

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G389	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/29/2016
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NAME OF PROVIDER OR SUPPLIER DEVELOPMENTAL SERVICE ALTERNATIVES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 823 ALHAMBRA ANDERSON, IN 46011
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W 0000 Bldg. 00	<p>This visit was for a fundamental annual recertification and state licensure survey.</p> <p>Dates of Survey: 4/18, 4/19, 4/20, 4/21, 4/22, 4/25, and 4/29/2016.</p> <p>Facility Number: 000903 Provider Number: 15G389 AIMS Number: 100244370</p> <p>The following federal deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review of this report completed by #15068 on 5/12/16.</p>	W 0000		
W 0104 Bldg. 00	<p>483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility.</p> <p>Based on observation, record review, and interview, for 3 of 3 sample clients (clients #1, #2, and #3) and 3 additional clients (clients #4, #5, and #6), the governing body failed to exercise operating direction over the facility to ensure maintenance and repairs were completed at the group home for clients #1, #2, #3, #4, #5, and #6.</p> <p>Findings include:</p>	W 0104	<p>The following repair needs have been completed; a closetdoor has been installed in the shared closet that did not have a door, thekitchen floor has been replaced, and the kitchen counter and cabinets have beenreplaced. Additionally the replacement of the living room flooring is scheduledto be completed. Agency administratorshave a routine presence in the facility this includes an assessment for anymaintenance</p>	05/29/2016

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

TITLE

(X6) DATE

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

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	<p>Observations and interviews were conducted at the group home on 4/19/16 from 3:25pm until 5:30pm, and on 4/20/16 from 6:25am until 7:55am. Clients #1, #2, #4, #5, and #6 were observed at the group home. Client #3 was gone on a Leave of Absence (LOA) with her mother. During both observation periods the following needed repairs were observed with the Program Quality Coordinator (PQC) and the Residential Manager (RM):</p> <ul style="list-style-type: none"> -Clients #1 and #6's shared closet was missing a closet door. On 4/20/16 at 7:15am, Group Home Staff (GHS) #1 stated clients #1 and #6's "missing closet door" had been missing over "several months." On 4/20/16 at 7:15am, client #1 stated his closet door had been missing "for over a year." -The kitchen floor was uneven and slanted. Clients #1, #2, #4, #5, and #6 walked throughout the kitchen and the kitchen floor went downhill from the sink and stove areas to the opposite end where the pantry cabinet and pass through window to the living room were located. -The kitchen counter tops had cracks in the finish. -The kitchen cabinets had chipped and worn wood finish. -The living room carpet had an exposed 		<p>needs. A log of maintenance needs is kept electronically and is accessible to the administrator and maintenance supervisor for review. When a maintenance need is observed or reported to the administrator she ensures the need is listed on the log. The maintenance supervisor is notified immediately to coordinate repair of any immediate maintenance needs. The administrator will have ongoing communication with the maintenance supervisor to ensure maintenance needs are met in a timely manner. Agency QIDPs and administrators will also notate on a facility home visit note if any maintenance needs are observed. Completed house visit notes are circulated to administrators to ensure compliance.</p> <p>Responsible Party: Area Director</p>				

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W 0149 Bldg. 00	<p>seam in the carpet.</p> <p>On 4/20/16 at 9:00am, the PQC provided a "4/16/16" dated list with documented pending maintenance. The 4/16/16 maintenance list indicated "7/10/14 Cracked counter tops in kitchen...7/10/14 living room carpet has ripped seam...4/17/15 Cabinets in kitchen need refinished or replaced...4/15 Kitchen floor uneven...."</p> <p>On 4/20/16 at 9:00am, an interview with the PQC was conducted. The PQC indicated the listed items had not been repaired and/or replaced.</p> <p>9-3-1(a)</p> <p>483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. Based on record review and interview, for 3 of 16 BDDS (Bureau of Developmental Disabilities Services) reports reviewed for 2 of 6 clients (clients #1 and #4), the facility neglected to implement their policy and procedures for abuse, neglect, and/or mistreatment, to implement sufficient corrective actions for client #1's continued AWOL (Absent Without Leave) behaviors, and to ensure</p>	W 0149	Client #1's team including the client, his parents, the behavior consultant, QIDP, day program manager, BDDS service coordinator, and two agency administrators met on 5/3/16. The repeated AWOL behavior was discussed at this meeting. At this time the team, including the employer, has determined that the client cannot safely maintain the community job from which he has gone AWOL on two occasions at this	05/29/2016

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	<p>sufficient staff were available to supervise client #4 when he was left home alone.</p> <p>Findings include:</p> <p>On 4/18/16 at 12:45pm and on 4/20/16 at 11:30am, the facility's BDDS (Bureau of Developmental Disabilities Services) Reports, non reportable incident reports, and investigations were reviewed and included the following for clients #1 and #4:</p> <p>1. For client #1: -A 4/20/16 BDDS report for an incident on 4/19/16 at 12:30pm indicated client #1 "left his community employment at [Name of Restaurant] 5 minutes before the end of shift and walked to a restaurant next door. The two businesses share a parking lot and [client #1] didn't cross any intersections...[Name of Community employment Restaurant] located [client #1]...and brought him back to [Name of Community employment Restaurant] where [Group Home Staff] then transported him to [Name of Workshop]." The report indicated staff will continue to monitor. No corrective actions were available for review.</p> <p>-A 2/3/16 BDDS report for an incident on 2/3/16 at 12:30pm indicated staff from</p>		<p>time. He understands this. The team also discussed the function of this behavior was to access a telephone. He has had an increase in his obsession about a female in the community and a need to use a telephone to request assistance to locate and communicate with her. The team agreed that his access to phones shall be restricted to supervised use only and that minutes will not be added to a cell phone he possesses. It was also identified he would benefit from living in a home where there is more staffing support available. The process has started with BDDS to apply for and plan for transition to a facility with a higher staffing level. The facility is also assisting his parents with completing the process to become this client's legal guardian. The team also recommended that the client be evaluated by his psychiatry provider regarding a noted increase in obsessive behavior. He was evaluated on 5/5/16 and a medication change was made. This change has been implemented and is being monitored for effectiveness. The team will be meeting again in 3 months to discuss progress. The QIDP and administrator have identified that in the future the Individual Support Team for any client shall convene to develop and monitor strategies following any incident during the safety of a client and/or the community may be at risk such as going AWOL from the team</p>				

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	<p>the group home "dropped [client #1] off at his community employment [name of Restaurant], and watched [client #1] walk inside. [Client #1] waited on staff to leave the area and walked back outside to a bank located a few blocks away where he inquired about his finances. [Client #1] then walked back to his community employment where he completed his job requirements for his shift...The QIDP (Qualified Intellectual Disabilities Professional) has also reviewed with [client #1] not to leave his community job without a staff person until (the Interdisciplinary Team) has agreed it is appropriate for him to do so." No corrective actions were available for review.</p> <p>-A 3/4/16 Follow up BDDS report indicated client #1 "does receive 24 hour staff supervision in the group home. He does work at [name of Restaurant] in the community. He does not receive staff supervision...when at this job. He is not approved for any other time that is not supervised by (staff)." No corrective actions were available for review.</p> <p>2. For client #4: -A 1/5/16 BDDS report for an incident on 1/4/16 at 5:00pm indicated Group Home Staff (GHS) #3 "drove [client #4] home from day program and watched him walk</p>		<p>agreed neededlevel of supervision. Also to ensureimplementation of strategies immediately to ensure safety until the team meets.The Program Quality Coordinator reviews all incident reports and associatedinvestigations and other corrective activities. This administrator will alsomonitor to ensure implementation and discussion of ongoing strategies to ensuresafety. At this time no other immediate safety concerns involving any otherclients in the home have been identified.</p> <p>The staff person who failed to ensure client #4 had staffsupervision on 1/4/16 did receive disciplinary action. The facility has alsoimplemented a procedure in which staff must communicate face to face any timethe responsibility of supervision of a client changes from one employee toanother. There have been no furtherincidents of this nature. The QIDP and administrator have a routine presence inthe home to ensure all needs are met of the clients, including theirsupervision needs. Responsible Party: QIDP</p>		

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	<p>into the group home. [Client #4] walked into the home without incident and [GHS #3] left without verifying that staff were in the home. [Client #4] was able to enter the home as the door had not latched properly when the last person left. [Client #4] was left unattended for a short amount of time until another staff member arrived for her shift and discovered him there alone."</p> <p>-A 1/7/16 Follow up BDDS report indicated "the staff in question admitted to not ensuring staff were in the home before leaving...[Client #4] was in the home for 30 minutes prior to the next staff arriving at the home...Transportation procedures now include that any staff providing transportation to [client #4] or any other consumer to a home where they are not going to remain as staff will assure that staff are present to provide the required supervision prior to leaving."</p> <p>On 4/21/16 at 8:30am, an interview with the Program Quality Coordinator (PQC) was conducted. The PQC indicated the facility followed the BDDS reporting guidelines for abuse, neglect, and/or mistreatment. The PQC indicated the facility Interdisciplinary Team (IDT) met after client #1's continued AWOL behaviors and continue to monitor client #1's behaviors. The PQC stated clients</p>			

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	<p>#1 and #4 should be supervised by the facility staff "at all times." The PQC indicated client #1 worked in the community and did not have facility staff at his community employment position. The PQC indicated clients #1 and #4 did not have safety skills to be safe alone in the community. The PQC indicated neglect included leaving the clients alone without staff supervision. The PQC indicated no corrective actions after client #1's AWOL behavioral incidents were provided for review.</p> <p>On 4/25/16 at 8:30am, and on 4/29/16 at 3:40pm, the PQC indicated no further information was available for review.</p> <p>Client #1's record was reviewed on 4/21/16 at 10:20am. Client #1's 3/29/16 ISP (Individual Support Plan), 12/2015 BSP (Behavior Support Plan), and 2016 Risk Plans indicated client #1 "required" staff supervision 24 hours a day. Client #1's plans indicated he had targeted behaviors of: physical aggression, vacating, Inappropriate social behaviors, and anger control. Client #1's BSP and Risk Plan indicated client #1 should "be kept within eye sight" for staff supervision. Client #1's 12/2015 "Levels of Community Risk Assessment" indicated "Level 3: Individual is considered to be at a high risk level while</p>			

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	<p>in the community. Areas of risk jeopardize the safety of the individual exposing them to dangerous situations and possible loss. The individual requires constant supervision while in the community."</p> <p>Client #4's record was reviewed on 4/21/16 at 9:35am. Client #4's 9/9/15 ISP and 6/15 BSP indicated client #4 "required" staff supervision "at all times." Client #4's 8/15 FA (Functional Assessment) indicated client #4 was not able to be left home alone without staff supervision. Client #4's plans indicated staff were to be within eye sight of client #4.</p> <p>On 4/18/16 at 12:00noon, a record review was conducted of the 10/2005 "Bureau of Developmental Disabilities Services Policy and Guidelines." The BDDS policy and procedure indicated "...Abuse, Neglect, and Mistreatment of Individuals...it is the policy of the company to ensure that individuals are not subjected to physical, verbal, sexual, or psychological abuse or exploitation by anyone including but not limited to: facility staff...other individuals, or themselves." The policy indicated "Neglect, the failure to supply an individual's nutritional, emotional, physical, or health needs although</p>			

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W 0157 Bldg. 00	<p>sources of such support are available and offered and such failure results in physical or psychological harm to the individual." The BDDS policy indicated each allegation of abuse, neglect, and/or mistreatment should be immediately reported.</p> <p>On 4/18/16 at 12:00noon, the facility's 10/13 "Preventing Abuse and Neglect" policy and procedure indicated "Abuse means the following: 1. Intentional or willful infliction of physical injury...7. Corporal Punishment which includes forced physical (sic), hitting, pinching, application of painful or noxious stimuli, use of electric shock, and the infliction of physical pain...9. Violation of individual rights....Neglect means failure to provide supervision, training, appropriate care, food, medical care, or medical supervision to an individual." The policy and procedure indicated "all" allegations of abuse and/or neglect should be immediately reported to the administrator and to BDDS in accordance with State Law and should be thoroughly investigated.</p> <p>9-3-2(a)</p> <p>483.420(d)(4) STAFF TREATMENT OF CLIENTS If the alleged violation is verified, appropriate</p>			

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	<p>corrective action must be taken.</p> <p>Based on record review and interview, for 3 of 16 BDDS (Bureau of Developmental Disabilities Services) reports reviewed for 1 of 3 sampled clients (client #1), the facility failed to implement sufficient corrective actions for client #1's continued AWOL (Absent Without Leave) behaviors.</p> <p>Findings include:</p> <p>On 4/18/16 at 12:45pm and on 4/20/16 at 11:30am, the facility's BDDS (Bureau of Developmental Disabilities Services) Reports, non reportable incident reports, and investigations were reviewed and included the following for client #1:</p> <p>-A 4/20/16 BDDS report for an incident on 4/19/16 at 12:30pm indicated client #1 "left his community employment at [Name of Restaurant] 5 minutes before the end of shift and walked to a restaurant next door. The two businesses share a parking lot and [client #1] didn't cross any intersections...[Name of Community employment Restaurant] located [client #1]...and brought him back to [Name of Community employment Restaurant] where [Group Home Staff] then transported him to [Name of Workshop]." The report indicated staff will continue to monitor. No corrective</p>	W 0157	<p>Client #1's team including the client, his parents, the behavior consultant, QIDP, day program manager, BDDS service coordinator, and two agency administrators met on 5/3/16. The repeated AWOL behavior was discussed at this meeting. At this time the team, including the employer, has determined that the client cannot safely maintain the community job from which he has gone AWOL on two occasions at this time. He understands this. The team also discussed the function of this behavior was to access a telephone. He has had an increase in his obsession about a female in the community and a need to use a telephone to request assistance to locate and communicate with her. The team agreed that his access to phones shall be restricted to supervised use only and that minutes will not be added to a cell phone he possesses. It was also identified he would benefit from living in a home where there is more staffing support available. The process has started with BDDS to apply for and plan for transition to a facility with a higher staffing level. The facility is also assisting his parents with completing the process to become this client's legal guardian. The team also recommended that the client be evaluated by his psychiatry provider regarding a noted increase in obsessive behavior. He was evaluated on 5/5/16 and a</p>	05/29/2016
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	<p>actions were available for review.</p> <p>-A 2/3/16 BDDS report for an incident on 2/3/16 at 12:30pm indicated staff from the group home "dropped [client #1] off at his community employment [name of Restaurant], and watched [client #1] walk inside. [Client #1] waited on staff to leave the area and walked back outside to a bank located a few blocks away where he inquired about his finances. [Client #1] then walked back to his community employment where he completed his job requirements for his shift...The QIDP (Qualified Intellectual Disabilities Professional) has also reviewed with [client #1] not to leave his community job without a staff person until (the Interdisciplinary Team) has agreed it is appropriate for him to do so." No corrective actions were available for review.</p> <p>-A 3/4/16 Follow up BDDS report indicated client #1 "does receive 24 hour staff supervision in the group home. He does work at [name of Restaurant] in the community. He does not receive staff supervision...when at this job. He is not approved for any other time that is not supervised by (staff)." No corrective actions were available for review.</p> <p>On 4/21/16 at 8:30am, an interview with</p>		<p>medication change was made. This change has been implemented and is being monitored for effectiveness. The team will be meeting again in 3 months to discuss progress. The QIDP and administrator have identified that in the future the Individual Support Team for any client shall convene to develop and monitor strategies following any incident during the safety of a client and/or the community may be at risk such as going AWOL from the team agreed needed level of supervision. Also to ensure implementation of strategies immediately to ensure safety until the team meets. The Program Quality Coordinator reviews all incident reports and associated investigations and other corrective activities. This administrator will also monitor to ensure implementation and discussion of ongoing strategies to ensure safety. At this time no other immediate safety concerns involving any other clients in the home have been identified.</p> <p>Responsible Party: QIDP</p>		

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	<p>the Program Quality Coordinator (PQC) was conducted. The PQC indicated the facility Interdisciplinary Team (IDT) met after client #1's continued AWOL behaviors and continue to monitor client #1's behaviors. The PQC stated client #1 should be supervised by the facility staff "at all times." The PQC indicated client #1 worked in the community and did not have facility staff at his community employment position. The PQC indicated client #1 did not have safety skills to be safe alone in the community. The PQC indicated no corrective actions after client #1's AWOL behavioral incidents were provided for review.</p> <p>On 4/25/16 at 8:30am, and on 4/29/16 at 3:40pm, the PQC indicated no further information was available for review.</p> <p>Client #1's record was reviewed on 4/21/16 at 10:20am. Client #1's 3/29/16 ISP (Individual Support Plan), 12/2015 BSP (Behavior Support Plan), and 2016 Risk Plans indicated client #1 "required" staff supervision 24 hours a day. Client #1's plans indicated he had targeted behaviors of: physical aggression, vacating, Inappropriate social behaviors, and anger control. Client #1's BSP and Risk Plan indicated client #1 should "be kept within eye sight" for staff supervision. Client #1's 12/2015 "Levels</p>						

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(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
W 0210 Bldg. 00	<p>of Community Risk Assessment" indicated "Level 3: Individual is considered to be at a high risk level while in the community. Areas of risk jeopardize the safety of the individual exposing them to dangerous situations and possible loss. The individual requires constant supervision while in the community." No revisions to client #1's plans after the continued incidents were available for review.</p> <p>9-3-2(a)</p> <p>483.440(c)(3) INDIVIDUAL PROGRAM PLAN Within 30 days after admission, the interdisciplinary team must perform accurate assessments or reassessments as needed to supplement the preliminary evaluation conducted prior to admission. Based on record review and interview, for 2 of 2 sampled clients (clients #2 and #3) who were new admissions to the facility, the facility failed to ensure clients #2 and #3's new admission assessments were completed within 30 days of admission to the facility.</p> <p>Findings include:</p> <p>1. Client #3's record was reviewed on 4/21/16 at 11:15am. Client #3's record indicated she was admitted to the facility on 2/27/16. Client #3's record indicated a</p>	W 0210	The QIDP and facility nurse understand their responsibility to ensure completion of all new admission assessments to include a complete physical by a primary care physician, nursing admission assessment, a hearing assessment, a vision assessment, a dental assessment, a functional assessment, and TB testing. Those items that are listed as needed for client #3 and client #2 have been completed or are scheduled to be completed by the professional required to complete the assessment at the earliest time	05/29/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G389		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 04/29/2016	
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	<p>Functional Assessment completed on 4/2016, a Mantoux (TB testing) completed 3/24/16, and did not include a history and physical (H & P) completed by her physician, a nursing admission assessment, a hearing assessment, a visual assessment, and a dental assessment available for review. Client #3's 3/28/16 ISP (Individual Support Plan) indicated she wore glasses to see.</p> <p>On 4/25/16 at 8:00am, an interview was conducted with the PQC (Program Quality Coordinator). The PQC stated client #3's history and physical will be completed 5/17/16, a dental exam and cleaning will be completed on 5/4/16, a PT/OT (Physical Therapy/Occupational Therapy) assessment will be completed on 5/17/16, client #3's "next scheduled Psychiatry appointment will be (on) 6/1/16," and client #3 "is due for a vision exam next year per Medicaid. We have requested documentation from her last exam." The PQC indicated client #3's assessments were not completed within 30 days of admission to the facility on 2/27/16.</p> <p>2. Client #2's record was reviewed on 4/21/16 at 8:40am. Client #2's record indicated he was admitted on 12/31/15. Client #2's record indicated a Functional Assessment completed on 2/2016,</p>		<p>they were available. The Program Quality Coordinator has also developed and is utilizing a tracking system to ensure all new admission assessments are completed and current within the first 30 days of admission to any DSA facility. The QIDP and nurse are prompted as needed to ensure completion and to provide verification of completion. The administrator is updated regarding status as needed.</p> <p>Responsible Party: QIDP</p>				

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W 0440 Bldg. 00	<p>4/22/16 history and physical, a Mantoux completed on 3/14/16, a hearing assessment completed 9/30/2008, a 9/25/2012 visual assessment which indicated full time wear of his prescribed glasses, and a 5/8/15 dental assessment which indicated to be seen again in three (3) months. Client #2's record had no updated assessments completed within 30 days of admission to the facility.</p> <p>On 4/25/16 at 8:00am, an interview was conducted with the PQC (Program Quality Coordinator). The PQC indicated client #2 had his history and physical completed by his physician on 4/22/16. The PQC indicated client #2's assessments were not completed within 30 days of his admission to the facility on 12/30/15.</p> <p>9-3-4(a)</p> <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, the facility failed for 3 of 3 sampled clients (#1, #2, and #3) and 3 additional clients (#4, #5, and #6), by not ensuring an evacuation drill was conducted quarterly for the overnight shift (10:00pm - 7:00am) from 6/24/15 until 11/20/15,</p>	W 0440	The agency has a Professional Presence policy which includes the use of a home visit note that directs items professional staff review when in the program. The QIDP is in the home no less than weekly and completed the form. This form has been updated to	05/29/2016

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	<p>from 11/20/15 until 4/19/16 for the overnight shift, for the day shift (6:00am until 2:00pm) from 7/19/15 until 12/31/15, and for the evening shift (2:00pm until 10:00pm) from 5/9/15 until 10/6/15.</p> <p>Findings include:</p> <p>The facility's evacuation drills were reviewed on 4/19/16 at 4:55pm. The review indicated the facility had failed to conduct evacuation drills for clients #1, #2, #3, #4, #5, and #6 for the following:</p> <ul style="list-style-type: none"> -After an emergency drill 6/24/15 at 3:40am and before 11/20/15 at 4:03am, for the overnight shift personnel. -After an emergency drill on 11/20/15 and before 4/19/16 for the overnight shift personnel. -After an emergency drill on 7/19/15 at 1:20pm and before 12/31/15 at 1:40pm for the day shift personnel. -After an emergency drill on 5/9/15 at 6:55pm and before 10/6/15 at 4:10pm for the evening shift personnel. <p>An Interview with the PQC (Program Quality Coordinator) was conducted on 4/21/16 at 11:00am, 4/25/16 at 8:30am, and on 4/29/16 at 3:40pm. The PQC indicated she was unable to locate any further evacuation drills for the</p>		<p>include areview of evacuation drills that have been completed and to take steps toensure any needed drills are completed. A copy of this form is provided for review as an attachment. The QIDPwill be trained on this updated expectation. The QIDP will also will retrainall staff in the home regarding the expectations for completing evacuationdrills. The administrator will be copied on provided training to verifycompletion. The administrator is also provided copies of the completed homevisit notes to verify the QIDP is reviewing and ensuring completion of requiredevacuation drills.</p> <p>Responsible Party: QIDP</p>				

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/27/2016
FORM APPROVED
OMB NO. 0938-0391

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	overnight, day, and evening shifts of personnel for clients #1, #2, #3, #4, #5, and #6. 9-3-7(a)				