

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G730	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  08/21/2015
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NAME OF PROVIDER OR SUPPLIER  IN-PACT INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1487 W 4TH ST HOBART, IN 46342
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W 0000  Bldg. 00	<p>This visit was for an annual fundamental recertification and state licensure survey.</p> <p>Dates of Survey: August 18, 19, 20 and 21, 2015</p> <p>Facility number: 011241 Provider number: 15G730 AIM number: 200837460</p> <p>The following federal 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 The governing body must exercise general policy, budget, and operating direction over the facility.</p> <p>Based on observation, record review and interview, for 3 of 3 sampled clients and 3 additional clients (clients #1, #2, #3, #4, #5 and #6), the governing body failed to exercise general policy and operating direction over the facility to ensure the clients were provided a functioning television in the back living room area.</p> <p>Findings include:</p>	W 0104	<p>This group home has two TV's in the home in both common areas and each client also has a TV in their own bedrooms. The one TV that did has some discoloration in the picture tube will be replaced. Responsible person: Sandy Phillips, GH Manager. The manager will check the equipment in the home at least monthly to ensure everything is properly working and report it to the QIDP and maintenance. To ensure future compliance, monthly the home</p>	09/20/2015

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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W 0126  Bldg. 00	<p>An evening observation was conducted at the group home on 8/18/15 from 5:20 P.M. until 7:00 P.M.. During the entire observation the back living room television where clients #1, #2, #3, #4, #5 and #6 sat was observed to have the television screen dark pink and purple in color.</p> <p>A morning observation was conducted at the group home on 8/21/15 from 5:40 A.M. until 7:00 A.M.. During the entire observation the back living room television where clients #1, #2, #3, #4, #5 and #6 sat was observed to have the television screen dark pink and purple in color.</p> <p>An interview with the Qualified Intellectual Disabilities Professional (QIDP) was conducted on 8/21/15 at 1:25 P.M.. The QIDP indicated the clients should have a television that properly works in the back living room area.</p> <p>9-3-1(a)</p> <p>483.420(a)(4) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must allow individual clients to manage their financial affairs and teach them to do so to the extent</p>		will be checked that everything is in proper working order. Responsible person: Patti Harris, QIDP & Sheila O'Dell, GH Director.		

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	<p>of their capabilities.</p> <p>Based on observation and interview, for 1 of 3 sampled clients (client #2), the facility failed to implement client #2's money management objectives utilizing United States currency.</p> <p>Findings include:</p> <p>An evening observation was conducted at the group home on 8/18/15 from 5:20 P.M. until 7:00 P.M.. At 5:55 P.M., Direct Support Professional (DSP) #2 prompted client #2 to start his programs. DSP #2 retrieved client #2's program book and took out laminated fake pictures of quarters. DSP #2 asked client #2 to hand her two quarters and then prompted him to pick his item for purchase, which was one piece of a fruit snack. Then DSP #2 asked client #2 to hand her 1 quarter and then prompted him to hand her his item of purchase which was one piece of a fruit snack. DSP #2 implemented client #2's money management objective not utilizing United States currency.</p> <p>An interview with the Qualified Intellectual Disabilities Professional (QIDP) was conducted on 8/21/15 at 1:25 P.M.. The QIDP indicated the group home staff should only use U.S. currency when implementing client #2's money</p>	W 0126	<p>Direct care staff will be re-trained on the money program and to utilize real United States currency. Responsible person: Patti Harris, QIDP. All the clients have a money goal/program in place that includes using real US currency. Responsible person: Patti Harris, QIDP. Client #2's money program is to use real United States currency. Responsible person: Patti Harris, QIDP. To ensure future compliance, a program reliability will be completed to ensure real U.S. currency is being used. Responsible person: Sandy Phillips, Group Home Manager. The QIDP will randomly ask staff to run the money program to ensure they are continuing to use real US currency. Responsible person: Patti Harris, QIDP.</p>	09/20/2015

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W 0154 Bldg. 00	<p>management training objectives.</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.</p> <p>Based on record review and interview for 1 of 1 incident, involving 1 of 3 sampled clients (client #2), the facility failed to provide written evidence thorough investigations were conducted in regard to an injury of unknown origin.</p> <p>Findings include:</p> <p>A review of the facility's records was conducted at the facility's administrative office on 8/19/15 at 3:00 P.M.. Review of the facility's Bureau of Developmental Disabilities Services (BDDS) reports, Internal Reports (IR) and investigation records indicated:</p> <p>-BDDS report dated 7/28/15 involving client #2 indicated: "Injury of Unknown origin: Upon waking [client #2] in the morning staff noticed blood on his comforter. There was not blood on his sheets. She immediately examined [client #2] to see where it might have</p>	W 0154	<p>All incidents of unknown origin are to thoroughly investigated which includes interviewing all of the clients. All management staff are training to do thorough investigation for all injuries of unknown injuries, which includes interviewing all of the clients. Responsible person: Sheila O'Dell, GH Director. Our investigation packet will be revised to check that all clients have been interviewed. Responsible person: Sheila O'Dell, GH Director. To ensure future compliance, all investigations of unknown origin get turned into the Director for review. Responsible person: Patti Harris, QIDP and Sheila O'Dell, GH Director.</p>	09/20/2015

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W 0189 Bldg. 00	<p>been coming from. Everything was clear except he had some redness/bruise like area on 3 of his knuckles on his right hand....The exact cause of the injury has not been determined." The record failed to indicate there was written documentation to indicate the facility interviewed all clients who reside at the group home in regard to the injury of unknown origin.</p> <p>An interview with the Qualified Intellectual Disabilities Professional (QIDP) was conducted on 8/21/15 at 1:25 P.M.. The QIDP indicated she did not interview any of the clients who reside at the group home in regard to the documented injury of unknown origin.</p> <p>9-3-2(a)</p> <p>483.430(e)(1) STAFF TRAINING PROGRAM</p> <p>The facility must provide each employee with initial and continuing training that enables the employee to perform his or her duties effectively, efficiently, and competently.</p> <p>Based on record review and interview, the facility failed for 2 additional clients (clients #4 and #6), to ensure staff was sufficiently trained to assure competence</p>	W 0189	All staff are trained upon hire on med core A & B and pill passing and then at least annually thereafter. Responsible person: Sherri DiMarco, RN. All staff must pass a med reliability prior to passing medications on site. Responsible	09/20/2015	

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	<p>in documentation of medication changes to ensure proper administration of medication as ordered.</p> <p>Findings include:</p> <p>A review of the facility's BDDS (Bureau of Developmental Disabilities Services) reports, Internal Reports (IRs) and investigations was conducted on 8/19/15 at 3:00 P.M.. Review of the records indicated:</p> <p>-BDDS report dated 1/14/15 involving client #4 indicated: "On 1/1/15 I was checking the nurse's book and she wrote a note questioning medication that was given to [client #4] in December of 2014. On 11/18/14 [client #4]'s Luvox (depression) was increased by [Physician's name] by 100 mg (milligrams) 2x (two times) day (sic). When the medication was delivered to the group home the Data Specialist added it to the medication sheet. She did not discontinue the 50 mg dose he was taking 2x a day. Staff passed both the 100 mg dose and the 50 mg dose from December 31st 2014 to December 31st 2014....I (Group Home Manager) as well as appointed staff, will double check the medication book within 24 hours of a medication change to ensure the change</p>		<p>person: Sandy Phillips, Manager. Manager will check for a med change upon returning to her shift to ensure the change was correct. Responsible person: Sandy Phillips, GH Manager. The nurse will be notified of any changes and given a copy of the script. Responsible person: Sandy Phillips, GH Manager. A med check-in list will be completed whenever medications are delivered from the pharmacy. Responsible person: Sandy Phillips, GH Manager To ensure competency, a med reliability will be completed on each staff at 100 % and then done monthly there after. Responsible person: Sandy Phillips, Manager. To ensure future compliance, a buddy check will be put into place to double check that all medication were passed per orders. Responsible person: Sandy Phillips, Manager. Addendum: The nurse makes all of the medication administration records and then reviews them at least twice a month. All medications scripts are reviewed by the nurse and compared &amp;/or changed on the MARs. The nurse reviews/compares the labels to the scripts and to the MARs to ensure that it is being administered as ordered by the physician. Annually the nurse re-trains all of the staff and watches each of them do a mock medication pass.</p>				

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	<p>is correct. All staff will check changes in the medication book before medication is given. They will be retrained on 1/20/15 to so this. We will also wait till we have a hard copy of the script before any changes are made to the medication sheet to ensure that the right does (sic) is correctly put on the medication sheet. Hopefully this will ensure that this situation does not happen again."</p> <p>-BDDS report dated 6/18/15 involving client #6 indicated: "Staff found two of [client #6]'s medications, Risperdal 1 mg and Atenolol 50 mg on the morning of 6/19/15 that were still on his medication card for 6/18/15. They had not been passed that morning. The agency nurse was notified as well as his primary Dr. (Doctor). Their recommendations are to observe [client #6] for any effects of him not receiving the medication such as behavior issues or higher blood pressure. Supervision notes given to staff involved."</p> <p>An interview with the Qualified Intellectual Disabilities Professional (QIDP) was conducted on 8/21/15 at 1:25 P.M.. The QIDP indicated the staff should have properly documented the medication change for client #4's medication change. The QIDP indicated</p>			

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W 0249 Bldg. 00	<p>all staff are trained on medication administration upon hire and then annually. The QIDP indicated clients #4 and #6's medications should have been administered as ordered by their physicians.</p> <p>9-3-3(a)</p> <p>483.440(d)(1) PROGRAM IMPLEMENTATION As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan. Based on observation, record review, and interview, the facility failed to implement written medication objectives during times of opportunity for 2 of 2 clients observed during medication administration, (clients #1 and #6).</p> <p>Findings include:</p> <p>A morning observation was conducted at the group home on 8/21/15 from 5:40 A.M. until 7:00 A.M.. At 6:45 A.M., Direct Support Professional (DSP) #5</p>	W 0249	Client's objectives that are formal or informal will be done during all times of opportunities across all settings. Client's objectives that are formal or informal will be done during all times of opportunities across all settings. Responsible person: Sandy Phillips, Manager. Staff will be retrained on the goals and that each client's programs (including self med admin) need to be ran in sufficient number and frequency to support the achievement of the objective. They also will implement the clients training	09/20/2015

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	<p>began administering client #6's prescribed medications. DSP #5 retrieved client #6's medications, popped each medication out of the medication packets and administered his medications. Client #6 did not and was not prompted to get his cup of water, did not open the cabinet, did not get the med box out and did not put medications away. At 6:50 A.M., DSP #5 began administering client #1's prescribed medications. DSP #5 retrieved client #1's medications, popped each medication out of the medication packets and administered his medications. Client #1 did not and was not prompted to identify his medication and did not state the time frame it is ok to take his medication.</p> <p>A review of client #1's records was conducted on 8/21/15 at 11:30 A.M.. A review of the client's "Program: Self Medication" August 2015 tracking sheet, indicated: "Program Description: The purpose of the program is to teach [client #1] to initiate his own medications. [Client #1] is to tell the staff when it is time to take his own medications....Identify his AM medication time...Able to state the medication window (time frame it is ok to take his medication)."</p> <p>A review of client #6's records was</p>		<p>objectives at all times of opportunity as the arise throughout the day across all settings. Responsible person: Patti Harris, QIDP &amp; Sandy Phillips, Group Home Manager. To ensure future compliance and that the minimum frequency per objective is completed, all programs will be scheduled on the each client's daily activity schedule at least the minimum amount for formal training. Responsible person: Patti Harris, QIDP &amp; Sandy Phillips, Group Home Manager. To ensure future compliance, monthly a frequency report will be completed to compare number of times the objective should be ran verses the number of actual times the objective was completed and documented for formal training. This will be an on-going monthly report to ensure formal training is completed. Responsible person: Patti Harris, QIDP &amp; Sandy Phillips, Group Home Manager. To ensure future compliance, reliabilities will be completed on each staff to spot check that they are implementing objectives for the clients during formal and informal opportunities across all settings. Responsible person: Patti Harris, QIDP &amp; Sandy Phillips, Group Home Manager. To ensure future compliance, these reliabilities will then be completed randomly 5 times per week for one month and then 1 time per week</p>		

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W 0368  Bldg. 00	<p>conducted on 8/21/15 at 12:45 P.M.. A review of the client's "Program: Self Medication" August 2015 tracking sheet, indicated: "Program Description: The purpose of the program is to teach [client #6] how to administer his own medication...Get cup of water...Open cabinet...Get med box out...Take medication out...Take medication...Put medication away...Throw away cup."</p> <p>The Qualified Intellectual Disabilities Professional (QIDP) was interviewed on 8/21/15 at 1:25 P.M.. The QIDP stated client objectives should be implemented "daily." The QIDP indicated client objectives should be implemented at all times of opportunity.</p> <p>9-3-4(a)</p> <p>483.460(k)(1) DRUG ADMINISTRATION 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 to assure drugs administered to 1 additional client (client #4) were administered in compliance with the physician's orders.</p>	W 0368	<p>for 1 month. To continue monitoring for compliance, monthly a reliability will be completed on-going. Responsible person: Patti Harris, QIDP &amp; Sandy Phillips, Group Home Manager.</p> <p>All staff are trained upon hire on med core A &amp; B and pill passing and then at least annually thereafter. Responsible person: Sherri DiMarco, RN. All staff must pass a med reliability prior to passing medications on site. Responsible</p>	09/20/2015			

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	<p>Findings include:</p> <p>A review of the facility's BDDS (Bureau of Developmental Disabilities Services) reports, Internal Reports (IRs) and investigations was conducted on 8/19/15 at 3:00 P.M.. Review of the records indicated:</p> <p>-BDDS report dated 1/14/15 involving client #4 indicated: "On 1/1/15 I was checking the nurse's book and she wrote a note questioning medication that was given to [client #4] in December of 2014. On 11/18/14 [client #4]'s Luvox (depression) was increased by [Physician's name] by 100 mg (milligrams) 2x (two times) day (sic). When the medication was delivered to the group home the Data Specialist added it to the medication sheet. She did not discontinue the 50 mg dose he was taking 2x a day. Staff passed both the 100 mg dose and the 50 mg dose from December 31st 2014 to December 31st 2014....I (Group Home Manager) as well as appointed staff, will double check the medication book within 24 hours of a medication change to ensure the change is correct. All staff will check changes in the medication book before medication is given. They will be retrained on 1/20/15 to so this. We will also wait till we have</p>		<p>person: Sandy Phillips, Manager. Manager will check for a med change upon returning to her shift to ensure the change was correct. Responsible person: Sandy Phillips, GH Manager. The nurse will be notified of any changes and given a copy of the script. Responsible person: Sandy Phillips, GH Manager. A med check-in list will be completed whenever medications are delivered from the pharmacy. Responsible person: Sandy Phillips, GH Manager. To ensure competency, a med reliability will be completed on each staff at 100 % and then done monthly there after. Responsible person: Sandy Phillips, Manager. To ensure future compliance, a buddy check will be put into place to double check that all medication were passed per orders. Responsible person: Sandy Phillips, Manager. Addendum: The nurse makes all of the medication administration records and then reviews them at least twice a month. All medications scripts are reviewed by the nurse and compared &amp;/or changed on the MARs. The nurse reviews/compares the labels to the scripts and to the MARs to ensure that it is being administered as ordered by the physician. Annually the nurse re-trains all of the staff and watches each of them do a mock medication pass.</p>		

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W 0433 Bldg. 00	<p>a hard copy of the script before any changes are made to the medication sheet to ensure that the right does (sic) is correctly put on the medication sheet. Hopefully this will ensure that this situation does not happen again."</p> <p>An interview with the Qualified Intellectual Disabilities Professional (QIDP) was conducted on 8/21/15 at 1:25 P.M.. The QIDP indicated client #4's medication should have been administered as ordered by the physician.</p> <p>9-3-6(a)</p> <p>483.470(f)(3) FLOORS</p> <p>The facility must have exposed floor surfaces and floor coverings that promote mobility in areas used by clients. Based on observation and interview for 1 of 3 sampled clients and 1 additional client (clients #2 and #5), who walked with an unsteady gait, the facility failed to have level flooring that promoted mobility in areas used by clients.</p> <p>Findings include:</p> <p>An evening observation was conducted at the group home on 8/18/15 from 5:20 P.M. until 7:00 P.M.. During the entire</p>	W 0433	<p>The carpeting in the bedrooms and the flooring in the hall were being replaced. The bedrooms and been completed and the hall flooring was not yet completed during survey observation. We told surveyor that and she acknowledged that it looked like it was being replaced and would probably be done by the time we get this report. The hall floor has been replaced/completed and is level. The flooring is being maintained and replaced when needed. Responsible person:</p>	09/20/2015

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	<p>observation clients #2 and #5 walked back and forth from the back living room down the hall way leading to the bedrooms and front door area. The hallway floor was observed to be uneven, in that the flooring was missing down to the sub flooring down the entire hallway. Clients #2 and #5 walked with an unsteady gait, leaning to the right and hunched over with their legs facing inward.</p> <p>A morning observation was conducted at the group home on 8/21/15 from 5:40 A.M. until 7:00 A.M.. During the entire observation clients #2 and #5 walked back and forth from the back living room down the hall way leading to the bedrooms and front door area. The hallway floor was observed to be uneven, in that the flooring was missing down to the sub flooring down the entire hallway. Clients #2 and #5 walked with an unsteady gait, leaning to the right and hunched over with their legs facing inward.</p> <p>An interview with the Qualified Intellectual Disabilities Professional (QIDP) was conducted on 8/21/15 at 1:25 P.M.. The QIDP indicated the surfaces should be level at the group home to ensure mobility for clients #2 and #5.</p>		Maintenance.To ensure future compliance, we will continue to monthly check the condition of the home and complete maintenance request when needed. Responsible person: Sheila O'Dell, GH Director & Patti Harris, QIDP.		

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W 0436 Bldg. 00	<p>9-3-7(a)</p> <p>483.470(g)(2) SPACE AND EQUIPMENT</p> <p>The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client.</p> <p>Based on observation, record review, and interview, the facility failed for 1 of 3 sampled clients who use a wheelchair (client #3) to teach and encourage the use of his foot rests.</p> <p>Findings include:</p> <p>An evening observation was conducted at the group home on 8/18/15 from 5:20 P.M. until 7:00 P.M.. During the entire observation, client #3 was observed in a manual wheelchair with his legs dangling. The wheelchair did not have footrests.</p> <p>A morning observation was conducted at the group home on 8/21/15 from 5:40 A.M. until 7:00 A.M.. During the entire observation, client #3 was observed in a</p>	W 0436	<p>Wheelchair foot rest will be put onto clients #3 chair and he will be encouraged to use them.</p> <p>Responsible person: Patti Harris, QIDP. Staff will be trained to use and to encourage the use of the footrest. Responsible person: Patti Harris, QIDP. Client #3 has been fitted for a new wheelchair. Responsible person: Sandy Phillips, GH Manager. To ensure future compliance, regular checks will be done to see that the wheelchair is in good condition. Responsible person: Sandy Phillips, GH Manager.</p>	09/20/2015

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W 0440 Bldg. 00	<p>manual wheelchair with his legs dangling. The wheelchair did not have footrests.</p> <p>A review of client #3's record was conducted on 8/21/15 at 12:20 P.M.. Review of client #3's 8/20/14 Individual Support Plan (ISP) indicated client #3 used a wheelchair for mobility.</p> <p>An interview with the Qualified Intellectual Disabilities Professional (QIDP) was conducted on 8/21/15 at 1:25 P.M.. The QIDP indicated client #3's wheelchair should have had his footrests on it to prevent his legs from dangling.</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, the facility failed to conduct evacuation drills for shifts of personnel which affected 6 of 6 clients living in the facility (clients #1, #2, #3, #4, #5 and #6).</p>	W 0440	<p>Manager/staff will be retrained to complete and review for completion of all required fire drills, including 1st, 2nd &amp; 3rd shift drill during each quarter within 90 days. Responsible person: Patti Harris, QIDP. An extra third shift drill will be completed. Responsible person:</p>	09/20/2015

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W 0441 Bldg. 00	<p>Findings include:</p> <p>The facility's records were reviewed on 8/21/15 at 11:20 A.M.. The review failed to indicate the facility held an evacuation drill for clients #1, #2, #3, #4, #5 and #6 on the overnight shift (11:00 P.M. to 7:00 A.M.) during the last quarter (October 1st through December 31st) of 2014.</p> <p>An interview with the Qualified Intellectual Disabilities Professional (QIDP) was conducted on 8/21/15 at 1:25 P.M.. The QIDP indicated evacuation drills are to be conducted during each quarter for each shift of staff.</p> <p>9-3-7(a)</p> <p>483.470(i)(1) EVACUATION DRILLS</p> <p>The facility must hold evacuation drills under varied conditions.</p> <p>Based on record review and interview, the facility failed to hold evacuation drills at varied times during the over night hours (11:00 P.M. to 7:00 A.M.) for 6 of 6 clients living at the group home (clients #1, #2, #3, #4, #5 and #6).</p> <p>Findings include:</p>	W 0441	<p>Sandy Phillips, Group Home Manager. A summary sheet will be completed to show which drill have been completed, when and by who. Responsible person: Sandy Phillips, Group Home Manager. To ensure future compliance, monthly the drills will be reviewed to ensure completion of all required drills for each shift, each quarter. Responsible person: Sheila O'Dell, Group Home Director &amp; Patti Harris, QIDP.</p> <p>Manager/staff will be retrained to complete and review for completion of all required fire drills, including 1st, 2nd &amp; 3rd shift drill during each quarter within 90 days and that they are varied times throughout the night shift. Responsible person: Patti Harris, QIDP. An extra third shift drill will be completed.</p>	09/20/2015			

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	<p>The facility's evacuation drills from 7/1/14 to 6/30/15, were reviewed on 8/21/15 at 11:20 A.M.. The review indicated the facility evacuated clients #1, #2, #3, #4, #5, and #6, on 9/23/14 at 11:01 P.M., no evacuation drill was conducted during the over night shift for the fourth quarter of 2014 (October 1 to December 31st), 3/9/15 at 11:00 P.M. and 6/6/15 at 11:00 P.M..</p> <p>An interview with the Qualified Intellectual Disabilities Professional (QIDP) was conducted on 8/21/15 at 1:25 P.M.. The QIDP indicated facility staff should evacuate clients at various times throughout the over night shift.</p> <p>9-3-7(a)</p>		<p>Responsible person: Sandy Phillips, Group Home Manager. A summary sheet will be completed to show which drill have been completed.</p> <p>Responsible person: Sandy Phillips, Group Home Manager. To ensure future compliance, monthly the drills will be reviewed to ensure completion of all required drills for each shift, each quarter. Responsible person: Sheila O'Dell, Group Home Director &amp; Patti Harris, QIDP.</p>		