

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G220	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 12/12/2013
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NAME OF PROVIDER OR SUPPLIER STONE BELT ARC INC	STREET ADDRESS, CITY, STATE, ZIP CODE 4700 HITE DR BLOOMINGTON, IN 47408
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W000000	<p>This visit was for a full recertification and state licensure survey.</p> <p>This visit was in conjunction with the post certification revisit (PCR) to the investigation of complaint #IN00137851 completed on 10/30/13.</p> <p>Survey Dates: December 9, 10, 11 and 12, 2013.</p> <p>Facility Number: 000744 Provider Number: 15G220 AIM Number: 100234860</p> <p>Surveyor: Steven Schwing, QIDP</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 12/16/13 by Ruth Shackelford, QIDP.</p>	W000000		
W000140	<p>483.420(b)(1)(i) CLIENT FINANCES The facility must establish and maintain a system that assures a full and complete accounting of clients' personal funds entrusted to the facility on behalf of clients. Based on record review and interview for 1 of 1 client who was discharged from the facility (E), the facility failed to</p>	W000140	W140 Plan of Correction: Facility Coordinator and GHM will be retrained to use the "Money On	01/11/2014

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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W000149	<p>keep a full and complete accounting of the client's personal funds.</p> <p>Findings include:</p> <p>A review of client E's funds was conducted on 12/9/13 at 3:52 PM. Client E's Money on Hand ledger, dated December 2013, did not indicate the balance of his personal funds. A review of client E's November 2013 Money on Hand ledger indicated client E had \$21.06 on 11/30/13. Upon counting client E's personal funds, client E had \$11.06. There was no documentation accounting for the \$10.00 difference between November and December 2013. A review of client E's record was conducted on 12/11/13 at 12:13 PM. Client E was discharged from the facility on 12/6/13.</p> <p>On 12/11/13 at 2:33 PM, the Director of Supported Group Living (DSGL) indicated the facility should account for the client's funds.</p> <p>9-3-2(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.</p>		<p>Hand" form. Plan of Prevention: The group home manager will conduct a weekly audit of clients' personal financial account ledger and turn it into the agency's financial services department for review. Quality Assurance Monitoring: The Quality Assurance Monitoring checklist has been updated to include a review of the weekly personal ledger and a reconciliation of cash and purchases.</p>		

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	<p>Based on record review and interview for 3 of 19 incident/investigative reports reviewed affecting clients D, E, F and G, the facility neglected to implement its policies and procedures to prevent and investigate incidents of client to client abuse.</p> <p>Findings include:</p> <p>A review of the facility's incident/investigative reports was conducted on 12/9/13 at 1:14 PM.</p> <p>1) On 11/7/13 at 6:30 AM, client E called client D a name. Client D hit client E on the arm near his elbow. The facility did not provide documentation an investigation was conducted.</p> <p>2) On 11/18/13 at 7:30 AM, clients E and F both wanted to sit in the front seat. Client F kicked client E two times on the leg. The facility did not provide documentation an investigation was conducted.</p> <p>3) On 11/21/13 at 7:30 AM, client F kicked client G. The facility did not provide documentation an investigation was conducted.</p> <p>On 12/10/13 at 12:33 PM, the Coordinator indicated he completed an</p>	W000149	W149 Plan of Prevention: Facility staff will be retrained on Prevention of Abuse, Neglect, Exploitation and Incident Reporting. Clients will receive retraining on agency's Client Responsibilities and Rules in Residential Living which include but are not limited to; No hitting, kicking or trying to hurt other people. Plan of Prevention: The agency has implemented a new internal incident reporting system designed to address various failures in implementing the agency's procedures on reporting and investigation allegation A/N/E. The process included the following steps: The written incident report is submitted within 24 hours (or immediately if it contains an allegation A/N/E) to a designated administrative staff. The staff enters the incident into the electronic system, attaches required follow up/investigative forms, completes a BDDS report if indicated, notifies a supervisor if indicated and sends an electronic copy of the report to the facility support team. Each member of the support team reads, reviews, documents actions taken and signs the report. The report requires the review and signature of the director before the report is electronically files. Quality Assurance Monitoring: The group home internal audit will be revised to reflect all of the required elements of an incident report. The QA team process will be	01/11/2014			

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	<p>inquiry into the incident dated 11/7/13 but did not know where the investigation was located. The Coordinator indicated the inquiry of Client to Client Aggression should be in the facility's electronic record system. The Coordinator indicated he was on vacation during the incidents on 11/18/13 and 11/21/13. The Coordinator was unsure if an inquiry was completed. The Coordinator indicated inquiries should have been completed for the incidents of client to client aggression.</p> <p>On 12/11/13 at 2:16 PM, the Director of Supported Group Living (DSGL) indicated client to client inquiries (investigations) should be completed for client to client aggression. The DSGL indicated the staff should prevent client to client aggression.</p> <p>A review of the facility's abuse and neglect policy, dated September 2013, was conducted on 12/9/13 at 1:49 PM. The policy indicated, "Abuse and neglect are never acceptable. Abuse is defined as the willful/purposeful infliction of physical or emotional pain, injury, physical violation, revilement, malignment, exploitation and/or otherwise disregard of an individual. Neglect is the failure to provide</p>		revised to include a review of all ISDH surveys; a review and report of all SGL A/N/E investigations by third party QA team member and the QA team will recommend and monitor corrective actions.				

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	<p>appropriate care, food, medical care or supervision of an individual, whether purposeful or due to carelessness, inattentiveness, or omission of the responsible party which results in risk of physical harm and/or emotional trauma." The policy indicated, "Cases or suspected cases of mistreatment/neglect/abuse involving the implementation of behavioral intervention techniques or any incident involving the use of physical intervention, accident or injury to a Client shall be reported according to the Incident Reporting Procedure. The Executive Director will be notified in accordance with this procedure. A file of these Incident Reports shall be maintained by the appropriate agency personnel. This file is accessible to the Chairperson of the Human Rights Committee for review upon request. An investigation of any incident may be requested by a client, parent/guardian, advocate, staff member, or other involved party."</p> <p>9-3-2(a)</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 for 3 of 19 incident/investigative reports reviewed affecting clients D, E, F and G, the facility failed to investigate incidents of client to client abuse.</p> <p>Findings include:</p> <p>A review of the facility's incident/investigative reports was conducted on 12/9/13 at 1:14 PM.</p> <p>1) On 11/7/13 at 6:30 AM, client E called client D a name. Client D hit client E on the arm near his elbow. The facility did not provide documentation an investigation was conducted.</p> <p>2) On 11/18/13 at 7:30 AM, clients E and F both wanted to sit in the front seat. Client F kicked client E two times on the leg. The facility did not provide documentation an investigation was conducted.</p> <p>3) On 11/21/13 at 7:30 AM, client F kicked client G. The facility did not provide documentation an investigation was conducted.</p>	W000154	<p>W154 Plan of Correction: Coordinator will be retrained on following agency policy of investigating client to client aggression, regardless of vacation or absences. The agency's new electronic incident reporting system has been updated to include a start date for any incident requiring follow up and an alert to be sent on the fifth day that the follow up is completed. Plan of Prevention: The new electronic Incident Reporting System attaches Inquiries to incidents of client to client aggression and injuries of unknown origin. Coordinator will complete the inquiries within five days. The Director of SGL will review all client to client aggression and injury of unknown origin to ensure completion. Quality Assurance Monitoring: The agency's new electronic incident reporting system has been revised to alert the facility director after 5 days that the follow up report needs to be completed.</p>	01/11/2014			

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W000159	<p>On 12/10/13 at 12:33 PM, the Coordinator indicated he completed an inquiry into the incident dated 11/7/13 but did not know where the investigation was located. The Coordinator indicated the inquiry of Client to Client Aggression should be in the facility's electronic record system. The Coordinator indicated he was on vacation during the incidents on 11/18/13 and 11/21/13. The Coordinator was unsure if an inquiry was completed. The Coordinator indicated inquiries should have been completed for the incidents of client to client aggression.</p> <p>On 12/11/13 at 2:16 PM, the Director of Supported Group Living (DSGL) indicated client to client inquiries (investigations) should be completed for client to client aggression.</p> <p>9-3-2(a)</p> <p>483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional. Based on record review and interview</p>	W000159	W159 Plan of Correction: Coordinator has completed	01/11/2014			

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	<p>for 2 of 3 clients in the sample (D and F), the Qualified Intellectual Disabilities Professional (QIDP/Coordinator) failed to conduct quarterly reviews of the clients' program plans.</p> <p>Findings include:</p> <p>A review of client D's record was conducted on 12/12/13 at 11:02 AM. Client D's record did not contain documentation the Coordinator reviewed client D's progress toward completing his training objectives since April 2013 (covering January, February and March 2013).</p> <p>A review of client F's record was conducted on 12/11/13 at 3:00 PM. Client F's record did not contain documentation the Coordinator reviewed client F's progress toward completing his training objectives since August 2013 (covering May, June and July 2013).</p> <p>On 12/12/13 at 11:34 AM, the Coordinator indicated for client F, he was one quarterly behind. The Coordinator indicated for client D, he needed to complete two quarterly reviews he had not completed. The Coordinator indicated he knew he was behind and the quarterly reviews needed</p>		<p>missing Quarterly Reviews. Coordinator will receive retraining on coordinating and monitoring active treatment programs. Plan of Prevention: The facility has also reorganized the home management system to include more coordination (Q) positions in order to increase client support, staff training and supervision, facility monitoring and compliance with incident reporting and investigation. Quality Assurance Monitoring: Facility coordinator will supervise and monitor implementation of active treatment, according to agency policy. Facility coordinator will monitor and review monthly tracking of personal program goal progress. For the next quarter, Director of SGL will review and sign off on monthly tracking of personal program goal progress to ensure appropriate monitoring and coordination. The agency's record/document monitoring system has been updated to include group home quarterly reports. The facility coordinator will receive alerts that the quarterlies are due and alerts when the quarterlies have not yet been submitted to the record (i.e are late).</p>				

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W000249	<p>to be conducted.</p> <p>9-3-3(a)</p> <p>483.440(d)(1) PROGRAM IMPLEMENTATION 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, interview and record review for 4 of 5 clients living at the group home (B, D, F and G), the facility failed to ensure the direct care staff implemented the clients' program plans as written.</p> <p>Findings include:</p> <p>An observation was conducted at the group home on 12/10/13 from 5:58 AM to 7:43 AM.</p> <p>-At 6:25 AM, client B received his medications from staff #9. Staff #9 did not prompt client B to say the name, amount, purpose and one side effect of each of his medications. Staff #9 did not provide medication training to client B during the medication pass. At 6:31 AM, staff #9 put client B's bottom</p>	W000249	<p>W249 Plan of Correction: Staff #9 was immediately suspended from medication administration until the successful completion of medication administration retraining. Staff #9 will be re-trained on client IHPs for the facility. Plan of Prevention: Facility staff are trained on medication administration and IHPs for all clients. Coordinator (Q) will immediately review training documentation for the facility to ensure all facility staff have received appropriate site training. Coordinator will review facility training documents biweekly for the next quarter to ensure staff have received site specific training, including training on active treatment and clients' personal program plans. During the next quarter, Coordinator will fade to reviewing training documentation on a monthly basis. Coordinator will</p>	01/11/2014
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	<p>denture into client B's mouth. Client B brushed his teeth for 10 seconds. Staff #9 did not prompt client B to gather his materials, turn on the water, uncap his toothpaste, wet his toothbrush, brush his lower left and right, brush his upper left and right, rinse his toothbrush and floss.</p> <p>A review of client B's training objectives was conducted on 12/10/13 at 11:37 AM. Client B's Individual Support Plan (ISP), dated 8/1/13, indicated he had a training objective for toothbrushing. The training objective indicated client B was to gather his materials, turn on the water, uncap his toothpaste, wet his toothbrush, brush his lower left and right, brush his upper left and right, rinse his toothbrush and floss. The training objective for medication administration indicated client B was to request his medications on time, say the name of each medication, say the number of pills to take on medication log, say why he was taking the medication, and name one side effect of each medication.</p> <p>-At 6:43 AM, client F received his medications from staff #9. Staff #9 did not prompt client F to say the name, dosage, purpose and two side effects of his medications. Staff #9 did not provide medication training to client F during the medication pass. At 6:35</p>		<p>will provide supervision and monitoring of active treatment (including medication administration training) at least twice a week for the next quarter. During the second quarter, the facility coordinator will provide supervision and monitoring at least once a week and then fade to agency policy on supervision and monitoring which states: All day and evening shifts will have monitoring visits by management at least one time per month. All overnight shifts will be monitored at least two times per quarter with one visit performed during a week-end shift. Items reviewed: Monitors will assess general interactions and active engagement with clients, cleanliness, and appropriateness of activities. Quality Assurance Monitoring: The facility Coordinator will complete Quality Assurance Monitoring Checklist, at least annually, which includes Quarterly reviews of ISPs, active treatment schedules and informal goals.</p>				

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	<p>AM, staff #9 prompted client F to brush his teeth. Client F brushed his teeth for 6 seconds. Staff #9 did not prompt client F to continue brushing or to brush his upper and lower teeth.</p> <p>A review of client F's record was conducted on 12/11/13 at 3:00 PM. Client F's ISP, dated 2/1/13, indicated he had a training objective for medication administration. The training objective indicated client F was to go to the medication area for his medications, know the name of his medications, state the dosage of his medication, know why the medication was prescribed, and know two side effects of his medications. Client F's training objective for toothbrushing indicated he was to brush his lower left and right teeth and gums and upper left and right teeth and gums.</p> <p>-At 6:53 AM, client G received one medication from staff #9. Staff #9 did not prompt client G to say the name and purpose of his medication. Staff #9 did not provide medication training to client G during the medication pass.</p> <p>A review of client G's medication administration objective was conducted on 12/10/13 at 11:34 AM. Client G's ISP, dated 10/1/13, indicated he had a</p>			

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	<p>medication training objective. The training objective indicated client G should name his medication and purpose.</p> <p>-At 7:02 AM, client D received his medications from staff #9. Staff #9 did not prompt client D to read his medication log for the medication time and dose (read aloud). Staff #9 did not prompt client D to state the name, purpose, one side effect, and amount (number of pills he was taking) of his medications. Staff #9 did not prompt client D to put his medications into the medication storage cabinet. Staff #9 did not provide medication training to client D during the medication pass.</p> <p>A review of client D's medication training objective was conducted on 12/10/13 at 11:28 AM. Client D's medication training objective, included in his ISP dated 2/6/13, indicated client D would read (aloud) his medication log for the time and dose, state name, purpose and one side effect, the number of pills he was taking and put his medications back into the cabinet.</p> <p>On 12/10/13 at 11:32 AM, staff #9 indicated she did not implement the clients' medication training objectives. Staff #9 indicated she did not know the</p>			

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	<p>clients' medication training objectives.</p> <p>On 12/10/13 at 11:53 AM, the Coordinator indicated client B and F's toothbrushing training objectives could not be implemented in the amount of time they were observed to be brushing their teeth. The Coordinator indicated the clients should not brush their teeth for less than 2 minutes. The Coordinator indicated the staff should observe the toothbrushing and prompt the clients for proper toothbrushing. The Coordinator indicated the clients' medication training objectives should be implemented at each medication pass.</p> <p>On 12/11/13 at 1:04 PM, the Registered Nurse (RN) indicated the amount of time clients B and F were observed to brush would not meet their toothbrushing training objective. The RN indicated the staff should prompt the clients to brush their teeth for a longer period of time.</p> <p>On 12/11/13 at 2:12 PM, the Director of Supported Group Living (DSGL) indicated the staff should prompt the clients to brush for a longer period of time. The DSGL indicated the clients' medication training objectives should be implemented at each medication pass.</p>						

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W000331	<p>9-3-4(a)</p> <p>483.460(c) NURSING SERVICES</p> <p>The facility must provide clients with nursing services in accordance with their needs. Based on observation, interview and record review for 1 of 3 clients in the sample (D), the facility's nursing services failed to ensure there was a working blood pressure machine at the group home in order to take client D's blood pressure.</p> <p>Findings include:</p> <p>An observation was conducted at the group home on 12/10/13 from 5:58 AM to 7:43 AM. At 7:04 AM during the medication pass to client D, staff #9 indicated she was supposed to take client D's blood pressure on this date. Staff #9 indicated the blood pressure machine broke on 12/9/13 and indicated "error" when attempted to be used on 12/9/13. Staff #9 indicated she was unable to obtain client D's blood pressure.</p> <p>A review of client D's Physician's Orders, dated November 2013, was conducted on 12/12/13 at 10:53 AM. Client D's Physician's Orders indicated,</p>	W000331	<p>W331 Plan of Correction: The facility immediately obtained a working blood pressure machine and all clients in the home who required blood pressure monitoring were tested. Facility staff received training on appropriate action to be taken when there are failures or problems with medical equipment, including notifying the nurse. The facility staff were retrained on the new blood pressure equipment (manual). Review of facility clients' Medication Log Sheets shows inconsistent blood pressure readings. Staff will be retrained on completing all required treatments as indicated in clients' personal program plans, as well as training clients on the importance of following doctor recommendations. Plan of Prevention: The facility's battery operated blood pressure machine was replaced with a manually operated blood pressure system and all facility staff have been trained on taking manual blood pressures. Coordinator will review facility training documents on a biweekly basis for the next</p>	01/04/2014

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NAME OF PROVIDER OR SUPPLIER STONE BELT ARC INC				STREET ADDRESS, CITY, STATE, ZIP CODE 4700 HITE DR BLOOMINGTON, IN 47408			
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W000369	<p>"Blood pressure checks 3x/wk (three times per week)." Client D's Medication Information Sheet (MIS), dated 11/25/13, indicated, "BP checks 3 x weekly (blood pressure checks 3 times weekly)." The MIS indicated, "Notify (name of physician) if BP greater than 150/90."</p> <p>On 12/12/13 at 9:16 AM, the Nursing Services Director (NSD) indicated the staff were supposed to be monitoring client D's blood pressure three times a week due to client D having a stroke in December 2012. The NSD indicated the group home should have a blood pressure machine in working order. The NSD indicated the staff were to contact client D's physician if his blood pressure was over a certain criteria.</p> <p>9-3-6(a)</p> <p>483.460(k)(2) DRUG ADMINISTRATION The system for drug administration must assure that all drugs, including those that are self-administered, are administered without error. Based on observation, record review and interview for 2 of 4 clients (D and F) observed to receive their medications, the facility failed to ensure the clients</p>	W000369	<p>quarter to ensure staff have received site specific training, to include clients' medical treatment and training needs. Coordinator will provide supervision and monitoring at least twice weekly for the next quarter and then fade to agency policy on supervision and monitoring (see W249). Quality Assurance Monitoring: The facility nurse will complete quarterly reviews to ensure clients are receiving services in accordance with their needs and individualized plans.</p> <p>W369 Plan of Correction: Staff #9 was immediately suspended from medication administration until the successful completion of medication administration</p>	01/11/2014			

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	<p>received their medications as ordered.</p> <p>Findings include:</p> <p>An observation was conducted at the group home on 12/10/13 from 5:58 AM to 7:43 AM. At 6:43 AM, client F received his medications from staff #9. Staff #9 did not administer Fluticasone nasal spray for rhinitis during the medication pass. At 7:02 AM, staff #9 did not administer Fluticasone nasal spray for allergies to client D.</p> <p>A review of client F's Physician's Orders, dated 9/12/13, was conducted on 12/11/13 at 3:00 PM. Client F's Physician's Orders indicated client F was to receive Fluticasone nasal spray daily at 8:00 AM.</p> <p>A review of client D's Physician's Orders, dated 9/12/13, was conducted on 12/12/13 at 10:45 AM. Client D's Physician's Orders indicated client D was to receive Fluticasone nasal spray daily at 8:00 AM.</p> <p>On 12/11/13 at 2:14 PM, the Director of Supported Group Living indicated the clients' medications should be administered as ordered.</p> <p>On 12/11/13 at 1:01 PM, the Registered</p>		<p>retraining. Plan of Prevention: Facility nurses have revised the medication administration procedures to require that all staff successfully completing Core A/B medication administration training also complete three successful supervised medication passes before passing medications without supervision. The nurses have also revised retraining for staff who commit medication errors to ensure that they know and follow the agency's medication administration procedures including the 'three part check' system. Quality Assurance Monitoring: A new electronic alert system notifies supervisors and nurses of med errors to ensure appropriate disciplinary action and/or retraining takes place.</p>				

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W000440	<p>Nurse (RN) indicated the clients' medications should be administered as ordered. The RN indicated the orders were current for clients D and F and it was a medication error.</p> <p>9-3-6(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 for 5 of 5 clients living in the group home (B, C, D, F and G), the facility failed to conduct quarterly evacuation drills for each shift.</p> <p>Findings include:</p> <p>A review of the facility's evacuation drills was conducted on 12/10/13 at 11:38 AM. During the day shift (6:00 AM to 2:00 PM) there were no drills completed from 7/13/13 to 12/10/13 at the time the records were reviewed. During the night shift (10:00 PM to 6:00 AM) there were no drills completed from 6/29/13 to 12/10/13 at the time the records were reviewed. This affected clients B, C, D, F and G.</p> <p>On 12/9/13 at 6:02 AM, staff #7</p>	W000440	<p>W440 Plan of Correction: Facility did conduct at least one drill per shift, per quarter. Please see attachment W440. The documentation was not readily available during this survey. Facility staff will be retrained on conducting drills according to agency and state regulations, including timely submission of Drill Report. Facility will post Emergency Drill Record which indicates when drills are due. Plan of Prevention: The agency has implemented a new electronic fire drill notification system overseen by the agency's Organizational Effectiveness Coordinator. This system will notify facility coordinators to ensure agency drill protocols are being followed. Quality Assurance Monitoring: The facility Coordinator will complete Quality Assurance Monitoring Checklist, at least annually, which</p>	01/11/2014			

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	<p>indicated he had worked the overnight shift for 6 months and had not conducted an evacuation drill.</p> <p>On 12/10/13 at 12:16 PM, the Coordinator indicated the facility should conduct one drill per shift per quarter.</p> <p>On 12/11/13 at 2:19 PM, the Director of Supported Group Living indicated there should be one drill per shift per quarter.</p> <p>9-3-7(a)</p>		<p>includes review of evacuation and emergency drills of the facility.</p>				