

| | | | | | |
|---|--|---|---|----------------------|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G401 | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | | X3) DATE SURVEY COMPLETED 02/09/2012 |
| NAME OF PROVIDER OR SUPPLIER TRANSITIONAL SERVICES SUB LLC | | | STREET ADDRESS, CITY, STATE, ZIP CODE 1603 S LYNHURST DR INDIANAPOLIS, IN 46241 | | |
| (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 | |
| W0000 | <p>This visit was for the annual recertification and state licensure survey.</p> <p>Survey dates: February 6, 7, 8, and 9, 2012.</p> <p>Facility number: 000915 Provider number: 15G401 AIMS number: 100244390</p> <p>Surveyor: Brenda Nunan, RN, CDDN, Public Health Nurse Surveyor III</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 2/21/12 by Ruth Shackelford, 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.

| | | | | | | | |
|---|--|---|--|---|--|---|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G401 | | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | | X3) DATE SURVEY COMPLETED 02/09/2012 | |
| NAME OF PROVIDER OR SUPPLIER TRANSITIONAL SERVICES SUB LLC | | | | STREET ADDRESS, CITY, STATE, ZIP CODE 1603 S LYNHURST DR INDIANAPOLIS, IN 46241 | | | |
| (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 | | | |
| W0104 | <p>The governing body must exercise general policy, budget, and operating direction over the facility.</p> <p>Based on observation and interview, the governing body failed to exercise operating direction over the facility to ensure a bedroom was free from environmental hazards for 1 of 4 sampled clients and 1 additional client (clients #1 and #5).</p> <p>Findings include:</p> <p>During observations on 02/06/2012 at 5:55 p.m., a full length mirror was propped against the wall by the entry door into client #1's and client #5's bedroom. The mirror had multiple 1/4 inch nails poking out from its frame.</p> <p>During an interview on 02/06/2012 at 5:55 p.m., the House Manager indicated she was not aware the mirror had been removed from the wall.</p> <p>During an interview on 02/08/2012 at 2 p.m., the House Manager indicated the mirror had been removed from client #1's and client #5's bedroom wall when maintenance resurfaced the walls recently. She was unable to provide a date in which the repair was completed, but indicated the mirror had been off the wall for more than a few days.</p> | W0104 | <p>Home Manager has removed and disposed of the full length mirror in the home.</p> <p>Area Director will retrain Home Manager on proper escalation of reported maintenance issues to ensure that all maintenance issues are addressed in a timely manner.</p> <p>Office Manager will retrain maintenance staff to ensure that repair projects are left in a safe manner.</p> <p>PD will inspect home for hazardous conditions during routine bi-weekly visit for the next 3 months.</p> <p>Responsible party: Program Director, Home Managers, Area Director, Office Manager</p> <p>Completion date: 03/13/12</p> | 03/13/2012 | | | |

| | | | |
|---|--|--|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G401 | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | X3) DATE SURVEY COMPLETED 02/09/2012 |
|---|--|--|--|

| | |
|---|---|
| NAME OF PROVIDER OR SUPPLIER TRANSITIONAL SERVICES SUB LLC | STREET ADDRESS, CITY, STATE, ZIP CODE 1603 S LYNHURST DR INDIANAPOLIS, IN 46241 |
|---|---|

| (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 |
|--------------------------|--|---------------------|--|----------------------------|
|--------------------------|--|---------------------|--|----------------------------|

| | | | | |
|--|----------|--|--|--|
| | 9-3-1(a) | | | |
|--|----------|--|--|--|

| | | | |
|--|---|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G401 | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | X3) DATE SURVEY COMPLETED 02/09/2012 |
|--|---|--|---|

| | |
|---|---|
| NAME OF PROVIDER OR SUPPLIER TRANSITIONAL SERVICES SUB LLC | STREET ADDRESS, CITY, STATE, ZIP CODE 1603 S LYNHURST DR INDIANAPOLIS, IN 46241 |
|---|---|

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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 |
|--------------------|---|---------------|--|----------------------|
| W0227 | <p>The individual program plan states the specific objectives necessary to meet the client's needs, as identified by the comprehensive assessment required by paragraph (c)(3) of this section.</p> <p>Based on record review and interview, the facility failed to initiate training objectives when recommended for 1 of 4 sampled clients (client #1).</p> <p>Findings include:</p> <p>Client #1's record was reviewed on 02/07/2012 at 11:32 a.m.</p> <p>An ISP (Individual Support Plan), dated 11/05/2011, indicated client #1 had goals for awareness of medication times, increasing dining skills, clipping his fingernails, increasing money management skills and sweeping the dining room floor. The ISP did not include a goal for toothbrushing or flossing.</p> <p>A "Dental Examination Report," dated 01/11/2012, indicated, "...increase brushing and flossing. Floss holders would be helpful..." The client's record did not include documentation to indicate skills training had been implemented for this recommendation.</p> <p>During an interview on 02/08/2012 at 2:00 p.m., the House Manager and</p> | W0227 | <p>Area Director will retrain PD on implementing training with addendums to ISP to follow medical recommendations.</p> <p>Program Director will implement goal in conjunction with IDT for increased tooth brushing and flossing for client #1.</p> <p>Home Manager/Program Director will train staff on implemented dental hygiene goal for client #1.</p> <p>The Facility Nurse is responsible for completing a monthly Health Care Coordination to include medical recommendations made for that month. The Program Director will be retrained on reviewing the Monthly Health Care Coordination and ensuring all medical recommendations have been addressed programmatically.</p> | 03/13/2012 |

| | | | |
|--|---|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G401 | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | X3) DATE SURVEY COMPLETED 02/09/2012 |
|--|---|--|---|

| | |
|---|---|
| NAME OF PROVIDER OR SUPPLIER TRANSITIONAL SERVICES SUB LLC | STREET ADDRESS, CITY, STATE, ZIP CODE 1603 S LYNHURST DR INDIANAPOLIS, IN 46241 |
|---|---|

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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 |
|--------------------|---|---------------|--|----------------------|
| | <p>Program Director indicated skills training had not been implemented for brushing and flossing client #1's teeth.</p> <p>9-3-4(a)</p> | | <p>The Area Director will complete random audit once monthly for 3 months of Health Care Coordination and programs to ensure PD is addressing</p> <p>Responsible Party: Area Director, Facility Nurse, Program Director</p> <p>Completion Date: 03/13/12</p> | |

| | | | | | | | |
|---|---|---|--|---|---|---|----------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G401 | | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | | X3) DATE SURVEY COMPLETED 02/09/2012 | |
| NAME OF PROVIDER OR SUPPLIER TRANSITIONAL SERVICES SUB LLC | | | | STREET ADDRESS, CITY, STATE, ZIP CODE 1603 S LYNHURST DR INDIANAPOLIS, IN 46241 | | | |
| (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 |
| W0248 | <p>A copy of each client's individual plan must be made available to all relevant staff, including staff of other agencies who work with the client, and to the client, parents (if the client is a minor) or legal guardian.</p> <p>Based on interview and record review, the facility failed to ensure the day service provider received a current Individual Support Plan (ISP) for 1 of 4 sampled clients (client #3).</p> <p>Findings include:</p> <p>Client #3's record was reviewed on 02/07/2012 at 11:50 a.m. Review of the client's record indicated an ISP dated 10/17/2011.</p> <p>The Day Service record was reviewed on 02/09/2012 at 12:15 p.m. An ISP was not included in the record.</p> <p>During an interview on 02/09/2012 at 12:15 p.m., Day Service Team Lead #1 indicated the facility had not provided client #3's current ISP. She indicated client #3's day service goal expired 01/31/2012.</p> <p>During an interview on 02/09/2012 at 1:30 p.m., the House Manager indicated a copy of the current ISP had been left on her desk for facility staff to deliver to the day service provider. She indicated the copy was no longer on her desk and</p> | | | W0248 | <p>Area Director will retrain PD on which documents need to be sent to Day Service representatives. Program Director will email client #3 ISP. All documents required to be sent to Day Services representatives will be sent electronically with the Area Director included in the e-mail. The Area Director will review the Annual Update report monthly and compare email notices to ensure all documents required by Day Services representatives are current. Responsible Party: Area Director, Program Director Completion Date: 03/13/12</p> | | 03/13/2012 |

| | | | |
|--|---|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G401 | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | X3) DATE SURVEY COMPLETED 02/09/2012 |
|--|---|--|---|

| | |
|---|---|
| NAME OF PROVIDER OR SUPPLIER TRANSITIONAL SERVICES SUB LLC | STREET ADDRESS, CITY, STATE, ZIP CODE 1603 S LYNHURST DR INDIANAPOLIS, IN 46241 |
|---|---|

| (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 |
|--------------------|--|---------------|---|----------------------|
|--------------------|--|---------------|---|----------------------|

| | | | | |
|--|--|--|--|--|
| | <p>stated, "I assumed staff had given it to day services."</p> <p>9-3-4(a)</p> | | | |
|--|--|--|--|--|

| | | | | | | | |
|---|--|---|---|---|--|---|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G401 | | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | | X3) DATE SURVEY COMPLETED 02/09/2012 | |
| NAME OF PROVIDER OR SUPPLIER TRANSITIONAL SERVICES SUB LLC | | | | STREET ADDRESS, CITY, STATE, ZIP CODE 1603 S LYNHURST DR INDIANAPOLIS, IN 46241 | | | |
| (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 | | | |
| W0423 | <p>The facility must provide suitable storage space, accessible to clients, for personal possessions, such as TVs, radios, prosthetic equipment and clothing.</p> <p>Based on observation and interview, the facility failed to ensure suitable storage space for clothing for 1 of 4 sampled clients (client #2).</p> <p>Findings include:</p> <p>During observations on 02/06/2012 at 5:55 p.m., client #1's clothes were bulging out of his chest of drawers. The client's pants were stored in stacks on 2 open shelves above the chest of drawers. One shirt was mixed with the stacks of pants.</p> <p>During an interview on 02/06/2012 at 5:55 p.m., the House Manager indicated client #2 had more clothes than his chest of drawers could hold. She indicated client #2 did not use the closet in his bedroom because it was shared with his roommate. She indicated client #2 was not able to distinguish his clothes from his roommate's due to blindness. She indicated his pants are usually the only items stored on the shelves so client #2 can easily grab a pair.</p> <p>9-3-7(a)</p> | W0423 | <p>Area Director will retrain HM/DPD on ensuring Interdisciplinary Team approval when personal items such as clothing will be stored in a manner different from typical storage methods.</p> <p>HM will purchase a new dresser for the clothing of client #2. The HM will introduce client #2 to the change in method for storing his clothing.</p> <p>PD will visit home to ensure that new dresser is in place and client #2's clothing is stored in a typical manner by 3/13/12.</p> <p>Area Director will send email to all supervising PDs to verify each client has appropriate furnishings and storage for personal items.</p> <p>Responsible Party: Area Director, Program Director, Home Manager</p> | 03/13/2012 | | | |

| | | | |
|---|--|--|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G401 | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | X3) DATE SURVEY COMPLETED 02/09/2012 |
|---|--|--|--|

| | |
|---|---|
| NAME OF PROVIDER OR SUPPLIER TRANSITIONAL SERVICES SUB LLC | STREET ADDRESS, CITY, STATE, ZIP CODE 1603 S LYNHURST DR INDIANAPOLIS, IN 46241 |
|---|---|

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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 |
|--------------------------|--|---------------------|--|----------------------------|
|--------------------------|--|---------------------|--|----------------------------|

| | | | | |
|--|--|--|---------------------------|--|
| | | | Completion Date: 03/13/12 | |
|--|--|--|---------------------------|--|

| | | | | | | | |
|---|--|---|--|---|---|---|----------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G401 | | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | | X3) DATE SURVEY COMPLETED 02/09/2012 | |
| NAME OF PROVIDER OR SUPPLIER TRANSITIONAL SERVICES SUB LLC | | | | STREET ADDRESS, CITY, STATE, ZIP CODE 1603 S LYNHURST DR INDIANAPOLIS, IN 46241 | | | |
| (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 |
| W9999 | <p>STATE FINDINGS:</p> <p>1. The following Community Residential Facilities for Persons with Developmental Disabilities Rule was not met:</p> <p>460 IAC 9-3-3 Facility Staffing</p> <p>Sec. 3(e) Prior to assuming residential job duties and annually thereafter, each residential staff person shall submit written evidence that a Mantoux (5TU, PPD) tuberculosis skin (TB) test or chest x-ray was completed. The result of the Mantoux shall be recorded in millimeter of induration with the date given, date read, and by whom administered. If the skin test result is significant (ten (10) millimeters or more), then a chest film shall be done with other physical and laboratory examinations as necessary to complete a diagnosis. Prophylactic treatment shall be provided as per diagnosis for the length of time prescribed by the physician.</p> <p>THIS STATE RULE WAS NOT MET AS EVIDENCED BY:</p> <p>Based on record review and interview, the facility failed to obtain yearly PPDs and/or a chest x-ray and/or annual</p> | | | W9999 | <p>The staff with the expired TB was suspended and was not return allowed to work until TB was updated.</p> <p>Staff will not pass medication until Core A & B exam has been taken and passed</p> <p>Area Director will retrain HM/PD on reviewing the monthly staff development record and ensuring any staff that does not have a current mantoux is suspended.</p> <p>The Area Director will review the monthly staff development record every 2 weeks and verify those staff without a current mantoux have been suspended.</p> <p>Responsible Party: Area Director, Program Director, Home Manager</p> <p>Completion Date: 3/13/12</p> | | 03/13/2012 |

| | | | |
|--|---|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G401 | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | X3) DATE SURVEY COMPLETED 02/09/2012 |
|--|---|--|---|

| | |
|---|---|
| NAME OF PROVIDER OR SUPPLIER TRANSITIONAL SERVICES SUB LLC | STREET ADDRESS, CITY, STATE, ZIP CODE 1603 S LYNHURST DR INDIANAPOLIS, IN 46241 |
|---|---|

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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 |
|--------------------|--|---------------|---|----------------------|
|--------------------|--|---------------|---|----------------------|

| | | | | |
|--|--|--|--|--|
| | <p>tuberculosis screening for 1 of 5 sampled staff (Direct Support Professional #1).</p> <p>Findings include:</p> <p>Employee records were reviewed on 02/07/2012 at 10:17 a.m. The record indicated DSP (Direct Support Professional) #1's chest x-ray on 05/26/2010 indicated she was free from active pulmonary disease. The record did not include documentation to indicate DSP #1 had an annual risk assessment or chest x-ray during the past year.</p> <p>During an interview on 02/07/2012 at 10:30 a.m., Administrative Staff #1 indicated she was not able to locate documentation to indicate the annual risk assessment or annual chest x-ray had been completed during the past year.</p> <p>2. The following Community Residential Facilities for Persons with Developmental Disabilities Rule was not met:</p> <p>460 IAC 9-3-6 Health Care Services</p> <p>Sec. 6 (b) All personnel who administer medication to residents or observe residents self-administering medication shall have received and successfully completed training using materials</p> | | | |
|--|--|--|--|--|

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G401 | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | | X3) DATE SURVEY COMPLETED 02/09/2012 |
|---|--|---|---|----------------------|---|
| NAME OF PROVIDER OR SUPPLIER TRANSITIONAL SERVICES SUB LLC | | | STREET ADDRESS, CITY, STATE, ZIP CODE 1603 S LYNHURST DR INDIANAPOLIS, IN 46241 | | |
| (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 | |
| | <p>approved by the council.</p> <p>THIS STATE RULE WAS NOT MET AS EVIDENCED BY:</p> <p>Based on record review and interview for 1 of 5 staff (DSP #1), the facility failed to ensure all personnel had completed core A/B training to administer medications.</p> <p>Findings include:</p> <p>Employee records were reviewed on 02/07/2012 at 10:17 a.m. The records did not include a certificate to indicate DSP #1 completed the medication administration training curriculum, "Living in the Community Core A and B Medication Administration" to administer medications to clients #1, #2, #3, #4, #5, #6, #7, and #8.</p> <p>During an interview on 02/07/2012 at 10:30 a.m., Administrative Staff #1 indicated she was not able to locate a certificate to indicate DSP #1 completed training for medication administration.</p> <p>9-3-6(b)</p> | | | | |