

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G230	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 06/29/2012
NAME OF PROVIDER OR SUPPLIER REM-INDIANA INC			STREET ADDRESS, CITY, STATE, ZIP CODE 1221 WARREN DR LAFAYETTE, IN 47905		
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W0000	<p>This visit was for a recertification and state licensure survey.</p> <p>Survey Dates: June 25, 26, 27, 28, and 29, 2012</p> <p>Facility Number: 000754 Provider Number: 15G230 AIM Number: 100243370</p> <p>Surveyors: Tracy Brumbaugh, Medical Surveyor III, Team Leader Paul Rowe, QMRP/CMS Federal ICF/MR Surveyor</p> <p>These deficiencies also reflect state findings under 460 IAC 9.</p> <p>Quality review completed on July 06, 2012 by Dotty Walton, Medical Surveyor III.</p>	W0000			

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

TITLE

(X6) DATE

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

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W0104	<p>483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility.</p> <p>Based on record review and interview the governing body failed to ensure adequate monitoring of the facility's evacuation preparation system to prevent and identify falsification of 1 of 4 evacuation drill records documented by the facility for the 11 p.m. to 7 a.m. shift for 4 of 4 sampled clients (clients #1, #2, #3, and #4), and 4 additional clients (clients #5, #6, #7, and #8).</p> <p>Findings include:</p> <p>On 6/25/12 at 10:05 a.m. a review was initiated of the evacuation drills documented by the facility for the time period of 7/1/11 through 6/25/12. The drills were documented as being conducted for all quarters of the previous 12 month periods, the length of time for completion of each drill was recorded as exactly 2 minutes without exception. No problems during evacuation were documented in any of the drills.</p> <p>On 6/25/12 at 5:45 p.m. an interview was initiated with Direct Care Staff (DCS) #4. She reported she worked on the 3 p.m. to 11 p.m. shift and had been employed by the agency for 6 years. She said during that time she had conducted numerous evacuation drills. She identified 3 people living in the home with mobility issues requiring extra assistance and time to walk safely from the</p>	W0104	<p>The governing body exercises general policy, budget, and operating direction over the facility. The Area Director will complete an investigation to determine if it is possible to discover who completed the falsified fire drill in question. The Home Manager, or Program Director will train all staff, upon hire, during their initial shadowing phase of employment on conducting an evacuation drill. The Home Manager or Program Director will train and observe to ensure that any staff is trained and prepared to conduct a full scale evacuation drill. The Home Manager or Program Director will document this on the employees Shadowing Packet and will be kept in the employees personnel file. The facility provides a written schedule to each supervisor to assist in assuring that evacuation drills are held each quarter for each shift of personnel. (attached). The Area Director will verify, per the facility schedule that an evacuation drill is conducted per the policy and schedule. The Area Director will verify the information contained in each drill, and will implement of plan of correction, if needed. The Program Director will review each fire drill for accuracy. The</p>	07/29/2012			

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	<p>home to the designated meeting place. She said since there were always 2 staff on duty it was possible to provide them with enhanced supports needed to exit the home safely within 2 minutes.</p> <p>On 6/26/12 at 4:00 p.m. an interview was conducted with the Qualified Mental Retardation Professional (QMRP). The unusualness of each drill lasting exactly 2 minutes for the past 12 months was discussed. The QMRP offered no explanation but verified the staffing ratio of the 3 p.m. to 11 p.m. shift was 2, sometimes 3 staff and the staffing ratio on the 11 p.m. to 7 a.m. shift was 1. Asked if it was reasonable that 1 staff could evacuate all clients present, considering the mobility issues of 3 clients and the arousal from sleep that would be required on the 11 p.m. to 7 a.m. shift, the QMRP made no direct response.</p> <p>On 6/27/12 at 12:22 a.m. an interview was conducted DCS #3. He reported that he worked the 11:00 p.m. to 7:00 a.m. shift and had been employed by the agency for 4 months. He said he had never conducted a fire drill since beginning employment at the home in February 2012 and did not know how long it would take to evacuate everyone. He said his supervisor had once talked to him about fire drills and advised him that he would be trained on conducting fire drills and paired up with a more experienced employee to conduct his first drill. Until that training occurred he was advised in the event of an actual fire he was responsible for doing</p>		<p>Program Director will submit each fire drill to the Area Director, monthly, for verification of accuracy. The Area Director will review the evacuation drill and verify accuracy of the staff running the drill, the signature of the staff running the drill, as well as the outcomes of the drill. The Area Director will sign each fire drill and will maintain a copy of each drill in an office file, as well as a file in the home. Responsible Parties: Area Director, Program Director, Home Manager Completion Date: 7/29/12</p>				

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	<p>"whatever it takes" to evacuate everyone from the residence. He said that training had not yet occurred. He was shown a copy of a "Fire Drill Report" dated 6/8/12, documenting that he completed a fire drill at 2:15 a.m. that lasted 2 minutes, ending at 2:17 a.m. He checked his schedule and he verified was on duty on 6/7/12 at 11:00 p.m. and worked alone through the night until 6/8/12 at 7:00 a.m. He said he did not complete a drill on that date. He pointed out the signature on the "Signature/Title of Person Completing Drill" field of the "Fire Drill Report" was not his signature, and although his name was signed on this line, his last name was spelled incorrectly. He had no explanation for why this "Fire Drill Report" falsely documented he had completed the fire drill when he in fact had not.</p> <p>On 6/27/12 at 12:55 p.m. an interview was initiated with the Home Manager and the Regional Director. The Home Manager had no explanation for the evacuation drill recording DCS #3 completed a drill on 6/8/12 at 2:15 a.m. in light of his report he completed no such drill. She verified that her signature was on the document as the reviewing authority. She said she found the record of that drill placed in her mail slot at the residence. She said she was unable to recognize the handwriting on the evacuation drill. She verified she was the responsible person for assuring all drills were completed at the residence. She offered no information as to who would have falsified this evacuation drill report.</p>						

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	<p>The Regional Director reported having initiated interviews with staff to determine who falsified the evacuation drill report. In the absence of anyone admitting to having done so, it remained unknown who falsified the record. The Regional Director said she would continue to investigate the falsification of records. She added when she was first advised the surveyors were concerned about the discovery of all drills for the previous 12 months lasting exactly 2 minutes without exception, she had determined to return to previous monitoring methods, including signing off on all fire drills herself and re-instituting unannounced upper management monitoring of evacuation drills.</p> <p>9-3-1(a)</p>			

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W0120	<p>483.410(d)(3) SERVICES PROVIDED WITH OUTSIDE SOURCES The facility must assure that outside services meet the needs of each client.</p> <p>Based on observation, interview and record review the facility failed to ensure the day program provided sufficient training and oversight to meet the behavioral support needs of 1 of 1 client in the sample who was placed in time out at the day program (Client #1). Further, the facility failed to ensure the day program men's restroom was maintained in hygienic conditions for 1 of 4 sampled clients (client #1).</p> <p>Findings include:</p> <p>1. On 7/25/12 beginning at 1:30 p.m. an observation was initiated of Client #1 at his day program. He sat at a table with multi-colored blocks and a plastic container in front of him, walked about the room and was escorted to the restroom.</p> <p>On 7/25/12 a review was initiated of the record maintained by the day program. The record included a "Behavior Development Program" dated 10/10/09, including a staff instruction labeled, "Component #4. Relocation Procedure" which read, "This procedure is to be used if [Client #1] displays problem behavior that is dangerous to others.</p> <p>1. Escort [Client #1], using a one-person escort to an area in which he cannot see or hear others. This area must also be easily monitored by staff. If [Client #1] resists, use the</p>	W0120	The facility will ensure that outside services meet the needs of each client. The Program Director will schedule a re-training for day service supervisors to ensure that day service staff are fully trained on the behavior support plans of each client. The Program Director will ensure that day service supervisors are retrained on any component of a behavior support plan if it should change. The Program Director will document in the monthly or quarterly review if there have been revisions in any behavior support plan, and the date that the day service and residential staff have been trained on these revisions. These reviews will be submitted to the Area Director for review each month and quarter. The Area Director has met with the Day Service Administrator to address the cleanliness and maintenance concerns at the Day Service facility. Day Service maintenance personnel has initiated clean up and repair of the bathroom. (see attached). In addition, the Day Service Administrator has initiated a weekly follow up tracking form to ensure that the bathroom facilities remain clean and in good repair. Day Service staff will email this form to the	07/29/2012			

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	<p>two-person escort.</p> <p>2. While [Client #1] is in the safe area, he must remain seated in a chair. Use the minimum amount of physical guidance needed to ensure that he does not lie down or walk around.</p> <p>3. [Client #1] will remain in the safe area until he has been calm for five consecutive minutes.</p> <p>4. Stay at the doorway and if [Client #1] attempts to leave before five minutes of calm, redirect him to sit in the chair.</p> <p>5. If [Client #1] engages in physical assault during this procedure, block the assault using Indiana Mentor Physical Interventions Alternatives.</p> <p>6. After [Client #1] has been calm for five minutes, allow [Client #1] to leave the safe area and involve him in an activity on his preferred activity list."</p> <p>Client #1's record also included a "Monthly Data Summary" dated June 2012, documenting the use of the relocation procedure on 6/8/12 and 6/15/12.</p> <p>On 6/25/12 at 3:30 p.m. an interview was initiated with Direct Care Staff (DCS) #1 and DCS #2 assigned to the classroom where Client #1 received day supports. DCS #1 reported the relocation procedure was used regularly to calm Client #1 down when he exhibited targeted behaviors of aggression and property destruction. DCS #1 and DCS #2 described implementation of the</p>		<p>Area Director at the end of each week for review. The Program Director or Home Manager will conduct a Day Service Observation form at least one time per week. This observation will include observation of active treatment, behavior plan implementation if needed, and any facility cleanliness or maintenance needs. The day service observation form will be submitted to the Area Director by Friday of each week, for follow up on any corrective action needs. Day Service Personnel have verified that the "sensory room" is no longer in use for any client. (see attached) The Program Director and Home Manager will verify this weekly, and document on the Day Service Observation form. Responsible Parties: Area Director, Program Director, Home Manager and Day Service staff Completion Date: 7/29/12</p>				

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	<p>"relocation procedure" as physically moving Client #1 to the storage closet connected to the program room as needed, putting him in the room, prompting him to sit in the chair, closing the door and observing him through the window slit in the door. If he attempted to exit the room he would be redirected verbally and with physical presence to remain in the room. The DCS staff explained Client #1 was kept in the room for 5 minutes and then released if he was calm. If he wasn't calm he was supposed to stay in the room.</p> <p>On 6/26/12 at 9:00 a.m. an observation was conducted of the storage closet/relocation area where the Time Out procedure was implemented for Client #1. The room was 7 feet in width and 11 feet in length. It contained; a wheelchair, an open cabinet of clean and soiled clothing labeled with names, a metal file cabinet containing food, drinks and activity supplies, a particle board shelving unit containing adult briefs, a plastic bucket of markers, towels and a large quantity of plastic bags. A changing table pushed against a wall was piled with a large ball, many VHS movies, positioning mats, a trash can lid and seasonal decorations. Strewn about the floor was a pillow, a plastic crate with broken sharp edges filled with wooden musical toys and various seasonal decorations. One desk chair was positioned next to the door. The fabric upholstery across the seat and back of the chair was very soiled and stained with unidentified fluid spills. A wooden rod stuck upwards through the opening between the seat and the back</p>			

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	<p>support into the sitting space of the chair. The walls and floor of the room contained various spills and smears of what appeared to be food and fluids stains in indeterminate type. A plastic bag filled with empty soft drinks cans hung from the interior door knob. The wall surface was punched through in an approximately 3 and ½ inch diameter circle matching the spot on the wall where the interior door knob came into contact with the wall when opened. All interior space of the room was not visible from the window slit in the door way from outside the room, as is required for Time Out rooms. The door latch did not require constant staff pressure to keep the door closed, as is required for Time Out rooms.</p> <p>On 6/26/12 at 9:30 a.m. an interview was conducted with the Day Program Case Coordinator. She was asked for documentation of the use of the Time Out room for Client #1 between the months of 8/11 and 6/12. During this time frame Client #1 was placed in Time Out 35 times for periods of time from 3 minutes to 15 minutes. The Day Program Case Coordinator said she received a copy of Client #1's Behavior Development Plan, but never received training in the implementation of Client #1's Behavior Development Plan. She read the plan and provided training to all Day Program staff assigned to work with Client #1. She verified that DCS #1 and #2 had both received her version of training in implementing Client #1's Behavior Support Plan. She said her training directed staff to</p>						

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	<p>leave the door to the storage closet open when Client #1 was placed inside and she was unaware the plan was being implemented differently.</p> <p>On 6/26/12 at 10:15 a.m. an interview was conducted with the Qualified Mental Retardation Professional (QMRP). She reported being unaware of the Time Out room used for Client #1 at the Day Program and of the data collection forms documenting its use. She reported that she received Client #1's Behavior Development Program from the Behavior Consultant but never received training in the implementation of the plan. She forwarded the Behavior Development Program to the day program but never provided any training to the day program managers and staff to explain the implementation of the plan.</p> <p>2. On 6/25/12 beginning at 1:30 p.m. an observation was initiated of Client #1 at his day program. He left his classroom at 2:15 p.m., 2:45 p.m., 3:00 p.m. and 3:30 p.m. followed by staff to go to the restroom along the same hallway as his classroom. On 6/25/12 at 3:55 p.m., an observation was initiated of the restroom frequented by Client #1. Upon opening the Men's Room door a concentrated and strong odor of foul smelling urine and feces was evident. Two restroom stalls were located along the right wall. The accessible stall contained a wall mounted commode. The tile floor under and around the commode was stained yellow. The grout/sealant between individual tiles has</p>						

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	<p>missing and the cracks were filled with a concentrated yellow substance which emitted a very strong urine smell. Smearred fecal matter was present on the seat of the commode.</p> <p>The non-accessible stall contained a wall mounted commode. Urine spills were present on the toilet seat. The tile floor under and around the commode was stained yellow. The grout/sealant between individual tiles was missing and the cracks were filled with a concentrated yellow substance which emitted a very strong urine smell. Urine spills were present around the floor of the stall. Urine spills and brown smears were present on the interior walls surrounding each stall.</p> <p>On 6-26-12 at 9:40 a.m. an interview with DCS #1 indicated the bathroom did have urine and feces in it and a strong odor of urine was present.</p> <p>9-3-1(a)</p>			

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W0125	<p>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.</p> <p>Based on observation, record review, and interview for 2 of 4 sampled clients (clients #1 and #4) the facility failed to ensure a legally sanctioned representative was obtained to assist them with their needs per their assessments.</p> <p>Findings include:</p> <p>1. On 6-25-12 from 6:10 a.m. until 8:50 a.m. an observation at the home of client #4 was conducted. Client #4 was observed to "play" her organ and use her food processor with hand over hand assistance from direct care staff #5. On 6-25-12 from 1:00 p.m. until 2:55 p.m. an observation at the day program for client #4 was conducted. Client #4 sat in a chair and "played an organ" and ripped up paper. On 6-25-12 from 4:10 p.m. until 6:20 p.m. an observation at the home of client #4 was conducted. Client #4 "played" her organ and used her food processor with assistance.</p> <p>On 6-26-12 at 11:00 a.m. a record review for client #4 was conducted. The</p>	W0125	<p>The facility will ensure the rights of all clients. The facility allows and encourages individual clients to exercise their rights as citizens of the United States, including the right to file complaints, and the right to due process. The Program Director has submitted forms to the primary physician of client #1 and client #4. The facility has initiated the process of locating and establishing appropriate legal guardians, including contacting legal counsel and submitting legally required documentation to the client's physicians. The facility will continuously assess the needs of it's clients, to determine their abilities to advocate for themselves on an ongoing basis. The Program Director will document client abilities and needs in the Comprehensive Functional Assessment, and will update annually. Please note that the process for guardianship has been facilitated, however the court process may continue past the completion date of 7/29/12 Responsible Parties: Program Director Completion Date: 7/29/12</p>	07/29/2012			

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	<p>Individualized Support Plan (ISP) dated 1-4-12 indicated she was emancipated and her diagnosis included, but was not limited to, profound mental retardation. The ISP indicated client #4 needed training in the areas of medication administration, toileting, dental hygiene, personal hygiene, money skills, communication skills, eating skills, and laundry skills. The Comprehensive Functional Assessment (CFA) dated 1-2012 indicated client #4 was non-verbal and inconsistent with expressing pain or illness, she would let out cries or screams when uncomfortable and she needed staff to monitor her health closely. Client #4 relied "totally" on staff for medication administration and with all medical appointments. The CFA indicated client #4 relied on staff to assist her with her nutritional needs, and was unable to problem solve or reason at times. Client #4 was not capable of giving informed consent and needs physical assistance from staff to complete hygiene tasks. Client #4 received a social security check monthly and was unable to take care of her own finances. Client #4 was unable to make a purchase in the community without staff assistance and may need direction for choosing a purchase.</p> <p>2. On 6/26/12 a record review was completed for Client #1. His</p>			

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	<p>Individualized Support Plan, dated 2/1/12, documented his diagnoses as, "Profound Mental Retardation, Expressive Speech Difficulty, Mixed Bipolar Disorder, Dyskinesia and Drooling." The record included a physician's order dated 3/12/12 prescribing Risperidone, Mirtazapine, Valproic Acid and Clonazepam for behavior management. His Comprehensive Functional Assessment included an assessment of his capacity to provide informed consent, dated 2/1/12. This assessment concluded that Client #1 was unable to provide consent for rights restrictions and psychotropic medications. The record also included a Quarterly Program Review dated 8/31/11, which included a consent document for all interventions and programs signed with Client #1's mark.</p> <p>On 6/25/12 at 3:30 p.m. an interview was initiated with the QMRP. She verified the absence of legally adequate consent for the use of medications to manage behavior for Client #1. The Qualified Mental Retardation Professional (QMRP) reported there was an attempt in prior years to obtain consent from family members of Client #1 but no recent attempts had been made to establish legally adequate consent for Client #1's restrictive and intrusive behavioral interventions.</p>			

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	<p>On 6-26-12 at 12:30 p.m. an interview with the Qualified Mental Retardation Professional indicated clients #1 and #4 did not understand the concept of money and they needed complete assistance with their medical and financial needs.</p> <p>9-3-2(a)</p>				

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W0159	<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.</p> <p>Based on observation, interview and record review the facility failed to ensure 1 of 4 clients in the sample (Client #1) received effective active treatment program integration, coordination and monitoring by the Qualified Mental Retardation Professional (QMRP).</p> <p>Findings include:</p> <p>On 6/25/12 beginning at 1:30 p.m. an observation was initiated of Client #1 at his day program. He sat at a table with multi-colored blocks and a plastic container in front of him, walked about the room and was escorted to the restroom.</p> <p>On 7/25/12 a review was initiated of the record maintained by the day program. The record included a "Behavior Development Program" dated 10/10/09, including a staff instruction labeled, "Component #4. Relocation Procedure" which read, "This procedure is to be used if [Client #1 displays problem behavior that is dangerous to others."</p> <ol style="list-style-type: none"> Escort [Client #1], using a one-person escort to an area in which he cannot see or hear others. This area must also be easily monitored by staff. If [Client #1] resists, use the two-person escort. While [Client #1] is in the safe area, 	W0159	<p>The facility ensures that each client's active treatment program is integrated, coordinated and monitored by a qualified mental retardation professional. The Program Director will schedule a re-training for day service supervisors to ensure that day service staff are fully trained on the behavior support plans of each client. The Program Director will ensure that day service supervisors are retrained on any component of a behavior support plan if it should change. The Program Director will document in the monthly or quarterly review if there have been revisions in any behavior support plan, and the date that the day service and residential staff have been trained on these revisions. These reviews will be submitted to the Area Director for review each month and quarter. The Program Director or Home Manager will conduct a Day Service Observation form at least one time per week. This observation will include observation of active treatment, behavior plan implementation if needed, and any facility cleanliness or maintenance needs. The day service observation form will be</p>	07/29/2012			

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	<p>he must remain seated in a chair. Use the minimum amount of physical guidance needed to ensure that he does not lie down or walk around.</p> <p>3. [Client #1] will remain in the safe area until he has been calm for five consecutive minutes.</p> <p>4. Stay at the doorway and if [Client #1] attempts to leave before five minutes of calm, redirect him to sit in the chair.</p> <p>5. If [Client #1] engages in physical assault during this procedure, block the assault using Indiana Mentor Physical Interventions Alternatives.</p> <p>6. After [Client #1] has been calm for five minutes, allow [Client #1] to leave the safe area and involve him in an activity on his preferred activity list."</p> <p>Client #1's record also included a "Monthly Data Summary" dated June 2012 documenting the use of the relocation procedure on 6/8/12 and 6/15/12.</p> <p>On 6/25/12 at 3:30 p.m. an interview was initiated with Direct Care Staff (DCS) #1 and DCS #2 assigned to the classroom where Client #1 received day supports. DCS #1 reported the relocation procedure was used regularly to calm Client #1 down when he exhibited targeted behaviors of aggression and property destruction. DCS #1 and DCS #2 described implementation of the "relocation procedure" as physically moving Client #1 to the storage closet connected to</p>		<p>submitted to the Area Director by Friday of each week, for follow up on any corrective action needs. Day Service Personnel have verified that the "sensory room" is no longer in use for any client. (see attached) The Program Director and Home Manager will verify this weekly, and document on the Day Service Observation form. Responsible Parties: Area Director, Program Director, Home Manager and Day Service staff Completion Date: 7/29/12</p>				

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	<p>the program room as needed, putting him in the room, prompting him to sit in the chair, closing the door and observing him through the window slit in the door. If he attempted to exit the room, he would be redirected verbally and with physical presence to remain in the room. The DCS staff explained Client #1 was kept in the room for 5 minutes and then released if he was calm. If he wasn't calm he was supposed to stay in the room.</p> <p>On 6/26/12 at 9:00 a.m., an observation was conducted of the storage closet/relocation area where the Time Out procedure was implemented for Client #1. The room was 7 feet in width and 11 feet in length. It contained a wheelchair, an open cabinet of clean and soiled clothing labeled with names, a metal file cabinet containing food, drinks and activity supplies, a particle board shelving unit containing adult briefs, a plastic bucket of markers, towels and a large quantity of plastic bags. A changing table pushed against a wall was piled with a large ball, many VHS movies, positioning mats, a trash can lid and seasonal decorations. Strewn about the floor was a pillow, a plastic crate with broken sharp edges filled with wooden musical toys and various seasonal decorations. One desk chair was positioned next to the door. The fabric upholstery across the seat and back of the chair was very soiled and stained with unidentified fluid spills. A wooden rod stuck upwards through the opening between the seat and the back support into the sitting space of the chair. The walls and floor of the room contained</p>			

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	<p>various spills and smears of what appeared to be food and fluid stains in indeterminate type. A plastic bag filled with empty soft drinks cans hung from the interior door knob. The wall surface was punched through in an approximately 3 and ½ inch diameter circle matching the spot on the wall where the interior door knob came into contact with the wall when opened. All interior space of the room was not visible from the window slit in the doorway from outside the room, as is required for Time Out rooms. The door latch did not require constant staff pressure to keep the door closed, as is required for Time Out rooms.</p> <p>On 6/26/12 at 9:30 a.m., an interview was conducted with the Day Program Case Coordinator. She was asked for documentation of the use of the Time Out room for Client #1 between the months of 8/11 and 6/12. During this time frame Client #1 was placed in Time Out 35 times for periods of time from 3 minutes to 15 minutes. The Day Program Case Coordinator said she received a copy of Client #1's Behavior Development Plan, from the residential QMRP but never received training on that plan from anyone, specifically including the QMRP and the Behavior Specialist who wrote the plan. After receiving the plan, the Day Program Case Coordinator read it and started training all staff who work with Client #1 on her understanding of the plan. She verified that DCS #1 and #2 had both received her version of training to implement Client #1's Behavior Support Plan. She said</p>			

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	<p>her training directed staff to leave the door open when Client #1 was moved to the storage closet. She reported being unaware that Client #1 was placed inside the closet with staff preventing his egress by keeping the door closed.</p> <p>The Day Program Case Coordinator was asked how frequently the residential QMRP visited clients at the Day Program to monitor the implementation of programs. She reported no such visits had occurred during the previous 12 months.</p> <p>On 6/26/12 at 10:15 a.m. an interview was conducted with the QMRP. She reported being unaware of the Time Out room used for Client #1 at the Day Program and of the data collection forms documenting its use. She reported that she received Client #1's Behavior Development Program from the Behavior Consultant but never received training in the implementation of the plan. She forwarded the Behavior Development Program to the day program but never provided any training to the day program managers and staff to explain the implementation of the plan. She reported she had visited the Day Program sometime in the past 12 months; but did not recall when. She searched for and was unable to provide any documentation of those visits. She characterized those undocumented visits as brief and not including observations of implementation of programs.</p> <p>9-3-3(a)</p>				

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W0250	<p>483.440(d)(2) PROGRAM IMPLEMENTATION</p> <p>The facility must develop an active treatment schedule that outlines the current active treatment program and that is readily available for review by relevant staff.</p> <p>Based on observation, record review and interview, the facility failed for 2 of 4 sampled clients (clients #1 and #4), to ensure an active treatment schedule was available for staff to review during times of opportunity.</p> <p>Findings include:</p> <p>On 6-25-12 from 6:10 a.m. until 8:50 a.m. an observation at the home of clients #1 and #4 was conducted. Client #4 was observed to "play" her organ and use her food processor with hand over hand assistance from direct care staff #5. Client #1 walked around his home, walked into his bathroom and flushed the toilet several times (not using the restroom, just flushing), sat in a recliner, took his medication which were brought to him by his House Manager, then wandered around his home the rest of his morning before leaving for day program.</p> <p>On 6-25-12 from 4:10 p.m. until 6:20 p.m. an observation at the home of clients #1 and #4 was conducted. Client #4 "played" her organ and used her food processor with assistance. Client #1 wandered around his home, flushed</p>	W0250	<p>The facility develops an active treatment schedule that outlines the current active treatment program. The Area Director will retrain the Program Director on creation of individual active treatment schedules for each client. The Active Treatment schedules will be completed and available in the home, for staff to review at times of opportunity. The Home Manager will train staff on the location, implementation and usage of the active treatment schedules. Responsible Parties: Area Director, Program Director, Home Manager Completion Date: 7/29/12</p>	07/29/2012	

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	<p>toilets, and sat on the couch.</p> <p>On 6-26-12 at 11:00 a.m. a record review for client #4 was conducted. The review indicated there was no active treatment schedule available for staff to review to assist client #4 with structuring her time.</p> <p>On 6-26-12 at 1:00 p.m. a record review for client #1 was conducted. The review indicated there was no active treatment schedule available for staff to review to assist client #1 with structuring his time.</p> <p>On 6-26-12 at 3:45 p.m. an interview with the Qualified Mental Retardation Profession indicated there were no individual active treatment schedules available for review to assist staff with providing structure to client #1 and #4's day.</p> <p>9-3-4(a)</p>				

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W0261	<p>483.440(f)(3) PROGRAM MONITORING & CHANGE The facility must designate and use a specially constituted committee or committees consisting of members of facility staff, parents, legal guardians, clients (as appropriate), qualified persons who have either experience or training in contemporary practices to change inappropriate client behavior, and persons with no ownership or controlling interest in the facility.</p> <p>Based on record review and interview, the facility failed to ensure the Specially Constituted Committee (SCC) consisted of a client member who participated in the meetings for 8 of 8 clients (clients #1, #2, #3, #4, #5, #6, #7, and #8) who lived in the home.</p> <p>Findings include:</p> <p>On 6-26-12 at 11:00 a.m. a review of the facility's SCC minutes was conducted. The SCC minutes dated 6-12, 3-12, 12-11 and 9-11 did not show a client member had participated in the meetings.</p> <p>On 6-26-12 at 12:15 p.m. an interview with the Qualified Mental Retardation Professional indicated they did have clients that were appropriate to participate in the SCC meeting but none had attended the meetings over the past year.</p> <p>9-3-4(a)</p>	W0261	<p>The facility will designate and use a specially constituted committee or committees consisting of members of facility staff, parents, legal guardians, clients (as appropriate), qualified persons who have either experience or training in contemporary practices to change inappropriate client behavior, and persons with no ownership or controlling interest in the facility. The Area Director will meet with the current client member of the Human Rights Committee to determine if she is still willing to participate, and is able to because of her current work schedule. If this member is not available to participate in the Human Rights Committee, the Area Director will ensure that another client member, for the Human Rights Committee, is located prior to the next scheduled meeting. Once this has been determined, the facility will assist in facilitating the client's attendance at the meetings. Responsible Parties: Area Director Completion Date: 7/29/12</p>	07/29/2012	

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W0263	<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.</p> <p>Based on record review and interview the Specially Constituted Committee (SCC) failed to ensure written informed consent for the use of medications to manage behavior for 3 of 3 clients in the sample who were treated with such medications (Clients #1, #2 and #3). Further the Specially Constituted Committee failed to review and approve the use of a time out behavioral intervention used at the day program for 1 of 1 client placed in time out (Client #1).</p> <p>Findings include:</p> <p>On 6/26/12 a record review was completed for Client #1. The physician's order, dated 3/12/12, prescribed Risperidone, Mirtazapine, Valproic Acid, Clonazepam for behavior management. No evidence of written informed consent was present in the record. On 6/26/12 at 3:30 p.m. an interview was initiated with the Qualified Mental Retardation Professional (QMRP). She verified the absence of consent for the use of medications to manage behavior for Client #1. On 6/26/12 a record review was completed of the Minutes of the Specially Constituted Committee (referred to by the facility as the Human Rights Committee) for the period of time from July 2011 through June 2012. No evidence existed that the committee assured written informed consent</p>	W0263	The committee ensures that programs are conducted only with the written infromed consent of the client, parents or legal guardian.The Area Director will retrain the Program Director on policies and procedures for approval of programs, behavior support plans, and medications by clients, parents and legal guardians, and the Specially Constituted Committee. The Program Director will ensure that there is written consent, prior to the implementation of such programs, interventions or treatments.The Program Director will schedule a re-training for day service supervisors to ensure that day service staff are fully trained on the behavior support plans of each client. The Program Director will ensure that day service supervisors are retrained on any component of a behavior support plan if it should change. The Program Director will document in the monthly or quarterly review if there have been revisions in any behavior support plan, and the date that the day service and residential staff have been trained on these revisions. These reviews will be submitted to the Area Director for review each month and	07/29/2012			

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	<p>was present prior to approval of the use of Risperidone, Mirtazapine, Valproic Acid and Clonazepam for Client #1 or for the use of a time out behavioral intervention at his day program.</p> <p>On 6/25/12 beginning at 1:30 p.m. an observation was initiated of Client #1 at his day program. He sat at a table with multi-colored blocks and a plastic container in front of him, walked about the room and was escorted to the restroom.</p> <p>On 6/25/12 a review was initiated of the record maintained by the day program. The record included a "Behavior Development Program" dated 10/10/09, including a staff instruction labeled, "Component # 4. Relocation Procedure" which read, "This procedure is to be used if [Client #1 displays problem behavior that is dangerous to others.</p> <ol style="list-style-type: none"> 1. Escort [Client #1], using a one-person escort to an area in which he cannot see or hear others. This area must also be easily monitored by staff. If [Client #1] resists, use the two-person escort. 2. While [Client #1] is in the safe area, he must remain seated in a chair. Use the minimum amount of physical guidance needed to ensure that he does not lie down or walk around. 3. [Client #1] will remain in the safe area until he has been calm for five consecutive minutes. 4. Stay at the doorway and if [Client #1] attempts to leave before five 		<p>quarter. The Program Director or Home Manager will conduct a Day Service Observation form at least one time per week. This observation will include observation of active treatment, behavior plan implementation if needed, and any facility cleanliness or maintenance needs. The day service observation form will be submitted to the Area Director by Friday of each week, for follow up on any corrective action needs. Day Service Personnel have verified that the "sensory room" is no longer in use for any client. (see attached) The Program Director and Home Manager will verify this weekly, and document on the Day Service Observation form. Responsible Parties: Area Director, Program Director, Home Manager and Day Service staff Completion Date: 7/29/12</p>				

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	<p>minutes of calm, redirect him to sit in the chair.</p> <p>5. If [Client #1] engages in physical assault during this procedure, block the assault using Indiana Mentor Physical Interventions Alternatives.</p> <p>6. After [Client #1] has been calm for five minutes, allow [Client #1] to leave the safe area and involve him in an activity on his preferred activity list."</p> <p>Client #1's record also included a "Monthly Data Summary" dated June 2012 documenting the use of the relocation procedure on 6/8/12 and 6/15/12.</p> <p>On 6/25/12 at 3:30 p.m. an interview was initiated with Direct Care Staff (DCS) #1 and DCS #2 assigned to the classroom where Client #1 received day supports. DCS #1 reported the relocation procedure was used regularly to calm Client #1 down when he exhibited targeted behaviors of aggression and property destruction. DCS #1 and DCS #2 described implementation of the "relocation procedure" as physically moving Client #1 to the storage closet connected to the program room as needed, putting him in the room, prompting him to sit in the chair, closing the door and observing him through the window slit in the door. If he attempted to exit the room, he would be redirected verbally and with physical presence to remain in the room. The DCS staff explained Client #1 was kept in the room for 5 minutes and then released if he was calm. If he wasn ' t</p>			

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	<p>calm he was supposed to stay in the room.</p> <p>On 6/26/12 at 9:00 a.m., an observation was conducted of the storage closet/relocation area where the Time Out procedure was implemented for Client #1. The room was 7 feet in width and 11 feet in length. It contained a wheelchair, an open cabinet of clean and soiled clothing labeled with names, a metal file cabinet containing food, drinks and activity supplies, a particle board shelving unit containing adult briefs, a plastic bucket of markers, towels and a large quantity of plastic bags. A changing table pushed against a wall was piled with a large ball, many VHS movies, positioning mats, a trash can lid and seasonal decorations. Strewn about the floor was a pillow, a plastic crate with broken sharp edges filled with wooden musical toys and various seasonal decorations. One desk chair was positioned next to the door. The fabric upholstery across the seat and back of the chair was very soiled and stained with unidentified fluid spills. A wooden rod stuck upwards through the opening between the seat and the back support into the sitting space of the chair. The walls and floor of the room contained various spills and smears of what appeared to be food and fluid stains in indeterminate type. A plastic bag filled with empty soft drinks cans hung from the interior door knob. The wall surface was punched through in an approximately 3 and ½ inch diameter circle matching the spot on the wall where the interior door knob came into contact with the wall when opened. All interior space of the</p>			

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	<p>room was not visible from the window slit in the door way from outside the room, as is required for Time Out rooms. The door latch did not require constant staff pressure to keep the door closed, as is required for Time Out rooms.</p> <p>On 6/26/12 at 9:30 a.m., an interview was conducted with the Day Program Case Coordinator. She was asked for documentation of the use of the Time Out room for Client #1 between the months of 8/11 and 6/12. During this time frame Client #1 was placed in Time Out 35 times for periods of time from 3 minutes to 15 minutes.</p> <p>On 6/26/12 a record review was completed for Client #2. The physician's order, dated 3/12/12, prescribed Risperidone and Divalproex Sodium for behavior management. No evidence of written informed consent was present in the record.</p> <p>On 6/26/12 at 3:30 p.m. an interview was initiated with the Qualified Mental Retardation Professional (QMRP). She verified the absence of consent for the use of medications to manage behavior for Client #2.</p> <p>On 6/26/12 a record review was completed of the Minutes of Human Rights Committee for the period of time from July 2011 through June 2012. No evidence existed that the committee assured written informed consent was present prior to approval of the use of Risperidone and Divalproex Sodium for Client #2.</p>			

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	<p>On 6-26-12 at 1:00 p.m. a record review for client #3 was conducted. The physician's order dated 3-12 indicated client #3 was prescribed Buspar, Hydroxyzine, Trihexyphenidyl, Mirtazapine, and Clozaril for behavior management. The Human Rights Committee had reviewed the use of these medications on 6-19-12 but no guardian approvals were available for review.</p> <p>On 6-26-12 at 2:55 p.m. an interview with the Qualified Mental Retardation Professional indicated she did not have written guardian approvals for the use of client #3's medications for behavior management.</p> <p>9-3-4(a)</p>			

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W0440	<p>483.470(i)(1) EVACUATION DRILLS The facility must hold evacuation drills at least quarterly for each shift of personnel.</p> <p>Based on record review and interview the facility failed to ensure completion of an evacuation drill for 1 of 4 quarters (quarter 2, April, May, and June) of the year 2012 for the 11 p.m. to 7 a.m. shift of staff for 4 of 4 sampled clients (#1, #2, #3, and #4), and for 4 additional clients (clients #5, #6, #7, and #8).</p> <p>Findings include:</p> <p>On 6/25/12 at 10:05 a.m. a review was initiated of the evacuation drills documented by the facility for the time period of 7/1/11 through 6/25/12. The drills were documented as being conducted for all quarters of the previous 12 month period. The length of time for completion of each drill was recorded as exactly 2 minutes without exception. No problems during evacuation were documented in any of the drills.</p> <p>On 6/25/12 at 5:45 p.m. an interview was initiated with Direct Care Staff (DCS) #4. She reported she worked on the 3 p.m. to 11 p.m. shift and had been employed by the agency for 6 years. She said during that time she had conducted numerous evacuation drills. She identified 3 people</p>	W0440	<p>The facility ensures the evacuation drills are conducted at least quarterly for each shift of personnel. The Area Director will complete an investigation to determine if it is possible to discover who completed the falsified fire drill in question. The Home Manager, or Program Director will train all staff, upon hire, during their initial shadowing phase of employment on conducting an evacuation drill. The Home Manager or Program Director will train and observe to ensure that any staff is trained and prepared to conduct a full scale evacuation drill. The Home Manager or Program Director will document this on the employees Shadowing Packet and will be kept in the employees personnel file. The facility provides a written schedule to each supervisor to assist in assuring that evacuation drills are held each quarter for each shift of personnel. (attached). The Area Director will verify, per the facility schedule that an evacuation drill is conducted per the policy and schedule. The Area Director will verify the information contained in each drill, and will implement of plan of correction, if needed. The Program Director will review each fire drill for accuracy. The Program Director will submit each</p>	07/29/2012			

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	<p>living in the home with mobility issues requiring extra assistance and time to walk safely from the home to the designated meeting place. She said since there were always 2 staff on duty it was possible to provide them with enhanced supports needed to exit the home safely within 2 minutes.</p> <p>On 6/26/12 at 4:00 p.m. an interview was conducted with the Qualified Mental Retardation Professional (QMRP). The unusualness of each drill lasting exactly 2 minutes for the past 12 months was discussed. The QMRP offered no explanation but verified the staffing ratio of the 3 p.m. to 11 p.m. shift was 2, sometimes 3 staff and the staffing ratio on the 11 p.m. to 7 a.m. shift was 1. Asked if it was reasonable that 1 staff could evacuate all clients present, considering the mobility issues of 3 clients and the arousal from sleep that would be required on the 11 p.m. to 7 a.m. shift, the QMRP made no direct response.</p> <p>On 6/27/12 at 12:22 a.m. an interview was conducted with DCS #3. He reported that he worked the 11:00 p.m. to 7:00 a.m. shift and had been employed by the agency for 4 months. He said he had never conducted a fire drill since beginning employment at the home in February 2012 and did not know how</p>		<p>fire drill to the Area Director, monthly, for verification of accuracy. The Area Director will review the evacuation drill and verify accuracy of the staff running the drill, the signature of the staff running the drill, as well as the outcomes of the drill. The Area Director will sign each fire drill and will maintain a copy of each drill in an office file, as well as a file in the home. Responsible Parties: Area Director, Program Director, Home Manager Completion Date: 7/29/12</p>		

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	<p>long it would take to evacuate everyone. He said his supervisor had once talked to him about fire drills and advised him that he would be trained on conducting fire drills and paired up with a more experienced employee to conduct his first drill. Until that training occurred, he was advised in the event of an actual fire, he was responsible for doing "whatever it takes" to evacuate everyone from the residence. He said that training had not yet occurred. He was shown a copy of a "Fire Drill Report" dated 6/8/12, documenting that he completed a fire drill at 2:15 a.m. that lasted 2 minutes, ending at 2:17 a.m. He checked his schedule and verified was on duty on 6/7/12 at 11:00 p.m. and worked alone through the night until 6/8/12 at 7:00 a.m. He said he did not complete a drill on that date. He pointed out the signature on the "Signature/Title of Person Completing Drill" field of the "Fire Drill Report" was not his signature, and although his name was signed on this line, his last name was spelled incorrectly. He had no explanation why this "Fire Drill Report" falsely documented he had completed the fire drill when he in fact had not.</p> <p>On 6/27/12 at 12:55 p.m. an interview was initiated with the Home Manager and the Regional Director. The Home Manager had no explanation for the</p>			

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	<p>evacuation drill recording DCS #3 completed a drill on 6/8/12 at 2:15 a.m. in light of his report he completed no such drill. She verified that her signature was on the document as the reviewing authority. She said she found the record of that drill placed in her mail slot at the residence. She said she was unable to recognize the handwriting on the evacuation drill. She verified she was the responsible person for assuring all drills were completed at the residence. She offered no speculation as to who would have falsified this evacuation drill report.</p> <p>The Regional Director reported having initiated interviews with staff to determine who falsified the evacuation drill report. In the absence of anyone admitting to having done so, it remained unknown who falsified the record. The Regional Director said she would continue to investigate the falsification of records. She added when she was first advised the surveyors were concerned about the discovery of all drills for the previous 12 months lasting exactly 2 minutes without exception, she had determined to return to a previously used evacuation drill monitoring system which included signing off on all fire drills herself and re-instituting unannounced upper management monitoring of evacuation drills.</p>						

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W0442	<p>483.470(i)(1)(i) EVACUATION DRILLS</p> <p>The facility must hold evacuation drills to ensure that all personnel on all shifts are trained to perform assigned tasks.</p> <p>Based on record review and interview the facility failed to ensure facility staff held an evacuation drill for 1 of 4 quarters (quarter 2, April, May, and June) of the year 2012 for the 11 p.m. to 7 a.m. shift staff for 8 of 8 clients who lived in the home (clients #1, #2, #3, #4, #5, #6, #7 and #8).</p> <p>Findings include:</p> <p>On 6/25/12 at 10:05 a.m. a review was initiated of the evacuation drills documented by the facility for the time period of 7/1/11 through 6/25/12. The drills were documented as being conducted for all quarters of the previous 12 month period. The length of time for completion of each drill was recorded as exactly 2 minutes without exception. No problems during evacuation were documented in any of the drills.</p> <p>On 6/27/12 at 12:22 a.m. an interview was conducted Direct Care Staff (DCS) #3. He reported that he worked the 11:00 p.m. to 7:00 a.m. shift and had been employed by the agency for 4 months. He said he had never conducted a fire drill since beginning employment at the home in February 2012 and did not know how long it would take to evacuate everyone. He said his supervisor had once talked to him about fire drills and advised him that he would be trained on</p>	W0442	<p>The facility holds evacuation drills to ensure that all personnel on all shifts are trained to perform assigned tasks. The Home Manager, or Program Director will train all staff, upon hire, during their initial shadowing phase of employment on conducting an evacuation drill. The Home Manager or Program Director will train and observe to ensure that any staff is trained and prepared to conduct a full scale evacuation drill. The Home Manager or Program Director will document this on the employees Shadowing Packet and will be kept in the employees personnel file. The facility provides a written schedule to each supervisor to assist in assuring that evacuation drills are held each quarter for each shift of personnel. (attached). The Area Director will verify, per the facility schedule that an evacuation drill is conducted per the policy and schedule. The Area Director will verify the information contained in each drill, and will implement of plan of correction, if needed. The Program Director will review each fire drill for accuracy. The Program Director will submit each fire drill to the Area Director, monthly, for verification of accuracy. The Area Director will</p>	07/29/2012			

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	<p>conducting fire drills and paired up with a more experienced employee to conduct his first drill. Until that training occurred, he was advised in the event of an actual fire, he was responsible for doing "whatever it takes" to evacuate everyone from the residence. He said that training had not yet occurred. He was shown a copy of a "Fire Drill Report" dated 6/8/12 documenting that he completed a fire drill at 2:15 a.m. that lasted 2 minutes, ending at 2:17 a.m. He checked his schedule and verified he was on duty on 6/7/12 at 11:00 p.m. and worked alone through the night until 6/8/12 at 7:00 a.m. He said he did not complete a drill on that date. He pointed out the signature on the "Signature/Title of Person Completing Drill" field of the "Fire Drill Report" was not his signature; and although his name was signed on this line, his last name was spelled incorrectly. He had no explanation why this "Fire Drill Report" falsely documented he had completed the fire drill when he in fact had not.</p> <p>On 6-27-12 at 12:45 p.m. an interview with the House Manager indicated direct care staff #3 did work the 11 p.m. to 7 a.m. shift by himself and he had not run an evacuation by himself to ensure he was properly trained and could evacuate all clients appropriately. The House Manager indicated she had run a drill with direct care staff #3 during his orientation period but had not asked him if he had run a drill independently with success.</p> <p>9-3-7(a)</p>		<p>review the evacuation drill and verify accuracy of the staff running the drill, the signature of the staff running the drill, as well as the outcomes of the drill. The Area Director will sign each fire drill and will maintain a copy of each drill in an office file, as well as a file in the home. Responsible Parties: Area Director, Program Director, Home Manager Completion Date: 7/29/12</p>				

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