STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G331	A. BUILDING 00 B. WING	01/15/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARENTS AND FRIENDS INC	1709 FARRAND AVE LA PORTE, IN 46350

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W000000	This visit was for a fundamental recertification and state licensure survey. Dates of Survey: January 8, 9, 10, 13, 14, and 15, 2014. Facility number: 000849 Provider number: 15G331 AIM number: 100243820 Surveyor: Tim Shebel, LSW The following federal deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 1/17/14 by Ruth Shackelford, QIDP.	W000000		
W000104	483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility. Based on record review, observation, and interview, the facility's governing body failed to exercise general operating direction over the facility to: 1. Ensure snow was removed from the running board of the group home van and the walkway area into the group home, and	W000104	Any remaining snow on the running boards of the van has beenremoved. A clear path has been shoveled from where the van parks leading to thegarage entrance. Much of the construction debris has been cleared, creating an8 foot wide clearance the length of the inside	02/21/2014

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	to ensure the area of the group home's garage was clear to walk through, and 2. Ensure direct care staff were trained to assist clients in ambulation for 1 of 4 sampled clients who had a history of falls (client #6). Findings include: The facility's records were reviewed on 1/8/13 at 2:17 P.M. A review of accident/incident reports from 6/1/13 to 1/8/14 indicated the following: _"Full Name: [client #6], Date & Time of Incident/Injury: 10-31-13, 5:55 A (A.M.) Describe how incident/injury occurred in detail: [Client #6] was walking from the garage w/ (with) his snack and tripped & fell onto his left knee." Further review of the incident report indicated client #6 was not injured in the fall. _"Full Name: [client #6], Date & Time of Incident/Injury: 9-3-13, 3:50pm. Describe how incident/injury occurred in detail: [Client #6] was climbing the steps from the garage and fell on the last one (step)." Further review of the incident report indicated client #6 was not injured in the fall. _"Full Name: [client #6], Date & Time		of the garage. Staff were allretrained on the sample client's fall risk plan and more specifically, theproper use of his gait belt. Staff havebeen instructed that during inclement weather they must ensure all clients areable to safely ambulate to and from the home and van. Staff were instructed toensure the running boards were free of snow and ice, walkways were free ofdebris, snow, ice, standing water or any other trip hazard. They were instructedto follow the instructions for gait belt use at all times, especially duringthe above mentioned times and when transitioning from one height to another orchange in surface texture. To ensure future compliance of this tag, theInterdisciplinary Team will be conducting ongoing "Group Home Environmental Observations"on a monthly basis. The observation will consist of at least two team memberswho will monitor the homes for maintenance, housekeeping and otherenvironmental needs/repairs. The team members will submit a list of needs tothe Residential Director who will then review the list with the maintenancesupervisor. For more immediate or urgentneeds, such as unexpected winter storms, the Residential Director will contactthe maintenance supervisor if he has not cleared the snow within a	

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	of Incident/Injury: 7-8-13, 4:00pm. Describe how incident/injury occurred in detail: [Client #6] was coming into the house from the garage when he tripped up the stairs coming in." Further review indicated client #6 received "a scrape on both shins" due to the fall. _"Name: [Client #6], Date: 6/24/13, Narrative: Monday, June 24th at 3:30pm, [client #6] fell coming in from the garage into the house. At that time a small abrasion on the left knee was noticed by staff, [direct care staff #1]. First aid was given at that time and a band aid was applied. Nurse was notified. Tuesday morning (6/25/13) the abrasion was observed by [direct care staff #1]. There was no bleeding or bruising at that time, however there was a small half inch area of broken skin. Another band aid was applied. Later that day after workshop, the area of skin that was initially abraded was now bleeding. [Client #6] was asked what happened and he said 'bumped it.' Tuesday evening the RN (registered nurse) looked at it, cleaned it up and put steri-strips on it. Staff kept noticing [client #6] picking at the steri-strips which caused the abrasion to open up even more. On Thursday morning (6/27/13) staff noticed that [client #6's] knee was bleeding again. It appeared		reasonableamount of time prior to the staff taking individuals out. The team will ensureall shovels, brooms and snow brushes for the vehicles are stored in aconvenient place so that staff may have access to them in an urgent situation. Further, the team will review all fall risk plans forclients who require assistance with ambulation and provide them with therespective retraining. (Responsible Parties: Stephenie Dreessen, ResidentialDirector; Jeff Rupe, QDDP; Ron Kuta, Maintenance Supervisor; Debi Hagglund,Residential Program Manager; Tori Penny, Team Leader)	

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	that he bumped it again and had continued to pick at it enough to require medical attention. Staff, [medical appointment staff #7] took [client #6] to urgent care this morning (6/27/13) where he received 3 stitches. The doctor stated the abrasion was in a difficult spot and may take time to heal due to the skin movement from bending the knee. He (physician) gave instructions for our agency nurse to remove the stitches in 7 days. [Client #6] went back to work this morning and did fine throughout the day. When asked how he is feeling, he said he is doing good. Plan to Resolve: Staff will continue to follow [client #6's fall risk plan. Staff will encourage [client #6] to slow down when he is walking and will be standing by to assist when he is using stairs. Staff will continue to monitor [client #6] and discourage him from picking at his knee." Client #6 was observed during the 1/8/13 group home observation period from 3:08 P.M. until 5:15 P.M. At 3:31 P.M., client #6, while exiting the van, stepped onto the running board of the group home van, slipped, and fell. Direct care staff #1 and #2 were not observed to assist client #6 in getting off the van. Direct care staff #1 assisted client #6 to his feet and visually checked			

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	the client for injuries. Client #6 stated to direct care staff #1 he was "okay" and the client continued into the group home by walking eight feet through 5 inches of drifted snow to the garage, through a narrow walkway in the garage, up the garage steps, and into the group home without further incident. At 3:35 P.M., the garage area was noted to be filled with boxes and remodeling debris (interior doors, lumber) and lawn care equipment. A narrow 28 inch walking area existed from the large garage door to the garage steps (18 feet) leading into the group home. Direct care staff #1 was interviewed on 1/8/14 at 3:42 P.M. When asked about the boxes and debris in the garage, direct care staff #1 stated, "We (the facility) have been doing some early spring cleaning and some remodeling. I know it's a narrow pathway into the house but we manage to get through." Client #6 was observed during the group home observation periods on 1/8/14 from 3:08 P.M. until 5:15 P.M., and on 1/9/14 from 5:42 A.M. until 7:17 A.M. During the group home observation periods, client #6 wore a gait belt and ambulated independently around the group home without needed assistance			

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	from staff. Client #6's record was reviewed on 1/13/14 at 9:58 A.M. The review of Fall Risk assessments dated 11/28/12 and 11/21/13 indicated client #6 had a history of falls and had been assessed as a "high risk" for falls. Client #6's 10/12/13 Nursing Quarterly indicated client #6 wore a gait belt and staff were to assist the client as necessary for safe ambulation and transfers. The facility records were reviewed on 1/13/14 at 9:11 A.M. Review of personnel records failed to indicate direct care staff who worked with client #6 at the group home were trained in assisting client #6 with his ambulation and transfer needs. Nurse #1 was interviewed on 1/13/14 at 1:47 P.M. Nurse #1 stated, "I have trained staff (direct care staff working at the group home) in assisting [client #6] when he needs it. I don't have documentation though to show that they (direct care staff) were trained on assisting [client #6]." Residential Director #1 was interviewed on 1/13/14 at 1:47 P.M.. Residential Director #1 stated it was the facility's "maintenance department's job to make			

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	sure the snow was cleared off the group home van's running board, driveway." Residential Director #1 indicated it was the facility's maintenance department's responsibility to ensure a clear walkway through the garage to the garage steps leading into the group home. 9-3-1(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, observation, and interview, the facility neglected to implement its abuse/neglect policy to protect 1 of 4 sampled clients (client #6) from falling by ensuring snow was removed from the running board of the group home van and the walkway area into the group home, to ensure the area of the group home's garage clear to walk through, by ensuring direct care staff were trained to assist clients in ambulation, and implementing effective corrective action to prevent falls for 1 of 4 sampled clients who had a history of falls (client #6). Findings include:	W000149	Any remaining snow on the running boards of the van has beenremoved. A clear path has been shoveled from where the van parks leading to thegarage entrance. Much of the construction debris has been cleared, creating an8 foot wide clearance the length of the inside of the garage. Staff were allretrained on the sample client's fall risk plan and more specifically, theproper use of his gait belt. Staff havebeen instructed that during inclement weather they must ensure all clients areable to safely ambulate to and from the home and van. They were instructed toensure the running boards were free of snow and ice, walkways were free	02/21/2014

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	The facility's records were reviewed on 1/8/13 at 2:17 P.M. A review of accident/incident reports from 6/1/13 to 1/8/14 indicated the following: _"Full Name: [client #6], Date & Time of Incident/Injury: 10-31-13, 5:55 A (A.M.) Describe how incident/injury occurred in detail: [Client #6] was walking from the garage w/ (with) his snack and tripped & fell onto his left knee." Further review of the incident report indicated client #6 was not injured in the fall. _"Full Name: [client #6], Date & Time of Incident/Injury: 9-3-13, 3:50pm. Describe how incident/injury occurred in detail: [Client #6] was climbing the steps from the garage and fell on the last one (step)." Further review of the incident report indicated client #6 was not injured in the fall. _"Full Name: [client #6], Date & Time of Incident/Injury: 7-8-13, 4:00pm. Describe how incident/injury occurred in detail: [Client #6] was coming into the house from the garage when he tripped up the stairs coming in." Further review indicated client #6 received "a scrape on both shins" due to the fall.		ofdebris, snow, ice, standing water or any other trip hazard. They wereinstructed to follow the instructions for gait belt use at all times andespecially during the above mentioned times and when transitioning from oneheight to another or a change in surface texture. To ensure future compliance of this tag, theInterdisciplinary Team will be conducting ongoing “Group Home EnvironmentalObservations” on a monthly basis. The observation will consist of at least twoteam members who will monitor the homes for maintenance, housekeeping and otherenvironmental needs/repairs. The team members will submit a list of needs tothe Residential Director who will then review the list with the maintenancesupervisor. For more immediate or urgentneeds, such as unexpected winter storms, the Residential Director will contactthe maintenance supervisor if he has not cleared the snow within a reasonableamount of time prior to the staff taking individuals out. The team will ensureall shovels, brooms and snow brushes for the vehicles are stored in aconvenient place so that staff may have access to them in an urgent situation. The safety Committee will create an electronic spreadsheetconsisting of all Incident/Injuries. The spreadsheet will be able to	

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	_"Name: [Client #6], Date: 6/24/13, Narrative: Monday, June 24th at 3:30pm, [client #6] fell coming in from the garage into the house. At that time a small abrasion on the left knee was noticed by staff, [direct care staff #1]. First aid was given at that time and a band aid was applied. Nurse was notified. Tuesday morning (6/25/13) the abrasion was observed by [direct care staff #1]. There was no bleeding or bruising at that time, however there was a small half inch area of broken skin. Another band aid was applied. Later that day after workshop, the area of skin that was initially abraded was now bleeding. [Client #6] was asked what happened and he said 'bumped it.' Tuesday evening the RN (registered nurse) looked at it, cleaned it up and put steri-strips on it. Staff kept noticing [client #6] picking at the steri-strips which caused the abrasion to open up even more. On Thursday morning (6/27/13) staff noticed that [client #6's] knee was bleeding again. It appeared that he bumped it again and had continued to pick at it enough to require medical attention. Staff, [medical appointment staff #7] took [client #6] to urgent care this morning (6/27/13) where he received 3 stitches. The doctor stated the abrasion was in a difficult spot and may take time to heal due to the skin		identifytrends immediately so quick action canbe taken to resolve problems. The incidents will be entered into thespreadsheet as they arrive to the PAF office and will be checked for trendseach time a new incident is added. All trends or other recurring issues willthen be communicated to the Interdisciplinary Team for resolution. (Responsible Parties: Stephenie Dreessen, ResidentialDirector; Jeff Rupe, QDDP; Matt Cunningham, Behavior Resource Specialist; MartiPizzinni, RN; Ron Kuta, Maintenance Supervisor; Debi Hagglund, ResidentialProgram Manager; Tori Penny, Team Leader; Safety Committee Members)	

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	movement from bending the knee. He (physician) gave instructions for our agency nurse to remove the stitches in 7 days. [Client #6] went back to work this morning and did fine throughout the day. When asked how he is feeling, he said he is doing good. Plan to Resolve: Staff will continue to follow [client #6's fall risk plan. Staff will encourage [client #6] to slow down when he is walking and will be standing by to assist when he is using stairs. Staff will continue to monitor [client #6] and discourage him from picking at his knee." Client #6 was observed during the 1/8/13 group home observation period from 3:08 P.M. until 5:15 P.M. At 3:31 P.M., client #6, while exiting the van, stepped onto the running board of the group home van, slipped, and fell. Direct care staff #1 and #2 were not observed to assist client #6 in getting off the van. Direct care staff #1 assisted client #6 to his feet and visually checked the client for injuries. Client #6 stated to direct care staff #1 he was "okay" and the client continued into the group home by walking eight feet through 5 inches of drifted snow to the garage, through a narrow walkway in the garage, up the garage steps, and into the group home without further incident.			

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At 3:35 P.M., the garage area was noted to be filled with boxes and remodeling debris (interior doors, lumber) and lawn care equipment. A narrow 28 inch walking area existed from the large garage door to the garage steps (18 feet) leading into the group home.

Direct care staff #1 was interviewed on 1/8/14 at 3:42 P.M. When asked about the boxes and debris in the garage, direct care staff #1 stated, "We (the facility) have been doing some early spring cleaning and some remodeling. I know it's a narrow pathway into the house but we manage to get through."

Client #6 was observed during the group home observation periods on 1/8/14 from 3:08 P.M. until 5:15 P.M., and on 1/9/14 from 5:42 A.M. until 7:17 A.M. During the group home observation periods, client #6 wore a gait belt and ambulated independently around the group home without needed assistance from staff.

Client #6's record was reviewed on 1/13/14 at 9:58 A.M. The review of Fall Risk assessments dated 11/28/12 and 11/21/13 indicated client #6 had a history of falls and been assessed as a "high risk" for falls. Client #6's

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	10/12/13 Nursing Quarterly indicated client #6 wore a gait belt and staff were to assist the client as necessary for safe ambulation and transfers. Review of client #6's Individual Program Plan, dated 7/16/13, failed to indicate an effective plan or program had been developed and implemented to address client #6's falls. QIDP (Qualified Intellectual Disabilities Professional) #1 was interviewed on 1/13/14 at 1:30 P.M. QIDP #1 stated, "We are trying to keep [client #6] from falling and will keep working on ways to keep him from falling." The facility records were reviewed on 1/13/14 at 9:11 A.M. Review of personnel records failed to indicate direct care staff who worked with client #6 at the group home were trained in assisting client #6 with his ambulation and transfer needs. Nurse #1 was interviewed on 1/13/14 at 1:47 P.M. Nurse #1 stated, "I have trained staff (direct care staff working at the group home) in assisting [client #6] when he needs it. I don't have documentation though to show that they (direct care staff) were trained on assisting [client #6]."			

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	Residential Director #1 was interviewed on 1/13/14 at 1:47 P.M.. Residential Director #1 stated it was the facility's "maintenance department's job to make sure the snow was cleared off the group home van's running board, driveway." Residential Director #1 indicated it was the facility's maintenance department's responsibility to ensure a clear walkway through the garage to the garage steps leading into the group home. The facility's records were further reviewed on 1/14/14 at 9:08 A.M. Review of the facility's "Adult Protective Policy", dated 4/08, indicated, in part, the following: "PAF prohibits mistreatment, neglect, or abuse of a consumer (client) by any employee." 9-3-2(a)			
W000157	483.420(d)(4) STAFF TREATMENT OF CLIENTS If the alleged violation is verified, appropriate corrective action must be taken. Based on record review, observation, and interview, the facility failed to implement effective corrective action to prevent falls for 1 of 4 sampled clients who had a history of falls (client #6).	W000157	On January 16, 2014 staff were retrained on the proper useof the individual's gait belt. Staff were instructed to use side by sideassistance when the individual is ambulating. Previous physical therapy evaluations foundthe client was a poor	02/21/2014

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	Findings include: The facility's records were reviewed on 1/8/13 at 2:17 P.M. A review of accident/incident reports from 6/1/13 to 1/8/14 indicated the following: _"Full Name: [client #6], Date & Time of Incident/Injury: 10-31-13, 5:55 A (A.M.) Describe how incident/injury occurred in detail: [Client #6] was walking from the garage w/ (with) his snack and tripped & fell onto his left knee." Further review of the incident report indicated client #6 was not injured in the fall. _"Full Name: [client #6], Date & Time of Incident/Injury: 9-3-13, 3:50pm. Describe how incident/injury occurred in detail: [Client #6] was climbing the steps from the garage and fell on the last one (step)." Further review of the incident report indicated client #6 was not injured in the fall. _"Full Name: [client #6], Date & Time of Incident/Injury: 7-8-13, 4:00pm. Describe how incident/injury occurred in detail: [Client #6] was coming into the house from the garage when he tripped up the stairs coming in." Further review indicated client #6 received "a scrape on both shins" due to the fall.		candidate for a standard walker. We will request anotherphysical therapy evaluation to determine what alternate assistive devices couldbe used. Maintenance will evaluate the possibility of a modification to theexisting steps that lead from the garage to the house.To ensure future compliance of this tag the safety Committeewill create an electronic spreadsheet consisting of all Incident/Injuries. Thespreadsheet will be able to identify trends immediately so quick action can betaken to resolve problems. The incidents will be entered into the spreadsheetas they arrive to the PAF office and will be checked for trends each time a newincident is added. All trends or other recurring issues will then becommunicated to the Interdisciplinary Team for resolution. A record review of all clients with a fallrisk plan will be completed and all staff will be trained on the specificplans. The Interdisciplinary Team will complete ongoing “Group HomeEnvironmental Observations” on a monthly basis, at least. During theseobservations the team will identify any trip hazards or significant transitionin surface that could result in a fall and ensure the outside and garagewalkways are clear. (Responsible Parties: Stephenie Dreessen, ResidentialDirector; Jeff Rupe,	

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	_"Name: [Client #6], Date: 6/24/13, Narrative: Monday, June 24th at 3:30pm, [client #6] fell coming in from the garage into the house. At that time a small abrasion on the left knee was noticed by staff, [direct care staff #1]. First aid was given at that time and a band aid was applied. Nurse was notified. Tuesday morning (6/25/13) the abrasion was observed by [direct care staff #1]. There was no bleeding or bruising at that time, however there was a small half inch area of broken skin. Another band aid was applied. Later that day after workshop, the area of skin that was initially abraded was now bleeding. [Client #6] was asked what happened and he said 'bumped it.' Tuesday evening the RN (registered nurse) looked at it, cleaned it up and put steri-strips on it. Staff kept noticing [client #6] picking at the steri-strips which caused the abrasion to open up even more. On Thursday morning (6/27/13) staff noticed that [client #6's] knee was bleeding again. It appeared that he bumped it again and had continued to pick at it enough to require medical attention. Staff, [medical appointment staff #7] took [client #6] to urgent care this morning (6/27/13) where he received 3 stitches. The doctor stated the abrasion was in a difficult spot		QDDP; Matt Cunningham, Behavior Resource Specialist; MartiPizzinni, RN; Ron Kuta, Maintenance Supervisor; Debi Hagglund, ResidentialProgram Manager; Tori Penny, Team Leader; Safety Committee Members)	

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	and may take time to heal due to the skin movement from bending the knee. He (physician) gave instructions for our agency nurse to remove the stitches in 7 days. [Client #6] went back to work this morning and did fine throughout the day. When asked how he is feeling, he said he is doing good. Plan to Resolve: Staff will continue to follow [client #6's fall risk plan. Staff will encourage [client #6] to slow down when he is walking and will be standing by to assist when he is using stairs. Staff will continue to monitor [client #6] and discourage him from picking at his knee." Client #6 was observed during the 1/8/13 group home observation period from 3:08 P.M. until 5:15 P.M. At 3:31 P.M., client #6, while exiting the van, stepped onto the running board of the group home van, slipped, and fell. Direct care staff #1 and #2 were not observed to assist client #6 in getting off the van. Direct care staff #1 assisted client #6 to his feet and visually checked the client for injuries. Client #6 stated to direct care staff #1 he was "okay" and the client continued into the group home by walking eight feet through 5 inches of drifted snow to the garage, through a narrow walkway in the garage, up the garage steps, and into the group home			

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	without further incident. Client #6 was observed during the group home observation periods on 1/8/14 from 3:08 P.M. until 5:15 P.M., and on 1/9/14 from 5:42 A.M. until 7:17 A.M. During the group home observation periods, client #6 wore a gait belt and ambulated independently around the group home without needed assistance from staff. Client #6's record was reviewed on 1/13/14 at 9:58 A.M. The review of Fall Risk assessments dated 11/28/12 and 11/21/13 indicated client #6 had a history of falls and been assessed as a "high risk" for falls. Client #6's 10/12/13 Nursing Quarterly indicated client #6 wore a gait belt and staff were to assist the client as necessary for safe ambulation and transfers. Review of client #6's Individual Program Plan, dated 7/16/13, failed to indicate an effective plan or program had been developed and implemented to address client #6's falls. QIDP (Qualified Intellectual Disabilities Professional) #1 was interviewed on 1/13/14 at 1:30 P.M. QIDP #1 stated, "We are trying to keep [client #6] from falling and will keep working on ways to keep him from falling."			

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	9-3-2(a)			
W000192	483.430(e)(2) STAFF TRAINING PROGRAM For employees who work with clients, training must focus on skills and competencies directed toward clients' health needs. Based on record review, observation, and interview, the facility failed to ensure direct care staff were trained to assist 1 of 4 sampled clients, (client #6) who had a history of falls, with ambulation. Findings include: The facility's records were reviewed on 1/8/13 at 2:17 P.M. A review of accident/incident reports from 6/1/13 to 1/8/14 indicated the following: _"Full Name: [client #6], Date & Time of Incident/Injury: 10-31-13, 5:55 A (A.M.) Describe how incident/injury occurred in detail: [Client #6] was walking from the garage w/ (with) his snack and tripped & fell onto his left knee." Further review of the incident report indicated client #6 was not injured in the fall.	W000192	On January 16, 2014, staff were trained on the individual'sfall risk plan and specifically the proper use of his gait belt. Staff inattendance signed a training roster. Staff were instructed to be stand byassisting this individual during ambulation. To ensure future compliance of this tag, theinterdisciplinary team will set up an annual schedule to retrain staff on allrisk plans and any other medical conditions requiring special attention by thestaff. Additional training will be provided to staff for risk plan changes andother health status changes on an as needed basis. Staff trainingrosters/signature sheets will continue to be kept in the employee training fileand the client file. The Safety Committee will also make recommendations to theIDT when they discover trends that may be corrected with additional training. (Responsible Parties: Stephenie Dreessen, ResidentialDirector; Jeff Rupe, QDDP; Matt Cunningham,	02/21/2014

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	_"Full Name: [client #6], Date & Time of Incident/Injury: 9-3-13, 3:50pm. Describe how incident/injury occurred in detail: [Client #6] was climbing the steps from the garage and fell on the last one (step)." Further review of the incident report indicated client #6 was not injured in the fall. _"Full Name: [client #6], Date & Time of Incident/Injury: 7-8-13, 4:00pm. Describe how incident/injury occurred in detail: [Client #6] was coming into the house from the garage when he tripped up the stairs coming in." Further review indicated client #6 received "a scrape on both shins" due to the fall. _"Name: [Client #6], Date: 6/24/13, Narrative: Monday, June 24th at 3:30pm, [client #6] fell coming in from the garage into the house. At that time a small abrasion on the left knee was noticed by staff, [direct care staff #1]. First aid was given at that time and a band aid was applied. Nurse was notified. Tuesday morning (6/25/13) the abrasion was observed by [direct care staff #1]. There was no bleeding or bruising at that time, however there was a small half inch area of broken skin. Another band aid was applied. Later that day after workshop, the area of skin		Behavior Resource Specialist; MartiPizzinni, RN; Debi Hagglund, Residential Program Manager; Tori Penny, TeamLeader; Safety Committee Members)	

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	that was initially abraded was now bleeding. [Client #6] was asked what happened and he said 'bumped it.' Tuesday evening the RN (registered nurse) looked at it, cleaned it up and put steri-strips on it. Staff kept noticing [client #6] picking at the steri-strips which caused the abrasion to open up even more. On Thursday morning (6/27/13) staff noticed that [client #6's] knee was bleeding again. It appeared that he bumped it again and had continued to pick at it enough to require medical attention. Staff, [medical appointment staff #7] took [client #6] to urgent care this morning (6/27/13) where he received 3 stitches. The doctor stated the abrasion was in a difficult spot and may take time to heal due to the skin movement from bending the knee. He (physician) gave instructions for our agency nurse to remove the stitches in 7 days. [Client #6] went back to work this morning and did fine throughout the day. When asked how he is feeling, he said he is doing good. Plan to Resolve: Staff will continue to follow [client #6's fall risk plan. Staff will encourage [client #6] to slow down when he is walking and will be standing by to assist when he is using stairs. Staff will continue to monitor [client #6] and discourage him from picking at his knee."			

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	Client #6 was observed during the 1/8/13 group home observation period from 3:08 P.M. until 5:15 P.M. At 3:31 P.M., client #6, while exiting the van, stepped onto the running board of the group home van, slipped, and fell. Direct care staff #1 and #2 were not observed to assist client #6 in getting off the van. Direct care staff #1 assisted client #6 to his feet and visually checked the client for injuries. Client #6 stated to direct care staff #1 he was "okay" and the client continued into the group home by walking eight feet through 5 inches of drifted snow to the garage, through a narrow walkway in the garage, up the garage steps, and into the group home without further incident. Client #6 was observed during the group home observation periods on 1/8/14 from 3:08 P.M. until 5:15 P.M., and on 1/9/14 from 5:42 A.M. until 7:17 A.M. During the group home observation periods, client #6 wore a gait belt and ambulated independently around the group home without needed assistance from staff. Client #6's record was reviewed on 1/13/14 at 9:58 A.M. The review of Fall Risk assessments dated 11/28/12 and 11/21/13 indicated client #6 had a			

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	history of falls and been assessed as a "high risk" for falls. Client #6's 10/12/13 Nursing Quarterly indicated client #6 wore a gait belt and staff were to assist the client as necessary for safe ambulation and transfers. Review of client #6's Individual Program Plan, dated 7/16/13, failed to indicate an effective plan or program had been developed and implemented to address client #6's falls. The facility records were reviewed on 1/13/14 at 9:11 A.M. Review of personnel records failed to indicate direct care staff who worked with client #6 at the group home were trained in assisting client #6 with his ambulation and transfer needs. Nurse #1 was interviewed on 1/13/14 at 1:47 P.M. Nurse #1 stated, "I have trained staff (direct care staff working at the group home) in assisting [client #6] when he needs it. I don't have documentation though to show that they (direct care staff) were trained on assisting [client #6]." 9-3-3(a)			

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W000312	483.450(e)(2) DRUG USAGE Drugs used for control of inappropriate behavior must be used only as an integral part of the client's individual program plan that is directed specifically towards the reduction of and eventual elimination of the behaviors for which the drugs are employed. Based on record review and interview, the facility failed to assure psychotropic drug usage was addressed in the Individual Program Plan of 1 of 4 sampled clients (client #2) with a Behavior Modification Program. Findings include: Client #2's records were reviewed on 1/13/14 at 10:07 A.M. A review of the client's 12/23/13 Physician Orders indicated client #2 was receiving Zyprexa (mood stabilizing medication) for Mood Disorder. Client #2's records were further reviewed on 1/13/14 at 10:14 A.M. A review of the client's 6/26/13 Individual Program Plan and his 8/30/13 Behavior Modification Program failed to indicate the use of Zyprexa was addressed in the client's active treatment program. Behavior Specialist #1 was interviewed on 1/13/14 at 1:04 P.M. Behavior Specialist #1 indicated client #2's use of	W000312	The Behavior Management Plan has been updated to include thepsychotropic medication in question. A review of all other Behavior SupportPlans has been completed and compared to the psychotropic medication list foreach individual. No other issues were discovered. To ensure future compliance of this tag, the BehaviorSupport Specialist will review all psychotropic medications, used to modifybehaviors, at the annual case conferences or when there is a medication changeand ensure they are addressed in the Behavior Support Plans. (Responsible Parties: Stephenie Dreessen, ResidentialDirector; Matt Cunningham, Behavior Support Specialist; Marti Pizzinni, RN;Jeff Rupe, QDDP)	02/21/2014

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	Zyprexa had not been incorporated into his Individual Program Plan. 9-3-5(a)			
W000436	483.470(g)(2) SPACE AND EQUIPMENT The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client. Based on observation, record review, and interview, the facility failed to encourage and teach 1 of 2 sampled clients who wore eyeglasses (client #2) to wear his prescribed eyeglasses. Findings include: Client #2 was observed at the group home during the 1/8/14 observation period from 3:08 P.M. until 5:15 P.M. and on 1/9/14 from 5:42 A.M. until 7:17 A.M. During the observation periods, client #2 did not wear his eyeglasses nor did direct care staff #1, #2, #3, and #4 prompt or assist client #2 to wear his eyeglasses. Client #2's record was reviewed on 1/13/14 at 10:07 A.M. A review of the	W000436	On January 16, 2014, staff were trained and reminded thatthey must routinely prompt individuals to use their adaptive devices andexplain the natural benefits and consequences associated with their decision. To ensure future compliance of this tag systemically, theQDDP will provide a training with all staff on how to properly promptindividuals to make informed choices as they relate to adaptive devices. Staffwill be reminded that it is their duty to provide individuals with routineprompting to use their adaptive devices. Staff will also be trained to notifythe IDT right away if they find an individual suddenly begins to refuse to useadaptive devices they have grown accustomed to wearing regularly. In thatsituation the IDT will assess the devicefor it's effectiveness or need for repair.	02/21/2014

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	client's 7/25/13 vision exam indicated client #2 was to be "wearing glasses." QIDP (Qualified Intellectual Disabilities Professional) #1 was interviewed on 1/13/14 at 1:30 P.M. QIDP #1 stated, "[Client #2] should be wearing his glasses and staff (direct care staff #1, #2, #3, and #4) should prompt him to wear them." 9-3-7(a)		(Responsible Parties: Stephenie Dreessen, ResidentialDirector; Jeff Rupe, QDDP; Matt Cunningham, Behavior Resource Specialist; MartiPizzinni, RN; Ron Kuta, Maintenance Supervisor; Debi Hagglund, ResidentialProgram Manager; Tori Penny, Team Leader; Safety Committee Members)	