the bathroom to shower while client #6 monitored the kitchen area. Client #1 sat at the table indicating she was hungry and ready to eat. At 6:46 AM, staff #2 arrived to work at the group home. Client #1 immediately told staff #2 she was ready to eat breakfast. Staff #2 assisted client #2 to get her breakfast, and client #5 came out of her bedroom with a roller walker.</p>			

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	<p>During the above mentioned 4/20/16 observation period, 2 facility staff worked in the group home with clients #1, #2, #3, #4, #5 and #6 from 5:46 AM until 7:45 AM when the clients got ready to leave out of the group home. Clients #1, #3 and #5 utilized roller walkers in the bi-level group home. Client #2 wore a helmet and required staff physical assistance to maneuver the flight of stairs in the group home. Staff #3 went to warm up the van as staff #2 assisted clients to walk down 1 flight of steps to get to the front door. Staff #2 assisted client #1 to walk down the steps first after taking the client's walker to the bottom of the steps and then physically holding onto client #1's gait belt to walk/ambulate 1 step at a time down the steps/stairs. Staff #2 got client #1 at the bottom of the steps and then staff #3 came to physically assist the client to walk down 2 different steps to get out the door with a roller walker and to the van lift. Clients #4 and #6 walked down the steps independently and got on the van. Staff #3 then assisted client #5 to walk down the steps once the staff person sat the client's walker at the bottom of the steps. Client #5 required one on one staff assistance to maneuver and get down the steps to the landing. Client #2 who was standing at the top of the steps, started to walk down the steps without staff. Staff</p>			

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	<p>#3 turned around and ran up the steps to physically assist client #2 to walk down the steps as staff #3 was still assisting client #1 to get on the van, and client #5 stood at the front door waiting for staff #3 to come and assist her. Client #3 stood at the top of the steps with her roller walker waiting to be assisted down the stairs/steps. Once staff #3 assisted client #5 to walk to the van and client #2, staff #3 returned to the group home to assist staff #2 with client #3. One staff stood in front of client #3 and one staff behind client #3 to physically assist the client to walk down the stairs/steps leaving clients #1, #2, #4, #5 and #6 in the running van.</p> <p>Client #1's record was reviewed on 4/20/16 at 10:30 AM. Client #1's 8/5/15 Individual Support Plan (ISP) indicated client #1's diagnoses included, but were not limited to, Epilepsy and Right Sided Hemiplegia. Client #1's ISP indicated client #1 was seen by her doctor on 4/7/16 for "frequent falls." The ISP indicated "...Dr. (doctor) thinks it's not medical, needs to slow down and be careful...."</p> <p>Client #1's 4/5/16 Fall Protocol indicated "[Client #1] is at high risk for falling; due to the use of a wheeled walker and unsteady gait. [Client #1] will use a</p>			

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	<p>HRC (Human Rights Committee) approved gait belt during ambulation, (sic) Staff is to walk along side of [client #1] while ambulating, using the gait belt as instructed. [Client #1] will wear non-skid foot wear when up to decrease fall risk and increase safety. Staff will encourage [client #1] to walk slowly if she begins to move at a faster rate than safety allows. Staff will stay with [client #1] at all times when showering, and will assist [client #1] in and out of the bathtub to prevent falls. Shower curtain will be clear for constant observation and improved safety. [Client #1] will have gait belt in place when transferring/ambulating...."</p> <p>Client #2's record was reviewed on 4/20/16 at 11:55 AM. Client #2's 2/17/16 ISP indicated client #2's diagnoses included, but were not limited to, Arthritis in left shoulder, Arthritis in knee, Osteoporosis and Macular Degeneration. Client #2's 2/17/16 ISP indicated "...[Client #2] has fallen 5 times and these have occurred both at ADC (facility owned day program) and at home. In two of the incidences [client #2] has had a UTI (Urinary Tract Infection)...[Client #2] has been diagnosed with Macular degeneration (sic) in her right eye and this could be part of the issue with her depth</p>			

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	<p>perception. The PT (Physical Therapy) instructor said that he did not feel that it was an physical therapy issue but more depth perception...."</p> <p>Client #2's 2/17/16 Fall Protocol indicated "[Client #2] is at high risk for falling. [Client #2] should be walked to and from vehicles. Staff will hold her arm while walking to and from vehicle...."</p> <p>Client #3's record was reviewed on 4/20/16 at 12:38 PM. Client #3's 11/1/15 ISP indicated client #3's diagnoses included, but were not limited to, Degenerative knees, Left knee Replacement, Slipped Vertebrae and Arthritis in back.</p> <p>Client #3's 11/11/15 Fall Protocol indicated "[Client #3] is at high risk for falling; due to arthritis in of the knee (sic). [Client #3] ambulates with the assistance of a wheeled walker. [Client #3] may complain of hip or knee pain which may add to fall risk...."</p> <p>Client #5's record was reviewed on 4/20/16 at 1:15 PM. Client #5's 5/14/15 ISP indicated client #5's diagnoses included, but were not limited to, Macular Degeneration and Osteoporosis. Client #5's ISP indicated the client</p>			

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	<p>utilized a wheeled walker and used a wheelchair for long distances. Client #5's ISP indicated client #5 was at risk for falls.</p> <p>Interview with staff #3 on 4/20/16 at 7:30 AM indicated she worked by herself from 5:00 AM until 6:00 AM when the second staff came in. Staff #3 indicated she was to get client #1 up first and get her showered. Staff #3 indicated once she woke client #1 up, the other clients would start to get up on their own. Staff #3 indicated it was hard for her to assist all the clients to get up and dressed, and to assist clients who needed staff with them to ambulate from 5:00 AM to 6:00 AM.</p> <p>Interview with staff #2 and #3 on 4/20/16 at 7:40 AM indicated it was difficult for 2 staff to assist clients #1, #2, #3 and #5 down the steps/stairs to get them loaded on the van in the morning. Staff #2 indicated it would leave no staff at the top of the stairs to monitor the clients who were waiting to come down the steps/stairs. Staff #2 and #3 indicated client #1 required 2 staff to assist the client to come down the stairs due to the client's knees.</p> <p>Interview with administrative staff #1 and the Qualified Intellectual Disabilities</p>			

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W 0261 Bldg. 00	<p>Professional (QIDP) on 4/21/16 at 11:30 AM indicated client #1 required one on one staff to assist the client to ambulate with her roller walker and gait belt. The QIDP and administrative staff #1 indicated they thought a second staff came in at 5:30 AM. The QIDP indicated the overnight staff was to get client #1 up first to shower and be with her and then wake the other clients. The QIDP and administrative staff #1 did not realize the other clients were getting up. The QIDP indicated the overnight staff was new at the group home. The QIDP and administrative staff #1 indicated they realized it was difficult for staff to get the clients out of the group home due to the steps/stairs. The QIDP and administrative staff #1 indicated they had not looked at the staffing at the group home.</p> <p>9-3-3(a)</p> <p>483.440(f)(3) PROGRAM MONITORING & CHANGE The facility must designate and use a specially constituted committee or committees consisting of members of facility staff, parents, legal guardians, clients (as appropriate), qualified persons who have either experience or training in contemporary practices to change inappropriate client behavior, and persons with no ownership or controlling interest in the facility.</p>			

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W 0331 Bldg. 00	<p>Based on interview and record review for 3 of 3 sampled clients (#1, #2 and #3) and for 3 additional clients (#4, #5 and #6), the facility failed to ensure an appropriate client participated in its Human Rights Committee (HRC) meetings.</p> <p>Findings include:</p> <p>The facility's HRC minutes were reviewed on 4/20/16 at 11:50 AM. The facility's HRC minutes from 4/15 to 3/16 indicated the facility had monthly meetings. The facility's HRC minutes indicated the facility did not have a client, who was a HRC member, at its meetings in the past year which represented clients #1, #2, #3, #4, #5 and #6.</p> <p>Interview with administrative staff #1 on 4/21/16 at 11:30 AM indicated the facility used to have a client who sat on the committee. Administrative staff #1 stated "We are still looking for one."</p> <p>9-3-4(a)</p> <p>483.460(c) NURSING SERVICES The facility must provide clients with nursing services in accordance with their needs. Based on observation, interview and</p>	W 0261	Findings conclude that all clients were affected by this deficient practice. The agency has found a client to serve on the Human Rights Committee and they are currently an active member.	05/16/2016
		W 0331	A file audit has been conducted,	05/16/2016

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	<p>record review for 1 of 3 sampled clients (#1) and for 1 additional client (#5), the facility's nursing services failed to update a client's protocols and/or failed to develop a needed protocol for skin integrity for a client.</p> <p>Findings include:</p> <p>1. The facility's Generated Events Reports (GERs), reportable incident reports and/or investigations were reviewed on 4/19/16 at 1:16 PM. The facility's 11/3/15 GER indicated client #5 had a "skin tear" on right forearm. The GER indicated "...[Client #5] has a history of getting skin tears due to her skin being sensitive. Staff will monitor the skin tear until it is completely healed..." The GER indicated RN #1 assessed "...[Client #5] with a complaint of a cut and excess blood. Upon assessment, [client #5] has a skin tear. Antibiotic ointment was placed with gauze and non adhesive tape to cover the wound. Directions given to staff to clean and apply antibiotic ointment and change dressing daily and PRN (as needed). Instructed staff not to use tape and provided Coban self stick dressing to decrease further injury....."</p> <p>Client #5's record was reviewed on 4/20/16 at 1:15 PM. Client #5's 5/14/15</p>		<p>to ensure that no other clients have been affected by this deficient practice; findings conclude that no other clients were affected. On April 22nd, 2016, the registered nurse developed and implemented skin integrity protocols for Client #1 and Client #5. To ensure this deficient practice does not reoccur, the Registered Nurse, QDDP, and/or Group Home Director will review all medical protocols during the monthly IDT meeting. Documentation of appointment dates will be kept with the client's monthly summary, and housed in their client record.</p>	

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	<p>Individual Support Plan (ISP) protocols indicated client #5 did not have risk plan/protocols which addressed the client's history of and/or skin tears.</p> <p>Interview with RN #1 on 4/21/16 at 11:30 AM stated client #5 would have skin tears as "Older population and just bumping on a door. She is so fragile and bruises easy." RN #1 stated it was "not unusual" for client #5 to have a skin tear. RN #1 indicated client #5 did not have a risk plan for skin integrity and/or skin tears.</p> <p>2. During the 4/20/16 observation period between 5:25 AM and 8:00 AM, at the group home, client #1 and staff #3 could be heard on a monitor in the living room area of the group home while staff #3 assisted client #1 in her bedroom to dress. During the 4/20/16 observation period while client #1 was sitting on her bed in her bedroom waiting for staff #2 to administer the client's medications, a baby monitor was on the floor of the client's bedroom. The baby monitor was on.</p> <p>Client #1's record was reviewed on 4/20/16 at 10:30 AM. Client #1's 8/5/15 ISP, 3/7/16 Seizure Management Plan and/or 3/22/16 Fall Protocol indicated the use of a monitor was not part of the</p>			

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	<p>client's fall and/or seizure protocols.</p> <p>Interview with staff #2 and #3 on 4/20/16 at 7:40 AM indicated the baby monitor was used to monitor client #1 when the client was in her bedroom as the client had falls and seizures.</p> <p>Interview with the Qualified Intellectual Disabilities Professional (QIDP) and RN #1 on 4/21/16 at 11:30 AM indicated client #1 had a history of falls and seizures. RN #1 and the QIDP indicated client #1 had a baby monitor in her room and the staff had the receiver they carried on them which allowed them to here what was going on in the client's bedroom. RN #1 and the QIDP indicated client #1's fall and/or seizure protocols did not include the use of a baby monitor to monitor client #1 when she was in her bedroom. RN #1 indicated client #1's protocols would need to be updated.</p> <p>9-3-6(a)</p>			