

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G307	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/04/2013
NAME OF PROVIDER OR SUPPLIER CHILD ADULT RESOURCES SRV INC			STREET ADDRESS, CITY, STATE, ZIP CODE 206 W STATE ST KINGMAN, IN 47952		
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W000000	<p>This visit was for a recertification and state licensure survey.</p> <p>Dates of Survey: September 25, 30 and October 4, 2013</p> <p>Provider Number: 15G307 Aims Number: 100249120 Facility Number: 000826</p> <p>Surveyor: Mark Ficklin, QIDP</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 10/16/13 by Ruth Shackelford, QIDP.</p>	W000000			

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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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 record review and interview, the facility failed to implement its policy and procedures to prevent client to client abuse (physical aggression) and thoroughly investigate 1 of 5 incidents reviewed for allegations of abuse (clients #1, #3, #4, #6).</p> <p>Findings include:</p> <p>The facility's reportable incidents were reviewed on 9/25/13 at 12:12p.m. A reportable incident report, dated 8/27/13, indicated: clients #1 and #3 had a physical altercation and client #1 was redirected to his bedroom by staff. The report indicated there were 2 staff involved with the intervention. On the way to his bedroom client #1 went past the dining room table where clients #4 and #6 were seated. The report indicated client #1 hit client #4 on the head and grabbed client #6's left arm as he passed by them on the way to his bedroom. The incident report investigation indicated the facility had interviewed one staff and one client (#3).</p> <p>The facility's policy and procedures were reviewed on 9/30/13 at 8:04a.m. The</p>	W000149	<p>October 21, 2013 – C.A.R.S. Investigation Policy & Procedure was updated to note the following additions / changes (1) Time Frame of Investigation - The entire investigation will be completed within 5 business days of the initial identification of the incident – including Notification, Investigation Report, Findings and Corrective Action [originally the procedure was 7 business days] (2) Investigation Report - If a staff person, individual, witness and/or an alleged victim was not able to be interviewed – the Investigator will document the reasoning on the final report [originally this statement was not in the procedure] (3) Investigation Report – The Investigator will also submit the Investigation Report to Quality Assurance Coordinator(s) due to QA assists Division Director with Follow-Up tasks. [Originally procedure did not include submitting report to QA]. Furthermore, allowing Quality Assurance Coordinator(s) to review all investigation reports, this will allow for a thorough quality check to ensure the C.A.R.S. Investigation Policy & Procedure is being followed. October 22, 2013 – Both Quality Assurance Coordinators were trained on the updated C.A.R.S.</p>	11/04/2013	

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	<p>facility's "Investigation POLICY AND PROCEDURE," dated 1/13 and identified as current, indicated, "...It is C.A.R.S. policy to ensure that all allegations of abuse, neglect, exploitation, mistreatment as well as injuries of an unknown origin are reported immediately to the Division Director...and that an internal investigation can be initiated to protect the individual. ...Client to client physical aggression is to be considered abuse and needs to be investigated. ...the investigator is encouraged to complete the following steps that may include but not limited to.. identify all staff persons and/or individuals who may be potential witnesses to the incident...interview the following participants, alleged staff persons, alleged victims, witnesses and any other pertinent person to the investigation."</p> <p>Professional staff #2 (Quality Assurance) was interviewed on 9/30/13 at 9:24a.m. Staff #2 indicated there were 2 staff and 4 clients involved in the incident. Staff #2 indicated they had interviewed one staff and one client (#3). Staff #2 indicated the other staff and the 3 other clients involved had not been interviewed.</p> <p>9-3-2(a)</p>		<p>Investigation Policy & Procedure dated 10/2013 noting the above mentioned additions / changes. It was also noted in this training that the Investigator needs to identify and interview all staff, individuals, witnesses and alleged victims that are either mentioned in the initial report or thought to have pertinent information to the investigation. November 4, 2013 – Adult Management Team Members will be trained on the updated 10/2013 Investigation Policy & Procedure noting the above mentioned additions / changes. It will also be noted that the Investigator needs to identify and interview all staff, individuals, witnesses and alleged victims that are either mentioned in the initial report or thought to have pertinent information to the investigation. Training material will be reviewed again on November 8th during the Management Team Meeting.</p>				

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W000154	<p>483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated.</p> <p>Based on record review and interview, the facility failed to thoroughly investigate 1 of 5 incidents reviewed for allegations of (physical aggression) client to client abuse (clients #1, #3, #4 and #6).</p> <p>Findings include:</p> <p>The facility's reportable incidents were reviewed on 9/25/13 at 12:12p.m. A reportable incident report, dated 8/27/13, indicated: clients #1 and #3 had a physical altercation and client #1 was redirected to his bedroom by staff. The report indicated there were 2 staff involved with the intervention. On the way to his bedroom client #1 went past the dining room table where clients #4 and #6 were seated. The report indicated client #1 hit client #4 on the head and grabbed client #6's left arm as he passed by them on the way to his bedroom. The incident report investigation indicated the facility had interviewed one staff and one client (#3).</p> <p>Professional staff #2 (Quality Assurance) was interviewed on 9/30/13 at 9:24a.m. Staff #2 indicated there were 2 staff and 4 clients involved in the incident. Staff #2</p>	W000154	<p>October 21, 2013 – C.A.R.S. Investigation Policy & Procedure was updated to note the following additions / changes (1) Time Frame of Investigation - The entire investigation will be completed within 5 business days of the initial identification of the incident – including Notification, Investigation Report, Findings and Corrective Action [originally the procedure was 7 business days] (2) Investigation Report - If a staff person, individual, witness and/or an alleged victim was not able to be interviewed – the Investigator will document the reasoning on the final report [originally this statement was not in the procedure] (3) Investigation Report – The Investigator will also submit the Investigation Report to Quality Assurance Coordinator(s) due to QA assists Division Director with Follow-Up tasks. [Originally procedure did not include submitting report to QA]. Furthermore, allowing Quality Assurance Coordinator(s) to review all investigation reports, this will allow for a thorough quality check to ensure the C.A.R.S. Investigation Policy & Procedure is being followed.</p> <p>October 22, 2013 – Both Quality Assurance Coordinators were trained on the updated C.A.R.S.</p>	11/04/2013			

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	indicated they had interviewed one staff and one client (#3). Staff #2 indicated the other staff and the 3 other clients involved had not been interviewed. 9-3-2(a)		Investigation Policy & Procedure dated 10/2013 noting the above mentioned additions / changes. It was also noted in this training that the Investigator needs to identify and interview all staff, individuals, witnesses and alleged victims that are either mentioned in the initial report or thought to have pertinent information to the investigation. November 4, 2013 – Adult Management Team Members will be trained on the updated 10/2013 Investigation Policy & Procedure noting the above mentioned additions / changes. It will also be noted that the Investigator needs to identify and interview all staff, individuals, witnesses and alleged victims that are either mentioned in the initial report or thought to have pertinent information to the investigation. Training material will be reviewed again on November 8th during the Management Team Meeting.		

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W000189	<p>483.430(e)(1) STAFF TRAINING PROGRAM The facility must provide each employee with initial and continuing training that enables the employee to perform his or her duties effectively, efficiently, and competently.</p> <p>Based on record review and interview, the facility failed for 1 of 2 sampled clients (#1) with a social integration plan (SIP) to ensure all staff received initial and continued training on the client's SIP.</p> <p>Findings include:</p> <p>The facility incident reports were reviewed on 9/25/13 at 12:12p.m. Client #1 had an incident report on 9/4/13 for physical aggression. The report indicated client #1 had a "new SIP developed and continue to alert him to any changes in the home." The 9/4/13 incident report indicated staff were to be reminded of the importance of being able to keep other individuals safe during a behavior. There was documentation staff had been trained on the new SIP on 8/1/13. There was no documentation the facility staff had been retrained since the 8/1/13 training.</p> <p>The record of client #1 was reviewed on 9/30/13 at 12:29p.m. Client #1's record indicated he had a SIP updated on 8/1/13. The SIP indicated staff had been trained on 8/1/13.</p>	W000189	<p>August 19, 20, 21 2013 – Kingman house staff along with Shawnee center facility staff was trained on Client #1's August SIP. September 5, 2013 – Kingman house staff was trained on Client #1's September SIP. October 22/23 2013 – Shawnee Center facility staff was trained on client #1's September SIP November 4, 2013 – Kingman House staff will be trained by the Quality Assurance Coordinator on the C.A.R.S. Crisis Aversion Policy & Procedure. November 4, 2013 – Members of the Adult Management Team will be trained by the Quality Assurance Coordinator on the C.A.R.S. Crisis Aversion Policy & Procedure. This policy describes procedures for proper staff intervention during crisis situations, when to involve police, necessary notification and documentation of a crisis situation and necessary follow-up actions after a crisis situation such as re-training of direct care staff. QA will stress the importance to all direct care staff about following a behavior plan, using verbal de-escalation, least restrictive techniques and physical CPI techniques</p>	11/04/2013			

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	<p>Interview of direct care staff #5 on 9/30/13 at 6:57a.m., indicated they had been reminded about client #1's behavior interventions after the 9/4/13 incident.</p> <p>Interview of professional staff #2 was done on 9/30/13 at 9:24a.m. Staff #2 indicated direct care staff had been reminded of client #1's interventions since the 9/4/13 incident but did not know if there was documentation of this training. Staff #2 indicated they planned to retrain all staff on client #1's SIP.</p> <p>9-3-3(a)</p>		<p>systematically before police should be involved. QA will stress the importance to the Management Team members about re-training direct care staff when police are involved and/or physical CPI techniques are used. Training material will also be reviewed again on November 7th during the Residential In-service and on November 8th during the Management Meeting. Effective October 1, 2013 – The QMRP along with other members of the C.A.R.S. Management Team will oversee direct care staff to (1) ensure staff are implementing resident's behavior plan as it is written (2) ensure staff is able to demonstrate continuous competency in implementing a resident's behavior plan (3) assess staff's ongoing training needs in regards to implementing a residents behavior plan. Overseeing may include but is not limited to: (a) Direct observation of direct care staff while they are performing direct care/active treatment (b) Conducting a review of all incident reports that have been submitted by direct care staff (c) Interviewing direct care staff to analyze their knowledge in regards to implementing a resident's behavior plan. (d) Interviewing direct care staff after a crisis situation to analyze their actions and determine if staff properly followed the behavior plan. Based on what information</p>		

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			<p>the QMRP and members of C.A.R.S. Management Team has gathered by overseeing direct care staff – it will determine if staff person(s) need further training in implementing a resident's behavior plan.</p> <p>Effective October 1, 2013 – each month during Quality Assurance reviews, Quality Assurance Coordinators will review Care Tracker reports, Quarterly Plan Services Review forms, meeting notes, behavior plans, ISP and other relevant documentation to ensure appropriate individual program plans and behavior plans are in place as deemed necessary for all residents. Quality Assurance Coordinators will also review staff training sheets to ensure all appropriate staff has been trained on the implementation of resident's individual program / behavior plans.</p>		

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W000249	<p>483.440(d)(1) PROGRAM IMPLEMENTATION</p> <p>As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan.</p> <p>Based on observation, record review, and interview, the facility failed for 1 of 4 sampled clients (#2) to ensure client #2's training program (refrain from completing others task in the kitchen) was implemented when opportunities were present.</p> <p>Findings include:</p> <p>An observation was done at the group home on 9/30/13 from 6:43a.m. to 8:01a.m. At 7:11a.m. staff prompted client #5 to put a roast in the crock pot for supper. Client #2 was in the kitchen and opened the roast packages and started toward the crock pot. Staff #4 reminded client #2 that it was client #5's turn to cook. Client #2 remained in the kitchen and received no more prompts from staff to let client #5 do his assigned job in the kitchen. Client #5 then took the roast and put it in the crock pot. Client #2 tried to get to the crock pot to set the cooking temperature. Client #5 blocked him from the crock pot and verbally redirected</p>	W000249	<p>November 4, 2013 – Client #2's objective (Refrain from completing other's tasks each day with 3 or less verbal prompts) will be reinstated. Shawnee Center staff was trained on Client #2's objective on October 23rd while Kingman staff will be trained on Client #2's objective on November 4th. October 3, 2013 –Quality Assurance Coordinator trained all residential staff during the Residential In-service regarding Regulation W249. QA trained on the importance of completing individual program plans as they are scheduled as well as during all informal opportunities. QA trained on how individual program plans cannot be considered "achieved" unless there are sufficient number / frequency of trials. QA trained on the necessity of implementing training programs during scheduled times – such as during meal preparation and during all informal opportunities. Since May 1, 2012, C.A.R.S. has been utilizing an electronic data collection system called Care</p>	11/04/2013	

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	<p>client #2 to leave the kitchen. Client #2 stayed in the kitchen.</p> <p>The record of client #2 was reviewed on 9/30/13 at 11:10a.m. Client #2's 1/10/13 individual support plan (ISP) indicated he had a training program to refrain from completing others task. The plan indicated client #2 enjoys cooking and often will disrupt others if they are cooking. The plan indicated client #2 requires excessive prompts to not disrupt others in the kitchen.</p> <p>Professional staff #1 was interviewed on 9/30/13 at 1:02p.m. Staff #1 indicated client #2's training program to refrain from disrupting others in the kitchen should have been implemented at all opportunities.</p> <p>9-3-4(a)</p>		<p>Tracker. Direct Care staff can input data into the system 24 / 7 through a computer / kiosk. QMRP along with other members of the C.A.R.S. Management Team are able to go into Care Tracker on a daily basis and pull information/reports out of Care Tracker to view a resident's progress on individual program plans. QMRP along with other members of the C.A.R.S. Management Team are also able to retrieve a "Missed Observation" report showing what direct care staff has not tracked on. Based on this Missed Observation report – the appropriate management supervisor can immediately discuss with direct care staff the circumstances as to why an individual program plan was not implemented and/or documented on. Effective October 1, 2013 – The QMRP along with other members of the C.A.R.S. Management Team will oversee direct care staff to (1) ensure staff are implementing resident's individual program plan as they are scheduled (2) ensure staff is able to demonstrate continuous competency in implementing resident's individual program plans (3) assess staff's ongoing training needs in regards to implementing residents individual program plans. Overseeing may include but is not limited to: (a) Reviewing Care Tracker Missed Observation Report (b) Direct observation of direct care staff</p>		

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			<p>while they are performing direct care/active treatment (c) Conducting a review of all incident reports that have been submitted by direct care staff (d) Interviewing direct care staff to analyze their knowledge in regards to implementing resident's individual program plans. Based on what information the QMRP and members of C.A.R.S. Management Team has gathered by overseeing direct care staff – it will determine if staff person(s) need further training in implementing resident's individual program plans. Effective October 1, 2013 – each month during Quality Assurance reviews, Quality Assurance Coordinators will review Care Tracker reports, Quarterly Plan Services Review forms, meeting notes, ISP and other relevant documentation to ensure appropriate individual program plans are in place as deemed necessary for all residents. Quality Assurance Coordinators will also review staff training sheets to ensure all appropriate staff has been trained on the implementation of resident's individual program plans. Information based on Care Tracker is discussed during the resident's 90-day review meetings – meetings include but is not limited to the QMRP, resident, family members and other members of the IDT. Discussion includes: what</p>		

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			<p>changes need to be made to the resident's individual program plans, what progress a resident is making with his/her program plans, if a new program plan is needed for a resident, etc.</p> <p>Determining whether an individual program plan needs to be rewritten / discontinued / achieved is based on number of trials, achievement percentage and achievement criteria.</p> <p>C.A.R.S. IDT follows the standard that in order for an individual program plan to be achieved – there must be sufficient number / frequency of trials for that plan.</p>		

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W000289	<p>483.450(b)(4) MGMT OF INAPPROPRIATE CLIENT BEHAVIOR</p> <p>The use of systematic interventions to manage inappropriate client behavior must be incorporated into the client's individual program plan, in accordance with §483.440(c)(4) and (5) of this subpart. Based on record review and interview, the facility failed for 1 of 2 sampled clients (#1) with a restrictive behavior management plan, to ensure that all interventions (call the police) to manage client #1's behavior were included in the client's Social Integration Plan (SIP).</p> <p>Findings include:</p> <p>Record review of the facility incident reports was done on 9/25/13 at 12:12p.m. Client #1 had the following behavior reports where it was indicated police had been called for assistance: 7/1/13, behavior with physical aggression; 8/27/13, behavior with physical aggression; 9/4/13 behavior with physical aggression.</p> <p>Record review for client #1 was done on 9/30/13 at 12:29p.m. Client #1 had a 8/13 SIP that addressed physical aggression. Client #1's 8/13 SIP did not address the behavior intervention (police) of when to call the police.</p>	W000289	<p>"When to call police" is not included in a behavior plan because direct care staff are expected to follow the C.A.R.S. Crisis Aversion policy & procedure. November 4, 2013 – Kingman House staff will be trained by the Quality Assurance Coordinator on the C.A.R.S. Crisis Aversion Policy & Procedure. November 4, 2013 – Members of the Adult Management Team will be trained by the Quality Assurance Coordinator on the C.A.R.S. Crisis Aversion Policy & Procedure. This policy describes procedures for proper staff intervention during crisis situations, when to involve police, necessary notification and documentation of a crisis situation and necessary follow-up actions after a crisis situation such as re-training of direct care staff. QA will stress the importance to all direct care staff about following a behavior plan, using verbal de-escalation, least restrictive techniques and physical CPI techniques systematically before police should be involved. QA will stress the importance to the</p>	11/04/2013			

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	<p>Professional staff #1 was interviewed on 9/30/13 at 1:02p.m. Staff #1 indicated staff had called the police for behavior intervention assistance for client #1 on 7/1/13, 8/27/13 and on 9/4/13. Staff #1 indicated direct care staff had called professional staff before calling the police. Staff #1 indicated client #1 did not have the behavior intervention to call the police as a part of his SIP.</p> <p>9-3-5(a)</p>		<p>Management Team members about re-training direct care staff when police are involved and/or physical CPI techniques are used. Training material will also be reviewed again on November 7th during the Residential In-service and on November 8th during the Management Meeting. Effective October 1, 2013 – The QMRP along with other members of the C.A.R.S. Management Team will oversee direct care staff to (1) ensure staff are implementing resident's behavior plan as it is written (2) ensure staff is able to demonstrate continuous competency in implementing a resident's behavior plan (3) assess staff's ongoing training needs in regards to implementing a residents behavior plan. Overseeing may include but is not limited to: (a) Direct observation of direct care staff while they are performing direct care/active treatment (b) Conducting a review of all incident reports that have been submitted by direct care staff (c) Interviewing direct care staff to analyze their knowledge in regards to implementing a resident's behavior plan. (d) Interviewing direct care staff after a crisis situation to analyze their actions and determine if staff properly followed the behavior plan. Based on what information the QMRP and members of C.A.R.S. Management Team has</p>	

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			gathered by overseeing direct care staff – it will determine if staff person(s) need further training in implementing a resident’s behavior plan. Effective October 1, 2013 – each month during Quality Assurance reviews, Quality Assurance Coordinators will review Care Tracker reports, Quarterly Plan Services Review forms, meeting notes, behavior plans, ISP and other relevant documentation to ensure appropriate individual program plans and behavior plans are in place as deemed necessary for all residents. Quality Assurance Coordinators will also review staff training sheets to ensure all appropriate staff has been trained on the implementation of resident’s individual program / behavior plans.		

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W000455	<p>483.470(l)(1) INFECTION CONTROL</p> <p>There must be an active program for the prevention, control, and investigation of infection and communicable diseases. Based on observation and interview, the facility failed for 1 non-sampled client (#5) to ensure client #5 washed his hands after handling raw meat (a roast).</p> <p>Findings include:</p> <p>An observation was done at the group home on 9/30/13 from 6:43a.m. to 8:01a.m. At 7:11a.m., client #5 was observed to handle raw meat with no gloves on. Client #5 had put a roast into the crock pot. Client #5 did not wash his hands after handling the raw meat. Client #5 then prepared toast, handling the bread. Staff #4 was in the kitchen area. Client #5 was not prompted to wash his hands after handling the raw meat.</p> <p>Staff #1 was interviewed on 9/30/13 at 1:02p.m. Staff #1 indicated client #5 should have been prompted to wash his hands after handling the raw meat.</p> <p>9-3-7(a)</p>	W000455	<p>October 3, 2013 – Quality Assurance Coordinator trained all Residential staff during the monthly Residential In-Service on Nutrition / Dietary topics – this training included the importance of staff washing hands and staff prompting clients to wash hands during meal preparation as well as during all available/informal opportunities. This training issue will be re-addressed on November 7, 2013 at the next scheduled Residential In-Service. November 4, 2013 – Quality Assurance Coordinator will train Kingman House staff the importance of staff washing hands and staff prompting clients to wash hands during meal preparation, meal clean-up and during all available/informal opportunities. This training will stress the importance of staff washing hands and staff prompting clients to wash hands when working with raw meat. Training material will also be reviewed again on November 7th during the Residential In-service. The CARS Residential In-Service Schedule also consists of Client Safety / C.A.R.S. Infection Control Policy & Procedures that will be presented again in January 2014. Effective October 1, 2013 – to evaluate the</p>	11/04/2013	

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			effectiveness of infection control procedures, members of the C.A.R.S. Management Team will oversee direct care staff to (1) ensure staff is able to demonstrate continuous competency in implementing infection control procedures (2) assess staff's ongoing training needs in regards to implementing infection control procedures (3) Assess the progress and effectiveness of all risk reduction plans that were put into place to minimize the potential spread of infections Overseeing may include but is not limited to...(a) Direct observation of direct care staff while they are performing direct care/active treatment (b) Conducting a review of all incident reports that have been submitted by direct care staff (c) Interviewing direct care staff to analyze their knowledge in regards to implementing infection control procedures. Based on what information the members of C.A.R.S. Management Team has gathered by overseeing direct care staff – it will determine if staff person(s) need further training in implementing infection control procedures.		