

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G480	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/17/2015
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NAME OF PROVIDER OR SUPPLIER DEVELOPMENTAL SERVICE ALTERNATIVES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 9520 E GEMINI DR INDIANAPOLIS, IN 46229
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W 0000 Bldg. 00	<p>This visit was for an extended annual recertification and state licensure survey.</p> <p>Dates of Survey: 6/8/15, 6/9/15, 6/10/15, 6/11/15, 6/15/15 and 6/17/15.</p> <p>Facility Number: 000994 Provider Number: 15G480 AIMS Number: 100244960</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9.</p>	W 0000		
W 0104 Bldg. 00	<p>483.410(a)(1) GOVERNING BODY</p> <p>The governing body must exercise general policy, budget, and operating direction over the facility.</p> <p>Based on record review and interview for 3 of 3 sampled clients (#1, #2 and #3) plus 3 additional clients (#4, #5 and #6), the governing body failed to exercise general policy, budget and operating direction over the facility to ensure the facility met the Condition of Participation: Client Protections for 1 of 3 sampled clients, to ensure the facility implemented its policy and procedures to</p>	W 0104	<p>The following is being implemented to address the standard for which the agency Governing Body is responsible in the area of operating direction over the facility to ensure the Condition of Participation: Client Protections was met. The agency has a new administrative position, Program Quality Coordinator, as of March 2015. The person in this position has at least 10 years of experience</p>	07/17/2015

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

TITLE

(X6) DATE

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

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	<p>prevent neglect of client #1 regarding timely medical attention for her fractured ankle and to complete a thorough investigation regarding client #1's ankle.</p> <p>The governing body failed to exercise general policy, budget and operating direction over the facility to ensure the QIDP (Qualified Intellectual Disabilities Professional) integrated, coordinated and monitored clients #1, #2 and #3's active treatment programs by failing to review their formal program objectives for progression/regression of skills, to ensure client #1's ISP (Individual Support Plan) was revised annually, to ensure recommended less restrictive techniques were implemented prior to initiating a new psychotropic medication to manage client #3's behavior and to ensure the use of audio monitoring alarms to manage client #3's behavior was incorporated into client #3's ISP/BDP (Behavior Development Program).</p> <p>The governing body failed to exercise general policy, budget and operating direction over the facility to ensure the facility nursing services ensured client #2 had a skilled home health assessment, nursing care plans to monitor client #2 regarding pneumonia/respiratory infections, atrial fibrillation, congestive heart failure or renal failure.</p>		<p>completing investigations and has completed training on thorough investigations as provided by the Indiana State Department of Health. This administrator does complete the agency administrative review of all investigations. The Program Quality Coordinator ensures each submitted investigation is thorough by making sure that all applicable information is obtained and reviewed, this does include interview of all individuals who may have information regarding the issue being investigated including any clients involved or present. In the case of serious injuries, such as fractures, the Program Quality Coordinator now completes these investigations. In the course of completing such investigations, the Program Quality Coordinator looks at the facts of the incident, but also staff response (including the facility nurse and QIDP) to the injury to ensure the response of all involved was appropriate. If it determined that any level of response was not appropriate, the investigation will include recommendations for corrective action. These completed investigations are reviewed by the agency Program Services Director. The Area Director is responsible for ensuring completion of any needed corrective action that may result. This process will ensure the completion of a thorough investigation and that any failure to provide timely medical attention is</p>	

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	<p>Findings include:</p> <ol style="list-style-type: none"> 1. The governing body failed to exercise general policy, budget and operating direction over the facility to ensure the facility met the Condition of Participation: Client Protections for 1 of 3 sampled clients (#1). Please see W122. 2. The governing body failed to exercise general policy, budget and operating direction over the facility to ensure the facility implemented its policy and procedures to prevent neglect of client #1 regarding timely medical attention for her fractured ankle and to complete a thorough investigation regarding client #1's ankle. Please see W149. 3. The governing body failed to exercise general policy, budget and operating direction over the facility to ensure the facility implemented its policy and procedures to complete a thorough investigation regarding client #1's ankle. Please see W154. 4. The governing body failed to exercise general policy, budget and operating direction over the facility to ensure the QIDP (Qualified Intellectual Disabilities Professional) integrated, coordinated and monitored clients #1, #2 and #3's active 		<p>addressed properly. The direct care staff will receive further training regarding a need to report all complaints of or behavior that indicates a client is in pain or discomfort. The administrator and facility nurse are notified of all client falls. The administrator will direct the facility nurse to ensure completion of a physical assessment of any client who falls by a medical professional to rule out injury when a client is at risk for injury as determined by the administrator and facility nurse.</p> <p>The following is being implemented to ensure direction over the facility QIDP. The administrator is providing oversight over all responsibilities of the QIDP. This oversight includes needed training, direction, monitoring and verification for completion of required responsibilities as the QIDP. This will include but is not limited to the following: monitoring the active treatment programs for all clients by reviewing their progress with formal training objectives for progression/regression of skills, ensuring each client's Individual Support Plan is revised annually, ensuring recommended less restrictive techniques are implemented prior to initiating new psychotropic medications to manage client behavior, and to ensure the use of any restrictive techniques such as an audiometer to manage client behavior is</p>	

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	<p>treatment programs by failing to review their formal program objectives for progression/regression of skills, to ensure client #1's ISP (Individual Support Plan) was revised annually, to ensure recommended less restrictive techniques were implemented prior to initiating a new psychotropic medication to manage client #3's behavior and to ensure the use of audio monitoring alarms to manage client #3's behavior was incorporated into client #3's ISP/BDP (Behavior Development Program). Please see W159.</p> <p>5. The governing body failed to exercise general policy, budget and operating direction over the facility to ensure the facility nursing services ensured client #2 had a skilled home health assessment, nursing care plans to monitor client #2 regarding pneumonia/respiratory infections, atrial fibrillation, congestive heart failure or renal failure. Please see W331.</p> <p>9-3-1(a)</p>		<p>incorporated into the client'sISP/Behavior Development Program. The Program Quality Coordinator hasimplemented a monitoring system to track for and ensure completion of requiredreviews of training objectives for the presence of progression/regression ofskills. These reviews will be completed and current through June 2015. The QIDP and Area Director will be promptedas needed each month to ensure completion of this review. The ISP for client #1was revised as required as of 6/19/15. The Program Quality Coordinator is alsotracking completion of ISPs to ensure they are revised no less than annuallyfor each client in the facility. This administrator will verify that ISPs forall clients in the facility have been revised as required within the past year. This tracking includes a system by whichthere is a schedule of ISP's due each month for the facility. The QIDP will bedirected to complete the proposed ISP revision the month before it is due andto present to the administrator for review. When the ISP has been updatedduring the annual meeting a copy of the complete and signed revision will beposted for review and tracking purposes. The administrator will verify that therevision is complete with participation of required team members including theclient and their legal guardian as applicable. The Program Quality</p>	

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			<p>Coordinator is participating in IST meetings for all clients and is tracking team recommendations to ensure follow-through. As a member of the IST, this administrator will also prompt team members to recommended less restrictive techniques are implemented prior to proceeding with addition of psychotropic medications. The IST will follow-up and review the IST recommendations and decisions regarding client #3 and how her behavior is being managed. Client #3's Behavior Development Program has been updated as of 5/31/15 to include use of the audio monitor. The administrator will ongoing ensure that the use of any monitors for the purpose of managing behavior is added to the Behavior Development Program as required. The following is being implemented to ensure direction over the facility nurse. The Registered Nurse and administrator will provide needed training, direction and oversight to ensure the nurse properly monitors for and addresses health and medical concerns for all clients in the home. This will include but not be limited to ensuring all recommendations and orders from physicians including discharge orders and recommendations are followed and addressed with the IST and ensuring nurse care plans or risk plans are in place to monitor for all diagnosed and treated conditions.</p>	

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W 0122 Bldg. 00	483.420 CLIENT PROTECTIONS The facility must ensure that specific client protections requirements are met. Based on record review and interview, the facility failed to meet the Condition	W 0122	The IST will address the order from February 2015 for client #2 to have a skilled home health assessment completed. Her physician will be consulted as part of this review. The nurse has developed and implemented risk plans for client #2 regarding recurrent diagnoses and treatment of pneumonia/respiratory infections, and congestive heart failure. Her presence will be increased during the time of Plan of Correction, at the direction of the administrator. The nurse will complete a comprehensive review of the medical record for each client to ensure all risk issues are adequately addressed. The RN and administrator will provide oversight to ensure all areas are properly addressed. A summary of compliance with those areas cited at this condition will be provided to the agency Executive Council (Governing Body) by the administrator for review at each scheduled meeting. The administrator will be responsible for ensuring any resulting recommendations are addressed and that proper follow-up is provided to this council. Responsible Party: Area Director The agency has a new administrative position, Program Quality	07/17/2015	

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	<p>of Participation: Client Protections for 1 of 3 sampled clients (#1). The facility failed to implement its policy and procedures to prevent neglect of client #1 regarding timely medical attention for her fractured ankle and to complete a thorough investigation regarding client #1's fractured ankle.</p> <p>Findings include:</p> <p>1. The facility failed to implement its policy and procedures to prevent neglect of client #1 regarding timely medical attention for her fractured ankle and to complete a thorough investigation regarding client #1's fractured ankle. Please see W149.</p> <p>2. The facility failed to conduct a thorough investigation regarding client #1's fractured ankle. Please see W154.</p> <p>9-3-2(a)</p>		<p>Coordinator, as of March 2015. The person in this position has at least 10 years of experience completing investigations and has completed thorough investigations as provided by the Indiana State Department of Health. This administrator does complete the agency administrative review of all investigations. The Program Quality Coordinator ensures each submitted investigation is thorough by making sure that all applicable information is obtained and reviewed, this does include interview of all individuals who may have information regarding the issue being investigated including any clients involved or present. In the case of serious injuries, such as fractures, the Program Quality Coordinator now completes these investigations. In the course of completing such investigations, the Program Quality Coordinator looks at the facts of the incident, but also staff response (including the facility nurse and QIDP) to the injury to ensure the response of all involved was appropriate. If it determined that any level of response was not appropriate, the investigation will include recommendations for corrective action. These completed investigations are reviewed by the agency Program Services Director. The Area Director is responsible for ensuring completion of any needed corrective action that may result. This process</p>		

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W 0149 Bldg. 00	<p>483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. Based on record review and interview for 1 of 3 sampled clients (#1), the facility failed to implement its policy and procedures to prevent neglect of client #1 regarding timely medical attention for her fractured ankle and to complete a thorough investigation regarding client #1's fractured ankle.</p> <p>Findings include: The facility's BDDS (Bureau of</p>	W 0149	<p>will ensure the completion of a thorough investigation and that any failure to provide timely medical attention is addressed properly. The direct care staff will receive further training regarding a need to report all complaints of or behavior that indicates a client is in pain or discomfort. The administrator and facility nurse are notified of all client falls. The administrator will direct the facility nurse to ensure completion of a physical assessment of any client who falls by a medical professional to rule out injury when a client is at risk for injury as determined by the administrator and facility nurse. Responsible Party: Program Quality Coordinator</p> <p>The agency has a new administrative position, Program Quality Coordinator, as of March 2015. The person in this position has at least 10 years of experience completing investigations and has completed training on thorough investigations as provided by the Indiana State Department of Health. This administrator does complete the agency administrative review of all investigations. The Program Quality Coordinator ensures each submitted investigation is thorough</p>	07/17/2015

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	<p>Developmental Disabilities Services) reports and investigations were reviewed on 6/9/15 at 12:45 PM. The review indicated the following:</p> <p>-BDDS report dated 2/19/15 indicated, "[Client #1] fell in the home when tripping over her roommate's walker on 2/17/15. There were no signs of injury at the time and [client #1] resumed normal activity. The nurse was notified and directed staff to administer Tylenol for pain. The next day, [client #1] was complaining of having pain in her right foot on 2/18/15 and it was decided that she should get x-rays completed on the foot. The x-ray showed a closed fibular fracture and sprain of right medial ankle joint. [Client #1] was fitted with a splint on 2/18/15 and a cast was placed on 2/19/15."</p> <p>-Investigation Summary Form dated 2/25/15 included a written narrative statement from staff #1 which indicated, "February 17, 2015. Consumers were sitting down eating breakfast. [Client #1] finished her breakfast and put dishes in (the) dishwasher. [Client #1] then head (sic) towards her room to get her toothbrush and toothpaste. [Client #5's] walker was against the wall next to her seat and close to the walkway of [client #1's] room. While going to her room,</p>		<p>by making sure that all applicable information isobtained and reviewed, this does include interview of all individuals who mayhave information regarding the issue being investigated including any clientsinvolved or present. In the case ofserious injuries, such as fractures, the Program Quality Coordinator nowcompletes these investigations. In the course of completing suchinvestigations, the Program Quality Coordinator looks at the facts of theincident, but also staff response (including the facility nurse and QIDP) tothe injury to ensure the response of all involved was appropriate. If itdetermined that any level of response was not appropriate, the investigationwill include recommendations for corrective action. These completedinvestigations are reviewed by the agency Program Services Director. The AreaDirector is responsible for ensuring completion of any needed corrective actionthat may result. This process will ensure the completion of a thoroughinvestigation and that any failure to provide timely medical attention isaddressed properly. The direct care staff will receive further trainingregarding a need to report all complaints of or behavior that indicates aclient is in pain or discomfort. The administrator and facility nurse arenotified of all client falls. The administrator will direct the facility nurseto ensure</p>	

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	<p>[client #1] tripped over [client #5's] walker and fell in (to) the medication room. [Staff #1] was standing about 2 feet from where she fell. [Client #1] immediately starting (sic) crying and [staff #2] and [staff #1] went to her aide (sic). [Staff #1] helped her sit up (still on the ground) and looked at her leg. We then helped her to the couch, propped her leg up, removed her shoes and brace and checked her foot. Everything looked fine (no bruises). I, [staff #1], asked [client #1] did it still hurt? Her response was yes. I, [staff #1], told her to stay seated (sic) after about 15 minutes I, [staff #1], told her to see if she can walk. [Client #1] then proceeded to walk to the restroom. There was a little limp at the time. [Staff #2] call (sic) to notify. [Client #1] walked with my assistance to load the van, walked ok, but with a little limp. [Client #1] seemed ok and was no longer crying. Once we got to [day services] and unloaded (van) [client #1] began crying again and stated her ankle hurt. I, [staff #1], brought [client #1] back to the group home. [RD (Residential Director #1] was notified."</p> <p>The 2/25/15 Investigation Summary Form did not indicate documentation of analysis of staff #1's statement regarding client #1's complaints of pain on 2/17/15 as it relates to the time medical treatment</p>		<p>completion of a physical assessment of any client who falls by amedical professional to rule out injury when a client is at risk for injury asdetermined by the administrator and facility nurse. Responsible Party: Program Quality Coordinator</p>		

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	<p>was provided, as well as, the discrepancy in the time line of events as reported in the 2/19/15 BDDS report. The Investigation Summary Form dated 2/25/15 did not include an interview/statement from the facility nurse or RD #1 to reconcile staff #1's reporting and nursing actions to address client #1's fractured ankle in a timely manner.</p> <p>LPN (Licensed Practical Nurse) #1 was interviewed on 6/17/15 at 9:56 AM. LPN #1 stated, "I wasn't informed that night (2/17/15) that [client #1] had any issues with her ankle. I was told that she fell but that there were no injuries." LPN #1 stated, "I went to [day services] the next morning (2/18/15) to assess her. It was purple and her ankle was the size of a baseball, very swollen. I had her sent to [hospital], she was not happy that morning and in pain."</p> <p>AS (Administrative Staff) #1 was interviewed on 6/9/15 at 12:42 PM. AS #1 indicated the facility's abuse and neglect policy should be implemented and the investigation of all allegations of abuse, neglect, mistreatment should be thorough and include all witnesses and potential witnesses to the alleged event.</p> <p>The facility's policies and procedures</p>			

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W 0154 Bldg. 00	<p>were reviewed on 6/15/15 at 10:54 AM. The facility's policy entitled, 'Preventing Abuse and Neglect' dated 10/2013 indicated the following:</p> <p>- "DSA (Developmental Service Alternatives), incorporated prohibits abuse, neglect, exploitation, mistreatment or violation of the rights of the consumers it serves."</p> <p>- "B. Neglect means failure to provide supervision, training, appropriate care, food, medical care, or medical supervision to an individual."</p> <p>- "Immediately upon being notified of the incident, the RD or on-call RD must:...; (2.) Document the investigation procedures and results."</p> <p>9-3-2(a)</p> <p>483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated. Based on record review and interview for 1 of 9 allegations of abuse, neglect or mistreatment reviewed, the facility failed to conduct a thorough investigation regarding client #1's fractured ankle.</p>	W 0154	The agency has a new administrative position, ProgramQuality Coordinator, as of March 2015. The person in this position has at least 10 years of experience completing investigations and has completed training on thorough investigations	07/17/2015			

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	<p>Findings include:</p> <p>The facility's BDDS (Bureau of Developmental Disabilities Services) reports and investigations were reviewed on 6/9/15 at 12:45 PM. The review indicated the following:</p> <p>-BDDS report dated 2/19/15 indicated, "[Client #1] fell in the home when tripping over her roommate's walker on 2/17/15. There were no signs of injury at the time and [client #1] resumed normal activity. The nurse was notified and directed staff to administer Tylenol for pain. The next day, [client #1] was complaining of having pain in her right foot on 2/18/15 and it was decided that she should get x-rays completed on the foot. The x-ray showed a closed fibular fracture and sprain of right medial ankle joint. [Client #1] was fitted with a splint on 2/18/15 and a cast was placed on 2/19/15."</p> <p>-Investigation Summary Form dated 2/25/15 included a written narrative statement from staff #1 which indicated, "February 17, 2015. Consumers were sitting down eating breakfast. [Client #1] finished her breakfast and put dishes in (the) dishwasher. [Client #1] then head (sic) towards her room to get her toothbrush and toothpaste. [Client #5's]</p>		<p>as provided by the Indiana State Department of Health. This administrator does complete the agency administrative review of all investigations. The Program Quality Coordinator ensures each submitted investigation is thorough by making sure that all applicable information is obtained and reviewed, this does include interview of all individuals who may have information regarding the issue being investigated including any clients involved or present. In the case of serious injuries, such as fractures, the Program Quality Coordinator now completes these investigations. In the course of completing such investigations, the Program Quality Coordinator looks at the facts of the incident, but also staff response (including the facility nurse and QIDP) to the injury to ensure the response of all involved was appropriate. If it determined that any level of response was not appropriate, the investigation will include recommendations for corrective action. These completed investigations are reviewed by the agency Program Services Director. The Area Director is responsible for ensuring completion of any needed corrective action that may result. This process will ensure the completion of a thorough investigation and that any failure to provide timely medical attention is addressed properly.</p>	

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	<p>walker was against the wall next to her seat and close to the walkway of [client #1's] room. While going to her room, [client #1] tripped over [client #5's] walker and fell in (to) the medication room. [Staff #1] was standing about 2 feet from where she fell. [Client #1] immediately starting (sic) crying and [staff #2] and [staff #1] went to her aide (sic). [Staff #1] helped her sit up (still on the ground) and looked at her leg. We then helped her to the couch, propped her leg up, removed her shoes and brace and checked her foot. Everything looked fine (no bruises). I, [staff #1], asked [client #1] did it still hurt? Her response was yes. I, [staff #1], told her to stay seated (sic) after about 15 minutes I, [staff #1], told her to see if she can walk. [Client #1] then proceeded to walk to the restroom. There was a little limp at the time. [Staff #2] call (sic) to notify. [Client #1] walked with my assistance to load the van, walked ok, but with a little limp. [Client #1] seemed ok and was no longer crying. Once we got to [day services] and unloaded (van) [client #1] began crying again and stated her ankle hurt. I, [staff #1], brought [client #1] back to the group home. [RD (Residential Director #1) was notified."</p> <p>The 2/25/15 Investigation Summary Form did not indicate documentation of</p>		Responsible Party: Program Quality Coordinator	

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	<p>analysis of staff #1's statement regarding client #1's complaints of pain on 2/17/15 as it relates to the time medical treatment was provided, as well as, the discrepancy in the time line of events as reported in the 2/19/15 BDDS report. The Investigation Summary Form dated 2/25/15 did not include an interview/statement from the facility nurse or RD #1 to reconcile staff #1's reporting and nursing actions to address client #1's fractured ankle in a timely manner.</p> <p>LPN (Licensed Practical Nurse) #1 was interviewed on 6/17/15 at 9:56 AM. LPN #1 stated, "I wasn't informed that night (2/17/15) that [client #1] had any issues with her ankle. I was told that she fell but that there were no injuries." LPN #1 stated, "I went to [day services] the next morning (2/18/15) to assess her. It was purple and her ankle was the size of a baseball, very swollen. I had her sent to [hospital], she was not happy that morning and in pain."</p> <p>AS (Administrative Staff) #1 was interviewed on 6/9/15 at 12:42 PM. AS #1 indicated the investigation of all allegations of abuse, neglect, mistreatment should be thorough and include all witnesses and potential witnesses to the alleged event.</p>			

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W 0159 Bldg. 00	<p>9-3-2(a)</p> <p>483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL</p> <p>Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional. Based on record review and interview for 3 of 3 sampled clients (#1, #2 and #3) the QIDP (Qualified Intellectual Disabilities Professional) failed to integrate, coordinate and monitor clients #1, #2 and #3's active treatment programs by failing to review their formal program objectives for progression/regression of skills, to ensure client #1's ISP (Individual Support Plan) was revised annually, to ensure recommended less restrictive techniques were implemented prior to initiating a new psychotropic medication to manage client #3's behavior and to ensure the use of audio monitoring alarms to manage client #3's behavior was incorporated into client #3's ISP/BDP (Behavior Development Program).</p> <p>Findings include:</p> <p>1. Client #1's record was reviewed on 6/10/15 at 8:32 AM. Client #1's ISP dated 1/17/14 indicated, "Data to be reviewed monthly and then presented to</p>	W 0159	The administrator is providing oversight over all responsibilities of the QIDP. This oversight includes needed training, direction, monitoring and verification for completion of required responsibilities as the QIDP. This will include but is not limited to the following: monitoring the active treatment programs for all clients by reviewing their progress with formal training objectives for progression/regression of skills, ensuring each client's Individual Support Plan is revised annually, ensuring recommended less restrictive techniques are implemented prior to initiating new psychotropic medications to manage client behavior, and to ensure the use of any restrictive techniques such as an audio monitor to manage client behavior is incorporated into the client's ISP/Behavior Development Program. The Program Quality Coordinator has implemented a monitoring system to track for and ensure completion of required reviews of training	07/17/2015

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	<p>the IST (Individual Support Team) on a semi annual basis."</p> <p>Client #1's Goals Summary Report (GSR) dated 6/10/15 indicated client #1 had formal training objectives to increase her independence with cooking, leisure skills, money management, oral hygiene, knowledge of her address, communication, medication self-administration, shaving, interpersonal skills and safety skills.</p> <p>Client #1's GSR dated 6/10/15 indicated client #1's formal training objectives had been implemented on 5/21/14. Client #1's GSR dated 6/10/15 indicated client #1's goals had been reviewed by the QIDP for progression/regression of skills on 6/10/15, 6/9/15, 6/2/15, 1/28/15, 12/2/14, 10/1/14, 9/24/14, 8/7/14 and 6/20/14. The review did not indicate documentation of monthly QIDP review of client #1's formal training objectives.</p> <p>2. Client #2's record was reviewed on 6/10/15 at 9:45 AM. Client #2's ISP dated 5/21/15 indicated, "Progress reviewed by QIDP monthly."</p> <p>Client #2's GSR dated 6/10/15 indicated client #2's formal training objectives to increase her independence with cooking, daily living, exercise, money</p>		<p>objectives for the presence of progression/regression of skills. These reviews will be completed and current through June 2015. The QIDP and Area Director will be prompted as needed each month to ensure completion of this review. The ISP for client #1 was revised as required as of 6/19/15. The Program Quality Coordinator is also tracking completion of ISPs to ensure they are revised no less than annually for each client in the facility. This administrator will verify that ISPs for all clients in the facility have been revised as required within the past year. This tracking includes a system by which there is a schedule of ISP's due each month for the facility. The QIDP will be directed to complete the proposed ISP revision the month before it is due and to present to the administrator for review. When the ISP has been updated during the annual meeting a copy of the complete and signed revision will be posted for review and tracking purposes. The administrator will verify that the revision is complete with participation of required team members including the client and their legal guardian as applicable. The Program Quality Coordinator is participating in IST meetings for all clients and is tracking team recommendations to ensure follow-through. As a member of the IST, this administrator will also prompt team members to recommended less restrictive</p>	

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	<p>management, medication self-administration, oral hygiene, phone use, laundry, decision making and cleaning her bedroom. Client #2's GSR dated 6/10/15 indicated client #2's formal training objectives began on 5/21/14 and were scheduled to be implemented through 8/1/15. Client #2's GSR dated 6/10/15 indicated client #2's goals had been reviewed by the QIDP for progression/regression of skills on 6/10/15, 6/9/15, 6/2/15, 1/28/15, 12/2/14, 10/1/14, 9/24/14, 8/7/14 and 6/20/14. The review did not indicate documentation of monthly QIDP review of client #2's formal training objectives.</p> <p>3. Client #3's record was reviewed on 6/10/15 at 9:00 AM. Client #3's ISP dated 4/30/15 indicated client #3's formal training objectives would be reviewed monthly by the QIDP for progression/regression of skills.</p> <p>Client #3's GSR dated 6/10/15 indicated client #3 had formal training objectives to increase her independence with anger management skills, social skills, money management, medication self-administration, oral hygiene, leisure skills, hand washing, eating and clothing care.</p> <p>Client #3's GSR dated 6/10/15 indicated</p>		<p>techniques are implemented prior to proceeding with addition of psychotropic medications. The IST will follow-up and review the IST recommendations and decisions regarding client #3 and how her behavior is being managed. Client #3's Behavior Development Program has been updated as of 5/31/15 to include use of the audiomonitor. The administrator will ongoing ensure that the use of any monitors for the purpose of managing behavior is added to the Behavior Development Program as required.</p> <p>Responsible Party: Area Director</p>	

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	<p>client #3's formal training objectives began on 9/1/14 and were scheduled to be implemented through 9/1/15. Client #3's GSR dated 6/10/15 indicated client #3's goals had been reviewed by the QIDP for progression/regression of skills on 6/10/15, 6/9/15, 6/2/15, 1/28/15, 12/2/14, 10/1/14 and 9/23/14. The review did not indicate documentation of monthly QIDP review of client #3's formal training objectives.</p> <p>QIDP #1 was interviewed on 6/9/15 at 9:44 AM. QIDP #1 indicated clients #1, #2 and #3's formal training objectives should be reviewed on a monthly basis for progression/regression of skills.</p> <p>4. The QIDP failed to integrate, coordinate and monitor client #1's active treatment program by failing to ensure client #1's ISP was revised annually. Please see W260.</p> <p>5. The QIDP failed to integrate, coordinate and monitor client #3's active treatment program by failing to ensure recommended less restrictive techniques were implemented prior to initiating a new psychotropic medication to manage client #3's behavior. Please see W278.</p> <p>6. The QIDP failed to integrate, coordinate and monitor client #3's active</p>			

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W 0260 Bldg. 00	<p>treatment program by failing to ensure the use of audio monitoring alarms to manage client #3's behavior was incorporated into client #3's ISP/BDP. Please see W289.</p> <p>9-3-3(a)</p> <p>483.440(f)(2) PROGRAM MONITORING & CHANGE At least annually, the individual program plan must be revised, as appropriate, repeating the process set forth in paragraph (c) of this section.</p> <p>Based on record review and interview for 1 of 3 sampled clients (#1), the facility failed to ensure client #1's ISP (Individual Support Plan) was revised annually.</p> <p>Findings include:</p> <p>Client #1's record was reviewed on 6/10/15 at 8:32 AM. Client #1's ISP dated 1/17/14 indicated the most recent revision of the ISP was 1/17/14. The review did not indicate documentation of annual review since 1/17/14.</p> <p>AS (Administrative Staff) #1 was interviewed on 6/10/15 at 8:52 AM. AS #1 indicated client #1's ISP should be reviewed/revised on an annual basis. AS</p>	W 0260	<p>The ISP for client #1 was revised as required as of 6/19/15. The Program Quality Coordinator is also tracking completion of ISPs to ensure they are revised no less than annually for each client in the facility. This administrator will verify that ISPs for all clients in the facility have been revised as required within the past year. This tracking includes a system by which there is a schedule of ISP's due each month for the facility. The QIDP will be directed to complete the proposed ISP revision the month before it is due and to present to the administrator for review. When the ISP has been updated during the annual meeting a copy of the complete and signed revision will be posted for review and tracking purposes. The administrator will verify that the revision is complete</p>	07/17/2015

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W 0278 Bldg. 00	<p>#1 indicated there was not additional documentation available for review of a more recent annual ISP review since 1/17/14.</p> <p>9-3-4(a)</p> <p>483.450(b)(1)(iii) MGMT OF INAPPROPRIATE CLIENT BEHAVIOR Procedures that govern the management of inappropriate client behavior must insure, prior to the use of more restrictive techniques, that the client's record documents that programs incorporating the use of less intrusive or more positive techniques have been tried systematically and demonstrated to be ineffective.</p> <p>Based on record review and interview for 1 of 3 sampled clients (#3), the facility failed to ensure recommended less restrictive techniques were implemented prior to initiating a new psychotropic medication to manage client #3's behavior.</p> <p>Findings include:</p> <p>Client #3's record was reviewed on 6/10/15 at 9:00 AM. Client #3's Consultant Visit form dated 3/19/15</p>	W 0278	<p>with participation of required team members including the client and their legal guardian as applicable. Responsible Party: QIDP</p> <p>The Program Quality Coordinator is participating in IST meetings for all clients and is tracking team recommendations to ensure follow-through. As a member of the IST, this administrator will also prompt team members to recommended less restrictive techniques are implemented prior to proceeding with addition of psychotropic medications. The IST will follow-up and review the IST recommendations and decisions regarding client #3 and how her behavior is being managed. Responsible Party: Program Quality</p>	07/17/2015

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	<p>indicated, "[Client #3] is being seen for a follow up visit. Staff report an increase in her agitation and not sleeping much through the night. [Client #3] has historically not slept well but seems to have more trouble lately. [Client #3] has not had a medication changed in several years. I recommend a sleep aid such as Melatonin to see if that help her before looking at her behavior medications."</p> <p>Client #3's IST (Individual Support Team) meeting form dated 3/19/15 indicated, "[Psychiatrist] recommended an addition of Melatonin 5 milligrams (sleep aid) for [client #3] to help her sleep better. [Psychiatrist] also recommended starting a low dose of Abilify (anti-psychotic). [Client #3's guardian] is in agreement to try the Melatonin but hold off on the Abilify for now. [Client #3] has had trouble sleeping through the night and may be more agitated lately as a result. Staff also report an increase in behaviors at night. Recommend trying the Melatonin 5 milligrams and revisit the Abilify 5 milligrams at a later date with guardian approval."</p> <p>Client #3's IST meeting form dated 5/28/15 indicated, "[Client #3] had a medication added when she saw [psychiatrist] last. [Psychiatrist] added</p>		Coordinator	

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	<p>Abilify 5 milligrams. The medication change seemed to help at first but [client #3] is still not sleeping well at night and seems keyed up/anxious when spending time at home." The 5/28/15 IST meeting form indicated, "Discussion-Summarize following meeting: concern from [guardian] of adding more medication." The 5/28/15 IST meeting form did not indicate discussion regarding client #3's 3/19/15 recommendation to add Melatonin 5 milligrams to help client #3 sleep prior to starting additional behavior/psychotropic medications.</p> <p>Client #3's Physician's Orders (POs) form dated 4/23/15 indicated client #3 began receiving Abilify 5 milligrams for behaviors on 3/26/15. Client #3's POs form did not indicate documentation of client #3 receiving Melatonin 5 milligrams to assist with sleep.</p> <p>AS (Administrative Staff) #1 was interviewed on 6/10/15 at 9:13 AM. AS #1 indicated there was not documentation of client #3 utilizing Melatonin 5 milligrams to assist her sleep through the night to decrease behaviors prior to receiving Abilify 5 milligrams.</p> <p>9-3-5(a)</p>			

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W 0289 Bldg. 00	<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 for 1 of 3 sampled clients (#3), the facility failed to ensure the use of audio monitoring alarms to manage client #3's behavior was incorporated into client #3's ISP (Individual Support Plan)/BDP (Behavior Development Program).</p> <p>Findings include:</p> <p>Client #3's record was reviewed on 6/10/15 at 9:00 AM. Client #3's IST (Individual Support Team) form dated 4/1/15 indicated, "There was an incident between [client #3] and her roommate on 3/27/15. Her roommate was injured as a result of this incident. Measures have been put into place to protect the safety of both of the women. One such measure is to initiate the use of an audio monitor."</p> <p>Client #3's Behavior Development Program (BDP) dated September 2014 or ISP Individual Support Plan) dated 4/30/15 did not indicate documentation of the use of audio monitoring alarms to manage client #3's behavior.</p>	W 0289	<p>Client #3's Behavior Development Program has been updated as of 5/31/15 to include use of the audio monitor. The administrator will ongoing ensure that the use of any monitors for the purpose of managing behavior is added to the Behavior Development Programs required. A tracking system will be used to ensure these additions are made when the HRC approves this type of restrictive procedure.</p> <p>Responsible Party: Area Director</p>	07/17/2015

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W 0331 Bldg. 00	<p>AS (Administrative Staff) #1 was interviewed on 6/10/15 at 9:40 AM. AS #1 indicated an audio monitoring alarm was being utilized to monitor client #3. AS #1 indicated the use of the audio monitoring alarm should be included in client #3's BDP/ISP.</p> <p>9-3-5(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 record review and interview for 1 of 3 sampled clients (#2), the facility nursing services failed to ensure client #2 had a skilled home health assessment, nursing care plans to monitor client #2 regarding pneumonia/respiratory infections, atrial fibrillation, congestive heart failure and renal failure.</p> <p>Findings include:</p> <p>The facility's BDDS (Bureau of Developmental Disabilities Services) reports and investigations were reviewed on 6/9/15 at 12:45 PM. The review indicated the following:</p> <p>-BDDS report dated 1/8/15 indicated, "[Client #2] was admitted to the</p>	W 0331	<p>The Registered Nurse and administrator will provide needed training, direction and oversight to ensure the nurse properly monitors for and addresses health and medical concerns for all clients in the home. This will include but not be limited to ensuring all recommendations and orders from physicians including discharge orders and recommendations are followed and addressed with the IST and ensuring nurse care plans or risk plans are in place to monitor for all diagnosed and treated conditions. The IST will address the order from February 2015 for client #2 to have a skilled home health assessment completed. Her physician will be consulted as part of this review. The nurse has developed and implemented risk plans for client</p>	07/17/2015

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	<p>[hospital] on 1/7/15 due to low blood pressure readings and vomiting following a visit to [clinic]. [Client #2] had a CT (imaging testing) scan done and a sleep study was completed."</p> <p>-BDDS report dated 1/13/15 indicated, "[Client #2] was discharged from [hospital] and admitted to [transitional care facility] on 1/12/15. While at the hospital a PICC (catheter) line was placed and her physician ordered a 6 day treatment of IV (Intravenous) antibiotics. [Client #2] was admitted to the [transitional care facility] in order to complete the round of IV antibiotics." The 1/13/15 BDDS report indicated, "[Client #2] had a diagnosis of UTI (Urinary Tract Infection), dehydration and Escherichia Coli (bacteria infection)."</p> <p>-Follow up BDDS report dated 1/29/15 indicated, "[Client #2] was re-admitted to the group home on 1/20/15. She completed her intravenous antibiotic treatment at the [transitional care facility]. [Client #2] had a diagnosis of UTI, dehydration and Escherichia Coli. [Client #2] states she is feeling well and is happy to be home. There were no new medication changes made and no new protocols were put in place."</p>		<p>#2 regarding recurrent diagnoses and treatment of pneumonia/respiratory infections, and congestive heart failure. Her presence will be increased during the time of Plan of Correction, at the direction of the administrator. The nurse will complete a comprehensive review of the medical record for each client to ensure all risk issues are adequately addressed. The RN and administrator will provide oversight to ensure all areas are properly addressed. Responsible Party: Facility nurse</p>				

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	<p>-BDDS report dated 2/21/15 indicated, "On 2/2/15 (sic) (2/20/15), [client #2] was on an outing with her housemates and staff when she stated that she 'could not breathe.' So, staff had her sit down and rest for a moment. Soon after, she stated that she could continue and while doing so, she fainted. Emergency responders were called to the scene and escorted [client #2] to the ER (Emergency Room). The doctor concluded that her anxiety was high and worked herself into a panic attack. [Client #2] was released and sent home with instructions to monitor her."</p> <p>-BDDS report dated 2/28/15 indicated, "On 2/27/15, [client #2] was not feeling well. Staff reported to the agency nurse that she appeared to have a bluish tint to her lips along with a wheezy cough. [Client #2] had been seen earlier in the week by a physician and he had diagnosed her with an upper respiratory infection and prescribed Omnicef 300 milligrams (antibiotic)... As her condition did not appear to be improving the nurse directed her to be evaluated at the ER as her physician was not available. [Client #2] was diagnosed with unspecified pneumonia and admitted to the hospital."</p> <p>-Follow up BDDS report dated 3/9/15</p>			

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	<p>indicated, "[Client #2] does not have a history of anxiety attacks. Her diagnosis includes depression for which she is treated. Her physician was notified other incident. She was admitted to the hospital a week after for an upper respiratory infection."</p> <p>-BDDS report dated 6/15/15 indicated, "On 6/15/15, [client #2] reported to staff that she wasn't feeling well and had shortness of breath. Staff checked her vitals and found that her pulse and blood pressure were low. The [nurse] instructed staff to take her to the local ER for evaluation. After an evaluation it was determined that she has pneumonia and she was admitted for treatment. She remains inpatient at [hospital]."</p> <p>Client #2's record was reviewed on 6/15/15 at 9:45 AM. Client #2's Consultant Visit Form (CVF) dated 12/16/14 indicated, "[Client #2] feeling short of breath, lightheaded and stomach ache. Concerns with [client #2] falling out of bed on Saturday (12/13/14), unwitnessed fall. [Client #2] complains of dizziness now."</p> <p>Client #2's Hospital Admission form dated 1/7/15 indicated, "Your primary diagnosis was Bacteremia due to Escherichia Coli. Your diagnoses also</p>			

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	<p>included: Atrial Fibrillation...Congestive Heart Failure...UTI... and Acute Renal Failure."</p> <p>Client #2's Hospital Discharge Summary form dated 2/27/15 indicated, "Hospital problems. Chronic systolic congestive heart failure... pneumonia, Atrial fibrillation (chronic)... acute kidney injury... acute respiratory failure with hypoxia and Atrial fibrillation." Client #2's Hospital Discharge Summary form dated 2/27/15 indicated, "Discharge orders. Future labs/procedures. Skilled home care needed to evaluate and admit if appropriate to for (sic) assessment and treatment related to current diagnosis."</p> <p>Client #2's QNA (Quarterly Nursing Assessment) form dated December 2014 indicated, "History of Atrial Fibrillation, Congestive Heart Failure...."</p> <p>Client #2's QNA form dated March 2015 did not indicate documentation of skilled home care assessment being completed in the Medical Appointments section.</p> <p>Client #2's Monthly Nursing Summary dated April 2015 did not indicate documentation of skilled home care assessment being completed in the Medical Appointments section.</p>			

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W 0435 Bldg. 00	<p>Client #2's record did not indicate documentation of a skilled home health assessment, nursing care plans to monitor client #2 regarding pneumonia/respiratory infections, atrial fibrillation, congestive heart failure and renal failure.</p> <p>LPN (Licensed Practical Nurse) #1 was interviewed on 6/10/15 at 10:45 AM. LPN #1 indicated client #2 did not have nursing care plans for pneumonia/respiratory infections, atrial fibrillation, congestive heart failure and renal failure.</p> <p>9-3-6(a)</p> <p>483.470(g)(1) SPACE AND EQUIPMENT The facility must provide sufficient space and equipment in dining, living, health services, recreation, and program areas (including adequately equipped and sound treated areas for hearing and other evaluations if they are conducted in the facility) to enable staff to provide clients with needed services as required by this subpart and as identified in each client's individual program plan. Based on observation, record review and interview for 3 of 3 sampled clients (#1,</p>	W 0435	The administrator is working with maintenance staff to arrange for the completion of work that will open	07/17/2015

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	<p>#2 and #3) plus 3 additional clients (#4, #5 and #6), the facility failed to ensure there was sufficient space in the group home for client #5's walker to allow clients and staff to engage in programming activities in the home's dining and living room areas.</p> <p>Findings include:</p> <p>The facility's BDDS (Bureau of Developmental Disabilities Services) reports and investigations were reviewed on 6/9/15 at 12:45 PM. The review indicated the following:</p> <p>-BDDS report dated 2/19/15 indicated, "[Client #1] fell in the home when tripping over her roommate's walker on 2/17/15. There were no signs of injury at the time and [client #1] resumed normal activity. The nurse was notified and directed staff to administer Tylenol for pain. The next day, [client #1] was complaining of having pain in her right foot on 2/18/15 and it was decided that she should get x-rays completed on the foot. The x-ray showed a closed fibular fracture and sprain of right medial ankle joint. [Client #1] was fitted with a splint on 2/18/15 and a cast was placed on 2/19/15.</p> <p>-Investigation Summary Form dated</p>		<p>up the dining and living areato allow for more space for all clients to move about and to reduce chance of atight space causing further injury to clients. The completion of this work willbe monitored by the administrator. The administrator has an increased presence inthe facility. During observations in the facility the administrator willobserve to ensure all clients have the needed space to move about toparticipate in their daily activities in a safe manner.</p> <p>Responsible Party: Area Director</p>				

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	<p>2/25/15 indicated, "The space around the walker, table and entrance for walking is about 2 feet."</p> <p>Observations were conducted at the group home on 6/9/15 from 4:15 PM through 5:45 PM and on 6/10/15 from 6:30 AM through 7:30 AM. Clients #1, #2, #3, #4, #5 and #6 were observed in the home throughout the observation periods. Client #5 utilized a rolling walker to assist her with walking/ambulation. The entry way to the home's living room area and medication administration area runs through/connects directly from the kitchen/dining room area. The space to walk from the dining room area to the adjoined living room and medication administration area was less than 3 feet in width and when clients were seated at the dining room table the path was reduced to 2 feet. Throughout the observation period both clients #1, #2, #3, #4, #5 and #6 and staff had to walk in single file motion through the area to avoid bumping into each other or being in each other's way.</p> <p>Staff #1 was interviewed on 6/9/15 at 5:30 PM. Staff #1 indicated client #5 utilized a walker for ambulation/walking. Staff #1 stated, "It gets tight walking from the kitchen to the living room.</p>			

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W 0440 Bldg. 00	<p>Especially between the dining room table and counter."</p> <p>Staff #2 was interviewed on 6/10/15 at 7:15 AM. Staff #2 stated, "The whole house is kind of laid out weird. It's kind of small. I don't think there's really enough space for the walker in the kitchen area to get through to the living room."</p> <p>Client #5 was interviewed on 6/10/15 at 11:22 AM. Client #5 stated, "No, there's not enough room. It's hard to get through."</p> <p>Client #5's record was reviewed on 6/10/15 at 10:30 AM. Client #5's Fall Risk Plan dated 5/13/14 indicated client #5 utilized a walker full time when walking or standing.</p> <p>9-3-7(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 3 of 3 sampled clients (#1, #2 and #3) plus 3 additional clients (#4, #5 and #6), the facility failed to conduct evacuation drills quarterly for each shift of personnel.</p>	W 0440	The Residential Director for the home will be responsible for ensuring required fire evacuation drills are completed. Their completion will be scheduled on the staffing schedule. They will be scheduled so that a drill is completed	07/17/2015			

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	<p>Findings include:</p> <p>The facility's evacuation drill record was reviewed on 6/10/15 at 7:30 AM. The review indicated the facility failed to conduct evacuation drills for clients #1, #2, #3, #4, #5 and #6 for the overnight shift during the second quarter, April, May, June 2014, the day, evening and overnight shifts during the third quarter, July, August, September 2014 and for the evening and overnights shifts during the fourth quarter, October, November and December 2014.</p> <p>AS (Administrative Staff) #1 was interviewed on 6/9/15 at 7:30 AM. AS #1 indicated the group home should conduct evacuation drills one time per quarter per shift of personnel.</p> <p>9-3-7(a)</p>		<p>for each shift of personnel no less than quarterly. Drills will be scheduled to be completed by the 10th of each month. The Residential Director will ensure completion within 3 business days. The Residential Director will provide the Administrator documentation within 5 business days to verify completion of the drill and the timing of the drill. Should the Administrator not receive verification of the completed drill by the 20th of each month, the Residential Director will be directed to conduct the required drill and submit record of the completed drill by the 25th. The Administrator will use a tracking system to ensure compliance. The Residential Director will also ensure a copy of each drill report is maintained in the home and available for review. This will be checked routinely by administrators completing visits in the facility.</p> <p>Responsible Party: Residential Director</p>		