

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G376		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 07/01/2013	
NAME OF PROVIDER OR SUPPLIER REM-INDIANA INC				STREET ADDRESS, CITY, STATE, ZIP CODE 723 E 116TH ST CARMEL, IN 46032			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
W000000	<p>This visit was for a predetermined full annual recertification and state licensure survey.</p> <p>Dates of Survey: June 18, 19, 20, 21, 26, 27, and July 1, 2013.</p> <p>Facility Number: 000890 Provider Number: 15G376 AIMS Number: 100244260</p> <p>Surveyor: Susan Eakright, QIDP</p> <p>The following federal deficiencies also reflect state findings in accordance with 460 IAC 9.</p> <p>Quality review completed July 9, 2013 by Dotty Walton, QIDP.</p>			W000000			

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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W000104	<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 4 of 4 clients (clients #1, #2, #3, and #4), and 4 additional clients (clients #5, #6, #7, and #8) who lived in the group home, the governing body failed to exercise operating direction over the facility to complete maintenance and repairs at the group home.</p> <p>Findings include:</p> <p>On 6/18/13 from 2:30pm until 5:40pm, and on 6/19/13 from 5:20am until 7:30am, at the group home clients #1, #2, #3, #4, #5, #6, #7, and #8 were at the group home and the following was observed with the RM (Residential Manager), Group Home Staff (GHS) #1, and GHS #2.</p> <p>-On 6/18/13 at 2:50pm, the RM indicated clients #3 and #7's shared bedroom had six (6) one foot by one foot (1' x 1') areas in the floor that had gouges in the tiles.</p> <p>-On 6/18/13 at 2:50pm, the RM indicated clients #3 and #7's shared bedroom had missing knobs from the dresser drawers which were to be used to open and close each drawer.</p>	W000104	<p>The Program Director will submit requests for the following maintenance items to be completed: for the gouges in the floor tiles in Client #3 and #7 shared bedroom to be repaired and for the knobs to be replaced on the dresser drawers in Client #3 and #7 shared bedroom. The Program Director will work with maintenance staff to obtain a date for the completion of the all requested items.</p> <p>The Home Manager will provide the Program Director with a daily report on the progress of all of the repairs starting on the estimated date of completion.</p> <p>If the repairs are not completed within 3 days of the estimated date of completion the Program Director will inform the Area Director.</p> <p>The Area Director will ensure other arrangements are made to have all requested repairs completed by 7-31-13.</p> <p>In the future the Home Manager will electronically inform the</p>	07/31/2013			

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	<p>On 6/19/13 at 3:50pm and on 6/21/13 at 7:45am, the facility's maintenance items to be repaired and/or replaced was requested from the PD (Program Director) and none were available for review.</p> <p>An interview with the Site Director (SD) was conducted on 6/21/13 at 11:00am. The SD indicated no maintenance items had identified maintenance requests for needed repairs.</p> <p>9-3-1(a)</p>		<p>Program Director of maintenance needs in the home. The Program Director will ensure a maintenance request is submitted properly. The Home Manager will be responsible for keeping the PD informed of the progress on maintenance requests on a weekly basis. The PD will contact the Maintenance staff supervisor if the request has not been completed within 2 weeks of the request.</p> <p>Staff Responsible: Home Manager, program Director, Maintenance Staff, Office Manager</p>				

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W000112	<p>483.410(c)(2) CLIENT RECORDS</p> <p>The facility must keep confidential all information contained in the clients' records, regardless of the form or storage method of the records.</p> <p>Based on observation, record review, and interview, for 8 of 8 clients (clients #1, #2, #3, #4, #5, #6, #7, and #8), the facility failed to keep each client's personal information confidential by posting the client's day services locations with each client's full name on the living room wall and on the wall at the facility owned day service.</p> <p>Findings include:</p> <p>On 6/18/13 from 2:30pm until 5:40pm, and on 6/19/13 from 5:20am until 7:30am, observation was completed at the group home. During both observation periods a posted sheet of paper titled 6/2013 "Day Placement Attendance Report" was taped on the side of the living room cabinet and could be seen when entering the living room. Documented on this Attendance Report were clients #1, #2, #3, #4, #5, #6, #7, and #8's full first and last names, the "Service Provider" for each clients' day service location, and each clients' record of attendance.</p> <p>On 6/20/13 at 1:40pm, the facility owned</p>	W000112	<p>The Home Manager and/or Program Director will remove and secure all confidential information posted in this home. The Program Director will speak with the Day Services Administrator to ask them to remove and secure all confidential information posted where visitors, staff and other clients have access.</p> <p>The Home Manager and staff working in this home as well as Day Services staff will be retrained on confidentiality requirements.</p> <p>Program Director will be retrained on the requirement to be in the home at least once weekly to monitor the implementation of policy/procedures including those for confidentiality.</p> <p>Ongoing the Home Manager and Program Director will ensure all confidential information remains secured and confidential. The Program Director will visit the Day Services site a minimum of quarterly to ensure that all confidential information is secured.</p>	07/31/2013			

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	<p>day service site was visited. At 1:40pm, posted on the wall at the entrance doorway was a list of client #1, #3, #4, and #6's full first and last names and the attendance records for each day of the month each client attended.</p> <p>An interview with the QIDP (Qualified Intellectual Disabilities Professional) was conducted on 6/21/13 at 7:45am. At 7:45am, the QIDP indicated clients' full names, day service providers, and attendance records should not have been posted on the cabinet or at the facility owned day services where visitors, staff, and other clients had access.</p> <p>9-3-1(a)</p>		<p>Ongoing the Area Director, Quality Assurance Specialist and Regional Director will monitor the home and Day Service Programs to ensure confidentiality requirements are met whenever they happen to be on site.</p> <p>The Area Director will determine appropriate corrective action for any breach of confidentiality if necessary.</p> <p>Responsible Staff: Home Manager, Program Director, Day Services Administrator, Area Director, Quality Assurance Specialist</p>		

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W000316	<p>483.450(e)(4)(ii) DRUG USAGE Drugs used for control of inappropriate behavior must be gradually withdrawn at least annually.</p> <p>Based on record review and interview, for 1 of 4 sampled clients (client #4) who received psychotropic medications, the facility failed to evaluate client #4's status for an annual decrease or contraindication of psychotropic medication.</p> <p>Findings include:</p> <p>Client #4's record was reviewed on 6/20/13 at 10:35am. Client #4's 6/23/12 ISP (Individual Support Plan) and client #4's 11/14/12 BSP (Behavior Support Plan) indicated the targeted behaviors of temper and verbal assault. Client #4's plans indicated the use of Thioridazine (anti psychotic) 175mg (milligrams) daily for "Schizophrenia, self talk, verbal assaults, (and) temper outbursts." Client #4's 5/2013, 2/2013, 10/2012, 9/2012, and 7/2012 "Psych (Psychiatric) Medication Reviews" did not indicate a change in client #4's psychiatric medications or a contraindication. Client #4's 5/29/13 "Physician's Order" indicated client #4's Thioridazine was started on 2/17/2010. Client #4's record did not indicate the last psychotropic medication change or contraindication. No data of targeted behaviors was provided for review.</p>	W000316	<p>The QIDP will convene the IDT for client #4. The IDT will assess the behaviors for which client #4 is prescribed medication and develop an appropriate titration plan. At Client #4 next psychiatric review, the Program Director will discuss with the psychiatrist if it is appropriate to decrease the psychotropic medications. If the psychiatrist does not recommend a decrease in Client #4 psychotropic medications, the Program Director will obtain written documentation indicating the contraindication of decreasing the medications.</p> <p>The Program Director will be retrained on ensuring that accurate behavior data is presented at consumers' psychiatric reviews to aid the psychiatrist in determining if decreases in psychotropic medications can be made or if there is a contraindication to decreasing medications based on behavior data. Program Director will also be retrained to ensure that documentation is received from the psychiatrist justifying either a decrease or contraindication for psychotropic medications. The Program Director will note in the</p>	07/31/2013			

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	<p>Interview with the Site Director (SD) was conducted on 6/21/2013 at 11:15am. The SD indicated client #4's psychiatric medication had not been changed in over a year and no contraindication for client #4's psychiatric medication had been documented. The SD indicated she would look for additional documented written evidence for client #4.</p> <p>9-3-5(a)</p>		<p>consumers ISP a minimum of annually the recommendations for changes or contraindications for psychotropic medications.</p> <p>Ongoing the Program Director will ensure that accurate behavior data is presented at consumers' psychiatric reviews to aid the psychiatrist in determining if decreases in psychotropic medications can be made or if there is a contraindication to decreasing medications based on behavior data.</p> <p>The Area Director will review the next 3 ISPs completed by this QIDP to ensure recommendations for changes or contraindications for psychotropic medications are included.</p> <p>Responsible Staff: Program Director, Area Director, Behavior Consultant</p>		

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W000369	<p>483.460(k)(2) DRUG ADMINISTRATION</p> <p>The system for drug administration must assure that all drugs, including those that are self-administered, are administered without error.</p> <p>Based on observation, record review, and interview for 2 of 13 doses of medications administered at the evening and morning medication administration times, the facility failed to administer medications without error for clients #3 and #8.</p> <p>Findings include:</p> <ol style="list-style-type: none"> On 6/18/13 at 4:17pm, Group Home Staff (GHS) #2 administered client #8's "Prilesec (sic) (for acid reflux) 20mg (milligrams), in evening 30 min. (minutes) prior to meal" to client #8. At 4:20pm, client #8 took the medication with water at the dining room table. At 4:40pm, client #8 consumed her first bite of food at the supper meal. On 6/19/13 at 9:50am, client #8's record was reviewed. Client #8's 6/2013 MAR (Medication Administration Record) and 5/29/13 "Physician's Order" both indicated "Prilosec 20mg capsule, take 1 capsule by mouth in the evening 30 minutes prior to meal for Digestion." On 6/19/13 at 6:22am, GHS #3 administered client #3's "Levothyroxine 	W000369	<p>All staff will receive retraining on all consumers medication orders including Client #8 Prilosec and Client #3 Levothyroxine needing to be given 30 minutes prior to a meal.</p> <p>Home Manager and/or Program Director will complete medication administration observations at least twice per week for four weeks to ensure that all staff are following all consumers medication orders as written.</p> <p>Ongoing, the Home Manager and/or Program Director will complete medication administration observations at least once per week to ensure that all staff are following all consumers medication orders as written.</p> <p>Responsible staff: Home Manager, Program Director</p>	07/31/2013	

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	<p>(for Thyroid) 50mcg (micrograms), 1 tab (tablet) daily 30 minutes before meal." At 6:26am, GHS #3 gave client #3 her medication and client #3 took the medication with water. At 6:47am, client #3 consumed her first bite of the breakfast meal.</p> <p>On 6/20/13 at 11:00am, client #3's record was reviewed. Client #3's 6/2013 MAR and 5/29/13 "Physician's Order" both indicated "Levothyroxine 50mcg tablet, take 1 tablet by mouth every day 30 mins (minutes) before meal or meds (medications) for thyroid."</p> <p>On 6/21/13 at 11:15am, an interview with the SD (Site Director) was conducted. The SD indicated the Agency Nurse was not available at this time. The SD indicated clients #3 and #8 were not administered their medications according to physician's orders if the physician's instructions were not followed. The SD indicated physician's orders should be followed when administering medications. The SD indicated client #3 and #8's medications were given in error.</p> <p>9-3-6(a)</p>				

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W000382	<p>483.460(l)(2) DRUG STORAGE AND RECORDKEEPING The facility must keep all drugs and biologicals locked except when being prepared for administration. Based on observation, record review, and interview, for 4 of 4 sampled clients (clients #1, #2, #3, and #4), and for 4 additional clients (clients #5, #6, #7, and #8), the facility failed to ensure client medications were kept locked when not being readied for administration.</p> <p>Findings include:</p> <p>On 6/18/13 from 2:30pm until 5:40pm, observation and interview was completed at the group home. From 2:30pm until 4:00pm, the upper part of the medication cabinet in the living room where client #1, #2, #3, #4, #5, #6, #7, and #8's routine medications were stored was unlocked and unsecured. The lower cabinet which had PRN/as needed House Stock prescribed medications of Mylanta (stomach), Cough Syrup, Acetaminophen (pain), antibiotic creams/lotions, and Tylenol (pain) was unlocked and unsecured. At 4:00pm, GHS (Group Home Staff) #1 indicated the medication cabinet doors; both upper doors and lower doors, were unlocked and unsecured. GHS #1 indicated the upper door on the cabinet should be locked and secured. GHS #1 indicated the lower cabinet held</p>	W000382	<p>All consumers' medications have been secured in a locked cabinet. All staff will receive retraining on the need to ensure that all client medications are being kept locked when not being readied for administration.</p> <p>Home Manager and/or Program Director will complete medication administration observations at least twice per week for four weeks to ensure that all staff are following Core A/Core B medication training and are securing all medications when not being readied for administration.</p> <p>Ongoing, the Home Manager and/or Program Director will complete medication administration observations at least once per week to ensure that all staff are following Core A/Core B medication training and are securing all medications when not being readied for administration</p> <p>Responsible staff: Home Manager, Program Director</p>	07/31/2013			

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	<p>House Stock as needed medications and it did not have to be locked. At 4:50pm, the RM (Residential Manager) and the QIDP (Qualified Intellectual Disabilities Professional) both physically moved the House Stock medications from the lower cabinet of the medication cabinet and placed the items into the upper cabinet and locked/secured the medications. At 4:50pm, the QIDP indicated clients #1, #2, #3, #4, #5, #6, #7, and #8, visitors, and other employees had access to medications when the medications were left unsecured. At 4:50pm, the QIDP indicated medications are to be kept locked when not administering. The QIDP indicated the facility followed Living in the Community Core A/Core B medication administration training.</p> <p>An interview with the Site Director (S) was conducted on 6/21/13 at 11:15am. The SD indicated all medications should be kept locked in the medication cabinet. The SD indicated the facility followed the Living in the Community Core A/Core B medication administration training. No nurse was available for interview.</p> <p>On 6/21/13 at 12:30pm, a record review of the facility's undated "Living in the Community" Core A/Core B training for medication administration indicated "Core Lesson 3: Principles of</p>			

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	<p>Administering Medication" indicated medications should be secured.</p> <p>9-3-6(a)</p>			

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W000426	<p>483.470(d)(3) CLIENT BATHROOMS</p> <p>The facility must, in areas of the facility where clients who have not been trained to regulate water temperature are exposed to hot water, ensure that the temperature of the water does not exceed 110 degrees Fahrenheit.</p> <p>Based on observation, record review, and interview, the facility failed for 4 of 4 sampled clients (clients #1, #2, #3, and #4) and 2 additional clients (clients #5 and #6), to ensure the temperature of the water did not exceed 110 degrees Fahrenheit.</p> <p>Findings include:</p> <p>On 6/18/13 from 2:30pm until 5:40pm, and on 6/19/13 from 5:20am until 7:30am, observation was completed at the group home. On 6/18/13 at 2:30pm, the Residential Manager (RM) indicated the kitchen sink was 115.3 degrees Fahrenheit. At 3:30pm, the hallway bathroom sink was 115.6 degrees Fahrenheit. From 2:30pm until 5:40pm, clients #1, #2, #3, #4, #5, #6, #7, and #8 were prompted and encouraged to turn on the water to wash their hands in the sinks. On 6/19/13 at 5:45am, the hallway bathroom sink water temperature was 115.6 degrees Fahrenheit. At 6:30am, the RM indicated clients #1, #2, #3, #4, #5, #6, #7, and #8 did not have the skill to</p>	W000426	<p>A request has been made to maintenance staff to evaluate the water temperature to ensure it is below 110 degrees. If it is above 110 degrees, maintenance staff will schedule an appointment for the water heater to be evaluated and the temperature adjusted.</p> <p>The Home Manager will be retrained to ensure that water temperatures are being taken a minimum of weekly to ensure all water temperatures are below 110 degrees. All Direct Care staff will be retrained to report any instances when the water temperature is measuring above 110 degrees to the Home Manager immediately to ensure it can be corrected.</p> <p>Ongoing the Home Manager will review the water temperature logs a minimum of weekly to ensure that water temperatures are at or below 110 degrees. The Home Manager will report any instances of water temperature being higher than 110 degrees to the Program Director to ensure that a request is made for evaluation.</p>	07/31/2013			

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	<p>mix the water temperature below 110 degrees Fahrenheit.</p> <p>On 6/21/13 at 7:45am, the QIDP (Qualified Intellectual Disabilities Professional) was interviewed. The QIDP stated clients #1, #2, #3, #4, #5, and #6 "did not recognize the risks of hot water." The QIDP indicated monitoring of the group home water temperature log was completed by the overnight staff and the water temperature was not to exceed 110 degrees Fahrenheit.</p> <p>On 6/21/13 at 11:00am, a review of client #1, #2, #3, and #4's 6/15/12 "Water Temperature Control" assessments indicated clients #1, #2, #3, and #4 were not able to mix hot water above 110 degrees Fahrenheit to a safe temperature.</p> <p>9-3-7(a)</p>		Responsible staff: Home Manager, Program Director		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G376		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 07/01/2013	
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W000436	<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, for 2 of 4 sampled clients (clients #1 and #3) who had adaptive equipment, the facility failed to teach and encourage client #1 to wear his prescribed eye glasses and failed to furnish client #3's hearing aids.</p> <p>Findings include:</p> <p>1. On 6/18/13 from 2:30pm until 5:40pm, and on 6/19/13 from 5:20am until 7:30am, observation was completed at the group home of client #1 and client #1 did not wear his prescribed eyeglasses. During both observation periods client #1 folded towels and laundry, watched television, took out the trash, completed medication administration, and walked throughout the group home and did not wear his prescribed eye glasses. Client #1 was not prompted or encouraged to wear his prescription eye glasses.</p> <p>On 6/20/13 at 11:10am, client #1's record was reviewed. Client #1's 11/7/12 ISP (Individual Support Plan) and 11/8/12</p>	W000436	<p>A training goal is in place for Client #1 to wear his eyeglasses. A training goal will be developed for Client #3 to wear her hearing aids. All Direct Support Staff will receive training on implementing Client #1 and Client #3 training goals for their adaptive equipment.</p> <p>The Program Director will receive retraining to include the need to ensure that all consumers have training goals developed and implemented to provide support for them to use their adaptive equipment.</p> <p>Ongoing, the Program Director will ensure that all consumers have training goals developed and implemented to provide support for them to use their adaptive equipment. The Area Director will review the next 3 ISPs submitted by this Program Director to ensure that all consumers have training goals developed and implemented to provide support for them to use their adaptive equipment.</p> <p>Responsible Staff: Program</p>	07/31/2013			

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	<p>vision assessment indicated client #1 wore prescribed eye glasses. Client #1's ISP indicated a goal/objective for him to wear his prescribed eye glasses in the evening for two (2) hours.</p> <p>2. On 6/18/13 from 2:30pm until 5:40pm, and on 6/19/13 from 5:20am until 7:30am, observation was completed at the group home of client #3 and client #3 did not wear hearing aids. During both observation periods, client #3 was non verbal, appeared to read lips and gestures for other people to communicate with her. During both observation periods, client #3 folded laundry for twenty minutes and no further communication was completed by the staff on duty with client #3. No communication devices were observed used by staff to communicate with client #3 and client #3 did not have a communication device to communicate with the staff and other clients.</p> <p>On 6/20/13 at 11:00am, client #3's record was reviewed. Client #3's 1/23/13 ISP (Individual Support Plan) and 2/7/11 hearing assessment indicated client #3 "requires assistance caring for her hearing aids. [Client #3] does not like to wear her hearing aids." Client #3's ISP did not indicate a goal/objective for her to wear her prescribed hearing aids. Client #3's ISP indicated client #3 did not use</p>		Director, Area Director				

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	<p>communication devices. Client #3's ISP and 5/29/13 Physician's Order both indicated client #3 had a hearing impairment.</p> <p>On 6/21/13 at 7:45am, an interview was conducted with the QIDP (Qualified Intellectual Disabilities Professional). The QIDP indicated client #1 had a recommendation to wear his prescribed eye glasses during awake hours during formal and informal opportunities. The QIDP indicated client #1 should have worn his glasses. The QIDP indicated client #3 had hearing aids and did not like to wear her hearing aids. The QIDP indicated she did not know where client #3's hearing aids were located. The QIDP indicated she would look for additional information.</p> <p>On 6/21/13 at 1pm, an interview with the SD (Site Director) was completed. The SD indicated client #1 should have been prompted and taught to wear his eye glasses. The SD indicated client #3 should have been taught to wear her hearing aids.</p> <p>9-3-7(a)</p>			

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W000440	<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 for 4 of 4 sampled clients (#1, #2, #3, and #4), and 4 additional clients (#5, #6, #7, and #8), to ensure an evacuation drill was conducted quarterly for the day shift of personnel (7am - 2:30pm) from 1/22/2013 until 6/2013 and the overnight shift (11:00pm - 8:00am) from 6/27/12 until 12/8/12.</p> <p>Findings include:</p> <p>The facility's evacuation drills were reviewed on 6/18/13 at 12:12pm. The review indicated the facility had failed to conduct evacuation drills for clients #1, #2, #3, #4, #5, #6, #7, and #8 for the day shift (7:00am until 2:30pm) for the second quarter (April, May, and June) of 2013 period from 1/22/13 at 1:40pm until 6/18/2013 and on the overnight shift (11:00pm - 8:00am) for the third quarter (July, August, and September) of 2012 period from 6/27/12 at 2:00am until 12/8/12 at 2:39am, was missing a night shift drill.</p> <p>An interview with the QIDP (Qualified Intellectual Disabilities Professional) was completed on 6/21/13 at 7:45am. The</p>	W000440	<p>The Home Manager will be retrained on the policy and procedures for the completion of evacuation drills.</p> <p>The Home Manager will be responsible for submitting a copy of the fire drill to the Program Director and Quality Assurance Specialist before the last day of each month.</p> <p>The Quality Assurance Specialist will review the report and request any necessary follow-up. The Program Director will be responsible for ensuring the needed follow-up is completed.</p> <p>Responsible Staff: Program Director, Home Manager, Quality Assurance Specialist</p>	07/31/2013			

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	<p>QIDP indicated she was unable to locate any further evacuation drills for the day shift and the overnight shift of personnel for clients #1, #2, #3, #4, #5, #6, #7, and #8.</p> <p>9-3-7(a)</p>				