

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G291		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/01/2012	
NAME OF PROVIDER OR SUPPLIER LOGAN COMMUNITY RESOURCES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 119 SPRUCE ST SOUTH BEND, IN 46601			
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W0000	<p>This visit was for a fundamental recertification and state licensure survey.</p> <p>Survey Dates: January 30, 31, and February 1, 2012</p> <p>Facility Number: 000810 Provider Number: 15G291 AIM Number: 100249070</p> <p>Surveyor: Tracy Brumbaugh, Medical Surveyor III</p> <p>These deficiencies also reflect state findings under 460 IAC 9. Quality Review completed 2/14/12 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>The governing body must exercise general policy, budget, and operating direction over the facility.</p> <p>Based on observation, record review, and interview, the governing body failed to exercise general direction in a manner that resulted in the facility being well maintained for 8 of 8 clients (clients #1, #2, #3, #4, #5, #6, #7, and #8) residing in the group home and to ensure client #2 did not pay for her eyeglasses.</p> <p>Findings include:</p> <p>1. On 1-30-12 from 4:20 p.m. until 5:50 p.m. an observation at the home of clients #1, #2, #3, #4, #5, #6, #7, and #8 was conducted. The south dining room walls had 6 dime size circular areas with chipped and peeled paint, and the two floor vents were dusty and rusty. The living room (on the same side) had 3 one foot by one foot black stains on the carpet, and the walls had white and black marks with 2 two inch dents. The north dining room had two dusty, rusted vents on the floor, the walls had food on them and there were 6 areas where the paint was chipped and peeled. The floor vent in the main entry way into the house was dusty and rusted.</p> <p>2. On 1-31-12 at 9:30 a.m. a record review for client #2 was conducted. The</p>	W0104	<p>The facility is pursuing resolution for all maintenance and environmental issues cited.</p> <p>1.Areas on the walls that were chipped and peeled have been repainted. Chair rail was installed as a preventative measure to further protect the walls in a more adequate manner.</p> <p>2.Floor vents have been cleaned and/or replaced.</p> <p>3.Carpet stains have been cleaned</p> <p>4.Walls have been cleaned and scuff marks removed and/or repainted.</p> <p>In the future, the Progeram Coordinator will report needed repairs to the maintenance department by verbal and/or electronic communication in a timely manner.Routine walk thru and observations of the home by the QMRP and Director of Living will allow for timely report requests by verbal and/or electronic communication for any maintenance issuesThe agency will provide funds for the repair of adaptive equipment. On 2/22/12 a payment authorization was sent to reimburse client #2 for payment of eye glasses. In the future, when adaptive equipment needs replaced or repaired, the agency will pay for the expense or arrangements will be made for the agency to be billed to avoid clients using their own money to</p>	03/02/2012			

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	<p>financial records dated 3-11 through 12-11 indicated on 4-20-11 client #2 paid \$65.00 to [name of vision provider].</p> <p>On 1-31-12 at 12:10 p.m. an interview with Qualified Mental Retardation Professional (QMRP) indicated the carpets, walls, and vents needed to be taken care of, and there was no further documentation to review. The QMRP indicated client #2 purchased a replacement pair of glasses for \$65.00 and there was no documentation to show client #2 had been paid back.</p> <p>9-3-1(a)</p>		<p>pay for replacement/ repair of adaptive equipment. Persons Responsible: Program Coordinator QMRP Director of Group Living Director of Maintenance</p>				

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W0227	<p>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 record review and interview, the facility failed for 1 of 4 sampled clients (client #4) to ensure she had an oral hygiene goal in her Individualized Support Plan (ISP) per her dentist's recommendation.</p> <p>Findings include:</p> <p>On 1-31-12 at 11:15 a.m. a record review of a dental recommendation dated 12-1-11 indicated client #4 needed assistance with brushing and to allow flossing. The ISP dated 6-15-11 did not have a dental goal to assist client #4 with brushing and to allow flossing. Client #4's Comprehensive Functional Assessment dated 6-11 indicated client #4 needed assistance with her oral hygiene skills.</p> <p>On 1-31-12 at 12:10 p.m. an interview with the Qualified Mental Retardation Professional indicated client #4 did not have a oral hygiene goal to address the recommendation from the dentist.</p> <p>9-3-4(a)</p>	W0227	<p>A oral hygiene goal for client #4 was implemented on February 24, 2012. The QMRP will monitor goals on a monthly basis and revise them as necessary. In the future, the QMRP will ensure that dental recommendations are followed and implemented through formal goals as necessary.</p> <p>Persons Responsible: QMRP</p>	03/03/2012			

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W0247	<p>The individual program plan must include opportunities for client choice and self-management.</p> <p>Based on observation, record review, and interview, the facility failed for 1 of 1 client (client #5) who wanted to answer her telephone, to ensure she was given the choice to answer it.</p> <p>Findings include:</p> <p>On 1-31-12 from 6:45 a.m. until 7:45 a.m. an observation at the home of client #5 was conducted. At 7:40 a.m. the home telephone rang. Client #5 went to answer the phone when direct care staff (DCS) #7 stated "I will get it; remember, you're not staff." Client #5 followed DCS #7 to answer the phone. DCS #7 answered the phone then gave it to client #5 because the call was for her. Client #5 indicated she liked to answer the phone then went to her room to talk on the phone.</p> <p>On 2-1-12 at 10:00 a.m. a review of client #5's Individualized Support Plan dated 8-18-11 indicated no restrictions on phone use. Client #5's Comprehensive Functional Assessment dated 8-11 indicated she could use the phone independently.</p> <p>On 1-31-12 at 12:10 p.m. an interview with the Qualified Mental Retardation</p>	W0247	<p>The agency will allow individuals the opportunity choice and self management. Client # 7 is capable of appropriately answering the phone and should be given chance to do so when the opportunity presents itself. At a house staff meeting on February 16th , the direct care staff were re-trained regarding staff responsibility to always encourage client's to demonstrate and practice independence to each of their abilities. This included encouraging and allowing clients to answer the phone. In the future, observations completed by the QMRP and Program Coordinator will ensure that staff allow clients to complete/demonstrate skills commensurate with their identified abilities in their comprehensive functional assessment. Persons Responsible: Program Coordinator QMRP</p>	03/03/2012			

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	Professional indicated client #5 should be allowed to answer the telephone. 9-3-4(a)			
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W0249	<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 2 of 4 sampled clients (clients #1 and #4) to ensure their medication objectives were implemented per their Individualized Support Plans (ISP).</p> <p>Findings include:</p> <p>On 1-31-12 at 7:00 a.m. an observation for client #1 during her medication administration was conducted. Client #1 identified herself, punched out her own medications, and took her medications with water. (Risperdone for behaviors, Sertraline HCL for behaviors, and Calcium soft chew tab for bones).</p> <p>On 1-31-12 at 7:25 a.m. client #4 was observed during her medication administration. Client #4 was asked by direct care staff #7 what her name was and if she knew what her vitamin was. Client #1 took her medications in applesauce. (Tab-a-vite, Stress Formula with Zinc, Calcium with D, Oxcarbzipine for seizures, Omeprazole for her stomach,</p>	W0249	<p>On February 16, 2012 at the house staff meeting, the direct care staff were reminded that although medication administration goals may not be documented everyday, they should be taking advantage of all informal opportunities to practice the skill when administering medications. Client #1 should have been given the opportunity to count her vita chew tablets and client #4 should have been prompted to retrieve her vitamin out of the medication cabinet. Regular observation of staff passing medication to clients by management staff will provide the oversight to ensure staff are implementing all medication goals at medication pass times. Persons Responsible: Program Coordinator QMRP Director of Group Living</p>	03/02/2012	

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	<p>and Carbamazepine for seizures.)</p> <p>On 1-31-12 at 10:15 a.m. a record review for client #1 was conducted. The ISP dated 8-31-11 indicated client #1 had a medication goal to count her vita chew tablets.</p> <p>On 1-31-12 at 11:15 a.m. a record review for client #4 was conducted. The ISP dated 6-15-11 indicated client #4 was to pick out her vitamin out of the medication cabinet.</p> <p>On 1-31-12 at 12:10 p.m. an interview with the Qualified Mental Retardation Professional indicated medication goals should be implemented per client #1 and #4's ISPs.</p> <p>9-3-4(a)</p>			
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W0336	<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, the facility failed for 4 of 4 sampled clients (clients #1, #2, #3, and #4) to ensure nursing quarterlies were completed in a timely manner.</p> <p>Findings include:</p> <p>On 1-31-12 at 10:15 a.m. a record review for client #1 was conducted. The review indicated client #1 had nursing quarterlies for 11-8-11, 5-24-11, and 2-24-11. The review indicated a nursing quarterly had not been completed for the month of 8-11.</p> <p>On 1-31-12 at 9:30 a.m. a record review for client #2 was conducted. The review indicated client #2 had nursing quarterlies for 11-8-11, 5-24-11, and 2-24-11. The review indicated a nursing quarterly had not been completed for the month of 8-11.</p> <p>On 1-31-12 at 11:45 a.m. a record review for client #3 was conducted. The review indicated client #3 had nursing quarterlies for 11-8-11, 5-24-11, and 2-24-11. The review indicated a nursing quarterly had not been completed for the month of 8-11.</p> <p>On 1-31-12 at 11:15 a.m. a record review</p>	W0336	<p>We are unable to go back into time and complete a quarterly assessment for August 2011. LOGAN Community Resources makes every effort to meet all nursing and medical needs of each resident. In the future, we can identify and designate a nurse to complete quarterly assessments in effort to prevent missed quarterly assessments.</p> <p>Persons Responsible: Nurse Supervisor Nurse Director of Group Living</p>	03/02/2012
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	<p>for client #4 was conducted. The review indicated client #4 had nursing quarterlies for 11-8-11, 5-24-11, and 2-24-11. The review indicated a nursing quarterly had not been completed for the month of 8-11.</p> <p>On 1-31-12 at 12:10 p.m. an interview with the Qualified Mental Retardation Professional indicated nursing quarterlies for clients #1, #2, #3, and #4 should have been completed in August 2011.</p> <p>9-3-6(a)</p>			
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W0368	<p>The system for drug administration must assure that all drugs are administered in compliance with the physician's orders.</p> <p>Based on record review and interview, the facility failed for 2 of 8 clients (clients #2 and #8), who lived in the home, to ensure physician's orders were followed.</p> <p>Findings include:</p> <p>On 1-30-12 at 12:00 p.m. a review of the facility's Bureau of Developmental Disability (BDDS) reports was conducted. The BDDS reports indicated the following:</p> <ul style="list-style-type: none"> -A BDDS report dated 4-13-11 for client #2 indicated she was out of Benadryl which was to be taken at bedtime. -A BDDS report dated 4-9-11 for client #2 indicated she was out of Abilify which was to be taken in the morning. -A BDDS report dated 5-11-11 for client #2 indicated she was out of her Clozaril for her evening dose. -A BDDS report dated 7-14-11 for client #2 indicated she was out of her Clozaril for her evening dose. -A BDDS report dated 1-16-12 for client #8 indicated she was out of her Methylphenidate ER for attention deficit disorder. <p>On 1-31-12 at 9:30 a.m. a record review</p>	W0368	<p>All prescribed medication in the home are to be administered per physician's orders. There are protocols in place for monitoring and re-ordering medications 5-7 prior to running out. For the 4-13-11 BDDS report, there was question as to whether or not the medication was to be given short term or long term. When the staff thought that the medication had run out, they assumed it was given only short term and client #2 would longer be taking the medication. The medication was to be given long term and a supply for the month had been delivered the day before. For the 4-9-11 BDDS report, the Abilify was a new medication. When ordered from the pharmacy, only enough was sent until the monthly cycle fill was delivered. Further investigation found that the amount sent was still one day short to have enough until the monthly delivery. For the 5-11-11 BDDS report, the Clozaril will not be delivered until the appropriate labwork has been completed and the pharmacy receives the results. Client #2 had the appropriate labwork done, but the results had not been sent to the pharmacy and therefore the medication could not be released and delivered. For the 7-14-11 BDDS report, Client #2 had the appropriate labwork completed as</p>	03/02/2012	

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	<p>for client #2 was conducted. The Physician's Orders dated 1-1-12 indicated client #2 took Clozaril 100 milligrams, every morning and at noon time, the Benadryl was discontinued on 5-13-11 and the Abilify was discontinued on 10-6-11.</p> <p>On 1-31-12 at 12:30 p.m. a review of client #8's Physician's Orders dated 1-1-12 indicated client #8 took Methylpheridate ER 54 milligrams every morning.</p> <p>On 1-31-12 at 12:10 p.m. an interview with the Qualified Mental Retardation Professional indicated Physician's orders should be followed for clients #2 and #8.</p> <p>9-3-6(a)</p>		<p>noted above and the results were sent to the Pharmacy in a timely manner. Further investigation found that the pharmacy was waiting on prior authorization from the psychiatrist to deliver the medication. The nurse was able to arrange with the pharmacy for the agency to pay for a 7 day supply until the prior authorization was received. For the 1-16-12 BDDS report, the staff were not aware that the medication for client #8 did not come with the monthly cycle fill and therefore did not look further to ensure there was more medication in the house after the last pill was given. Because this medication has to be ordered with a written prescription every month, a protocol is in place for counting and ordering medications that do not come with the regular monthly cycle fill. Where appropriate, discipline was given to staff for not following protocols already in place to ensure medications are ordered in a timely fashion. In the future, the agency nurse will continue to work with the pharmacy, the lab and the prescribing physicians to ensure that medications are ordered and received in a timely manner and available to be given. Repeated follow up will take place in a timely manner until medication is prescribed, ordered and delivered. The agency will also continue to monitor the use of protocols that are currently in</p>		

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			place for staff to re-order medications. Continued disciplinary action will be taken when necessary. As appropriate, the agency will pay for prescribed medication when not readily covered or if needed in an expedient time frame. Persons Responsible: Nurse Program Coordinator QMRP Director of Group Living		

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W0440	<p>The facility must hold evacuation drills at least quarterly for each shift of personnel.</p> <p>Based on record review and interview, the facility failed for 8 of 8 clients (clients #1, #2, #3, #4, #5, #6, #7, and #8) to ensure evacuation drills were done for the midnight shift quarterly.</p> <p>Findings include:</p> <p>On 1-30-12 at 12:55 p.m. a review of the facility's evacuation drills for clients #1, #2, #3, #4, #5, #6, #7, and #8 was conducted. The review indicated a midnight drill for the third quarter, 7-11, 8-11, and 9-11 had not been completed. The following drills were conducted: 9-13-11 at 9:52 p.m., 9-8-11 at 8:33 p.m., 9-3-11 at 11:25 a.m., 8-6-11 at 12:06 p.m., 8-2-11 at 7:55 p.m., 7-19-11 at 8:30 a.m., 7-16-11 at 9:59 a.m., and 7-12-11 at 4:05 p.m.</p> <p>On 2-1-12 at 10:05 a.m. an interview with the Administrative Assistant indicated there was no evacuation drill for the midnight shift for the third quarter.</p> <p>9-3-7(a)</p>	W0440	<p>There is a schedule in place at the group home and staff are assigned to run drills on specific days and shifts to include all shifts. If the drills are missed the staff will make up the missed drill as soon as possible. The drills are tracked by the Group Living Administrative Assistant so a report is generated in order to catch missed drills and then avoid missing drills on each designated shift. The Group Living Administrative Assistant notifies the Director of Group Living and Program Coordinator so additional drills can be scheduled, as appropriate. A drill was completed on the overnight shift on 2/9/12 at 11:50pm. In the future, drills completed will continue to be monitored and tracked to catch any missed drills. If a drill is not completed as assigned on a designated day, the drill will be completed as soon as possible.</p> <p>Persons Responsible: Program Coordinator Group Living Administrative Assistant Director of Group Living</p>	03/02/2012			

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W0460	<p>Each client must receive a nourishing, well-balanced diet including modified and specially-prescribed diets.</p> <p>Based on observation, record review, and interview, the facility failed for 3 of 4 sampled clients (clients #1, #2, and #3) and 1 additional client (client #8) to ensure milk was offered at breakfast per the menu.</p> <p>Findings include:</p> <p>On 1-31-12 from 6:45 a.m. until 7:45 a.m. an observation at the home of clients #1, #2, #3, and #8 was conducted. At 7:15 a.m. clients #1, #2, #3, and #8 ate toast and grits with no milk on the table for their use.</p> <p>On 1-31-12 at 11:15 a.m. a review of the facility's menu dated January 29-February 4 was conducted. The menu indicated milk was on the menu.</p> <p>On 1-31-12 at 12:10 p.m. an interview with the Qualified Mental Retardation Professional indicated milk should be offered per the menu.</p> <p>9-3-8(a)</p>	W0460	<p>On February 16, 2012 at the house staff meeting, the direct care staff were reminded that items on the prescribed menu must be present for meals for all individuals unless otherwise noted. If the individuals are sitting at different tables, the same items must be available for both tables. In the future, management staff including the Program Coordinator, QMRP and Director of Group Living will make announced as well as unannounced visits at meal times to check on and ensure staff are providing all prescribed menu items to all clients at all meals at all tables. Persons Responsible: Program Coordinator QMRP Director of Group Living.</p>	03/02/2012			

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W0484	<p>The facility must equip areas with tables, chairs, eating utensils, and dishes designed to meet the developmental needs of each client.</p> <p>Based on observation and interview, the facility failed for 3 of 4 sampled clients (clients #1, #2, and #3) and 1 additional client (client #8) to ensure condiments were offered at breakfast.</p> <p>Findings include:</p> <p>On 1-31-12 from 6:45 a.m. until 7:45 a.m. an observation at the home of clients #1, #2, #3, and #8 was conducted. At 7:15 a.m. clients #1, #2, #3, and #8 ate toast and grits with no condiments on the table for their use. Clients #1, #2, #3, and #8 ate their toast and grits with no condiments added to them. The grits were plain and thick and the toast had no toppings.</p> <p>On 1-31-12 at 12:10 p.m. an interview with the Qualified Mental Retardation Professional indicated condiments should be offered for toast and grits.</p> <p>9-3-8(a)</p>	W0484	<p>On February 16, 2012, at the house staff meeting, the use of condiments and appropriate table settings was reviewed with the direct care staff. Examples of different meals were given and the staff had to identify what the appropriate condiments were that should be available. The use of utensils and other items was also reviewed at this time. Staff were able to successfully identify appropriate condiments depending on the type meal and meal items served. In the future, management staff including the Program Coordinator, QMRP and Director of Group Living will make announced as well as unannounced visits at meal times to check on and ensure staff are providing appropriate condiments to clients at all meals. Persons Responsible: Program Coordinator QMRP Director of Group Living.</p>	03/02/2012			

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W9999	<p>State Findings</p> <p>The following Community Residential Facilities for Persons with Developmental Disabilities rule was not met.</p> <p>460 IAC 9-3-1 Governing body Sec. 1. (b) The residential provider shall report the following circumstances to the division by telephone no later than the first business day followed by written summaries as requested by the division.</p> <p>The state rule was not met as evidenced by:</p> <p>Based on record review and interview, the facility failed for 5 of 24 reportable incident reports reviewed involving 4 of 8 clients living in the facility (clients #2, #4, #6, and #8) to submit the report to the Bureau of Developmental Disabilities Services (BDDS) within 24 hours, in accordance with state law.</p> <p>Findings include:</p> <p>The facility's reportable incidents to BDDS (Bureau of Developmental Disability Services) Reports, from 2-11 to 1-12, were reviewed on 1-30-12 at 12:00</p>	W9999	<p>For the 2-19-11 BDDS report, staff were following first aid instructions given by the nurse but when the abrasion on her foot did not appear to be healing, the Program Coordinator made the decision to take client #8 to Med Point. While the Program Coordinator made the appropriate decision to ensure the health and safety of client #8, she neglected to report to the nurse or QMRP so that the reportable could be submitted. For the 4-9-11 BDDS report, missing Abilify was reported to the QMRP on-call on 4-9-11 which was a Saturday. The QMRP on-call should have reported the missing medication. When the QMRP for the house received the information the reportable was completed. For the 6-16-11 BDDS report, the QMRP received the initial report but admittedly forgot to the complete the reportable until 6-22-11. For the 7-12-11 BDDS report, staff had been following the nurse's instruction to treat a rash for Client #4. When the rash did not appear to be healing, the Program Coordinator was instructed to make an appointment with the primary physician. When no appointment was available, client #4 was taken to Med Point for treatment. While the Program Coordinator made the appropriate decision to ensure the health and safety of</p>	03/02/2012	

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	<p>p.m. The review indicated the following:</p> <ul style="list-style-type: none"> -A BDDS report with an incident date of 2-19-11 and a submit date of 2-21-11 for client #8 indicated she was taken to [name of urgent care] for a foot abrasion. She was prescribed Keflex. -A BDDS report with an incident date of 4-9-11 and a submit date of 4-14-11 for client #2 indicated she was out of her Abilify. -A BDDS report with an incident date of 6-16-11 and a submit date of 6-22-11 for client #6 indicated she had a large bruise on the inside of her upper arm. -A BDDS report with an incident date of 7-12-11 and a submit date of 7-14-11 for client #4 indicated she went to [name of urgent care] for a rash under her arms. -A BDDS report with an incident date of 12-2-11 and a submit date of 12-5-11 for client #2 indicated she tripped over a broom and fell which caused a 1 1/4 inch skin tear on the right lower leg. <p>On 1-31-12 at 12:10 p.m. an interview with the Qualified Mental Retardation Professional indicated BDDS reports should be filed within 24 hours of the incident.</p> <p>9-3-1(b)</p>		<p>client #4, she neglected to report to the nurse or QMRP so that the reportable could be submitted. For the 12-2-11 BDDS report, the incident occurred in the workshop. Although the Program Coordinator was on vacation, the nurse treated client #2 and either the Director of Day Services or another Program Coordinator should have been contacted to report the incident in a timely manner. The Director of Day Services reports that there is a system in place for ensuring that the appropriate people receive this type of information in a timely fashion so the reportable can be completed. In the future, days services will implement their system by having a back up staff person complete the reportable incident in a timely manner or make a verbal report to the Day Services Director so that she can complete the report of the incident in a timely manner. For Group Living, the Program Coordinator will report to the QMRP immediately whenever a client is taken to Med Point so that a reportable can be completed in a timely manner. The Director of Group Living tracks all incidents that are potentially reportable and will follow up with the designated staff that needs to complete the report so that they may do so in a timely manner. Persons Responsible: Director of Day Services Director of Group</p>		

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			LivingQMRPPProgram Coordinator	
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