

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G483	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  01/24/2014
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W000000	<p>This visit was for a fundamental recertification and state licensure survey. This visit included the investigation of complaint #IN00141980.</p> <p>Complaint #IN00141980: Substantiated. Federal and state deficiency related to the allegation is cited at W104.</p> <p>Dates of Survey: January 14, 15, 16, 17, and 24, 2014.</p> <p>Facility Number: 000997 AIMS Number: 100249410 Provider Number: 15G483</p> <p>Surveyor: Susan Reichert, QIDP</p> <p>The following federal deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 1/30/14 by Ruth Shackelford, QIDP.</p>	W000000		
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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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W000104	<p>483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility.</p> <p>Based upon observation, record review and interview, the governing body failed to provide oversight and operating direction over the facility to ensure implementation of their prevention of bed bug procedures for 4 of 4 sampled clients (clients A, B, C, and D) and 4 additional clients (clients E, F, G and H).</p> <p>Findings include:</p> <p>Observations were completed in the group home on 1/15/14 from 6:04 AM until 8:49 AM. Clients A, B, C, D, E, F, G and H had plastic zippered covers over their mattresses and on their box springs. There was clothing on the floor in clients G and H's bedrooms. Client C's floor had a comforter on the floor and the bedclothes had been removed from the mattress. There was a strong odor in the room. There were 5 hooks in the garage on the wall.</p> <p>The facility's communication log was reviewed on 1/15/14 at 7:40 AM. A note dated 12/19/13 indicated "...Also be sure</p>	W000104	<p>To assure immediate compliance with W104, maintaence person completed installation of the remaining coat hooks in the garage area of the facility. Person Responsible: Maintaence Dept. .Completed 1-17-14 To assure ongoing compliance with W104, non emergency maintaence work orders will now be completed within 5 days of request with written notification of completed work sent to QIDP New procedure to begin: 2-09-14 Persons responsible: QIDP and maintaence dept Additionally, house manager has now created weekly bedroom cleaning checklist which contains recommended bed bug prevention strategies. Completed checklists to be reviewed by house manger each week to assure implementation and completion. All completed checklists submitted to QIDP each month. (New checklist attached as Document A) New checklist implemented 2-17-14 Persons Responsible: House Manager and QIDP</p>	02/17/2014
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	<p>to follow the bed bug cleaning procedures each week. [Staff name] is supposed to be hanging hooks in the garage this week...."</p> <p>Staff #7 was interviewed on 1/15/14 at 8:10 AM. She indicated the house had been infested with bedbugs and had been heat treated to exterminate them. When asked about procedures to prevent reoccurrence, she indicated the sheets were washed weekly. She indicated client C had developed urination of his bed clothing recently.</p> <p>The House Manager was interviewed on 1/15/14 at 8:15 AM. He indicated client C had developed incontinence within the last two weeks, and nursing staff were ruling out medical causes. He indicated bedbugs had been discovered in client A and F's bedroom. He indicated there were black spots on mattress covers that had been placed on the clients' beds after a previous infestation. He indicated the bugs had been found in client F's bed and had moved to client A's bed the same day. He indicated prevention had included checking the mattresses when the clients' sheets were changed weekly, and the bedbugs had been discovered during a bedding change. He indicated the staff were given information as to what to do and it was included in the</p>						

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	<p>staff communication logs.</p> <p>The communication log was reviewed again on 1/15/14 at 8:24 AM. A note dated 11/22/13 indicated clients were to stay out of client A and F's bedroom and "continue vacuuming the living room furniture and washing [client F and client A's] bedding." Included in the log was an undated "Weekly bed bug prevention" which indicated "*sheets changed each weekend *check cleanliness of the bedbug covers-wash and immediately place back on bed if soiled. Remember, bed bug poop looks like black mold, notify pager (sic) immediately if they were to be found, coats should be hung in designated area, not bedrooms. *If the bedbug cover is clean, immediately place clean sheets on the bed and take soiled sheets to the laundry area. *Spray the bedframe and headboard with 91% alcohol *all bedrooms vacuumed weekly *Rotating each week, 1 bedroom a week should have the bed moved to be vacuumed under and vacuum baseboards. *coats should be washed weekly as residents are doing their laundry *coats should be hung in designated area, not bedrooms. "</p> <p>There was no evidence of a documented checklist of the prevention steps.</p> <p>The House Manager was interviewed</p>						

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	<p>again on 1/15/14 at 8:46 AM. He indicated all of the hooks had not yet been hung in the garage and the clients had not yet implemented hanging their coats in the garage area and stored them in their bedrooms instead.</p> <p>The Community Services Director was interviewed on 1/15/14 at 12:50 PM. She indicated the weekly procedures were to be implemented including hanging the coats in the garage. She indicated she was unaware all of the hooks had not yet been installed in the garage as indicated in the plan to prevent re-infestation. She was uncertain if there was a documented checklist of the prevention plan.</p> <p>The facility's reports to the Bureau of the Developmental Disabilities Service (BDDS) were reviewed on 1/15/14 at 11:15 AM. A report dated 11/18/13 indicated bedbugs were found in client A's bedroom and 2 small pinpoint areas were found on the left side of client A's left collarbone. No other clients in the home were found with bites. The report indicated treatment included bed covers, cleaning rails, headboards, and coats to be washed weekly. Coat hooks were to be used to hang coats and frequent vacuuming was to be completed. The home was treated by a pest control</p>						

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W000125	<p>company on 11/25/13.</p> <p>This federal tag relates to complaint #IN00141980.</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 observation, record review, and interview, the facility failed to develop criteria for 1 of 4 sampled clients (client C) to access sharp implements and utensils, failed to ensure unimpeded access to sharp implements for 3 of 4 sampled clients (clients A, B, and D) who did not require restricted access to sharp implements and utensils, and failed to provide unrestricted access</p>	W000125	To assure immediate compliance with W125, Client C has now had behavior plan revised to include measureable criteria to once again allow access to sharps .Plan Revised 1-28-14 Persons Responsible: Behavior Mangement Consultant and QIDP To assure ongoing compliarence with W125, Behavior Consultant to review all plans with restrictions to assure	02/23/2014			

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	<p>to snacks in the home for 4 of 4 sampled clients (clients A, B, C and D).</p> <p>Findings include:</p> <p>During observations on 1/14/14 from 5:04 PM to 6:50 PM, the group home manager unlocked a cabinet which contained a plastic bin with knives, and shelves with pudding cups, soft drinks, powered drink mix and snack crackers.</p> <p>The group home manager was interviewed on 1/14/14 at 5:45 PM. He stated some of the items were "reward food" for behavior support plans, and some of the snacks belonged to client A. When asked why client A's food was locked, he stated "We have trouble with people stealing," and indicated clients D and F had historical issues with stealing. He stated client C had a "history of violence" and the sharps were locked for safety to prevent his access.</p> <p>The Behavioral Clinician was interviewed in the group home on 1/14/14 at 6:45 PM. When asked about the locked sharps for client C, she indicated the practice was not addressed in his plan.</p> <p>Client A's record was reviewed on 1/17/14 at 2:00 PM. A Semi-Annual</p>		<p>measurable criteria to remove restriction is in place for all plans. Date of Completion: 2-23-14 Persons Responsible: Behavior Consultant and QIDP Additionally for clients A, B and D who did not require restriction to sharp implements, a training program has been put in place to teach these individuals to access their own key to the locked storage area for sharp utensils when needed. Training program to begin 2-23-14 Persons Responsible QIDP Additionally, specifically for Clients A,B,C,D and the other 4 residents, dietician has revised menus to include a listing of healthy snacks that are to be available to residents with unrestrained access. House manager to assure these snacks are purchased and made available. (Snack listing attached as document B) Person Responsible; Facility Dietician and House Manager Date of Completion 2:23-14</p>	

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	<p>Review of Daily Living dated 11/14/13 indicated client A had a behavior of hoarding and required checks of his room to ensure there were no "hoarded items, (particularly spoiled foods) are present." The review failed to indicate client A had a need to lock sharps or food.</p> <p>Client B's record was reviewed on 1/17/14 at 3:45 PM. The review failed to indicate client B had a need to lock sharps or food.</p> <p>Client C's record was reviewed on 1/17/14 at 2:34 PM. The review failed to indicate specific criteria had been developed and implemented for client C to regain the right to unimpeded access to the group home's kitchen knives or food items stored in the locked closet.</p> <p>Client D's record was reviewed on 1/17/14 at 3:05 PM. A Semi-Annual Review of Daily Living dated 3/11/13 indicated client D required physical assistance when using a sharp knife, and had a behavior plan dated 2/22/13 to address physical aggression. The plan did not indicate a need to lock sharps.</p> <p>The QIDP (Qualified Intellectual Disabilities Professional) and the Community Services Director were</p>			

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	interviewed on 1/17/14 at 12:55 PM. The QIDP indicated the restricted use of sharps was for client C, but was not addressed in client C's plan. She indicated clients A, B, and D would need to gain access to the sharps via staff. The QIDP indicated the locked food was to be used during scheduled snack times and clients would attempt to eat the food at other times if it were not secured. She indicated there were other snack items available to the clients in the home to eat that were not secured.  9-3-2(a)						
W000149	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 record review and interview for 2 of 4 sampled clients (clients B and C), and for 2 additional clients (clients E and H), the facility neglected to implement policy and procedure to protect client B from injury as a result of falls, failed to protect client C from self injurious behavior resulting in injury, failed to protect client C from injury during restraint and failed to	W000149	As noted in survey, due to significant regression in ability to participate in active treatment and continued increase in uncontrolled seizure activity, Client B was in transition to be moved to skilled nursing facility. Client B was discharged from Hopewell Center and admitted to Edgewater Woods on 1-20-14. As we are no	02/23/2014			

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	<p>protect clients E and H from injury as a result of physical aggression by client C.</p> <p>Findings include:</p> <p>The facility's reports to the Bureau of Developmental Disabilities Services (BDDS) were reviewed on 1/15/14 at 11:15 AM and included the following:</p> <p>1. A BDDS report dated 10/13/13 indicated client B had a seizure when using the restroom and fell on his right side causing a laceration to his nose and top lip. An ambulance was called to transport client B to the hospital where client B received 4 stitches to close the wound. The report indicated client B was not cooperative with the procedure and was restrained by 2 nurses and 2 security officers during the procedure. Client B had a "large" 6 inch long and 1 and 1/2 inch wide abrasion to the top of his head. A CT (computed tomography) scan was completed with no findings. Corrective action indicated client B's neurologist was notified. "[Client B] has had an increase in seizures and changes in seizure meds (medications) over the past month. Residential nurse has been in weekly contact with the neurologist and his nurse. Residential Nurse will continue to closely monitor. [Client B] not attending workshop for the next few days. Residential Nurse will assess."</p> <p>A BDDS report dated 8/17/13 indicated client B was taking a nap and staff</p>		<p>longer able to correct deficiencies specifically cited for Client B, to assure ongoing compliance with W157 for all other residents, QIDP to now review previous 90 days of Incident Reports as part of each residents quarterly review meeting. If increased IR activity or patterns are noted, facility nurse or behavior consultant will review and update risk plan and/or/behavior plan specific to that concern. Persons Responsible: QIDP, Facility Nurse and Behavior Consultant Completion Date: 2-23-14 To assure immediate compliance with W157 for Client C, although there has been no additional SIB noted since the one incident on 10-22-13 a SIB tracking sheet is now in place for him as part of assessment to determine additional behavioral interventions needed to address this issue. Persons Responsible: QIDP and Behavior Consultant Date of Completion: 2-17-14 Additionally for Client C, Behavior Consultant to revise current behavior plan to include additional detail specific to safely administering a face up restraint as included in his plan. Also Behavior Consultant to provide a staff training session with demonstration and actual practice for staff to demonstrate competence in safely administering restraints as included in residents approved behavior plans. To assure</p>				

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	<p>immediately checked the bathroom in client B's bedroom after hearing him cry out. Client B fell due to a seizure causing a 2 inch laceration to the top right side of his head. Client B was taken to the emergency room and received 4 staples. Corrective action indicated client B had a follow up appointment to remove the staples, the nurse would monitor client B and staff were to continue to encourage client B to put his helmet on upon getting out of bed.</p> <p>There was no indication of additional corrective action to prevent future injury to client B during seizures in the reports.</p> <p>Accident injury reports were reviewed on 1/15/14 at 12:05 PM and indicated the following:</p> <p>a. On 9/7/13 client B fell after another client bumped into him, causing a nickel sized scrape to his left elbow. Corrective action indicated client B was evaluated by a nurse on 9/9/13 and found with a small scraped area the size of a nickel. No treatment was needed.</p> <p>b. On 9/10/13 at 3:30 PM client B fell after being startled by another client causing a scrape to his right knee and "painful to stand on (sic)." Corrective action indicated on 9/22/13 the nurse evaluated client B's right knee and found a dime sized abrasion on his knee cap and swelling around his knee cap and discomfort when standing or walking. Client B was taken to a walk in</p>		<p>ongoing compliance with W157 behavior specialist to provide demonstration/competence based staff training session no less then every 6 months for any residents plan that includes a restraint. Persons Responsible: Behavior Consultant and QIDP Date of Completion: 2-22-14 Additionally for Client C, behavior consultant has now included as part of his behavior intervention strategies, a behavior crises response plan to reduce the risk of injury for not only clients E and F as cited in survey but for all other residents who may be at risk for injury in the event of escalating physical agression from client C. Staff training on crises response plan scheduled for 2-19-14 Persons Responsible: Behavior Consultant and QIDP Date of Completion: 2-19-14</p>				

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	<p>clinic for evaluation.</p> <p>c. On 9/10/13 client B fell next to his bed after using the bathroom at 9:30 PM. Client B complained of pain in his knee. Corrective action indicated client B was being taken to a walk in medical clinic.</p> <p>d. On 9/15/13, client B was found by staff in the group home bathroom laying on his left side. The report indicated he fell with no injury. Corrective action indicated the QMRP (Qualified Mental Retardation Professional) checked client B for injury and found none. The nurse evaluated client B on 9/21/13 and found no injury.</p> <p>e. On 9/21/13 client B fell during a seizure in the group home living room with no injury. Corrective action indicated client B was evaluated by the nurse on 9/23/13 and no new injuries were found.</p> <p>f. On 9/26/13 client B fell on his right side during a seizure. Client B was limping when he was walking, but did not complain of pain when asked. Corrective action indicated the nurse evaluated and found no injury on 9/27/13. The QMRP reviewed the incident on 9/26/13 and indicated "SE (side effects) of seizure med (medication) Onfi, unsteady walking, unsteadiness, muscle control coordination. This med was decreased from 10 mg (milligrams) to 5 mg on 9/26/13."</p> <p>g. On 10/2/13 client B fell causing a 1/2</p>			

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	<p>inch cut above and on left side of his left eye. Client B was preparing for a shower when staff heard him cry out and found client B on his left side. "Staff discovered blood from the fall, and his face was bloody, bruised, and swollen. [Client B's] injuries was (sic) above and on the left side of his left eye. The nurse was contacted and she gave instruction." Corrective action indicated the nurse evaluated client B and found a 1/2 inch cut above his left eyebrow, and a nickel sized abrasion at the outside corner of his eye. Dark purple bruising was found around his eye with swelling. Staff were instructed to clean client B's eye area and apply ice for 30 minutes, give Tylenol and put antibiotic ointment and bandage over the cut.</p> <p>h. On 10/6/13 client B had a seizure while walking to the van and fell on his left side. Client B was found with scrapes to his left and right knee cap. Corrective action indicated the nurse evaluated his knees on 10/8/13 and found a small dime sized abrasion to each knee. "No further tx (treatment) needed."</p> <p>i. On 10/7/13 client B fell while walking to the medication room and "bumped his head and had a couple cuts on his forehead around left eye." Client B complained of pain in his left knee and it appeared to be swollen. Client B walked with a limp and staff notified the nurse. Corrective action indicated the nurse evaluated client B on 10/8/13 and found two 1/2 inch cuts</p>						

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	<p>between his eyebrows. No further treatment was needed. A note dated 10/8 (2013) indicated the residential nurse left a message with client B's neurologist about client B's continued falls and increase in seizures since the decrease in Onfi (seizure medication).</p> <p>j. On 10/13/13 client B fell during a seizure while in his closet and hit his head. Corrective action indicated client B received a 2 1/2 inch long cut on the inner corner of his left eyebrow. Corrective action indicated staff were instructed to give client B Tylenol, change the bandage twice daily and would be monitored. The QMRP indicated she reviewed the incident (undated).</p> <p>k. On 11/23/13 staff found client B lying on his right side on the floor next to the toilet. Staff responded after hearing him crying out "which is a warning of a seizure." Corrective action indicated the nurse evaluated him on 11/26/13 and found 3-4 small red areas to the top of his head. No treatment was needed. The QMRP reviewed the incident on 11/26/13.</p> <p>There was no additional corrective action indicated in the reports to protect client B from being injured during falls with seizures.</p> <p>The Community Services Director was interviewed on 1/15/14 at 12:50 PM. When asked about corrective action to</p>			

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	<p>protect client B from falls, she stated, "The biggest thing we did was to stop him from attending day services. Staff are with him one on one during the day to monitor and we added bars to the toilet this summer." She indicated she would need to check with the nurse regarding any revisions to client B's fall risk plan.</p> <p>Client B's record was reviewed on 1/17/14 at 3:45 PM. Client B's Risk Plan for Falling dated 5/14/13 indicated client B "had a history of falls, mostly due to his seizures and some medications he receives. He also has some balance issues that make him more prone to falling. He does however, wear his helmet during waking hours to prevent head injuries if he falls." The plan indicated staff were to prompt client B to wear his helmet during all waking hours, assist client B when walking on uneven terrain or when ambulating after a seizure or after a recent fall, staff "should be aware when [client B] is in a hurry or dancing (acting silly)" and staff should prompt him to slow down or be near him to assist in case he loses his balance, client B should use a shower chair and staff should assist client B with showering and dressing, staff should encourage client B to use the handrails on the toilet to sit or stand up</p>						

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	<p>when toileting, the side rails should be up on the side of the bed when client B is in bed, and staff should assist client B if he appeared unstable when standing or ambulating. There was no evidence of a revision of client B's fall risk plan after 5/14/13 and after the 13 falls client B experienced after the plan had been developed.</p> <p>The group home nurse and QIDP (Qualified Intellectual Disabilities Professional) were interviewed on 1/17/14 at 4:00 PM. The group home nurse indicated client B was to be within eyesight of staff during the day hours and client B's bed had been moved closer to the bathroom. She indicated there had been no revisions to client B's risk plan for falling. The QIDP indicated client B was being moved to a nursing facility to address his medical needs the following week.</p> <p>2. A BDDS report dated 3/4/13 indicated client C was sitting behind client H in the van. Client C was "agitated" and attempted to knock client C's hat off his head, and in the attempt hit him in the back of his head. There were no injuries noted. Corrective action indicated client C's behavior plan "will continue to be followed. Staff encouraged [client H] to stay near staff when in the common areas and will continue to do so."</p>						

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	<p>A BDDS report dated 3/12/13 indicated client C pulled his hand back to throw the salt and pepper shakers and staff implemented a "come along walk" with client C away from the table. Client C began hitting staff in the side of the head and 1 arm was restrained. Corrective action indicated the QMRP and House Manager met with the behavior consultant on 3/12/13 to discuss adding additional proactive techniques. Client C met with his psychiatrist on 3/11/13 with no changes made. Staff will continue to follow client C's behavior plan and "It appears that he is in a manic phase of his bipolar mood disorder. [Client C] does have 2 small, circular bruises which are smaller than a dime on his right bicep which appear to have been caused by the restraint."</p> <p>A BDDS report dated 8/22/13 indicated client C hit client H on his left side of his face. No marks were apparent. Corrective action indicated client C's behavior plan was followed and will continue to be followed. Client C "appears to be in a manic cycle of his bi-polar mood disorder." Client H was encouraged to have no contact with client C and staff would monitor.</p> <p>A BDDS report dated 9/23/13 indicated client C hit client H after staff placed themselves between clients C and H and</p>						

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	<p>client C reached around staff. No injuries were noted. Corrective action indicated client C's medication had been recently changed from Abilify (anti-depressive) to Latuda (bi-polar/depression). "Staff will continue to monitor interactions between [clients C and H]. Staff, Residential Nurse, and QIDP (Qualified Intellectual Disabilities Professional) will continue to monitor [client C's] adjustment to his new medication."</p> <p>A BDDS report dated 10/20/13 indicated client C had "been agitated and refusing to take his medications over the weekend. He kicked two housemates, threw furniture and was yelling/swearing throughout the weekend at staff and housemates. Ambulance was called to transport client to [hospital] ER for evaluation. He was given 40 mg (milligrams) of Geodon orally and was discharged...." Corrective action indicated the residential nurse was in contact with client C's doctor regarding the incident.</p> <p>A BDDS report dated 10/20/13 indicated client C kicked client H in the shin. Corrective action indicated there were no injuries and staff would continue to monitor client C and H's interactions.</p>						

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	<p>A BDDS report dated 10/20/13 indicated client C kicked client E in the left shin as he passed by. Corrective action indicated there were no injuries and "staff will continue to monitor interactions between [clients C and E]."</p> <p>A BDDS report dated 10/22/13 indicated client C had a skin abrasion on his forehead approximately 1 inch tall and 3 inches wide. The QIDP asked client C how the injury occurred and client C "stated that he did not know." The abrasion was not apparent on 10/21/13 and was discovered at 12:30 AM on 10/22/13 by staff. Staff reported that all other residents were in bed between 9:00 and 10:00 PM on 10/21/13 and no client aggression had occurred. Corrective action indicated client C did not know how the injury occurred. The residential nurse indicated the abrasion "appears to look like a rug burn. [Client C] has been very agitated, physically aggressive and manic since 10/18/13. [Client C] has been to the ER twice due to aggressive behavior since that time. The origin of the injury was unable to be absolutely discovered, however, it appears that the injury was likely self-injurious due to his manic/aggressive state." There was no indication as to what type of self</p>						

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	<p>injurious behavior was thought to have caused his rug burn like injuries.</p> <p>A BDDS report dated 10/22/13 indicated client C was physically aggressive causing injury to a client at the workshop. Client C was transported home and "continued threatening his housemates and staff. [Client C] refused to take his PRN (as needed) medication (not specified). The Residential Nurse called 911. Ambulance transported [client C] to the ER. IM (intramuscular injection) of Ativan 2 mg (anxiety) and Geodon 40 mg (anti-psychotic) was administered by hospital staff." Corrective action indicated client C was seen by his psychiatrist on 10/23/13 and Latuda 120 mg was discontinued. Zyprexa 20 mg (anti-psychotic) at HS (bedtime), Ativan 2 mg TID (three times daily), and Restorial (sic)30 mg (anxiety) at HS was prescribed. The Residential Nurse and staff will monitor [client C] and possible side effects."</p> <p>There was no evidence of additional corrective action to protect client C and other clients living in the home from client C's physically aggressive and self injurious behavior.</p> <p>The Community Services Director was interviewed on 1/15/14 at 12:50 PM.</p>						

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	<p>When asked what corrective action had been taken to protect client C and other clients living in the home from his physically aggressive and self injurious behavior, she indicated clients were encouraged to move away when client C was agitated, and client C's behavior had greatly improved since the Latuda had been discontinued. She indicated despite the encouragement of clients to stay away from client C when he was agitated, he would sometimes injure others. She stated, "Sometimes we could see it coming; other times he would lash out while walking through the room."</p> <p>Client C's record was reviewed on 1/17/14 at 2:34 PM. A Behavior Support Plan dated 1/27/13 indicated target behaviors of physical aggression, property destruction, making false statements, and agitation. There was no evidence of a revision to client C's plan to address his physical aggression resulting to injury to himself or others.</p> <p>The QIDP was interviewed on 1/17/14 at 12:55 PM. She indicated client H had been instructed to stay away from client C and staff were to monitor their interactions. She indicated the group home had ensured there were 3 staff in the evenings for a period of time to address client C's behavior, but there</p>			

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	<p>were no instructions to staff regarding his level of supervision. She indicated staff were to be aware of the clients' whereabouts at all times. She indicated client C's behavior had changed after adding Latuda and his physical aggression had worsened after its use until the medication had been discontinued.</p> <p>The facility's Policy on Protection of Service Recipient From Abuse and Neglect dated 9/2006 was reviewed on 1/15/14 at 11:05 AM and indicated "No employee shall abuse, neglect, exploit, or mistreat an individual or violate the rights of an individual receiving services at Hopewell Center of by their inaction allow abuse, neglect, exploitation or violation of rights."</p> <p>9-3-2(a)</p>				

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W000157	<p>483.420(d)(4) STAFF TREATMENT OF CLIENTS If the alleged violation is verified, appropriate corrective action must be taken.</p> <p>Based on record review and interview for 2 of 4 sampled clients (clients B and C), and for 2 additional clients (clients E and H), the facility failed to develop and implement effective corrective action to a) protect client B from injury as a result of falls, b) to protect client C from self injurious behavior resulting in injury, c) protect client C from injury during restraint and d) failed to protect clients E and H from injury as a result of physical aggression by client C.</p> <p>Findings include:</p> <p>The facility's reports to the Bureau of Developmental Disabilities Services (BDDS) were reviewed on 1/15/14 at 11:15 AM and included the following:</p> <p>1. A BDDS report dated 10/13/13 indicated client B had a seizure when using the restroom and fell on his right side causing a laceration to his nose and top lip. An ambulance was called to transport client B to the hospital where client B received 4 stitches to close the wound. The report indicated client B was not cooperative with</p>	W000157	<p>As noted in survey, due to significant regression in ability to participate in active treatment and continued increase in uncontrolled seizure activity, Client B was in transition to be moved to skilled nursing facility. He actually was transferred to that facility on 1-20-14. As we are no longer able to correct deficiencies specifically cited for Client B, to assure ongoing compliance with W149 for all other residents QIDP to now review last 90 days of Incident Reports as part of each residents quarterly review meeting. If increased IR activity or patterns are noted, facility nurse or behavior consultant will review and update risk plan/behavior plan specific to that concern. Persons Responsible: QIDP and Facility Nurse Completion Date: 2-23-14 To assure immediate compliance with W149 for Client C, although there has been no additional SIB noted since the one incident on 10-22-13 a SIB tracking sheet is now in place for him as part of assessment to determine additional behavioral</p>	02/23/2014
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	<p>the procedure and was restrained by 2 nurses and 2 security officers during the procedure. Client B had a "large" 6 inch long and 1 and 1/2 inch wide abrasion to the top of his head. A CT (computed tomography) scan was completed with no findings. Corrective action indicated client B's neurologist was notified. "[Client B] has had an increase in seizures and changes in seizure meds (medications) over the past month. Residential nurse has been in weekly contact with the neurologist and his nurse. Residential Nurse will continue to closely monitor. [Client B] not attending workshop for the next few days. Residential Nurse will assess."</p> <p>A BDDS report dated 8/17/13 indicated client B was taking a nap and staff immediately checked the bathroom in client B's bedroom after hearing him cry out. Client B fell due to a seizure causing a 2 inch laceration to the top right side of his head. Client B was taken to the emergency room and received 4 staples. Corrective action indicated client B had a follow up appointment to remove the staples, the nurse would monitor client B and staff were to continue to encourage client B to put his helmet on upon getting out of bed.</p> <p>There was no indication of additional corrective action to prevent future injury to client B during seizures in the reports.</p> <p>Accident injury reports were reviewed on 1/15/14 at 12:05 PM and indicated the</p>		<p>intervention needed to address this issue. Persons Responsible: QIDP and Behavior Consultant Date of Completion: 2-17-14 Additionally for Client C, Behavior Consultant to revise current behavior plan to include additional detail specific to safely administering a face up restraint as included in his plan. Also Behavior Consultant to provide a staff training session with demonstration and actual practice for staff to demonstrate competence in safely administering restraints as included in residents approved behavior plans. To assure ongoing compliance with W149, behavior special isti to provide demonstration/competance based training session no less then every 6 months for any residents plan that includes a restraint. Persons Responsible: Behavior Consultant and QIDP Date of Completion: 2-22- Additionally for Client C, behavior consultant has now included as part of his behavior intervention strategies, a behavior crises response plan to reduce the risk of injury for not only clients E and F but for all other residents who may be at risk for injury in the event of escalating physical agression from client C. Staff training on crises response plan scheduled for 2-19-14 Persons Responsible: Behavior Consultant and QIDP Date of Completion:</p>				

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	<p>following:</p> <p>a. On 9/7/13 client B fell after another client bumped into him, causing a nickel sized scrape to his left elbow. Corrective action indicated client B was evaluated by a nurse on 9/9/13 and found with a small scraped area the size of a nickel. No treatment was needed.</p> <p>b. On 9/10/13 at 3:30 PM client B fell after being startled by another client causing a scrape to his right knee and "painful to stand on (sic)." Corrective action indicated on 9/22/13 the nurse evaluated client B's right knee and found a dime sized abrasion on his knee cap and swelling around his knee cap and discomfort when standing or walking. Client B was taken to a walk in clinic for evaluation.</p> <p>c. On 9/10/13 client B fell next to his bed after using the bathroom at 9:30 PM. Client B complained of pain in his knee. Corrective action indicated client B was being taken to a walk in medical clinic.</p> <p>d. On 9/15/13, client B was found by staff in the group home bathroom laying on his left side. The report indicated he fell with no injury. Corrective action indicated the QMRP (Qualified Mental Retardation Professional) checked client B for injury and found none. The nurse evaluated client B on 9/21/13 and found no injury.</p> <p>e. On 9/21/13 client B fell during a seizure</p>		2-19-14As				

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	<p>in the group home living room with no injury. Corrective action indicated client B was evaluated by the nurse on 9/23/13 and no new injuries were found.</p> <p>f. On 9/26/13 client B fell on his right side during a seizure. Client B was limping when he was walking, but did not complain of pain when asked. Corrective action indicated the nurse evaluated and found no injury on 9/27/13. The QMRP reviewed the incident on 9/26/13 and indicated "SE (side effects) of seizure med (medication) Onfi, unsteady walking, unsteadiness, muscle control coordination. This med was decreased from 10 mg (milligrams) to 5 mg on 9/26/13."</p> <p>g. On 10/2/13 client B fell causing a 1/2 inch cut above and on left side of his left eye. Client B was preparing for a shower when staff heard him cry out and found client B on his left side. "Staff discovered blood from the fall, and his face was bloody, bruised, and swollen. [Client B's] injuries was (sic) above and on the left side of his left eye. The nurse was contacted and she gave instruction." Corrective action indicated the nurse evaluated client B and found a 1/2 inch cut above his left eyebrow, and a nickel sized abrasion at the outside corner of his eye. Dark purple bruising was found around his eye with swelling. Staff were instructed to clean client B's eye area and apply ice for 30 minutes, give Tylenol and put antibiotic ointment and bandage over the cut.</p>						

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	<p>h. On 10/6/13 client B had a seizure while walking to the van and fell on his left side. Client B was found with scrapes to his left and right knee cap. Corrective action indicated the nurse evaluated his knees on 10/8/13 and found a small dime sized abrasion to each knee. "No further tx (treatment) needed."</p> <p>i. On 10/7/13 client B fell while walking to the medication room and "bumped his head and had a couple cuts on his forehead around left eye." Client B complained of pain in his left knee and it appeared to be swollen. Client B walked with a limp and staff notified the nurse. Corrective action indicated the nurse evaluated client B on 10/8/13 and found two 1/2 inch cuts between his eyebrows. No further treatment was needed. A note dated 10/8 (2013) indicated the residential nurse left a message with client B's neurologist about client B's continued falls and increase in seizures since the decrease in Onfi (seizure medication).</p> <p>j. On 10/13/13 client B fell during a seizure while in his closet and hit his head. Corrective action indicated client B received a 2 1/2 inch long cut on the inner corner of his left eyebrow. Corrective action indicated staff were instructed to give client B Tylenol, change the bandage twice daily and would be monitored. The QMRP indicated she reviewed the incident (undated).</p>						

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	<p>k. On 11/23/13 staff found client B lying on his right side on the floor next to the toilet. Staff responded after hearing him crying out "which is a warning of a seizure." Corrective action indicated the nurse evaluated him on 11/26/13 and found 3-4 small red areas to the top of his head. No treatment was needed. The QMRP reviewed the incident on 11/26/13.</p> <p>There was no additional corrective action indicated in the reports to protect client B from being injured during falls with seizures.</p> <p>The Community Services Director was interviewed on 1/15/14 at 12:50 PM. When asked about corrective action to protect client B from falls, she stated, "The biggest thing we did was to stop him from attending day services. Staff are with him one on one during the day to monitor and we added bars to the toilet this summer." She indicated she would need to check with the nurse regarding any revisions to client B's fall risk plan.</p> <p>Client B's record was reviewed on 1/17/14 at 3:45 PM. Client B's Risk Plan for Falling dated 5/14/13 indicated client B "had a history of falls, mostly due to his seizures and some medications he receives. He also has</p>			
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	<p>some balance issues that make him more prone to falling. He does however, wear his helmet during waking hours to prevent head injuries if he falls." The plan indicated staff were to prompt client B to wear his helmet during all waking hours, assist client B when walking on uneven terrain or when ambulating after a seizure or after a recent fall, staff "should be aware when [client B] is in a hurry or dancing (acting silly)" and staff should prompt him to slow down or be near him to assist in case he loses his balance, client B should use a shower chair and staff should assist client B with showering and dressing, staff should encourage client B to use the handrails on the toilet to sit or stand up when toileting, the side rails should be up on the side of the bed when client B is in bed, and staff should assist client B if he appeared unstable when standing or ambulating. There was no evidence of a revision of client B's fall risk plan after 5/14/13 and after the 13 falls client B experienced after the plan had been developed.</p> <p>The group home nurse and QIDP (Qualified Intellectual Disabilities Professional) were interviewed on 1/17/14 at 4:00 PM. The group home nurse indicated client B was to be within eyesight of staff during the day hours</p>			

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	<p>and client B's bed had been moved closer to the bathroom. She indicated there had been no revisions to client B's risk plan for falling. The QIDP indicated client B was being moved to a nursing facility to address his medical needs the following week.</p> <p>2. A BDDS report dated 3/4/13 indicated client C was sitting behind client H in the van. Client C was "agitated" and attempted to knock client C's hat off his head, and in the attempt hit him in the back of his head. There were no injuries noted. Corrective action indicated client C's behavior plan "will continue to be followed. Staff encouraged [client H] to stay near staff when in the common areas and will continue to do so."</p> <p>A BDDS report dated 3/12/13 indicated client C pulled his hand back to throw the salt and pepper shakers and staff implemented a "come along walk" with client C away from the table. Client C began hitting staff in the side of the head and 1 arm was restrained. Corrective action indicated the QMRP and House Manager met with the behavior consultant on 3/12/13 to discuss adding additional proactive techniques. Client C met with his psychiatrist on 3/11/13 with no changes made. Staff will continue to follow client C's behavior plan and "It appears that he is in a manic phase of his bipolar mood disorder. [Client C] does have 2 small,</p>						

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	<p>circular bruises which are smaller than a dime on his right bicep which appear to have been caused by the restraint."</p> <p>A BDDS report dated 8/22/13 indicated client C hit client H on his left side of his face. No marks were apparent. Corrective action indicated client C's behavior plan was followed and will continue to be followed. Client C "appears to be in a manic cycle of his bi-polar mood disorder." Client H was encouraged to have no contact with client C and staff would monitor.</p> <p>A BDDS report dated 9/23/13 indicated client C hit client H after staff placed themselves between clients C and H and client C reached around staff. No injuries were noted. Corrective action indicated client C's medication had been recently changed from Abilify (anti-depressive) to Latuda (bi-polar/depression). "Staff will continue to monitor interactions between [clients C and H]. Staff, Residential Nurse, and QIDP (Qualified Intellectual Disabilities Professional) will continue to monitor [client C's] adjustment to his new medication."</p> <p>A BDDS report dated 10/20/13 indicated client C had "been agitated and refusing to take his medications over the</p>						

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	<p>weekend. He kicked two housemates, threw furniture and was yelling/swearing throughout the weekend at staff and housemates. Ambulance was called to transport client to [hospital] ER for evaluation. He was given 40 mg (milligrams) of Geodon orally and was discharged..." Corrective action indicated the residential nurse was in contact with client C's doctor regarding the incident.</p> <p>A BDDS report dated 10/20/13 indicated client C kicked client H in the shin. Corrective action indicated there were no injuries and staff would continue to monitor client C and H's interactions.</p> <p>A BDDS report dated 10/20/13 indicated client C kicked client E in the left shin as he passed by. Corrective action indicated there were no injuries and "staff will continue to monitor interactions between [clients C and E]."</p> <p>A BDDS report dated 10/22/13 indicated client C had a skin abrasion on his forehead approximately 1 inch tall and 3 inches wide. The QIDP asked client C how the injury occurred and client C "stated that he did not know." The abrasion was not apparent on 10/21/13 and was discovered at 12:30</p>						

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	<p>AM on 10/22/13 by staff. Staff reported that all other residents were in bed between 9:00 and 10:00 PM on 10/21/13 and no client aggression had occurred. Corrective action indicated client C did not know how the injury occurred. The residential nurse indicated the abrasion "appears to look like a rug burn. [Client C] has been very agitated, physically aggressive and manic since 10/18/13. [Client C] has been to the ER twice due to aggressive behavior since that time. The origin of the injury was unable to be absolutely discovered, however, it appears that the injury was likely self-injurious due to his manic/aggressive state." There was no indication as to what type of self injurious behavior was thought to have caused his rug burn like injuries.</p> <p>A BDDS report dated 10/22/13 indicated client C was physically aggressive causing injury to a client at the workshop. Client C was transported home and "continued threatening his housemates and staff. [Client C] refused to take his PRN (as needed) medication (not specified). The Residential Nurse called 911. Ambulance transported [client C] to the ER. IM (intramuscular injection) of Ativan 2 mg (anxiety) and Geodon 40 mg (anti-psychotic) was administered by hospital staff."</p>			

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	<p>Corrective action indicated client C was seen by his psychiatrist on 10/23/13 and Latuda 120 mg was discontinued. Zyprexa 20 mg (anti-psychotic) at HS (bedtime), Ativan 2 mg TID (three times daily), and Restorial (sic)30 mg (anxiety) at HS was prescribed. The Residential Nurse and staff will monitor [client C] and possible side effects."</p> <p>There was no evidence of additional corrective action to protect client C and other clients living in the home from client C's physically aggressive and self injurious behavior.</p> <p>The Community Services Director was interviewed on 1/15/14 at 12:50 PM. When asked what corrective action had been taken to protect client C and other clients living in the home from his physically aggressive and self injurious behavior, she indicated clients were encouraged to move away when client C was agitated, and client C's behavior had greatly improved since the Latuda had been discontinued. She indicated despite the encouragement of clients to stay away from client C when he was agitated, he would sometimes injure others. She stated, "Sometimes we could see it coming; other times he would lash out while walking through the room."</p>						

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	<p>Client C's record was reviewed on 1/17/14 at 2:34 PM. A Behavior Support Plan dated 1/27/13 indicated target behaviors of physical aggression, property destruction, making false statements, and agitation. There was no evidence of a revision to client C's plan to address his physical aggression resulting to injury to himself or others.</p> <p>The QIDP was interviewed on 1/17/14 at 12:55 PM. When asked about corrective action to protect clients from client C's aggression, she indicated client H had been instructed to stay away from client C and staff were to monitor their interactions. She indicated the group home had ensured there were 3 staff in the evenings for a period of time to address client C's behavior, but there were no instructions to staff regarding his level of supervision. She indicated staff were to be aware of the clients' whereabouts at all times. She indicated client C's behavior had changed after adding Latuda and his physical aggression had worsened after its use until the medication had been discontinued. She indicated client C's behavior plan had not been revised since 1/27/13.</p> <p>9-3-2(a)</p>			

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W000304	<p>483.450(d)(5) PHYSICAL RESTRAINTS Restraints must be designed and used so as not to cause physical injury to the client. Based on record review and interview for 1 of 4 sampled clients (client C), the facility failed to ensure physical intervention was applied without injury.</p> <p>Findings included:</p> <p>The facility's reports to the Bureau of Developmental Disabilities Services (BDDS) were reviewed on 1/15/14 at 11:15 AM. A report dated 3/12/13 indicated client C pulled his hand back to throw the salt and pepper shakers and staff implemented a "come along walk" with client C away from the table. Client C began hitting staff in the side of the head and 1 arm was restrained. Corrective action indicated the QMRP and House Manager met with the behavior consultant on 3/12/13 to discuss adding additional proactive techniques. Client C met with his psychiatrist on 3/11/13 with no changes made. Staff will continue to follow client C's behavior plan and "It appears that he is in a manic phase of his bipolar mood disorder. [Client C] does have 2 small, circular bruises which are smaller than a dime on his right bicep which appear to have been caused by the restraint."</p>	W000304	To assure immediate compliance with W304, behavior management plan for Resident C to be revised to include additional detail on how to properly/and safely administer a face up restraint to prevent injury to Client C. Additionally, to assure ongoing compliance with W304 for Client C and all other residents, Behavior Consultant to provide demonstration/competance based staff training no less then every 6 months for any residents behavior plan that includes any type of physical restraint. Date of Completion: 2-23-14 Person Responsible: Behavior Consultant	02/23/2014			

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W009999	<p>Client C's record was reviewed on 1/17/14 at 2:34 PM. A Behavior Support Plan dated 1/27/13 included a technique to use a face up restraint on the floor. There was no evidence of a technique to hold client C's biceps during physical aggression.</p> <p>The QIDP (Qualified Intellectual Disabilities Professional) was interviewed on 1/17/14 at 3:11 PM. She indicated client C had been injured during the restraint on 3/12/13. She indicated staff had been trained on using restraint only as a last resort and had used the restraint because client C had shown extreme aggression, and client C had calmed after a minute of restraining his biceps to prevent him from injuring others. She indicated staff had not been retrained on client C's plan or how to apply restraints in such a way to prevent injury to client C if they were used.</p> <p>9-3-5(a)</p> <p>State Findings</p>	W009999	To assure immediate compliance with State Findings W9999,	02/17/2014			

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	<p>460 IAC 9-3-1(b) The following Community Residential Facilities for Persons with Developmental Disabilities rule was not met:</p> <p>The residential provider shall report the following circumstances to the division by telephone no later than the first business day followed by written summaries as requested by the division" ...A fall resulting in injury, regardless of the severity of the injury."</p> <p>This state rule is not met as evidence by:</p> <p>Based on record review and interview, the facility failed for 8 of 8 reportable incidents for 1 of 4 sampled clients (client B), to report to the Bureau of Developmental Disabilities Services (BDDS) in a timely manner.</p> <p>Findings include:</p> <p>Internal accident and injury reports for the facility were reviewed on 1/15/14 at 12:05 PM and indicated the following:</p> <p>1. On 9/7/13 client B fell after another client bumped into him, causing a nickel sized scrape to his left elbow. Corrective action indicated client B was evaluated by a nurse on 9/9/13 and found with a small scraped area the size of a nickel. No treatment was needed.</p>		<p>facility nurse and QIDP to be retrained on IR protocol including emphasis on required reporting of all falls resulting in any type of injury. Additionally, IR responsibilities to be re-assigned to be shared between facility nurse and QIDP. Facility nurse will be responsible for the reporting of all medical incidents including falls, injuries, medication errors , hospitalizations and/or change of status. QIDP will be responsible for reports of allegations of abuse, neglect, exploitation, resident to resident aggression,uninhabitable facilities etc .Date of re-training and new responsibilities to start 2-17-14 Persons Responsible: Community Services Director, QIDP and facility nurse.</p>				

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	<p>2. On 9/10/13 at 3:30 PM client B fell after being startled by another client causing a scrape to his right knee and "painful to stand on (sic)." Corrective action indicated on 9/22/13 the nurse evaluated client B's right knee and found a dime sized abrasion on his knee cap and swelling around his knee cap and discomfort when standing or walking. Client B was taken to a walk in clinic for evaluation.</p> <p>3. On 9/10/13 client B fell next to his bed after using the bathroom at 9:30 PM. Client B complained of pain in his knee. Corrective action indicated client B was being taken to a walk in medical clinic.</p> <p>4. On 10/2/13 client B fell causing a 1/2 inch cut above and on left side of his left eye. Client B was preparing for a shower when staff heard him cry out and found client B on his left side. "Staff discovered blood from the fall, and his face was bloody, bruised, and swollen. [Client B's] injuries was (sic) above and on the left side of his left eye. The nurse was contacted and she gave instruction." Corrective action indicated the nurse evaluated client B and found a 1/2 inch cut above his left eyebrow, and a nickel sized abrasion at the outside corner of his eye. Dark purple bruising was found around his eye with swelling. Staff were instructed to clean client B's eye area and apply ice for 30 minutes, give Tylenol and put antibiotic ointment and bandage over the cut.</p>			

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	<p>5. On 10/6/13 client B had a seizure while walking to the van and fell on his left side. Client B was found with scrapes to his left and right knee cap. Corrective action indicated the nurse evaluated his knees on 10/8/13 and found a small dime sized abrasion to each knee. "No further tx (treatment) needed."</p> <p>6. On 10/7/13 client B fell while walking to the medication room and "bumped his head and had a couple cuts on his forehead around left eye." Client B complained of pain in his left knee and it appeared to be swollen. Client B walked with a limp and staff notified the nurse. Corrective action indicated the nurse evaluated client B on 10/8/13 and found two 1/2 inch cuts between his eyebrows. No further treatment was needed. A note dated 10/8 (2013) indicated the residential nurse left a message with client B's neurologist about client B's continued falls and increase in seizures since the decrease in Onfi (seizure medication).</p> <p>7. On 10/13/13 client B fell during a seizure while in his closet and hit his head. Corrective action indicated client B received a 2 1/2 inch long cut on the inner corner of his left eyebrow. Corrective action indicated staff were instructed to give client B Tylenol, change the bandage twice daily and would be monitored. The QMRP indicated she reviewed the incident (undated).</p>						

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	<p>8. On 11/23/13 staff found client B lying on his right side on the floor next to the toilet. Staff responded after hearing him crying out "which is a warning of a seizure." Corrective action indicated the nurse evaluated him on 11/26/13 and found 3-4 small red areas to the top of his head. No treatment was needed. The QMRP reviewed the incident on 11/26/13.</p> <p>The QIDP was interviewed on 1/17/14 at 12:55 PM and indicated client B's falls with injury had not been reported to the BDDS.</p> <p>9-3-1(b)</p>			
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