COMMUNITY VENTURES IN LIVING, LTD

Annual Individual Paperwork Requirements

RESPONSIBILITY STATEMENT

The following paperwork needs to be filled out and ready to turn in to your Program Director at the time of the annual.

The lead CSC is responsible for having all the paperwork before the meeting, if something is needed, please let the home office know.

The lead CSC is responsible for all copies going into the home files.

PAPERWORK REQUIREMENTS

The paperwork needed includes, but not limited to:

- ☐ Quarterly Individual Review*
- ☐ Individual Information Form (InFocus > reports > individual sheet) (*review current, completed copy)*
- ☐ Emergency Plan (*review current, completed copy)*
- ☐ Emergency Evacuation Log* (*review current, completed copy)*
- ☐ Emergency Phone Numbers*
- ☐ Back-up Plan*
- ☐ Emergency Treatment Services Consent*
- ☐ Individual Rights*
- ☐ Individual Specific Training and High-Risk Plan Form (*review current, completed copy)*
- ☐ Risk Issues Identification Tool, Risk Analysis and Planning Tool
- ☐ Consents*
- ☐ Agency Service Survey*
- ☐ Updated Seizure Plan as needed*
- ☐ Privacy Practices Acknowledgement (HIPAA)*
- ☐ Individual Specific Medication Administration*
- ☐ Credit History Consent*
- ☐ Personal Preference Profile (P3) (*review current, completed copy)*
- ☐ Home Environment Checklist

**** items included in Annual Packet***

I have completed these requirements for _____ (Individual's Name)	
Lead CSC Signature:	**Date:**

COMMUNITY VENTURES IN LIVING, LTD

Quarterly Individual Review - Report Checklist

INDIVIDUAL SERVED: _____ **REVIEW DATE:** _____

RESPONSIBILITY STATEMENT

Each quarter the lead CSC is responsible to assure that the following review is completed with each of their individuals served. While in most instances this can be done in conjunction with a quarterly team meeting, if such a meeting does not take place the review may be completed with the individual and the lead CSC or their designee.

REVIEW REQUIREMENTS

Areas of Review Checklist – *Please use Recommendations Area to provide detail on any underlined responses*

☐Medical Condition: ☐ stable ☐ unstable ☐ continue ☐ revise
☐Free from unnecessary medications: ☐ yes ☐ no ☐ n/a
☐Free from unnecessary restrictions: ☐ yes ☐ no ☐ n/a
☐Opportunity to reduce medication dependence: ☐ yes ☐ no ☐ n/a
☐Opportunity to reduce restriction dependence: ☐ yes ☐ no ☐ n/a
☐Behavior Status: ☐ stable ☐ unstable ☐ continue ☐ revise
☐Developmental Status: ☐ stable ☐ unstable ☐ continue ☐ revise
☐Mental Health Status: ☐ stable ☐ unstable ☐ continue ☐ revise
☐Instructional Techniques: ☐ appropriate ☐ revise
☐Risk Plan / CST: ☐ appropriate ☐ revise

☐**Completed Annually**
☐ P3 ☐ Home Assessment ☐ Physical ☐ Dental
☐ Emergency Evacuation Log ☐ POM (as assigned)

☐Accepts Risk of Treatment: ☐ yes ☐ no – has been discussed with the individual in their usual mode of communication and they understand _____ (witness initials)
☐Wants to exercise Right to Refuse Treatment: ☐ yes ☐ no has been discussed with the individual in their usual comm. mode and they understand _____ (witness initials)
☐Opportunity to attend Human Rights Committee: ☐ yes ☐ no

☐**Additional Support Needs:**
– Financial (payee): ☐ yes ☐ no ☐ continue ☐ revise
– Guardianship: ☐ yes ☐ no ☐ continue ☐ revise
– Advocacy: ☐ yes ☐ no ☐ continue ☐ revise
– Advance Directives: ☐ yes ☐ no ☐ continue ☐ revise

Recommendations	
	Action Items:

Evaluation of Recommendations of Previous Review dated: _____	
	Action Items:

Recommendations from Personal Preference Profile/Personal Outcome Interview	
	Action Items:

Review Team Present	
Name/Signature	Affiliation

COMMUNITY VENTURES IN LIVING, LTD

Individual Information Form

First Name * | Middle Name | Last Name * | Gender * | SSN Last 5 * | DOB *

Medicaid # * | Medicare # | Region | Date Enrolled | Legal Status * | Waiver *

Contact *

Address | Phone | County

Emergency Contact *

Name | Address | Phone

Guardian *

Guardian | Address | Phone

Services Available

End of Contract(s)

Personal Supports

Case Manager

Case Manager | Address | Email | Cell | Fax

BDDS District / # | BDDS Service Coordinator | BDDS Service Coordinator - Email

Representative Payee / Trustee

Representative Payee / Trustee / Financial Support | Address | Phone

Residential Supports

Staff | Leads | Managers | Directors

Landlord

Landlord	Address	Phone

Employment

Employment	Address	Email	Phone

Day Services

Day Service	Address	Email	Phone

Behavior Specialist

Name	Address	Email	Phone

Medical Information

Physician *

Physician	Address	Phone

Last Medical Visits

Physical	Dental	Vision

Medical/Disability Concerns *	Special Precautions *	Allergies *
Medical Notes *		

Medical Supports

Name	Specialty	Contact	Notes

Medications

Comments or Other Information

Client Contact Notes

COMMUNITY VENTURES IN LIVING, LTD

Emergency Plan

INDIVIDUAL NAME: _____ **DATE**: _____

ADDRESS: _____

FIRE SAFETY

☐ INSTALL SMOKE DETECTORS AND A WORKING FIRE EXTINGUISHER IN YOUR HOME.

☐ PRACTICE A FIRE DRILL AT LEAST ONCE PER MONTH.

☐ IF YOU OR SOMEONE ELSE CATCHES FIRE, FOLLOW STOP, DROP AND ROLL TECHNIQUES:

- **STOP**; DO NOT RUN
- **DROP** TO THE FLOOR (COVER FACE WITH HANDS)
- **ROLL** OVER AND OVER TO SMOTHER THE FLAMES

FIRE EMERGENCY PLAN

IDENTIFY TWO ESCAPE ROUTES FROM YOUR HOME:

1. _____

2. _____

WHERE WILL YOU MEET ONCE YOU ARE OUTSIDE THE HOME?

_____

_____

_____

TORNADO SAFETY

☐ SEEK SHELTER ON THE LOWEST FLOOR OF YOUR HOME OR CURRENT BUILDING.

☐ IF YOUR HOME OR BUILDING DOES NOT HAVE A BASEMENT, SEEK SHELTER IN INTERIOR SPACES WITH NO WINDOWS (BATHROOM OR CLOSET)

☐ IF POSSIBLE, SIT/SQUAT AND USE YOUR ARMS TO PROTECT YOUR HEAD FROM FLYING OBJECTS

TORNADO EMERGENCY PLAN

IN THE EVENT OF A TORNADO, IDENTIFY THE TWO SAFEST LOCATIONS IN YOUR HOME OR BUILDING:

1. _____

2. _____

NATURAL GAS SAFETY

☐ A GAS LEAK SMELLS SIMILAR TO ROTTEN EGGS; THIS IS YOUR WARNING TO LEAVE THE HOME.

☐ INSTALL CARBON MONOXIDE DETECTORS IN YOUR HOME. AN ALARM WILL SOUND IF CARBON MONOXIDE IS DETECTED.

NATURAL GAS LEAK EMERGENCY PLAN

IF YOU THINK YOU MAY HAVE A LEAK OR YOUR CARBON MONOXIDE DETECTOR GOES OFF, DO THE FOLLOWING:

1. IF POSSIBLE, OPEN DOORS AND WINDOWS
2. LEAVE YOUR HOME IMMEDIATELY
3. CALL YOUR GAS COMPANY (FROM OUTSIDE THE HOME)

GAS COMPANY PHONE #: _____

Emergency Evacuation Log

Community Ventures in Living

Individual Served: _____

Address: _____

Support Professional (Print Name)	Initials	Date	Time	Notes or issues	Drill Type		Equipment Check		
					Gas Leak / Fire Drill	Tornado Drill	Carbon Monoxide Detector	Smoke Detector	Fire Extinguisher

Update this sheet after completing the Emergency Evacuation Drill webform (**www.cvl-in.org/emergency-evacuation-drill**) for a monthly Drills and Equipment Check.
Complete the Drill/Check information and select corresponding box for type of drill and /or equipment check.
If there are any issues such as an unsuccessful drill, equipment failure, or general comments, check the column '*Notes or Issues*' and describe issue fully in the webform.
As part of the individual's care team it is important to make sure that the individual served, to the best of their ability, understands safety precautions and their equipment.
Please document any areas where improvement can be made to ensure an individual's safety.
In order to maintain safety standards, individuals should be assisted in a minimum of the following inspections:
(6) Fire Drills, (6) Tornado Drills, (4) Carbon Monoxide, (9) Smoke Detector, (2) Fire Extinguisher

COMMUNITY VENTURES IN LIVING, LTD

Emergency Phone Numbers

INDIVIDUAL NAME: _____ **PHONE NUMBER:** _____

HOME ADDRESS: _____

POLICE OR FIRE: 911

COMMUNITY VENTURES IN LIVING, LTD		**765-449-0784**
COMMUNITY VENTURES IN LIVING, LTD		**1-800-474-2571**
BDDS SERVICE COORDINATOR		
WAIVER OMBUDSMAN		
ADULT PROTECTIVE SERVICES		**1-800-992-6978**
CHILD PROTECTIVE SERVICES		**1-800-422-4453**
POISON CONTROL		**1-800-222-1222**
WAIVER CASE MANAGER		
BEHAVIORIST		

EMERGENCY CONTACTS

COMMUNITY VENTURES IN LIVING, LTD

Life Sharing / Support Back-up Plan

SUPPORT PERSON: _____ **INDIVIDUAL SERVED:** _____

BACK-UP SUPPORT: _____ **PHONE NUMBER:** _____

ADDRESS: _____

BACK-UP PLAN OVERVIEW

This section should include the location where back-up services intend to be provided; whether the provider of back-up services is employed by CVL, a natural support or other; any other relevant information or instruction.

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____ _____

SIGNATURE, SUPPORT PERSON / DATE **SIGNATURE, BACK-UP SUPPORT / DATE**

COMMUNITY VENTURES IN LIVING, LTD

Emergency Treatment Services Consent

INDIVIDUAL NAME: _____

This document authorizes the Representatives of Community Ventures in Living to have my full and free consent to procure any medical care that may be required for emergencies in the areas of medical, dental, mental health and surgical services that may be deemed necessary for my health and welfare.

_____ _____

SIGNATURE OF INDIVIDUAL **DATE**

_____ _____

SIGNATURE OF PARENT OR GUARDIAN **DATE**

_____ _____

SIGNATURE OF WITNESS **DATE**

COMMUNITY VENTURES IN LIVING, LTD

Individual Rights Statement and Policy

INDIVIDUAL NAME: _____ DATE: _____

POLICY STATEMENT

Community Ventures in Living, Ltd (CVL) is committed to providing services in a manner that protects the rights of each individual and encourages an individual to exercise those rights when he or she so desires.
CVL will ensure that an individual's rights as guaranteed by the Constitution of the United States, the Constitution of Indiana and the United Nations statement on human rights are not infringed upon. CVL will provide a copy of this Individual Rights Statement Policy to the individual and/or individual's representative at the initial service establishment and in no case more than seven (7) days after providing services to the individual.

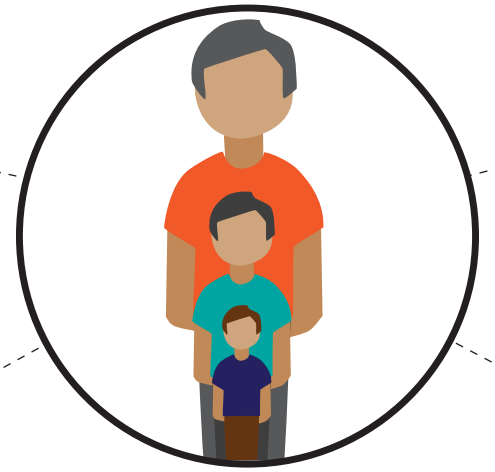
PROCEDURE

CVL will assure that every individual has the right to:

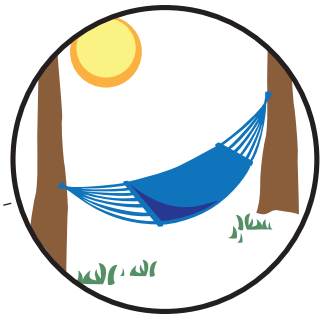
1. receive information necessary to give informed consents prior to the start of any service, and;
2. refuse treatments, intervention and services, and;
3. humane care and protection from harm, and;
4. be encouraged and assisted to submit complaints or recommendations concerning the policies and services of Community Ventures in Living, its Executive Director, Director of Quality, Program Directors, CSC or other employees, without fear of negative consequences to their services at 765.449.0784, and;
5. be treated with consideration, respect and to receive full recognition of dignity and individuality, and;
6. be protected from maltreatment, abuse, exploitation, or neglect. Any alleged violation of this right is to be reported to the agency's Executive Director and will be investigated, and;
7. be given privacy during the care of personal needs, and;
8. have records and service treated confidentially, including name, personal/family information and agency records. Also, to give written consent before information from records may be released to someone not otherwise authorized by law to receive it, and;
9. examine and copy records, at their expense, in accordance with applicable laws and proper notice, and;
10. be informed of anticipated termination of service or plans for the transfer of service to another agency, and;
11. have property treated with respect, and;
12. temporarily suspend, permanently terminate, temporarily add, and permanently add services in the service plan, and;
13. file grievances regarding services furnished or regarding the lack of respect for property by the personal services agency and is not subject to discrimination or reprisal for filing a grievance, and;
14. be free from verbal, physical, and psychological abuse and to be treated with dignity, and;
15. know that CVL office hours are Monday through Thursday 8:00am to 4:30 pm, Friday 8:00am to 2:00pm and our offices are closed Saturdays, Sundays, and all national holidays. Any changes in office hours will be communicated in writing to the individual at their home address, and that the CVL office contact information is:
    i. Office Address is: 60 Professional Court, Lafayette Indiana 47905
    ii. Office phone number is: 765.449.0784.
    iii. Toll free number is: 800.474.2571
    iv. Fax number is: 888.901.4782
16. know that CVL has a manager On-call after normal business hour and can be reached by calling: 765.449.0784 or 800.474.2571.

I have received a copy of these rights as an individual of CVL services.	
Individual or Individual's Rep Signature:	Date:
CVL Employee or Witness Signature:	Date:

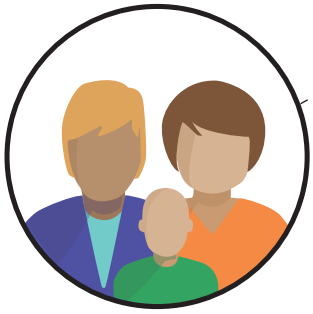
TYPICAL LIFE CYCLE



Work & Fair Pay



Leisure & Rest



Marriage & Children

Equal Education

HEALTH & SAFETY

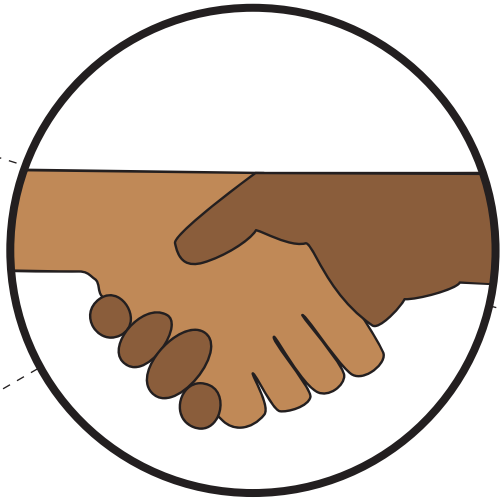
Access to Healthcare

Food Shelter & Clothing

Freedom from Harm

DIGNITY & RESPECT

Control of Finances



Privacy

Due Process

CHOICES & DECISIONS

Assembly & Association

Freedom of Religion

Freedom of Speech

Right to Vote & Citizenship

Posession & Ownership

Community Ventures in Living

Individual Training Layout

Individual: _____

Plan Reviewed: _____

Plan Updated: _____

Authorized By: _____

Individual Specific Training	
Dietary:	**Other Resources:**
•	•
Behavioral Support:	**Other Resources:**
•	•
Ambulation:	**Other Resources:**
•	•
Communication:	**Other Resources:**
•	•
Personality:	**Other Resources:**
•	•
Medical:	**Other Resources:**
•	•
Personal Care:	**Other Resources:**
•	•
Other:	**Other Resources:**
•	•

Community Ventures in Living

Individual Training Layout

Individual: _____

Plan Reviewed: _____

Plan Updated: _____

Authorized By: _____

Risk	Background / Baseline	Assessment / Outcome	Planning and Implementation	Evaluation
Identify specific risk area	Describe why the risk is a risk and why intervention is required	Describe the desired outcomes and illustrate what a successful plan looks like	Specify actions those working with the individual will take to ensure desired outcomes are accomplished	Describe responsibilities required to ensure the plan is adequate, followed, and updated as needed
•	•	•	•	•
•	•	•	•	•
•	•	•	•	•
•	•	•	•	•
•	•	•	•	•
•	•	•	•	•
•	•	•	•	•
•	•	•	•	•

Risk Issues Identification Tool

Name of Individual:	
Annual Meeting Date:	
Date Completed:	

Provider Name:	**Service(s):**
Name of Person Completing this Form:	**Role:**

Directions: When using this tool it should be completed by **all IST members** supporting the person noted above prior to the annual team meeting. The Case Manager will need this tool **no less than 5 days** prior to the annual team meeting date.

- Identify individual risks that are **specific to the Individual.**
- Include factual and detailed information as to why the noted area **currently** presents a particular risk to this Individual, or how the issue has presented **significant** risk in the past and might impact the Individual currently.
- You may include a recommended strategy for managing or eliminating the risk, if desired.
- During the annual team meeting, decisions and plans, if needed, will be made around each risk identified.

I. Individual Risks: Relevant to Health

✓	Identified Risk Issue	Describe the incident(s) or issue(s) that indicates this as a current Risk?	Is this risk issue addressed somewhere now? If so, how?
	Lack of Mobility: - Lack of mobility that could result in skin breakdown/pressure sores. - Substantially limits access to home or community.		
	Significant weight gain/loss or change in eating patterns: - Excessive weight loss or gain within the reporting year that is not intentional. - Weight loss so excessive that could be related to additional concerns. - Eating habits or patterns have changed to include loss or increase in appetite, not eating the foods that they had previously liked, coughing while eating, experiencing difficulty chewing or swallowing etc.		
	Choking and/or aspiration or swallowing disorders: - Has a diagnosis of dysphagia (difficulty swallowing) or demonstrates problems with swallowing, choking, refuses to eat or coughs while eating etc. - Has been treated for aspiration pneumonia		
	Inability to tolerate a medical examination/procedure: - Due to apprehension, fear, medical condition, previous unpleasant experiences etc. the person is unable to tolerate a medical examination or procedure. This might include dental visits, intrusive procedures, or responds negatively to any type of medical intervention for reasons unknown.		
	Increased or unusual falls: - Increased or unusual falling that results in injury such as fractures or severe injury.		
	Seizures: - Has a diagnosis of seizure disorder that is not controlled. - Has active seizures		

Disclaimer: The use of this tool is not a requirement for services received through the Bureau of the Developmental Disabilities Services.

Risk Issues Identification Tool

	Allergies/Allergic Reaction: □ Allergic reaction could cause serious illness or possible death.		

II. Individual Risks: Relevant to Personal Safety

✓	Identified Risk Issue	Describe the incident(s) or issue(s) that indicates this as a current Risk?	Is this risk issue addressed somewhere now? If so, how?
	History of smoking in bed: □ Individual smokes in bed but has a tendency to fall asleep.		
	Inability to pay bills: □ Individual has a tendency to give all their money away.		
	History of pedestrian safety issues: □ History of walking into street in front of cars. Lacks understanding of pedestrian safety.		
	Unable to safely evacuate during an emergency: □ Inability to evacuate from a building without assistance.		
	Exploitation: □ Allows individuals to live in home without being on the lease. □ Gives away or spends all their money to/on strangers. □		

III. Individual Risks: Relevant to Behavior

✓	Identified Risk Issue	Describe the behavior or issue(s) that indicates this as a current Risk?	Is this risk issue addressed somewhere now? If so, how?
	History of or presently engages in aggressive or dangerous behavior: □ History of extremely serious criminal acts such as: pedophilia, murder, rape, arson, etc. (Note: History of a less severe act, that is now managed and no longer occurs, should be closely reviewed to determine if it continues to be a risk.)		
	Criminal justice involvement: □ Criminal justice involvement which can lead to incarceration and/or the risk of being exploited, abused, medically neglected and loss of services.		
	Fascination with fire or of fire setting: □ Currently demonstrates or expresses an intense interest in fire, matches,setting fires etc. or has any history of arson.		

Disclaimer: The use of this tool is not a requirement for services received through the Bureau of the Developmental Disabilities Services.

Risk Issues Identification Tool

	Contact with Emergency Medical Services, law enforcement, or mobile crisis: ☐ Engages in dangerous behavior that can only be managed by calling an emergency entity. ☐ Recent suicidal ideation or attempts to commit suicide. ☐ Destruction of property so serious that it could lead to criminal charges.		

Disclaimer: The use of this tool is not a requirement for services received through the Bureau of the Developmental Disabilities Services.

Risk Analysis and Planning Tool

Name of Individual:	
Meeting Date:	
Date Completed:	
Name of Person Completing this Form:	

Team Members:

Directions: *Before the annual team meeting the case manager may use the following grid to record the individual risks that have been identified by all team members (e.g. Individual, guardian/family, providers, etc.) (i.e., using the "Risk Issues Identification Tool"). At the team meeting, you may use the grid to facilitate open discussion, analysis, brainstorming and planning in order to:*

- *Review with the team all the identified Individual risks that were recorded on the Risk Issues Identification Tool, or as otherwise identified during the team meeting;*
- *Review the reasons associated with each risk issue identified;*
- *Develop final actions, supports, and services for addressing each risk; and*
- *Note where the information to address each risk will be documented in the PCISP (i.e. which Life Domain).*

Risk Score

Risk	History/Frequency	Risk Matrix				Is a Risk Mitigation Plan needed to solve a problem?
		Severity	Likelihood	Total Risk Score	Risk Level	

Disclaimer: The use of this tool is not a requirement for services received through the Bureau of the Developmental Disabilities Services.

Risk Analysis and Planning Tool

Discuss during the Team Meeting

What is the risk?	What is the problem we are trying to solve with this risk mitigation plan?	What if we do not put a risk mitigation plan in place (e.g. do nothing)?	What action did the IST decide to take to manage this risk?	Which Life Domain should this risk be included? (Note: only should be noted once in PCISP.)

Identified Risks the IST agreed are no longer a risk or are not determined to be a risk or a risk that does not warrant a risk mitigation plan.

Identify the possible risk	Why the identified risk is no longer a risk or determined not to be a risk or a risk that does not warrant a risk mitigation plan by the IST?	Which Life Domain of the PCISP will this be noted?

COMMUNITY VENTURES IN LIVING, LTD

Consent to Release Information

I hereby request and authorize Community Ventures in Living to exchange information with _____ pertaining to _____ for the purpose of _____.

This consent is effective _____ and will be valid for a period of one year. I understand that I may contact a CVL representative to request that certain sections of the records not be released or referred to in the course of taking action upon this request. I understand that I may revoke this consent, verbally or in writing, at any time. I, the undersigned, have read or have had this consent fully explained to me and understand it. All blanks were filled in before I signed the consent.

_____	_____
(SIGNATURE OF INDIVIDUAL SERVED)	**(DATE)**
_____	_____
(SIGNATURE OF GUARDIAN/PARENT)	**(DATE)**
_____	_____
(SIGNATURE OF WITNESS)	**(DATE)**

INDIVIDUAL'S NAME: _____

DATE OF BIRTH: _____

ADDRESS: _____

_____

COMMUNITY VENTURES IN LIVING, LTD.

Agency Service Survey

LINK TO SURVEY: https://cvl-in.org/service-survey

Date Completed: _____ Location of Services (city): _____

Please use this questionnaire to offer us feedback on our services. For each item put a check to show how strongly you agree or disagree with the statement. Comments on these areas would be most helpful. If a statement is not applicable to your situation write N/A.

What is your involvement with Community Ventures in Living? (please check all that apply)
❑Individual ❑Family ❑Referral Agency ❑Funding Source ❑Advocate ❑Service Provider

What is the level of support provided by CVL?
❑Daily ❑Weekly ❑Monthly ❑Intermittent

What role do you see CVL playing in supporting you?
❑Continuous Support ❑Agency-directed Support ❑Individual-directed Support ❑Intermittent Support

Program and Staff responsiveness

1. **CVL staff is accessible to me as needed.**
   ❑Needs Improvement ❑Adequate ❑Above Average ❑Outstanding

   Comments:_____
   _____
   _____

2. **CVL staff members listen and respond to my concerns, questions, and ideas.**
   ❑Needs Improvement ❑Adequate ❑Above Average ❑Outstanding

   Comments:_____
   _____
   _____

3. **I feel comfortable approaching CVL staff if I have concerns or questions.**
   ❑Needs Improvement ❑Adequate ❑Above Average ❑Outstanding

Comments:_____

_____

_____

4. **CVL staff give information that is clear and useful to me.**
   ❑Needs Improvement ❑Adequate ❑Above Average ❑Outstanding

Comments:_____

_____

_____

5. **CVL staff appear to work as a team to offer an array of resources.**
   ❑Needs Improvement ❑Adequate ❑Above Average ❑Outstanding

Comments:_____

_____

_____

6. **In meetings with CVL staff (for assessment conferences, updates, etc.), I feel I am an active member of the team and not just a listener.**
   ❑Needs Improvement ❑Adequate ❑Above Average ❑Outstanding

Comments:_____

_____

_____

7. **CVL staff actively and creatively help me to solve problems.**
   ❑Needs Improvement ❑Adequate ❑Above Average ❑Outstanding

Comments:_____

_____

_____

8. **CVL staffing consistently meets my needs.**
   ❑Needs Improvement ❑Adequate ❑Above Average ❑Outstanding

Comments:_____

_____

_____

9. **CVL staff communicate clearly and promptly regarding changes in scheduling and staffing.**
   ❑Needs Improvement ❑Adequate ❑Above Average ❑Outstanding

Comments:_____
_____
_____

Implementation of Services

1. **The programs of CVL meet my needs and/or the needs of those I represent.**
   ❑Needs Improvement ❑Adequate ❑Above Average ❑Outstanding

Comments:_____
_____
_____

2. **The services provided are built around the strengths, capacities and interests of those receiving services.**
   ❑Needs Improvement ❑Adequate ❑Above Average ❑Outstanding

Comments:_____
_____
_____

3. **CVL services are able to deal with difficult or complex situations.**
   ❑Needs Improvement ❑Adequate ❑Above Average ❑Outstanding

Comments:_____
_____
_____

4. **The services assist in establishing ongoing connections in the community.**
   ❑Needs Improvement ❑Adequate ❑Above Average ❑Outstanding

Comments:_____
_____
_____

5. CVL makes use of community resources to allow for more independence.

❑Needs Improvement ❑Adequate ❑Above Average ❑Outstanding

Comments:_____

_____

_____

6. The goals addressed are attainable and appropriate for those receiving services.

❑Needs Improvement ❑Adequate ❑Above Average ❑Outstanding

Comments:_____

_____

_____

7. I am satisfied with the progress made through using CVL services.

❑Needs Improvement ❑Adequate ❑Above Average ❑Outstanding

Comments:_____

_____

_____

We would appreciate any further comments, feedback, suggestions, or recommendations you may have regarding our services and the way we provide them.

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Community Ventures in Living, Ltd

Seizure Observation and Tracking Log

Individual Name	Date of Seizure	Time Seizure Began	Time Seizure Ended

Name of Person Reporting	Where Did Seizure Occur?

Please List All Curent Medications and Dosages (Not just for seizures): _____

_____

_____

****

DURING SEIZURE, the individual was observed to: (Please check ALL Appropriate Categories Below)

CRY OUT ____ FALL ____ BECOME RIGID ____ BITE TONGUE ____ ROLL EYES _____ VOMIT _____

HAVE JERKING BODY MOTIONS _____ URINATE _____ DEFECATE _____ BECOME DISORIENTED _____

BECOME AGGRESSIVE _____ LOSE CONSCIOUSNESS _____ BECOME LIMP _____ STOP BREATHING _____

****

LENGTH OF TIME FOR SEIZURE _____ MORE THAN ONE SEIZURE? (If yes, how many?) _____

SEIZURE WAS OBSERVED BY (Name 1) _____ (Name 2) _____

INDIVIDUAL WAS INJURED? YES ___ NO ___ (If yes, describe all injuries) _____

_____

RECEIVED TREATMENT? YES ___ NO ___ (If yes, describe treatment) _____

_____

IMMEDIATELY AFTER SEIZURE (Briefly Describe Individual's Condition) _____

_____

_____

****

DOCTOR NOTIFIED? YES ___ NO ___ (If yes, doctor's recommendations) _____

_____

Follow-up Details: _____

BEFORE SEIZURE, INDIVIDUAL: (Please check ALL Appropriate Categories Below)

STOPPED FROM DOING SOMETHING _____ WAS LOUD/DISRUPTIVE _____ WAS PROVOKED BY OTHERS _____

WAS ASKED TO DO A TASK _____ WAS IN A NOISY ENVIRONMENT _____ HAD SELF INJURIOUS BEHAVIOR _____

DESTROYED OWN PROPERTY _____ DESTROYED PROPERTY OF OTHERS _____ REFUSED MEDICATIONS _____

BECAME DISORIENTED _____ BECAME AGGRESSIVE _____ APPEARED BORED _____ WAS POUTY / UPSET ____

****

Other Comments: _____

_____

Date Report Was Written	Date of Last Medication Level Check	Date of Next Visit

Signature of Individual Reporting	Date

Individual: _____ **Date:** _____

Recognition of seizure disorders and knowledge of first aid is important. Seizures are often mistaken for something else.

Seizure Type Characteristics	First-Aid
Generalized Tonic Clonic - body becomes rigid then jerking, usually last 2-5 minutes with complete loss of consciousness.	1. Stay with person. 2. Ease to floor if possible. 3. Turn on side. Protect head (blanket or soft material). 4. Loosen tight clothing. 5. Move objects from vicinity 6. Provide privacy. Observe. Notify nurse.
Atonic- sudden loss of muscle tone.	No first aid unless person gets hurt from fall.
Myoclonic- sudden muscle jerks.	No first aid
Absence- brief seizures with loss of consciousness, stare, blinking, rolling of eyes or mouth movement	No first aid
Partial Simple- starts in one part of body or brain. May have sensory experience not obvious to an onlooker.	No first aid unless becomes secondarily generalized.
Complex- loss or impaired consciousness. Activity inappropriate, purposeless (i.e., lip smacking, chewing).	Speak calmly and reassuringly to person and others. Guide gently away from hazards. Stay with person until completely aware of environment.
Secondarily Generalized- starts in one area but progresses.	1. Stay with person. 2. Ease to floor if possible. 3. Turn on side. Protect head (blanket or soft material). 4. Loosen tight clothing. 5. Move objects from vicinity. 6. Provide privacy. Observe. Notify nurse.

People who provide support to people who have seizures should recognize an emergency situation and notify appropriate medical support immediately if:

1. A person has 3 seizures without regaining consciousness
2. A seizure lasts longer than 3 minutes
3. A person does not breathe for 30-60 seconds
4. The level of consciousness has not returned within 15 minutes

Health Care Plan Issue:

Maintain optimal seizure management.

Issue Clarification:

Type of Seizure: _____
Last Seizure Activity: _____
Controlled with Medication: _____
*Please refer to home file for medication information including side effects.

Implementation Plan (continue on back as needed):_____
_____
_____

Training Implications:

- ☐ All staff will be appropriately trained in seizure management.
- ☐ All staff will be trained on individual's seizure medications, including side effects, signs & symptoms of toxicity.
- ☐ All staff will be trained in specific type, signs, and symptoms.
- ☐ All staff will be trained in proper documentation of seizure activity.

Implementation Plan (continued): _____

_____

_____

_____

_____

_____

_____

_____

COMMUNITY VENTURES IN LIVING, LTD

Notice of Privacy Practices Summary and Acknowledgement

INDIVIDUAL NAME: _____

YOUR RIGHTS - YOU HAVE THE RIGHT TO:

- ☐ Get a copy of your paper or electronic medical record
- ☐ Correct your paper or electronic medical record
- ☐ Request confidential communication
- ☐ Ask us to limit the information we share
- ☐ Get a list of those with whom we've shared your information
- ☐ Get a copy of this privacy notice
- ☐ Choose someone to act for you
- ☐ File a complaint if you believe your privacy rights have been violated

YOUR CHOICES - YOU HAVE SOME CHOICES IN THE WAY THAT WE USE AND SHARE INFORMATION AS WE:

- ☐ Tell family and friends about your condition
- ☐ Provide disaster relief
- ☐ Include you in an individual directory
- ☐ Provide mental health care
- ☐ Market our services
- ☐ Raise funds

OUR USES AND DISCLOSURES - WE MAY USE AND SHARE YOUR INFORMATION AS WE:

- ☐ Treat you
- ☐ Run our organization
- ☐ Bill for your services
- ☐ Help with public health and safety issues
- ☐ Do research
- ☐ Comply with the law
- ☐ Respond to organ and tissue donation requests
- ☐ Work with a medical examiner or funeral director
- ☐ Address workers' compensation, law enforcement, and other government requests
- ☐ Respond to lawsuits and legal actions

I acknowledge that I have reviewed and understand the CVL Notice of Privacy Practices "Your Information. Your Rights. Our Responsibilities" summarized above. This document was provided to me in writing and, if I require, in my usual mode of communication. I understand my Rights and Choices regarding my medical information.

INDIVIDUAL SIGNATURE: _____ **DATE:** _____

COMMUNITY VENTURES IN LIVING REPRESENTATIVE: _____

COMMUNITY VENTURES IN LIVING, LTD

Individual Specific Medication Administration

INDIVIDUAL NAME: _____ **DATE:** _____

Follow Community Ventures in Living Policies for all medication administration, but apply the following to meet this individual's specific needs:

How are the medications provided?

- ☐ Calendar Card/bubble packs
- ☐ Traditional Pharmacy Bottles
- ☐ Flip top pill boxes (*if checked, prepared by*): _____

Are the medications locked or unlocked?

- ☐ Locked at all times when not in use **per IDT approval.**
- ☐ May be left unlocked (Must be specified in ISP that the individual is safe with medications and is ok to have medications unlocked).

During Medication Administration:

Knowledge of Medication

- ☐ Individual to identify medication
- ☐ Individual to tell the purpose for the medication
- ☐ Will repeat name of medication and purpose for taking it
- ☐ Is to be informed of the medication and purpose for taking it
- ☐ The individual does not identify or state purpose for medication because: _____

_____

Oral Medications:

Calendar card/bubble packs

- ☐ Able to identify without any staff involvement, correct bubble to get medication from
- ☐ Requires staff assistance to monitor/identify correct bubbles to get medication from
- ☐ Able to pop medication out of bubble without any staff involvement
- ☐ Requires verbal prompts to punch medication out of bubble
- ☐ Requires physicial prompts to punch medication out of bubble
- ☐ Medication is punched out of card into medication cup
- ☐ Medication is punched out of card into individual's hand

Traditional Pharmacy Bottles

- ☐ Individual can identify correct bottle and amount to take
- ☐ Individual can prepare correct dose from the bottle without staff intervention
- ☐ Staff to assist individual in obtaining correct dose of medication from the bottle

Altering Medication

- ☐ Consumes all medication in form provided from pharmacy
- ☐ Requires pills crushed and placed in small amount of food*
- ☐ Requires capsules to be pulled apart and contents placed in small amount of food*
- ☐ Other _____

** must check with pharmacy on all new medications to assure effectiveness if altered*

*** if placing medication in food, follow dietary guidelines when applicable*

Getting the Medication to Mouth

- ☐ Individual is independent with ability to get hand / med cup to mouth without staff assistance
- ☐ Individual needs verbal prompts to get hand / med cup to mouth
- ☐ Individual needs physical prompts to get hand / med cup to mouth (hand over hand)
- ☐ Other _____

Swallowing

- ☐ Individual is independent with swallowing
- ☐ Requires verbal prompts to swallow medication

Checking Mouth

- ☐ No need to check the individual's mouth to assure the medication is swallowed
- ☐ Staff must check mouth to assure medication was consumed

Topical Medication:

- ☐ Independent in application of medication
- ☐ Requires Partial staff assistance with topical medications
  - ☐ Requires verbal prompts on identifying area of application
  - ☐ Requires physical prompts on identifying area of application
  - ☐ Requires verbal prompts on amount of medication required
  - ☐ Requires physical prompts on amount of medication required
  - ☐ Requires verbal prompts on actual application of topical medication
  - ☐ Requires physical prompts on actual application of topical medication

Eye/Ear Drops:

- ☐ Independent in application of eye/ear drops
- ☐ Requires partial staff assistance with eye/ear drops
  - ☐ Requires verbal prompts on administraion of eye/ear drops
  - ☐ Requires physicial prompts on administration of eye/ear drops

Inhalers:

- ☐ Independent with use of inhaled medication
- ☐ Requires partial staff assistance with inhaled medications
  - ☐ Independent with placement of inhaler/spacer in mouth
  - ☐ Requires staff prompting on placement of inhaler/spacer in mouth
  - ☐ Independent with pushing inhaler to dispense medication while individual is inhaling
  - ☐ Requires verbal prompts form staff on when to push inhaler to coincide with inhalation
  - ☐ Requires hand over hand and staff demonstration exhale and inhale to get the medication administered at correct time
- ☐ Independent with cleaning inhaler/spacer after use
- ☐ Requires verbal prompts with cleaning inhaler/spacer after use
- ☐ Requires physical prompts with cleaning inhaler/spacer after use
- ☐ Staff must clean inhaler/spacer after use

Nasal Sprays:

- ☐ Independent with use of nasal spray
- ☐ Requires partial staff assistance with nasal sprays
  - ☐ Requires verbal prompts on administration of nasal sprays
  - ☐ Requires physical prompts on administration of nasal sprays
- ☐ Independent with cleaning nasal spray after use
- ☐ Requires verbal prompts with cleaning nasal spray after use
- ☐ Requires physical prompts with cleaning nasal spray after use
- ☐ Staff must clean nasal spray after use

Other specific individual medication administration needs not listed above:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

COMMUNITY VENTURES IN LIVING, LTD

Credit History Consent

I, _____ give my permission for Community Ventures in Living to run a Credit Report to assure I am not a victim of exploitation.

Full Social Security Number: _____

_____ _____

Individual/Guardian Signature **Date**

_____ _____

Signature of Agency Representative Running Report **Date Processed**

Running Credit Scores/Reports

We recommend using a website that is both safe and easy to use. Many of our employees and individuals served use www.CreditKarma.com

Name *Preferred Name* My Interests My Supports

who I am & who I work with

family and friends

home and community

recreation and activities
(including spiritual persuits)

work
(vocation, education, volunteerism)

finances and money

choices and rights

other

Community Ventures in Living

Personal Preference Profile Triggers

cvl-in.org

Who Am I?

How would you describe yourself?
- -funny/serious
- -friendly
- -helpful
- -quiet/talkative
- -creative
- -anxious/calm
- -patient/impatient
- -Messy/Organized
- -on time/running late
- -making plans/being spontaneous
- -good memory/forgetful
- -fast paced/slow paced

What do you like?
- -social—go out/stay at home
- -outdoors/indoors
- -favorite season
- -best time of day (morning, afternoon, night)
- -try new things/routines

What things are important to you?
- -family/friends
- -good health
- -religion/spirituality
- -community
- -work
- -helping others
- -free time

Do you have any nicknames?

Who I am vs. Who I'd like to be:
- -What things would you like to work on/improve on?

My Family & Friends

Who do you share your feelings with?
Who do you talk to during tough times?
Who do you share happy times/ successes with?
Who do you laugh with?
Who makes you mad?
How close do you want to live to friends/family?
What activities do you like to do with friends or family?
How often do you want to see friends or family (more or less than now)?

Who do you wish you could spend time with again? Why don't you spend time with them now?
Do you share holidays or traditions with friends/family?
What do you want a friend to be?
- -funny
- -kind
- -helpful
- -outgoing
- -dependable
- -good listener

Do you prefer spending time with younger people or older people?

How do you prefer to communicate with your friends/family?
- -Email
- -phone calls
- -face to face
- -cards/letters
- -text messages

Do you want an intimate relationship?
- -boyfriend/girlfriend?
- -want to get married?
- -share a home with someone?

My Home & Community

Do you like your current living situation?
- -If not, what do you want to change?

Do you prefer an apartment; house; duplex?
Buy or rent?
Do you prefer a city or rural setting?
Do you want to live alone or with family or a roommate?
Do you want to live close to family or friends?
Do you feel safe in your home?
- -If not, what would make you feel safer?

What sort of physical support/ accessibility needs do you want at home?
- -no stairs
- -ramp
- -wider doorways
- -grab bars for balance/support

Are you able to do yard work; upkeep; household chores?
- -If not, who can help you?

Do you want a pet?
Do you want to be involved in your community? How?
- -access local stores/restaurants
- -join a gym
- -join local groups
- -volunteer
- -go to local parks

What kind of transportation do you prefer to use?
- -car/carpooling
- -bus
- -taxi
- -bicycle
- -walking

My Recreation & Activities

Prefer being inside or outside?
Music?
-concerts
-dancing
-playing instruments
-singing
Performing arts/acting/theater?
Animals? Certain type?
Prefer alone time or being with groups of people?
Cooking? Eating out?
Movies?
-what type?
-at home or theater?
-plays
Sports?
-what type?
-watch or play?
Museums?
Exercise?
Collecting items?
Church or spiritual pursuits?
Travel? Where?
Local events?
Playing games?
Social media?
Books?
Hobbies?
-fixing things
-building things
-painting
-photography
-decorating
-crafting
-sewing
Gardening? Indoor plants or outdoor?
Hosting guests?
Where to find ideas?
-Internet
-books
-magazines
-newspaper

My Work

Prefer paid work or volunteering?
Temporary or permanent jobs?
Continuing education? What areas?
Part-time or full-time work week?
-How long of a shift do you want to work?
Do you want to work weekends? Or weekdays?
What time of day do you prefer to work?
-morning
-afternoon
-evening
-night
How do you want to get to work?
-carpool
-bus
-drive
How much money do you want or need to make?
What sort of jobs or tasks do you prefer?
-work with people or alone?
-indoor/outdoor?
-physical tasks
-a seated job
-a lot of talking
-no talking
-cleaning, building, creating, taking care of others, selling?
Do you want to do the same thing every day or something different?
How much responsibility do you want?
What physical support/accessibility needs do you need to be successful?
Can you take directions from several people or just one boss?
Work pace: fast or slower?
What kind of support do you want in finding a job/volunteer/class?

My Finances & Money

Do you want/need to follow a budget?
How much involvement do you want in your finances?
-You want to take care of all aspects
-You want someone else to take care of financial tasks
-You want to take part in some tasks (ex. Budgeting but not bill paying)
Do you want a checking account?
Savings account? Trust fund?
What do you want to spend your money on?
-Essentials (bills, food, housing, insurance, taxes)
-Extras (cable/internet, outings, pets)
Do you want to use available resources or not?
-Medicaid
-Food stamps
-Housing assistance
Do you prefer using cash or checks or both?
What are your finance goals?
-Save for a trip; new furniture; gifts for others; different place to live

My Choices & Rights

Do you understand what rights you have? If not, where to find out?
Do you feel that you get to make choices?
-If not, what choices/options do you want?
-Do you think you have to make too many choices?
Do you feel respected?
Are you free from coercion and restraint?
Do you practice the right to:
-have visitors at any time?
-practice religion?
-access your own money?
-make a fair wage?
-access your own posessions?
-non-discrimination at your workplace?
Do you want/get to choose:
- your caregivers
-doctors
-leisure activities
-shopping locations
-home décor
-grocery items
-who you spend time with
Do you want more/less privacy; personal space?
Do you want to access and open your mail?
Do you want to make phone calls or use social media?
Do you have or want access to personal records (at service agencies, doctor offices, etc)?
Do you want to join an advocacy group or be a personal advocate for yourself or others?
Do you need more support to feel safe?
Do you want to be more/less involved with politics or voting?
Do you want to be able to ask more questions/get more information/file a complaint
Do you want more support to maintain your health or finances?
Do you want to set up a Medical or Psychological Advanced Directive?

COMMUNITY VENTURES IN LIVING, LTD

Annual Home Environment Checklist

INDIVIDUAL'S NAME: _____ **CHECK COMPLETED BY:** _____

ADDRESS: _____ **DATE:** _____

Exterior:

☐Yes ☐No ☐N/A	The foundation is solid and free from defects.
☐Yes ☐No ☐N/A	Sidewalks and driveway are in safe, usable condition.
☐Yes ☐No ☐N/A	Stairs, rails, and porches are sound and free from hazards.
☐Yes ☐No ☐N/A	Handrails are installed where there are four or more steps.
☐Yes ☐No ☐N/A	Roof, gutters, and downspouts are in sound, clean condition.
☐Yes ☐No ☐N/A	Walls of the residence look straight and are free from loose trim or siding.
☐Yes ☐No ☐N/A	Storage buildings and garages are in safe, solid condition.
☐Yes ☐No ☐N/A	Window and doorframes are weather-tight and watertight.
☐Yes ☐No ☐N/A	House number is visible from the street.
☐Yes ☐No ☐N/A	Fencing, gates, and safety covers are in place around a pool or hot tub.

Interior Physical Environment:

☐Yes ☐No ☐N/A	Electrical outlets and switches have unbroken cover plates.
☐Yes ☐No ☐N/A	Electrical outlets and switches are in working order.
☐Yes ☐No ☐N/A	Ceilings and walls are clean and free of dangerous hazards
☐Yes ☐No ☐N/A	Rooms are free from cracked, peeling paint.
☐Yes ☐No ☐N/A	Flooring is clean, level, and free from cracks and damage.
☐Yes ☐No ☐N/A	Baseboards are free from holes and/or gaps.
☐Yes ☐No ☐N/A	Windows are airtight and have no broken windowpanes.
☐Yes ☐No ☐N/A	Home is free from pest infestation.
☐Yes ☐No ☐N/A	All kitchen stove burners work and all knobs are present.
☐Yes ☐No ☐N/A	Kitchen has a working oven, refrigerator, sink, and properly installed plumbing.
☐Yes ☐No ☐N/A	Bathroom has a working toilet, sink, and tub or shower.
☐Yes ☐No ☐N/A	Home is equipped with hot and cold running water.
☐Yes ☐No ☐N/A	Temperature on water heater has been adjusted as needed to prevent scalding.

☐Yes ☐No ☐N/A	Bathroom plumbing is properly installed and in working order.
☐Yes ☐No ☐N/A	Basement is dry and there are no or minimal wall cracks.
☐Yes ☐No ☐N/A	Fireplaces or wood burning stoves are protected by guards to prevent burns.
☐Yes ☐No ☐N/A	Furnace is properly installed and in working order.
☐Yes ☐No ☐N/A	Room temperatures are at reasonable levels.
☐Yes ☐No ☐N/A	Home is entirely free of broken light fixtures.
☐Yes ☐No ☐N/A	Stairways are equipped with handrails.
☐Yes ☐No ☐N/A	There are adequate facilities for disposal of garbage.
☐Yes ☐No ☐N/A	All cleaners, detergents, medications, and potential poisons are stored separately from food.
☐Yes ☐No ☐N/A	Individual has their own space for storage of personal belongings and privacy.
☐Yes ☐No ☐N/A	Privacy is taken into consideration with regard to window coverings, interior door locks, and personal space.
☐Yes ☐No ☐N/A	Physical accessibly has been met with regard to width of doorways, grab bars in bathroom, non-skid pads and rugs, ramps, and window/door access.
☐Yes ☐No ☐N/A	Age-appropriate furnishings and décor have been encouraged and utilized.

Emergency Procedures:

☐Yes ☐No ☐N/A	All windows and doors are equipped with working locks.
☐Yes ☐No ☐N/A	There is more than one way to exit the unit.
☐Yes ☐No ☐N/A	There is more than one way to exit the individual's bedroom.
☐Yes ☐No ☐N/A	Exits are not obstructed and are easily opened.
☐Yes ☐No ☐N/A	Emergency lighting is readily available (flashlights, candles as appropriate).
☐Yes ☐No ☐N/A	There is at least one smoke alarm for each floor level.
☐Yes ☐No ☐N/A	There is a working fire extinguisher in the home.
☐Yes ☐No ☐N/A	A working phone is available for emergencies.
☐Yes ☐No ☐N/A	Back-up supply of non-perishable food and water is available in case of an emergency.
☐Yes ☐No ☐N/A	If home uses gas, there is at least one carbon monoxide detector on each floor level.
☐Yes ☐No ☐N/A	Emergency drills are conducted and logged on a monthly basis.

Recommendations/Remarks:

_____

_____

_____

_____

_____

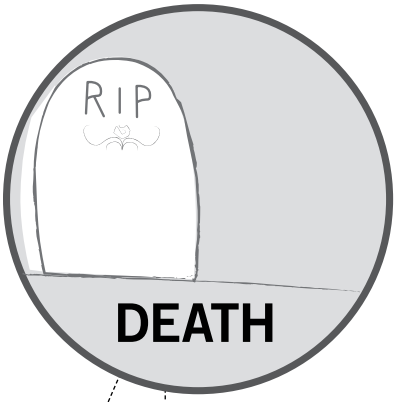
Community Ventures in Living

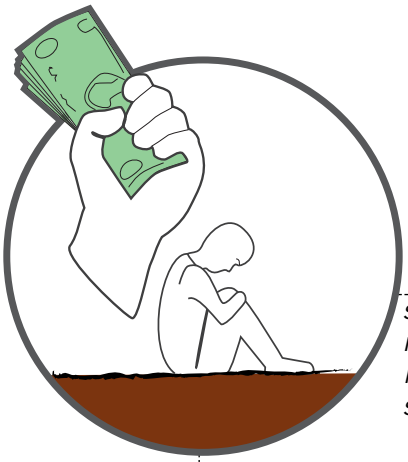
REPORTABLE INCIDENTS

CVL keeps track of certain incidents to insure the safety of those we serve. If something happens that puts an individual's health and safety at risk, please report it immediately to CVL at 1-800-474-2571 or 765-4490784. An incident report must be filed with the State within 24hrs of its occurence.

you don't have a safe place to live, food to eat or medicine that you need

someone has hurt or mistreated you in any way





EXPLOITATION

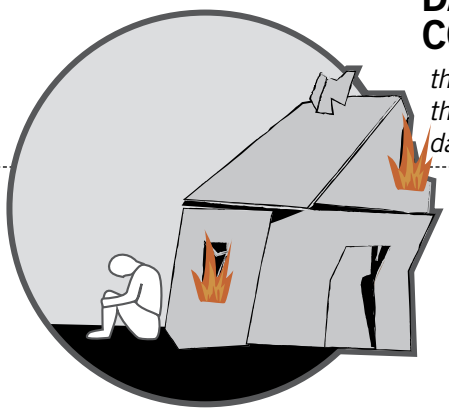
someone has used your money, belongings or identity for their own, or someone else's, profit

CRIMINAL ACTIVITY

anything that is against the law

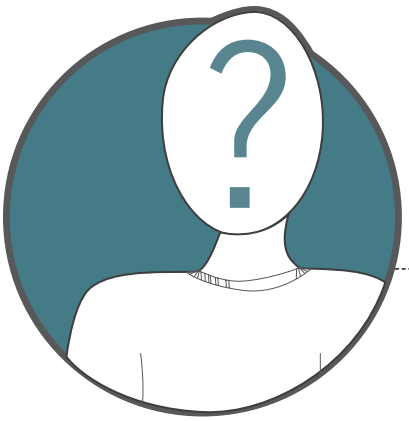
DANGEROUS CONDITIONS

things that make your home or the place that you receive services dangerous including infestation



PEER-TO-PEER AGGRESSION

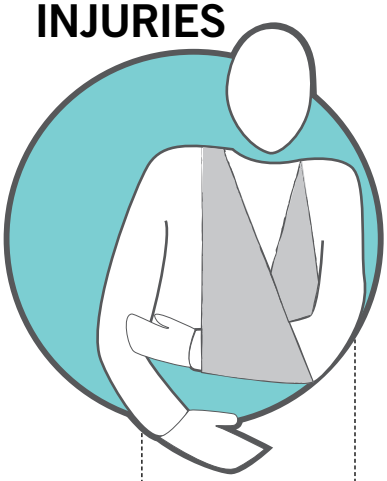
a peer hurts you so badly that you need first aid or help from a doctor or nurse



ELOPEMENT

someone has run away or is missing

SIGNIFICANT INJURIES

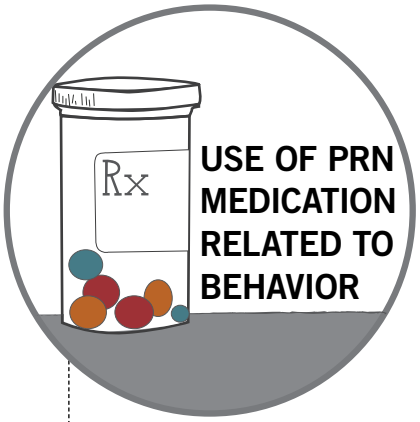


incuding, but not limited to: fractured or broken bones; any second or third degree burns; choking; three inch bruises or repeated bruising; a cut requiring nurse or doctor attention; bedsores; bite or puncture wounds; eating or drinking things that are not food or beverage

STAFF INJURIES

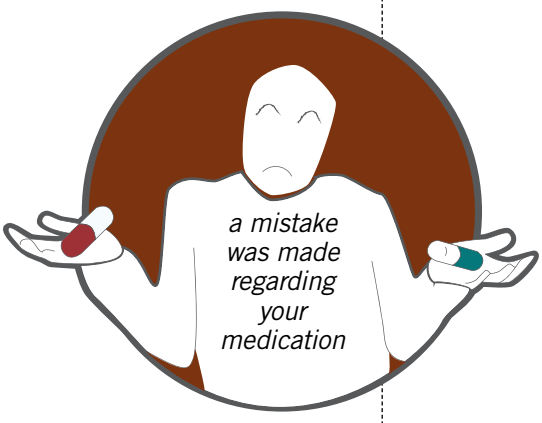
if an employee is injured while on the job

USE OF PRN MEDICATION RELATED TO BEHAVIOR

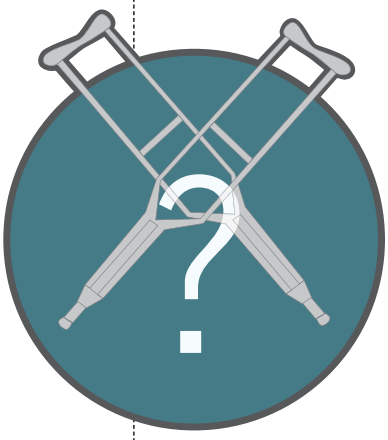


you are given medicine that you only receive when behaviors happen

MEDICATION ERROR



a mistake was made regarding your medication



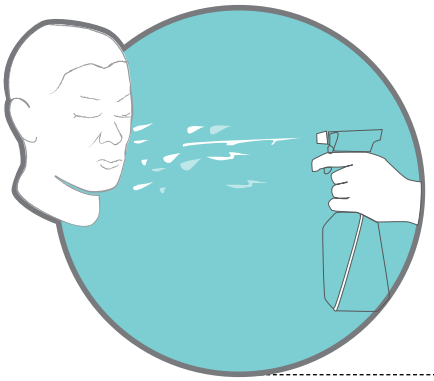
INJURY WITH UNKNOWN CAUSE

any type of injury and no one knows how it happened

EMERGENCY INTERVENTION

using emergency medical/pshyciatric services

USE OF ANY AVERSIVE TECHNIQUE



If any of these things is done to you, it must be reported.

any fall resulting in injury

USE OF ANY PHYSICAL OR MECHANICAL RESTRAINT

you are held in place so you cannot move