

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G229	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  01/31/2014
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NAME OF PROVIDER OR SUPPLIER  RES CARE COMMUNITY ALTERNATIVES SE IN	STREET ADDRESS, CITY, STATE, ZIP CODE 307 JOSEPHINE ST MILAN, IN 47031
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W000000	<p>This visit was for an annual fundamental recertification and state licensure survey.</p> <p>Dates of survey: January 29, 30, and 31, 2014.</p> <p>Facility Number: 000753 Provider Number: 15G229 AIM Number: 100243350</p> <p>Surveyor: Dotty Walton, QIDP.</p> <p>These deficiencies reflect state findings in accordance with 460 IAC 9. Quality Review completed 2/4/14 by Ruth Shackelford, QIDP.</p>	W000000		
W000125	<p>483.420(a)(3) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must allow and encourage individual clients to exercise their rights as clients of the facility, and as citizens of the United States, including the right to file complaints, and the right to due process.</p> <p>Based on record review and interview for 1 of 3 sampled clients (#1), the facility failed to secure a surrogate to assist client #1 with making informed choices and decisions.</p> <p>Findings include:</p>	W000125	<p>W125: 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. Corrective</p>	02/14/2014

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	<p>Client #1's record was reviewed on 1/30/14 at 8:30 AM. Client #1's record indicated she had been admitted to the facility on 8/8/13. The record contained an ICA/Informed Consent Assessment dated 9/4/13 by house manager/HM #2. The ICA assessed the client's ability to make informed choices and demonstrate understanding in money management, medical issues, programming, and sexual awareness. In all categories, it had been determined client #1 was not independent and required the help of a Health Care Representative. At the time of the survey, client #1 did not have a HCR or other surrogate to help her make informed choices and protect her rights.</p> <p>Interview with HM #2 on 1/30/14 at 9:50 AM indicated client #1 did not have a HCR or surrogate to assist her to make informed choices and decisions. HM #2 indicated client #1 was assessed as needing an HCR.</p> <p>9-3-2(a)</p>		<p>action: IDT has been held and Facility will try to find Health Care representative or refer Client #1 to a guardian service (Attachment A). How we will identify others: Clinical Supervisors will review Informed Consent Assessments to ensure that clients in need of representation have been referred. Measures to be put in place: Informed Consent Assessment will document need for and referral to obtain representation (Attachment B). Monitoring of Corrective Action: Operations Manager, Quality Assurance will perform bi monthly service reviews to ensure that procedure to obtain, if required, has been implemented. Completion Date: 2-14-2014</p>		

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W000149	<p>483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. Based on observation, record review and interview for 1 of 3 sampled clients (#1), the facility neglected to implement written policies and procedures which prohibited staff to client neglect (client elopement).</p> <p>Findings include:</p> <p>Review of facility internal incident reports and reportable incidents/BDDS (Bureau of Developmental Disabilities Services) reports on 1/29/14 at 2:30 PM indicated the following behaviors exhibited by client #1 who had been admitted to the facility on 8/8/13:</p> <p>1. Incident report dated 8/10/13 at 4:45 PM filled out by staff #5 indicated "[Client #1] - took off walking on her own staff went after her. She crying (sic) stated she did not know why she was upset. Walked back to group home happy. at (sic) 4:48 pm [client #1] locked her bedroom door and refused to open it and started cussing called staff a [derogatory term] also was beating on bedroom door (sic). Staff [#5] contacted [House Manager #2]. And managed to get door open and she stated she (client</p>	W000149	<p>W149: The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. Corrective Action: Clinical Supervisor has been inserviced on maintaining staffing ratio (Attachment C). Client #1 has been moved to a bedroom without outside exit (Attachment D). How we will identify others: Clinical Supervisors will review client Behavior Support Plans to ensure that clients with risk of elopement are not in bedrooms with an outside exit. Clinical supervisors will review staffing schedules to ensure that staffing is maintained.. Measures to be put in place: Operations Manager and Quality Assurance will continue to review incident reports to ensure that staffing is adequate and that clients with risk of elopement are not in a bedroom with outside exit.. Monitoring of Corrective Action: Operations Manager and Quality Assurance will continue to review incident reports to ensure that staffing is adequate and that clients with risk of elopement are not in a bedroom with outside exit.. Completion Date: 2-14-2014</p>	02/14/2014

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	<p>#1) wanted to kill staff, tried to calm her down and she started throwing things at staff [#5] so I left her alone for 5 mins (minutes) to calm self down (sic). I (staff #5) was standing outside of bedroom door listening and she keep (sic) kicking door. And then [client #1] got quite (sic) and started counting to 4 and came out of bedroom stated she was sorry (sic)...The behavior lasted about 45 mins...."</p> <p>HM #2 noted on 8/13/13 on the Incident Report form section "The Plan of Improvement/Prevention/Resolution: IDT (Interdisciplinary team) met and has put tracking in place for elopement, will monitor."</p> <p>2. Incident report dated 8/29/13 at 2:25 PM filled out by staff #5 indicated "[Client #1] walked away from group home on own with Staff following, cussed at staff (#5) and stated she hated it here and does not need a Babysitter and that she was running away - called staff names, refused to come back to group home and was screaming - staff talked in to coming back and fixing supper...."</p> <p>HM #2 noted on 8/29/13 on the Incident Report form section "The Plan of Improvement/Prevention/Resolution:</p>						

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	<p>When [client #1] gets upset, staff are to ask her if she would like to take a walk to calm down...will cont. (continue) to monitor."</p> <p>3. A 9/19/2013 BDDS report of an incident on 9/18/13 at 7:50 PM indicated, "[Client #1] became upset after staff had asked her if she would like to get her bath for the evening. [Client #1] began yelling stating she didn't need a babysitter and went to her bedroom. Staff followed her talking with her attempting to calm her down but [client #1] stated to leave her alone. Staff told [client #1] they would give her time to calm and check on her in a few minutes. [Client #1] had went (sic) to her bedroom at 7:35p (PM) and staff allowed her time to calm and returned to [client #1's] bedroom at 7:50pm finding her not in the bedroom. STaff (sic) checked the house, the yard up and down the street in front of and along side the house not seeing her. Staff notified supervisor and called the police. Police responded and assisted with finding her. Staff found [client #1] walking on a nearby street and returned her to the home around 8:30pm...."</p> <p>The "Plan to Resolve" component of the BDDS report indicated in part: "... [Client #1] has a BSP (Behavior Support</p>				

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	<p>Plan) for elopement...last night, preventative measures and revisions to her plan were 15 minute checks, her bedroom door remained open with staff outside the bedroom door. Further preventative measures are today [client #1] switched bedrooms to a bedroom less accessible to the outside. Staff will continue to monitor and make adjustments to her plan as needed."</p> <p>During observations at the facility on the evening of 1/29/14 from 4:10 PM until 6:00 PM client #1's current and former bedrooms were observed. The first bedroom client #1 had was on the east side of the house accessed via the laundry room. The bedroom had its own exit door leading to the street. On 1/29/14 at 4:20 PM, staff #1 was asked why client #1 had been in a bedroom on the far end of the house with its own exit door after she had vacated the premises on two occasions (8/10 and 29/13) previous to her elopement on 9/18/13. Staff #1 stated client #1 had vacated through the "front door" of the facility. Staff #1 stated, "We didn't think she would use her bedroom door."</p> <p>Confidential interview #1 indicated client #1 had eloped from the facility on the evening of 9/18/13 from the exit</p>				

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	<p>door in her bedroom. The interview indicated it was dark when client #1 had been found on a well traveled road heading out of the small town where she lived carrying a garbage bag of her belongings. The interview indicated staff #1 was the only staff on duty with clients #1, #2, #3, #4, #5 and #6 at the time of the elopement (9/18/13 between 7:35 PM and 7:50 PM).</p> <p>Interview with House Manager/HM #2 on 1/30/14 at 11:00 AM indicated the facility had not changed client #1's bedroom to one without an exit door until after she had eloped from the facility on 9/19/13. The interview indicated staff #1 was the only staff on duty that evening with six clients. The interview indicated client #1 was an emergency placement on 8/8/13 and her background information was unavailable from her prior placement which would have enhanced HM #2's ability to address client #1's behavioral needs.</p> <p>Review of agency policies and procedures on 1/29/14 at 3:45 PM indicated a Standard Operating Procedure for Identifying and Reporting Suspected Abuse and Neglect dated 7/18/11. The review indicated the agency prohibited client abuse and neglect. Definitions were in an undated</p>						

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	policy used for staff training purposes:  "Neglect means the failure of an individual to provide the treatment care, goods or services that are necessary to maintain the health or safety of a person we support."  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 observation, record review and interview for 1 of 3 sampled clients (#1), the facility neglected to implement corrective measures to prevent an	W000157	W157: If the alleged violation is verified, appropriate corrective action must be taken. Corrective Action: Clinical Supervisor has been inserviced on	02/14/2014			

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	<p>elopement by a client with known elopement issues.</p> <p>Findings include:</p> <p>Review of facility internal incident reports and reportable incidents/BDDS (Bureau of Developmental Disabilities Services) reports on 1/29/14 at 2:30 PM indicated the following behaviors exhibited by client #1 who had been admitted to the facility on 8/8/13:</p> <p>1. Incident report dated 8/10/13 at 4:45 PM filled out by staff #5 indicated "[Client #1] - took off walking on her own staff went after her. She crying (sic) stated she did not know why she was upset. Walked back to group home happy. at (sic) 4:48 pm [client #1] locked her bedroom door and refused to open it and started cussing called staff a [derogatory term] also was beating on bedroom door (sic). Staff [#5] contacted [House Manager #2]. And managed to get door open and she stated she (client #1) wanted to kill staff, tried to calm her down and she started throwing things at staff [#5] so I left her alone for 5 mins (minutes) to calm self down (sic). I (staff #5) was standing outside of bedroom door listening and she keep (sic) kicking door. And then [client #1] got quite (sic) and started counting to 4</p>		<p>maintaining staffing ratio (Attachment C). Client #1 has been moved to a bedroom without outside exit (Attachment D). How we will identify others:</p> <p>Clinical Supervisors will review client Behavior Support Plans to ensure that clients with risk of elopement are not in bedrooms with an outside exit. Clinical supervisors will review staffing schedules to ensure that staffing is maintained. Measures to be put in place: Operations Manager and Quality Assurance will continue to review incident reports to ensure that staffing is adequate and that clients with risk of elopement are not in a bedroom with outside exit. Monitoring of Corrective Action: Operations Manager and Quality Assurance will continue to review incident reports to ensure that staffing is adequate and that clients with risk of elopement are not in a bedroom with outside exit. Completion Date: 2-14-2014</p>				

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	<p>and came out of bedroom stated she was sorry (sic)...The behavior lasted about 45 mins...."</p> <p>HM #2 noted on 8/13/13 on the Incident Report form section "The Plan of Improvement/Prevention/Resolution: IDT (Interdisciplinary team) met and has put tracking in place for elopement, will monitor."</p> <p>2. Incident report dated 8/29/13 at 2:25 PM filled out by staff #5 indicated "[Client #1] walked away from group home on own with Staff following, cussed at staff (#5) and stated she hated it here and does not need a Babysitter and that she was running away - called staff names, refused to come back to group home and was screaming - staff talked in to coming back and fixing supper...."</p> <p>HM #2 noted on 8/29/13 on the Incident Report form section "The Plan of Improvement/Prevention/Resolution: When [client #1] gets upset, staff are to ask her if she would like to take a walk to calm down...will cont. (continue) to monitor."</p> <p>3. A 9/19/2013 BDDS report of an incident on 9/18/13 at 7:50 PM indicated, "[Client #1] became upset</p>						

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	<p>after staff had asked her if she would like to get her bath for the evening. [Client #1] began yelling stating she didn't need a babysitter and went to her bedroom. Staff followed her talking with her attempting to calm her down but [client #1] stated to leave her alone (sic). Staff told [client #1] they would give her time to calm and check on her in a few minutes. [Client #1] had went (sic) to her bedroom at 7:35p (PM) and staff allowed her time to calm and returned to [client #1's] bedroom at 7:50pm finding her not in the bedroom (sic). STaff (sic) checked the house, the yard up and down the street in front of and along side the house not seeing her (sic). Staff notified supervisor and called the police. Police responded and assisted with finding her. Staff found [client #1] walking on a nearby street and returned her to the home around 8:30pm...."</p> <p>The "Plan to Resolve" component of the BDDS report indicated in part: "... [Client #1] has a BSP (Behavior Support Plan) for elopement...last night, preventative measures and revisions to her plan were 15 minute checks, her bedroom door remained open with staff outside the bedroom door. Further preventative measures are today [client #1] switched bedrooms to a bedroom less accessible to the outside. Staff will</p>						

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	<p>continue to monitor and make adjustments to her plan as needed."</p> <p>During observations at the facility on the evening of 1/29/14 from 4:10 PM until 6:00 PM client #1's current and former bedrooms were observed. The first bedroom client #1 had was on the east side of the house accessed via the laundry room. The bedroom had its own exit door leading to the street. On 1/29/14 at 4:20 PM, staff #1 was asked why client #1 had been in a bedroom on the far end of the house with its own exit door after she had vacated the premises on two occasions (8/10 and 29/13) previous to her elopement on 9/18/13. Staff #1 stated client #1 had vacated through the "front door" of the facility. Staff #1 stated, "We didn't think she would use her bedroom door."</p> <p>Confidential interview #1 indicated client #1 had eloped from the facility on the evening of 9/18/13 from the exit door in her bedroom. The interview indicated it was dark when client #1 had been found on a well traveled road heading out of the small town where she lived carrying a garbage bag of her belongings. The interview indicated staff #1 was the only staff on duty with clients #1, #2, #3, #4, #5 and #6 at the</p>						

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	<p>time of the elopement (9/18/13 between 7:35 PM and 7:50 PM).</p> <p>Interview with House Manager/HM #2 on 1/30/14 at 11:00 AM indicated the facility had not changed client #1's bedroom to one without an exit door until after she had eloped from the facility on 9/19/13. The interview indicated staff #1 was the only staff on duty that evening with six clients. The interview indicated client #1 was an emergency placement on 8/8/13 and her background information was unavailable from her prior placement which would have enhanced HM #2's ability to address client #1's behavioral needs.</p> <p>9-3-2(a)</p>			

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W000227	<p>483.440(c)(4) INDIVIDUAL PROGRAM PLAN The individual program plan states the specific objectives necessary to meet the client's needs, as identified by the comprehensive assessment required by paragraph (c)(3) of this section. Based on observation, record review and interview for 1 of 3 sampled clients (#1), the facility failed to address client #1's refusals/non-compliance with medical assessments and failed to address her stuffing objects into the toilet or throwing her personal items away.</p> <p>Findings include:</p> <p>1. Observations were conducted at the home of clients #1, #2, #3, #4, #5 and #6, on the evening of 1/29/14 from 4:15 PM until 6:00 PM and on 1/30/14 from 6:00 AM until 12:00 PM. During the observations, the bathroom near the kitchen had a toilet which was not to be used. The replacement toilet was in a box in the kitchen area.</p> <p>Staff #1 was asked how long the toilet had been out of order on 1/29/14 at 4:25 PM. Staff #1 stated "two weeks." Staff indicated a new client (client #1) had put something into the toilet and it had to be</p>	W000227	<p>W227: The individual program plan states the specific objectives necessary to meet the client's needs, as identified by the comprehensive assessment required by paragraph (c)(3) of this section. Corrective Action: Tracking the behavior of stuffing items in the toilet has been implemented and staff inserviced (Attachment E). Stuffing items in toilet and throwing clothes away have been added to her Consumer Profile (Attachment F). A desensitization goal has been implemented for Client #1, and an order for PRN medication before medical appts, procedures has been obtained (Attachment E) How we will identify others: Clinical Supervisors will review daily progress notes to ensure that if a new behavior has been observed, it has been addressed per IDT and implementation of tracking behavior has been done, also, doctor's orders will be reviewed to ensure that clients have attended their appts without concerns. Measures to be put in</p>	02/14/2014

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	<p>replaced. House Manager/HM #2 was interviewed on 1/30/14 at 11:00 AM. HM #2 indicated client #1 had exhibited the behavior of throwing away her eyeglasses, personal clothing and stuffing bathroom tissue and clothing (socks) down the facility's toilets. The current problem with the toilet was caused when client #1 put something into the tank portion of the commode.</p> <p>Client #1's record was reviewed on 1/30/14 at 8:30 AM. Client #1's record contained an Individual Support Plan/ISP dated 9/04/13 with accompanying Behavior Support Plan dated 11/09/13. The ISP contained a training goal to use the correct amount of bathroom tissue when using the bathroom; but stuffing clothing or other items into the toilet was not addressed.</p> <p>2. Client #1's record was reviewed on 1/30/14 at 8:30 AM. Client #1's record contained an Individual Support Plan/ISP dated 9/04/13 with accompanying Behavior Support Plan dated 11/09/13 and health risk plans dated 9/04/13. The client's admittance physical exam dated 8/8/13 indicated client #1 had "broken teeth" and missing molars on the left side of her mouth. The record review indicated client #1 had refused to allow the dentist to examine</p>		<p>place: Clinical Supervisors will review Doctor's orders to ensure that appts are carried out as ordered and without concerns. Monitoring of Corrective Action: Nurses will perform weekly checks (Attachment G), including physician's orders, to ensure that appts are carried out as ordered and without concerns. .Completion Date: 2-14-2014</p>		

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	<p>her teeth on 11/14/13; there had been no other attempts. The client's ob/gyn pelvic and pap exam was accomplished 11/19/13 using Xanax 0.25 mg/milligrams (2) (for anxiety). Client #1 was examined by the podiatrist on 9/26/13 and it was noted she needed to have her right great toenail removed. On 10/3/13, client #1 went to the podiatrist but refused the procedure on her toenail. There had not been another attempt. The ISP/BSP/Risk Plans did not include methodologies to assist client #1 to comply with pelvic exams, dental or podiatry treatment/exams.</p> <p>Interview with House Manager #2 and staff #6 on 1/30/14 at 11:00 AM indicated client #1 would curse the doctors and leave the examining rooms. The interview indicated she required the Xanax to accomplish the necessary pelvic exam. The interviews indicated there were no desensitization plans/methodologies in place to assist client #1 with any feelings of anxiety she may have with the medical exams.</p> <p>9-3-4(a)</p>				

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W000385	<p>483.460(l)(3) DRUG STORAGE AND RECORDKEEPING The facility must maintain records of the receipt and disposition of all controlled drugs.</p> <p>Based on observation, record review and interview for 1 additional client (#5), the facility failed to ensure the disposition of the client's controlled drug was documented correctly.</p> <p>Findings include:</p> <p>During observations at the facility on 1/30/13 at 6:43 AM, client #5 received lorazepam/Ativan 0.5 milligram/mg pills (used for seizures or panic disorders) from staff #6. Three pills of lorazepam 0.5 mg. remained in the blister package after client #5 received her medication. Staff #6 filled out the "Controlled Drug Record" (CDR) attached to the pill package and the count sheet indicated a total of four 0.5 mg. lorazepam remained. Client #5 also had 1.0 mg of lorazepam amongst her medications so the count sheet and the pills in the blister packaging were examined with staff #6. The CDR indicated one 1.0 mg, lorazepam remained but there were two 1.0 mg. pills still in the blister pack of medication.</p> <p>Review of client #5's MAR/Medication Administration Record on 1/30/14 at</p>	W000385	<p>W385: The facility must maintain records of the receipt and disposition of all controlled drugs..Corrective action:· Clinical Supervisor and staff have been inserviced on correctly counting and documenting the disposition of controlled drugs. (Attachment H). How we will identify others: Nursing Coordinators will review Controlled Drug Audit sheets to ensure that medications are being counted correctly. Measures to be put in place: Nursing Coordinators will perform weekly home visits; including checking controlled medication audit records to ensure medications are counted correctly (Attachment G). Monitoring of Corrective Action: Nursing Program Manager will review weekly Nursing checklist and perform bi-annual checklist, including checking Controlled medication audits for correct documentation. Completion Date: 2-14-2014</p>	02/14/2014			

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	<p>8:00 AM indicated she was prescribed 1.0 milligram/mg of lorazepam at hour of sleep daily for anxiety. The record review indicated a 01/14 "Controlled Drug Record" (CDR) which listed the last pill dispensed on the evening of 1/29/14 with one pill remaining. The medication's blister package was examined with House Manager/HM #2 on 1/30/14 at 8:00 AM and two pills were noted. HM #2 determined the staff had incorrectly started the CDR as if the blister package contained thirty pills instead of thirty-one pills it actually contained on 1/01/14 and the count had been off since that time.</p> <p>The 8:00 AM 1/30/14 review of client #5's MAR indicated she received 0.5 mg of lorazepam twice daily (7:00 AM and 12:00 PM). The noon medication was normally dispensed at the client's workshop during weekdays. Staff #5 (1/30/14 8:00 AM) indicated she had gone to the workshop on 1/23/14 and picked up client #5's noon medications for administration at the facility since clients had stayed home due to severe weather conditions. Staff #5 found an empty blister pack belonging to client #5 in the trash can which had held nine 0.5 mg lorazepam tablets. A CDR was found which had been with the empty package. The CDR was examined and it</p>						

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	<p>indicated staff had dispensed medication from it on 1/28/14 at 7:00 AM and the client's noon dosage for 1/28/14 had been dispensed out of another package (the one originally containing 31 tablets). The staff had not filled out the CDR correctly on 1/28/14 at the noon dosage; no time or staff signature was evident.</p> <p>Review of the Food and Drug Administration's website on 1/29/14 at 8:30 PM indicated the medication lorazepam was a schedule IV controlled drug.</p> <p>The record reviews and interviews with staff #5 and HM #2 indicated the documentation for client #5's lorazepam had not been done correctly. The interview indicated the facility's "buddy check" system and medication audits done by staff had not found the issues with the incorrect counts/documentation by staff.</p> <p>9-3-6(a)</p>				

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W000440	<p>483.470(i)(1) EVACUATION DRILLS The facility must hold evacuation drills at least quarterly for each shift of personnel. Based on record review and interview for 3 of 3 sampled clients (#1, #2 and #3), and 3 additional clients (#4, #5 and #6), the facility failed to ensure day shift evacuation drills were conducted at least quarterly.</p> <p>Findings include:</p> <p>Fire evacuation drills from 1/30/13 to 12/03/13 with clients #1, #2, #3, #4, #5 and #6 as participants, were reviewed on 1/29/14 at 4:45 PM. The review indicated no daytime (6:00 AM to 2:00 PM) drills for the second quarter of 2013 (April, May and June) and none for the fourth quarter of 2013 (October, November and December).</p> <p>Interview with House Manager staff #2 on 1/30/14 at 8:45 AM indicated there were no additional drill records for the facility for the above mentioned times.</p>	W000440	<p>W440: The facility must hold evacuation drills at least quarterly for each shift of personnel..Corrective action:· Emergency drills were completed. (Attachment I). How we will identify others: Clinical Supervisors will review drills to ensure that drills have been completed per policy. Measures to be put in place: Clinical Supervisors will review drills to ensure that drills have been completed per policy. Monitoring of Corrective Action: Quality Assurance will continue to receive drills and monitor compliance. Completion Date: 2-14-2014</p>	02/14/2014	

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