

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G107		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  02/10/2012	
NAME OF PROVIDER OR SUPPLIER  CAREY SERVICES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 615 E NORTH ST HARTFORD CITY, IN 47348			
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W0000	<p>This visit was for a pre-determined full recertification and state licensure survey.</p> <p>Dates of survey: January 31, February 1, 2, 6, 7, 8, 9, and 10, 2012</p> <p>Surveyor: Susan Eakright, Medical Surveyor III</p> <p>Facility Number: 000644 Provider Number: 15G107 AIMS Number: 100234170</p> <p>The following federal deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 2/23/12 by Ruth Shackelford, Medical Surveyor III.</p>	W0000					

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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W0104	<p><b>483.410(a)(1) GOVERNING BODY</b> The governing body must exercise general policy, budget, and operating direction over the facility.</p> <p>Based on observation, interview, and record review, for 4 of 4 clients living in the group home (clients #1, #2, #3, and #4), the governing body failed to exercise operating direction over the facility to develop a policy and procedure for liquid oxygen storage, and to ensure staff followed the facility's medication administration policy and procedure.</p> <p>Findings include:</p> <p>1. On 1/31/12 at 6:40pm, the QDP (Qualified Developmental Professional) indicated clients #1, #2, #3, and #4 lived in the group home. The QDP opened a closet in an unoccupied client bedroom and inside the closet were two full Oxygen canisters both laying at a ninety degree angle on top of objects inside the unvented closet. At 6:50pm, the QDP instructed the facility staff to move both the two full Oxygen canisters from the closet and into an upright position. At 6:50pm, the QDP indicated the Oxygen was for a discharged client.</p> <p>On 2/1/12 at 9am, a review of the facility's undated "Oxygen Concentrator, Cleaning, Care, and Proper Maintenance" was completed. The policy indicated "Safety and Precautions...10. Do not store oxygen in a confined area or unventilated space. Example trunks of cars, closets..." The policy did not include precautions and care for liquid oxygen tanks.</p> <p>2. On 1/31/12 at 6pm, medication administration was completed for client #1 at the group home</p>	W0104	Carey Services must assure that policy is followed at the Group Home. The Facility failed to adequately assure compliance, as evidenced by non-compliance with oxygen storage and medication administration procedures. Specifically, it was noted that two full oxygen containers were stored on their side in a closet. Additionally, it was noted that a medication error was not found immediately and the caps of two identical vitamin bottles were swapped in violation of medication administration procedures. <b>CORRECTION</b> The tanks in question were immediately removed from the closet and placed in upright positions. As the tanks were from a discharged client, they were removed from the residence entirely on February 16 by Lincare. The medication error was documented on 1/31/12, and the vitamin lids were placed on the correct bottles on 2/1/2012. <b>PREVENTION</b> All clients in the home take some form of medication. Although only one consumer utilized the large oxygen canisters, and has been discharged from the home, preventative measures must be taken to ensure that if the need for large tanks occurs in the	02/16/2012	

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	<p>with DCS (Direct Care Staff) #3. At 6pm, client #1 was observed with DCS #3 in the medication room. At 6pm, DCS #3 selected client #1's oral medications which included "Seroquel 50mg (milligrams), give 1 tab by mouth twice a day." DCS #3 counted client #1's Seroquel and indicated he had an extra tablet of Seroquel. At 6pm, the agency LPN (Licensed Practical Nurse) reviewed client #1's medication card and client #1's 1/2012 MAR (Medication Administration Record), then stated "It's a med (medication) error from 1/19/12." At 6pm, the agency LPN indicated staff had not reported client #1's medication error from 1/19/12 through 1/31/12 at 6pm. The agency LPN stated staff should have identified the medication error during the "buddy" check of medications completed after each medication administration time. The LPN stated "The agency policy was not followed." At 6pm, client #1's 1/2012 MAR indicated "Seroquel 50mg (milligrams), give 1 tab by mouth twice a day" started 1/19/12 at 7am.</p> <p>On 2/1/12 at 9am, a record review of the facility's Living in the Community Core A/Core B medication training, not dated, indicated the facility staff should check to ensure the medication is administered according to physician's order. The training indicated staff should have checked the medication three times to ensure accuracy during medication administration.</p> <p>3. On 2/1/12 at 6:12am, medication administration was completed for client #3 at the group home with DCS (Direct Care Staff) #2. At 6:12am, client #3 was observed with DCS #2 in the medication room. At 6:12am, DCS #2 selected a bottle of "One A Day Vitamin" (for nutrition) from the medication cart drawer which had client #2's name on the label to the bottle and administered one tablet to client #3. At 6:25am, DCS #2 stated "I switched the lids on [client #2</p>		<p>future, they will be stored correctly per policy. All staff were retrained on the use of the "Buddy System" to check for medication errors and on the need to review the medication label when matching to the MAR. Training was completed on 2/13/12. Although proper storage of oxygen was also covered by internal training, Lincare provided staff with more in-depth training on 3/5/12. <b>MONITORING</b> The weekly safety review has been revised to include oxygen storage. The manager is responsible for turning in this review to the director to verify that oxygen storage has been inspected.</p>		

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	<p>and client #3's] medications." DCS #2 showed the bottles of the same One A Day Vitamin for both clients #2 and #3, client #2's pharmacy labeled bottle had the lid to client #3's One A Day Vitamin and client #3's pharmacy labeled bottle had the lid to client #2's One A Day Vitamin. DCS #2 stated she did not check the pharmacy label, she "only" checked the initials on the top of the bottle. At 6:25am, the LPN stated client #3 "got the correct medication, it's not an error." At 6:25am, client #3's 2/2012 MAR indicated "Thera Tab (One A Day) Vitamin, 1 tab by mouth daily."</p> <p>On 2/1/12 at 9am, a record review of the facility's Living in the Community Core A/Core B medication training, not dated, indicated the staff should check the label before administering medications to ensure the correct client, correct medication, and correct dosage.</p> <p>9-3-1(a)</p>			

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W0227	<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.</p> <p>Based on observation, record review, and interview, for 1 of 2 sample clients (client #1) who lived in the group home, the facility failed to develop a training objective based on her identified toothbrushing need.</p> <p>Findings include:</p> <p>On 2/2/12 at 12:30pm, client #1's record was reviewed. Client #1's 6/28/11 "Dental Visit" indicated a recommendation to "help with brushing." Client #1's 10/12/2011 ISP (Individual Support Plan) did not indicate a training objective for her identified toothbrushing need.</p> <p>On 2/7/12 at 12:30pm, an interview with the QDP (Qualified Developmental Professional) was completed. The QDP indicated client #1 did not have a documented training objective for her identified toothbrushing need.</p> <p>9-3-4(a)</p>	W0227	<p>Carey Services must assure that program plans address the clients' identified needs. The facility failed to meet this standard, as no tooth brushing objective was added after a dentist indicated that a client needed help with tooth brushing. <b>CORRECTION</b> The indicated objective was added to the client's plan on 2/8/2012 and staff were trained in its implementation. <b>PREVENTION</b> A systemic error was identified as a primary cause of the oversight. This could impact any consumer that receives a recommendation from an outside appointment. The recommendation was not passed to the QDDP for review. The current protocol of scanning appointment notes of documentation to the nurse and QDDP was retained, and an additional verifying procedure was added to assure that all steps were followed. The procedure was updated to reflect this change. <b>MONITORING</b> The Residential Nurse will be responsible for reviewing the previous day's appointments and verifying that all needed documentation has been distributed. The nurse will</p>	02/10/2012	

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			change the color of the appointment on the calendar from red to blue when documentation has been received.		

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W0331	<p>483.460(c) NURSING SERVICES The facility must provide clients with nursing services in accordance with their needs.</p> <p>Based on observation, interview, and record review, the facility's nursing services failed to implement a plan to prevent recurrent open areas for 1 of 1 client (client #4) with a history of recurrent skin ulcers.</p> <p>Findings include:</p> <p>On 1/31/12 at 6pm, DCS (Direct Care Staff) #3 stated client #4 had an open sore on his toe and was being seen by the clinic for the care of client #4's wound. DCS #3 indicated the facility did not have documentation for the treatment or the status of client #4's wound. At 6pm, client #4 sat in his wheelchair and did not move his feet/legs while seated.</p> <p>On 2/1/12 at 9:30am and on 2/1/12 at 8pm, client #4's record was reviewed. Client #4's single Nursing Quarterly dated 11/17/11 indicated "skin pink, warm, good no skin areas noted." Client #4's Nurse Practitioner 1/6/12 Note indicated "DM (Diabetes Mellitus) type II, Wound open toe." No stages, descriptions, or documentation of the wound were available for review. Client #4's record included a 1/2012 "Impaired Skin Integrity Protocol" that indicated client #4 had a "History of Pressure Ulcer."</p> <p>On 2/1/12 at 9am, an interview with the agency LPN (Licensed Practical Nurse) was completed. The LPN indicated no stages, descriptions, or further documentation was available for review of client #4's toe wound. The LPN indicated no skin tracking was available for review to determine when the wound appeared. The LPN stated she</p>	W0331	<p>Carey Services must provide needed nursing services to clients. The facility failed to provide service to a client with a history of skin ulcers. Specifically, the client had a wound on his toe that was being treated professionally, but a description of the wound, instructions to staff, and tracking mechanisms were not in place.</p> <p><b><u>CORRECTION</u></b> Staff were trained on skin assessments on 2/13/12, and a new assessment was developed to provide a more in-depth assessment of skin integrity.</p> <p><b><u>PREVENTION</u></b> Consumers who are at risk for pressure ulcers or other skin integrity issues are subject to increased frequency of skin checks. Skin assessments were performed weekly and documented in the MAR. The protocol for this was changed to include weekly assessments that are more in-depth, and scanned or faxed to the residential nurse on a weekly basis. A staging scale is now utilized when wounds are reviewed by the residential nurse.</p> <p><b><u>MONITORING</u></b> The residential nurse will verify that all skin assessments are turned in</p>	02/13/2012			

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	saw client #4's toe wound "two (2) weeks ago" and indicated it was covered by Duoderm skin treatment. The LPN stated she "did not document" client #4's skin care for his open area.  9-3-6(a)		weekly for review. Any missing assessments will be immediately reported to the group home director for follow-up.		

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W0336	<p>483.460(c)(3)(iii) NURSING SERVICES</p> <p>Nursing services must include, for those clients certified as not needing a medical care plan, a review of their health status which must be on a quarterly or more frequent basis depending on client need.</p> <p>Based on record review and interview, for 2 of 2 sampled clients (clients #1 and #3), the facility failed to complete nursing quarterlies.</p> <p>Findings include:</p> <p>On 2/2/12 at 12:30pm, client #1's record was reviewed and indicated "Nursing Quarterly" assessments completed on 11/17/11 and 8/27/11. No nursing quarterly assessments were available for review from 2/2011 through 8/27/11.</p> <p>On 2/1/12 at 12:55pm, and on 2/2/12 at 12:22pm, client #3's record was reviewed and indicated a "Nursing Quarterly" assessment completed on 11/17/11. No nursing quarterly assessments were available for review from 2/2011 through 11/17/11.</p> <p>On 2/2/12 at 12:40pm, an interview with the QDP (Qualified Developmental Professional) and the agency LPN (Licensed Practical Nurse) was completed. Both the QDP and the LPN</p>	W0336	<p>Carey Services must provide a health status assessment at least quarterly. The facility was unable to produce nursing quarterlies on two consumers.</p> <p><b>CORRECTION</b></p> <p>The missing nursing quarterlies were the responsibility of an LPN that is no longer employed by Carey Services. When contacted, the nurse stated that the quarterlies were completed. As the quarterlies have not yet become available for review, and information from previous months cannot be recreated, no replacement is possible. The need to verify that all required documentation is present was discussed with the management team on 2/29/12.</p> <p><b>PREVENTION</b></p> <p>Missing nursing information has the potential to impact every consumer in the home. Therefore, the quarterly nursing assessment was added to the documentation review list that is monitored by the director. All documentation is assigned a due date, and is tracked for completion.</p>	02/29/2012			

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	<p>indicated no nursing quarterly assessments for client #2 were available for review before 8/27/11. The LPN stated client #3's "only" nursing quarterly was 11/17/11.</p> <p>9-3-6(a)</p>		<p><b>MONITORING</b></p> <p>The nursing quarterlies will be monitored to verify that they are present and complete by the group home director.</p>		

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W0340	<p>483.460(c)(5)(i) <b>NURSING SERVICES</b> Nursing services must include implementing with other members of the interdisciplinary team, appropriate protective and preventive health measures that include, but are not limited to training clients and staff as needed in appropriate health and hygiene methods.</p> <p>Based on record review and interview, for 1 of 4 clients (client #4) who lived in the facility and for 1 of 2 discharged clients (client #5), the facility failed to ensure nursing services provided sufficient training to ensure staff were competent to respond to medical emergencies.</p> <p>Findings include:</p> <p>On 1/31/12 at 1:20pm, the facility's BDDS (Bureau of Developmental Disability Services) Reports from 1/2011 through 1/31/2012 were reviewed and indicated the following:</p> <p>For client #4:</p> <p>-a 11/9/11 BDDS report for an incident on 11/9/11 at 2:30am, indicated client #4 was "lethargic" with a temperature of "104 (one hundred and four) degrees" Fahrenheit, and the facility staff called the agency nurse before calling EMS (Emergency Medical Services). The report indicated client #4 was transported by EMS to the hospital, was admitted, and diagnosed with an Urinary Tract Infection (UTI).</p> <p>-a 9/19/11 BDDS report for an incident on 9/18/11 at 10:30pm, indicated client #4 was found by staff laying "half in and half out" of his bed and was "non responsive." The report indicated the staff called the agency nurse before calling EMS for client #4's medical care. The report indicated client #4 was diagnosed with "Bradycardia."</p>	W0340	<p>Carey Services is responsible for training staff in the appropriate ways to handle health issues. The agency failed to do so, as staff did not follow policy and procedure regarding the order of communication in an emergency. Specifically, staff contacted the nurse on duty prior to calling 911 on two occasions when the situation appeared to be emergent.</p> <p><b><u>CORRECTION</u></b> Carey Services retrained all staff on the appropriate use of EMS and on when to contact the nurse on duty on 2/13/12.</p> <p><b><u>PREVENTION</u></b> In a high medical needs home, any client can require emergency services. Therefore, a systemic improvement must be made to assure that the error will not be repeated. Upon investigation, it appears that the staff did not know whether or not each scenario could be considered an emergency, so contacted the nurse first to determine whether EMS should be activated. To assist in making a better determination, the procedure</p>	02/13/2012			

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	<p>For client #5:</p> <p>-a 1/20/12 BDDS report for an incident on 1/20/12 at 2am, indicated the nurse on duty was called "due to [client #5] having liquid bowel movements and his blood pressure dropping when staff got [client #5] out of bed to clean him up." The report indicated client #5 was taken by EMS (Emergency Medical Services) to the local hospital then was transferred to another hospital for medical care. The receiving hospital "requested permission to provide a blood transfusion."</p> <p>-a 10/28/11 BDDS report for an incident on 10/28/11 at 9:47pm, indicated after staff took his client #5's blood pressure five (5) times with readings of 60/54, the facility staff called the agency nurse who instructed the staff to call EMS (Emergency Medical Services).</p> <p>On 1/31/12 at 2:20pm, the facility's 9/20/10 "Health &amp; Safety Procedure, Nurse on Duty" policy and procedure was reviewed. The policy/procedure indicated "If it is an emergency - Call 9-1-1 immediately, do not call the nurse first or wait for a response from the nurse...."</p> <p>On 2/1/12 at 9am, an interview with the agency LPN (Licensed Practical Nurse) was completed. The LPN stated she retrained the facility staff after the 9/2011 incident, then retrained the staff after 10/2011 incident, and a third time was scheduled. The LPN indicated staff could contact the nurse if they have a question and stated "If it's an emergency, they should call 9-1-1." The LPN indicated the facility policy/procedure did not instruct or give information to staff for what was considered an emergency such as "non responsive or lethargic" clients.</p> <p>9-3-6(a)</p>		<p>was updated to contain examples of symptoms and situations that require EMS. Staff were trained on the additional procedures on 3/5/12.</p> <p><b>MONITORING</b> Nurse on duty contact logs and all incident reports concerning medical issues at Hartford City will be reviewed for three months by QA/QI and/or the director to verify that all procedures were followed correctly. If there are no further errors after three months, Incident reports will go back to being analyzed as part of the regular QA/QI process. The nurse on duty will report any items of concern immediately, as part of the incident report process.</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			
W0391	<p>483.460(m)(2)(ii) DRUG LABELING</p> <p>The facility must remove from use drug containers with worn, illegible, or missing labels.</p> <p>Based on observation, record review, and interview for 1 of 4 clients living in the facility (client #4), the facility failed to ensure medication had a pharmacy label which included client name and directions for the medication for 1 dose of 17 medications administered.</p> <p>Findings include:</p> <p>On 1/31/12 at 5:37pm, medication administration was completed for client #4 at the group home with DCS (Direct Care Staff) #3. At 5:37pm, client #4 was observed with DCS #3 in the medication room. At 5:37pm, DCS #3 selected client #4's "Alphagan Sol (Solution) 0.1%" for visual comfort/dry eyes from client #4's bin of medications. DCS #3 removed an unlabeled bottle from the storage box, and administered one drop of medication into each of client #4's eyes. At 6pm, client #4's 1/2012 MAR (Medication Administration Record) was reviewed and indicated "Alphagan Sol (Solution) 0.1%." At 6pm, DCS #3 indicated client #4's Alphagan did not have a label on the bottle of medication once DCS #3 had removed the unlabeled medication bottle from its storage container. At 6pm, the agency LPN (Licensed Practical Nurse) wrote client #4's name on the unlabeled medication bottle and stated "It does now."</p> <p>An interview was conducted on 2/1/12 at 9am, with the agency LPN and the QDP (Qualified Developmental Professional). The LPN indicated client #4's medication bottle inside the storage container was not labeled. The LPN indicated the</p>	W0391	<p>Carey Services must assure that all medications are properly labeled.</p> <p>The facility did not meet this standard, as eye drops were administered to a consumer from an unlabeled bottle. The bag that held the bottle was labeled by the pharmacy, but the bottle itself did not have a label.</p> <p><b>CORRECTION</b></p> <p>The client's name was written on the eye drop container by the residential nurse, to make it identifiable as belonging to that person on 1/31/12.</p> <p><b>PREVENTION</b></p> <p>Staff were trained to bring the plastic bag, along with the medication itself, when dispensing. That way, the label on the bag can be compared to the MAR.</p> <p>Additionally, the nurse will add identifying information to containers that have labels on separate, enclosing containers and assure that labels are legible.</p> <p><b>MONITORING</b></p> <p>Labels will be checked to verify that internal containers are identifiable and that all labels can be read by staff. This will be done each month, as part of the monthly Quality</p>	02/10/2012			

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	<p>agency followed Core A/Core B Medication Administration.</p> <p>On 2/1/12 at 9am, a record review of the facility's Living in the Community Core A/Core B medication training, not dated, indicated "Core Lesson 3: Principles of Administering Medication...Key points about maintaining medications, labels on medications are kept clean and readable. If the label is not readable notify the staff nurse, do not re label the medications. A pharmacist must re label medications. Never administer a medication from a container that has an unreadable label."</p> <p>9-3-6(a)</p>		Assurance Report that is completed by the residential nurse.		

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W0426	<p>483.470(d)(3) CLIENT BATHROOMS</p> <p>The facility must, in areas of the facility where clients who have not been trained to regulate water temperature are exposed to hot water, ensure that the temperature of the water does not exceed 110 degrees Fahrenheit.</p> <p>Based on observation, record review, and interview, the facility failed for 4 of 4 clients (clients #1, #2, #3, and #4), who lived in the group home, to ensure the temperature of the water did not exceed 110 degrees Fahrenheit.</p> <p>Findings include:</p> <p>On 1/31/12 from 4:15pm until 6:50pm, and on 2/1/12 from 6am until 7:45am, observation and interviews were completed at the group home with clients #1, #2, #3, and #4. The clients were observed to use the sink in the kitchen and bathrooms to wash their hands and completed bathing in two of the three bathrooms. During both observation periods clients #1, #2, #3, and #4 independently turned on the hot water only and staff assisted to turn on the cold water to mix water. On 1/31/12 at 5:30pm, the QDP (Qualified Developmental Professional) took the temperature in the hand sink in the hallway (bathroom #3) and the temperature was 115 degrees. On 2/1/12 at 6:48am, the QDP indicated the kitchen sink was 114 degrees. At 6:48am, the QDP indicated the hallway/bathroom #3 was 119 degrees.</p> <p>On 2/1/12 at 12:05pm, the QDP was interviewed. The QDP stated clients #1, #2, #3, and #4 "did not recognize the risks of hot water." The QDP indicated monitoring for the group home water temperature log was completed by the overnight staff and the water temperature had not exceeded 110 degrees Fahrenheit. The QDP indicated</p>	W0426	<p>Carey Services must assure that water temperature does not exceed 110 degrees for clients who have not been trained to mix water. The facility failed to meet the requirements of this standard, as evidenced by three temperature measurements during the survey process.</p> <p><b>CORRECTION</b></p> <p>The thermostat on the water heater was adjusted to a lower temperature by Carey Services Maintenance on 2/1/12. The temperature was checked throughout the month of February to assure that there were no more incidences of non-compliant water temperature.</p> <p><b>PREVENTION</b></p> <p>All clients who reside at the Hartford City Group Home have assessments that show the need to limit water temperature to 110 degrees. The group home uses a mixing valve as protection against scalding. This valve, according to Carey Services plant operations, can sometimes need cleaning to assure that lime and calcium do not alter the temperature mix. This valve was</p>	02/10/2012			

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	<p>clients #1, #2, #3, and #4 needed antiscald devices to control the water temperature.</p> <p>On 2/1/12 at 12:30pm, a review of client #1, #2, #3, and #4's "Water Temperature Training Competency Test" was completed and indicated the following.</p> <p>-Client #1's 9/30/11 "Water Temperature Training Competency Test" indicated she did not recognize danger and could not independently mix hot water.</p> <p>-Client #2's 9/30/11 "Water Temperature Training Competency Test" indicated she did not recognize danger and could not independently mix hot water.</p> <p>-Client #3's 9/30/11 "Water Temperature Training Competency Test" indicated she did recognize danger and could independently mix hot water.</p> <p>-Client #4's 9/30/11 "Water Temperature Training Competency Test" indicated he did not recognize danger and could not independently mix hot water.</p> <p>9-3-7(a)</p>		<p>cleaned and locked on 3/5/12, and will be inspected quarterly to determine if cleaning is necessary. Water temperature will be measured regularly and recorded on the safety verification log. Any temperature measurement over 110 degrees will be retested. If the temperature persists for more than an hour, management is to be immediately informed. During times when the water temperature is above the range, staff will assist and verify safety for all water usage until the situation is corrected.</p> <p><b>MONITORING</b></p> <p>All Safety verification logs are turned in to the group home director on a monthly basis. Any instance of a temperature over 110 degrees being recorded will be immediately reported to the manager if it persists for an hour.</p>		