

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G304	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/18/2014
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NAME OF PROVIDER OR SUPPLIER TRANSITIONAL SERVICES SUB LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 4812 W SR 45 BLOOMINGTON, IN 47401
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W000000	This visit was for a fundamental annual recertification and state licensure survey. Survey dates: February 12, 13, 14 and 18, 2014 Facility number: 000823 Provider number: 15G304 AIM number: 100249090 Surveyor: Steven Schwing, QIDP The deficiencies also reflect state findings in accordance with 460 IAC 9. Quality review completed February 21, 2014 by Dotty Walton, QIDP.	W000000		
W000125	483.420(a)(3) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must allow and encourage individual clients to exercise their rights as clients of the facility, and as citizens of the United States, including the right to file complaints, and the right to due process. Based on observation, interview and record review for 6 of 8 clients living in the group home (#1, #2, #3, #5, #7 and #8), the facility failed to ensure the rights of all clients by not obtaining written informed consent from the clients or the clients' legal guardians prior to implementation of restrictive	W000125	The Program Director was retrained on 2/18/14 on obtaining written informed consent from clients or the clients' legal guardians prior to implementation of restrictive interventions. All client and guardian consents have been obtained for restrictive interventions that are currently in the home. The Area Director will	03/20/2014

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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	<p>interventions (door alarm and a locked freezer).</p> <p>Findings include:</p> <p>Observations were conducted at the group home on 2/13/14 from 5:55 AM to 7:35 AM and 4:21 PM to 5:58 PM. During the observations, there was an audible door alarm activated on the basement entrance door to the group home. When the door opened, an audible alert sounded in the basement and on the main floor of the group home. During the observation, the chest freezer located in the basement laundry area was locked. The Home Manager used a key to unlock the freezer at 4:07 PM. This affected clients #1, #2, #3, #5, #7 and #8.</p> <p>A review of the facility's incident reports was conducted on 2/12/14 at 11:44 AM and indicated on 1/27/14 at 5:40 PM, client #6 took out the trash and ended up at the building next door. Client #6 was confused on where he was and he had poor eyesight. The investigation, not dated, indicated, "Staff went into [client #6's] room and realized he wasn't (sic) there and yelled outside for him. [Client #6] heard them (the staff) and hollared (sic) back. He said with the cold and wind, he got confused on where he was</p>		<p>ensure that the Program Director obtains all client and/or guardian consents prior to implementation of restrictive interventions. Persons Responsible: Program Director, Area Director</p>		

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	<p>and his sight isnt (sic) as good in the dark. Both staff and [client #6] went back inside the [name of group home]." The investigation indicated, "Program director received HRC approval for [client #6] and All other clients in the house and door alarms are being put on the basement door (which is next to [client #6's]) room."</p> <p>A review of client #1's record was conducted on 2/14/14 at 12:08 PM. There was no documentation in the record indicating client #1, who was emancipated, gave written informed consent for the use of a door alarm and the locked freezer.</p> <p>A review of client #2's record was conducted on 2/14/14 at 10:39 AM. There was no documentation in the record indicating client #2's guardian gave written informed consent for the use of a door alarm and the locked freezer.</p> <p>A review of client #3's record was conducted on 2/14/14 at 10:46 AM. There was no documentation in the record indicating client #3's guardian gave written informed consent for the use of a door alarm and the locked freezer.</p>			

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	<p>A review of client #5's record was conducted on 2/14/14 at 11:29 AM. There was no documentation in the record indicating client #5, who was emancipated, gave written informed consent for the use of a door alarm and the locked freezer.</p> <p>A review of client #7's record was conducted on 2/14/14 at 11:49 AM. There was no documentation in the record indicating client #7, who was emancipated, gave written informed consent for the use of a door alarm and the locked freezer.</p> <p>A review of client #8's record was conducted on 2/14/14 at 12:16 PM. There was no documentation in the record indicating client #8's guardian gave written informed consent for the use of a door alarm and the locked freezer.</p> <p>On 2/14/14 at 12:38 PM, the Area Director indicated the facility needed to obtain written informed consent for the use of restrictive interventions.</p> <p>On 2/14/14 at 11:00 AM, the Quality Assurance Specialist indicated the facility obtained verbal consent for the restrictive interventions but did not have documentation the clients or the clients'</p>			

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W000149	<p>guardian gave written informed consent. The QAS indicated the freezer was locked due to client #4's food seeking and the door alarm was installed due to client #6 getting lost while outside the group home.</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. Based on record review and interview for 2 of 8 incident/investigative reports reviewed affecting clients #6 and #9, the facility neglected to implement its policies and procedures to complete a thorough investigation, complete an investigation within 5 business days and report the results of an investigation to the administrator within 5 business days.</p> <p>Findings include:</p> <p>A review of the facility's incident/investigative reports was conducted on 2/12/14 at 11:44 AM and indicated the following:</p> <p>1) On 5/15/13 at 8:40 AM, former client #9 died of a pulmonary embolism.</p>	W000149	The Quality Assurance Specialist was retrained on Investigation Procedures and Timelines on 2/18/14 which includes concluding an investigation within five business days and reporting results to the administrator within five business days. The Program Director was retrained on Investigation Procedures and Completing Thorough Investigations on 2/18/14. The Area Director will meet with Program Directors weekly to ensure that all required investigations are thorough and complete within five business days of the incident. Persons Responsible: Program Director, Area Director, Quality Assurance Specialist	03/20/2014	

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	<p>The facility's investigation was dated 6/3/13. The Conclusion of the investigation indicated, "Based on the information received from [client #9's] family after the autopsy, the cause of death was Pulmonary Embolism and staff reacted appropriately during the time leading up to [client #9's] death." The facility failed to conclude the investigation within five business days.</p> <p>On 2/14/14 at 12:34 PM, the Area Director indicated investigations should be completed within five business days.</p> <p>On 2/14/14 at 12:34 PM, the Quality Assurance Specialist indicated investigations should be completed within five business days.</p> <p>2) On 1/27/14 at 5:40 PM, client #6 took out the trash. Client #6 was found at the building next door to the group home after staff went to his room and was unable to locate client #6. Staff went outside, called for client #6 and client #6 responded from the building next door to the group home. Client #6 indicated he was cold and got confused on where he was. The investigation, undated and not signed, indicated, "[Client #6] took out his trash (which he does all the time) and ended up a building over from the house. Staff</p>				

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	<p>went into [client #6's] room and realized he wasn't (sic) there and yelled outside for him. [Client #6] heard them and hollared (sic) back. He said with the cold and wind, he got confused on where he was and his sight isnt (sic) as good in the dark. both (sic) staff and [client #6] went back inside the [name of group home]. Program director called the [name of group home] and spoke to staff regarding incident. Staff stated that he took the trash out as usual and for the first time, did not come right back in. [Client #6] was only outside for approx (approximately) 10 min (minutes). Program director received HRC (Human Rights Committee) approval for [client #6] and All other clients in the house and Door alarms are being put on the basement door (which is next to [client #6's] room). Staff was told to do 15 min (minute) checks on [client #6] after this incident." The investigation was not dated, not signed, did not indicate which staff were on duty and who was interviewed. The investigation did not indicate the time of the incident. The investigation did not indicate where staff located client #6. There was no documentation indicating the results of the investigation were reported to the administrator or designated representative within five working days of the incident.</p>						

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	<p>On 2/14/14 at 12:34 PM, the Area Director indicated investigations should be completed within five business days.</p> <p>On 2/18/14 at 10:36 AM, the Area Director (AD) indicated the facility needed to conduct thorough investigations including the date and time of the incident, indication of the staff who conducted the investigation, staff involved during the incident and the location (distance) client #6 was found from the group home.</p> <p>On 2/14/14 at 12:34 PM, the Quality Assurance Specialist indicated investigations should be completed within five business days.</p> <p>A review of the facility's abuse and neglect policy, dated April 2011, was conducted on 2/12/14 at 11:34 AM. The policy indicated the following, "Any allegation of abuse or human rights violation is thoroughly investigated by the Area Director in consultation with Human Resources Department and/or Quality Assurance/Risk Management Department." The policy indicated, "Indiana MENTOR programs maintain a written list of rights, which take into account the requirements of applicable laws, regulations, and purchasing agencies. This list of rights should</p>						

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W000154	<p>include, but is not limited to: e. Ensure the clients are not subjected to physical, verbal, sexual, or psychological abuse or punishment... o. The following actions are prohibited by employees of Indiana MENTOR: 1) abuse, neglect, exploitation or mistreatment of an individual including misuse of an individual's funds. 2) violation of an individual's rights." The policy indicated, "Indiana MENTOR is committed to completing a thorough investigation for any event out of the ordinary which jeopardizes the health and safety of any individual served or other employee. 1. Investigation findings will be submitted to the Area Director for review and development of further recommendations as needed within 5 days of the incident."</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 8 incident/investigative reports reviewed affecting clients #6, the facility failed to complete a thorough investigation.</p> <p>Findings include:</p>	W000154	The Program Director was retrained on Investigation Procedures and Completing Thorough Investigations on 2/18/14. The Area Director will meet with Program Directors weekly to ensure that all required investigations are thorough and complete within five business	03/20/2014			

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	<p>A review of the facility's incident/investigative reports was conducted on 2/12/14 at 11:44 AM and indicated the following:</p> <p>On 1/27/14 at 5:40 PM, client #6 took out the trash. Client #6 was found at the building next door to the group home after staff went to his room and was unable to locate client #6. Staff went outside, called for client #6 and client #6 responded from the building next door to the group home. Client #6 indicated he was cold and got confused on where he was. The investigation, undated and not signed, indicated, "[Client #6] took out his trash (which he does all the time) and ended up a building over from the house. Staff went into [client #6's] room and realized he wasn't (sic) there and yelled outside for him. [Client #6] heard them and hollared (sic) back. He said with the cold and wind, he got confused on where he was and his sight isnt (sic) as good in the dark. both (sic) staff and [client #6] went back inside the [name of group home]. Program director called the [name of group home] and spoke to staff regarding incident. Staff stated that he took the trash out as usual and for the first time, did not come right back in. [Client #6] was only outside for approx (approximately) 10 min (minutes).</p>		<p>days of the incident. Persons Responsible: Program Director, Area Director, Quality Assurance Specialist</p>	

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W000156	<p>Program director received HRC (Human Rights Committee) approval for [client #6] and All other clients in the house and Door alarms are being put on the basement door (which is next to [client #6's] room). Staff was told to do 15 min checks on [client #6] after this incident." The investigation was not dated, not signed, did not indicate which staff were on duty and who was interviewed. The investigation did not indicate the time of the incident. The investigation did not indicate where staff located client #6.</p> <p>On 2/18/14 at 10:36 AM, the Area Director (AD) indicated the facility needed to conduct thorough investigations including the date and time of the incident, indication of the staff who conducted the investigation, staff involved during the incident and the location (distance) client #6 was found from the group home.</p> <p>9-3-2(a)</p> <p>483.420(d)(4) STAFF TREATMENT OF CLIENTS The results of all investigations must be reported to the administrator or designated representative or to other officials in accordance with State law within five working days of the incident. Based on record review and interview for 2 of 8 incident/investigative reports</p>	W000156	The Quality Assurance Specialist was retrained on Investigation Procedures and Timelines on	03/20/2014			

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	<p>reviewed affecting clients #6 and #9, the facility failed to complete investigations within 5 business days.</p> <p>Findings include:</p> <p>A review of the facility's incident/investigative reports was conducted on 2/12/14 at 11:44 AM and indicated the following:</p> <p>1) On 5/15/13 at 8:40 AM, former client #9 died of a pulmonary embolism. The facility's investigation was dated 6/3/13. The Conclusion of the investigation indicated, "Based on the information received from [client #9's] family after the autopsy, the cause of death was Pulmonary Embolism and staff reacted appropriately during the time leading up to [client #9's] death." The facility failed to conclude the investigation within five business days.</p> <p>2) On 1/27/14 at 5:40 PM, client #6 took out the trash. Client #6 was found at the building next door to the group home after staff went to his room and was unable to locate client #6. Staff went outside, called for client #6 and client #6 responded from the building next door to the group home. Client #6 indicated he was cold and got confused on where he was. The investigation,</p>		2/18/14 which includes concluding an investigation within five business days and reporting results to the administrator within five business days. The Area Director will meet with Program Directors weekly to ensure that all required investigations are thorough and complete within five business days of the incident. Persons Responsible: Program Director, Area Director, Quality Assurance Specialist				

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	<p>undated and not signed, indicated, "[Client #6] took out his trash (which he does all the time) and ended up a building over from the house. Staff went into [client #6's] room and realized he wasn't (sic) there and yelled outside for him. [Client #6] heard them and hollared (sic) back. He said with the cold and wind, he got confused on where he was and his sight isnt (sic) as good in the dark. both (sic) staff and [client #6] went back inside the [name of group home]. Program director called the [name of group home] and spoke to staff regarding incident. Staff stated that he took the trash out as usual and for the first time, did not come right back in. [Client #6] was only outside for approx (approximately) 10 min (minutes). Program director received HRC (Human Rights Committee) approval for [client #6] and All other clients in the house and Door alarms are being put on the basement door (which is next to [client #6's] room). Staff was told to do 15 min checks on [client #6] after this incident." There was no documentation indicating the results of the investigation were reported to the administrator or designated representative within five working days of the incident.</p> <p>On 2/14/14 at 12:34 PM, the Area Director indicated investigations should</p>				

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W000210	<p>be completed within five business days.</p> <p>On 2/14/14 at 12:34 PM, the Quality Assurance Specialist indicated investigations should be completed within five business days.</p> <p>9-3-2(a)</p> <p>483.440(c)(3) INDIVIDUAL PROGRAM PLAN Within 30 days after admission, the interdisciplinary team must perform accurate assessments or reassessments as needed to supplement the preliminary evaluation conducted prior to admission.</p> <p>Based on record review and interview for 4 of 4 clients in the sample (#2, #3, #5 and #7), the facility failed to ensure an accurate assessment was completed in regard to the clients carrying their own money and client #2 had a comprehensive functional assessment completed after he moved into the group home.</p> <p>Findings include:</p> <p>A review of the clients' finances was conducted on 2/13/14 at 1:41 PM and indicated the clients signed for their own cash on hand and carried their own money.</p> <p>On 2/13/14 at 1:41 PM the Home</p>	W000210	<p>The Program Director and Home Manager were retrained on 2/18/14 on completing assessments or reassessments as needed for clients prior to admission or at least annually thereafter. Each client's IDT will meet to assess how much money they can carry on their own on a weekly basis. Each client's Individual Support Plan will be updated with this information and the team will reassess at least yearly or more often as needed.</p> <p>Client #2's comprehensive functional assessments have been completed and will be reviewed at least annually. The Area Director will review with the Program Director on a weekly basis any annual client meetings that have occurred and ensure that assessments have been completed or reviewed as</p>	03/20/2014			

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	<p>Manager (HM) indicated clients #2, #3, #5 and #7 carried their own cash on hand. The HM indicated the facility did not keep the clients' cash on hand.</p> <p>A review of client #2's record was conducted on 2/14/14 at AM. Client #2 moved (transferred from another group home) into the group home on 1/15/14. Client #2's record did not contain a comprehensive functional assessment (CFA). There was no documentation the facility assessed the amount of money client #2 could safely carry on his person. Client #2's Risk Management Assessment and Plan (RMAP), dated 6/22/13, indicated "Unable to manage finances independently" and "Unable to recognize mismanagement of finances."</p> <p>A review of client #3's record was conducted on 2/14/14 at 10:46 AM. Client #3's CFA, dated 2/10/14, did not include an assessment of his money management skills (the CFA was missing the pages addressing money management). The CFA did not assess the amount of money client #3 could safely carry on his person. Client #3's RMAP, dated 2/11/14, indicated "[Client #3] has limited money management skills and a formal goal in place to increase independence with these skills. Requires staff assistance in</p>		required. Persons Responsible: Home Manager, Program Director, Area Director				

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	<p>dealing with finances. Needs verbal reminders to obtain receipts and turn them in for budgeting."</p> <p>A review of client #5's record was conducted on 2/14/14 at 11:29 AM. Client #5's CFA, dated 2/10/14, did not assess the amount of money client #5 could safely carry on his person. Client #5's RMAP, dated 2/11/14, indicated client #5 required assistance to manage his finances. The RMAP indicated, "[Client #5] lacks the budgeting skills and knowledge of finances to effectively recognize any mismanagement of funds."</p> <p>A review of client #7's record was conducted on 2/14/14 at 11:49 AM. Client #7's CFA, dated 2/10/14, did not assess the amount of money client #7 could safely carry on his person. The assessment indicated client #7 did not know about sales tax, how to plan on spending money for specific purposes, and budget his money. Client #7's RMAP, dated 2/11/14, indicated "[Client #7's] finances are managed by Indiana Mentor, however he receives a weekly allowance for smaller purchases of his choice."</p> <p>On 2/14/14 at 1:23 PM, the Program Director (PD) indicated she had not</p>				

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W000263	<p>assessed the clients' abilities to safely carry money. The PD indicated the clients needed to be assessed in order to figure out how much money they could safely carry.</p> <p>On 2/14/14 at 12:45 PM, the Area Director (AD) indicated the facility needed to assess the amount of money each client was able to safely carry on their person. The AD indicated he was unable to locate documentation the clients' skills were assessed. On 2/14/14 at 12:43 PM, the AD indicated the facility should have completed a CFA for client #2.</p> <p>9-3-4(a)</p> <p>483.440(f)(3)(ii) PROGRAM MONITORING & CHANGE The committee should insure that these programs are conducted only with the written informed consent of the client, parents (if the client is a minor) or legal guardian. Based on observation, interview and record review for 2 of 4 non-sampled clients (#4 and #6), the facility's specially constituted committee (Human Rights Committee - HRC) failed to ensure restrictive interventions (door alarm and a locked freezer) were implemented with written informed consent of the client or the client's legal</p>	W000263	The Program Director was retrained on 2/18/14 on obtaining written informed consent from clients or the clients' legal guardians prior to implementation of restrictive interventions and prior to obtaining HRC approvals. All client and guardian consents have been obtained for restrictive interventions that are currently in the home. The Area Director will ensure that the Program Director	03/20/2014			

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	<p>guardian.</p> <p>Findings include:</p> <p>Observations were conducted at the group home on 2/13/14 from 5:55 AM to 7:35 AM and 4:21 PM to 5:58 PM. During the observations, there was an audible door alarm activated on the basement entrance door to the group home. When the door opened, an audible alert sounded in the basement and on the main floor of the group home. During the observation, the chest freezer located in the basement laundry area was locked. The Home Manager used a key to unlock the freezer at 4:07 PM. This affected clients #2 and #4</p> <p>A review of the facility's incident reports was conducted on 2/12/14 at 11:44 AM and indicated on 1/27/14 at 5:40 PM, client #6 took out the trash and ended up at the building next door. Client #6 was confused on where he was and he had poor eyesight. The investigation, not dated, indicated, "Staff went into [client #6's] room and realized he wasn't (sic) there and yelled outside for him. [Client #6] heard them (the staff) and hollared (sic) back. He said with the cold and wind, he got confused on where he was and his sight isnt (sic) as good in the dark. Both staff and [client #6] went</p>		<p>obtains all client and/or guardian consents prior to obtaining HRC approvals and implementation of restrictive interventions. Persons Responsible: Program Director, Area Director</p>				

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	<p>back inside the [name of group home]." The investigation indicated, "Program director received HRC approval for [client #6] and All other clients in the house and door alarms are being put on the basement door (which is next to [client #6's]) room."</p> <p>A review of client #4's record was conducted on 2/14/14 at 12:12 PM. There was no documentation in the record indicating client #4's guardian gave written informed consent for the use of a door alarm and the locked freezer.</p> <p>A review of client #6's record was conducted on 2/14/14 at 12:14 PM. There was no documentation in the record indicating client #6, who was emancipated, gave written informed consent for the use of a door alarm and the locked freezer.</p> <p>On 2/14/14 at 12:38 PM, the Area Director indicated the facility needed to obtain written informed consent for the use of restrictive interventions.</p> <p>On 2/14/14 at 11:00 AM, the Quality Assurance Specialist indicated the facility obtained verbal consent for the restrictive interventions but did not have documentation the clients or the clients'</p>			

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W000440	<p>guardian gave written informed consent. The QAS indicated the freezer was locked due to client #4's food seeking and the door alarm was installed due to client #6 getting lost while outside the group home.</p> <p>9-3-4(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 8 of 8 clients living at the group home (#1, #2, #3, #4, #5, #6, #7 and #8), the facility failed to conduct quarterly evacuation drills for each shift of personnel.</p> <p>Findings include:</p> <p>A review of the facility's evacuation drills was conducted on 2/13/14 at 1:49 PM. The facility did not conduct evacuation drills during the day shift (7:00 AM to 3:00 PM) from 2/12/13 to 11/7/13. This affected clients #1, #2, #3, #4, #5, #6, #7 and #8.</p> <p>On 2/14/14 at 10:35 AM, the Area</p>	W000440	The Program Director and Home Manager were retrained on 2/18/14 on completing all required evacuation drills for all shifts of personnel. The Program Director will monitor evacuation drills each month on a monthly tracking sheet to ensure that all required drills are completed for each shift each quarter. The Area Director will monitor that all drills are completed as required at weekly meetings with Program Directors each month. Persons Responsible: Home Manager, Program Director, Area Director	03/20/2014

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	<p>Director indicated there should be evacuation drills conducted quarterly for each shift of personnel.</p> <p>9-3-7(a)</p>			