STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G618	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 06/25/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REM-INDIANA INC	10606 HAVERSTICK CARMEL, IN 46032

(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
W0000	This visit was for a fundamental recertification and state licensure survey. Dates of survey: June 18, 19, 20, 21, 22, and 25, 2012 Surveyor: Kathy Craig, Medical Surveyor III Facility Number: 001173 Provider Number: 15G618 AIMS Number: 100235540 These deficiencies also reflect state findings under 460 IAC 9. Quality Review completed 7/6/12 by Ruth Shackelford, Medical Surveyor III.	W0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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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W0120	483.410(d)(3) SERVICES PROVIDED WITH OUTSIDE SOURCES The facility must assure that outside services meet the needs of each client. Based on record review and interview, the facility failed for 1 of 4 sampled clients (client #1) by not ensuring the outside day program prevented client #1 from leaving the premises on 4 occasions and not providing sufficient corrective action to prevent it from happening three more times. Findings include: Review on 6/18/12 at 2:10 PM of the facility BDDS (Bureau of Developmental Disabilities Services) incident reports was conducted. The following BDDS reports occurred at the day program: 1. On 9/14/11 client #1 "was sitting in the rocking chair in the front room. [Client #1]'s staff person diverted his (staff's) attention, during which [client #1] ran out the back door. [Client #1] entered another office two doors down, poured himself a cup of coffee (6-8 ounces), and drank the coffee. [Client #1] was brought back to the day program and monitored for seizure activity." The Plan to Resolve indicated staff "will be retrained on [client #1's] risks of elopement and Polydipsia (excessive thirst). Director of Day	W0120	The new Program Director will be trained on completing Individualized Support Plan Meetings annual and more as needed. This training includes the need to these team meetings to occur when an incident occurs so that the entire team will be aware of all incidents and can work together to come to a solution. The Area Director will participate in the first 4 meetings to observe and ensure that the IST meetings occur and address all issues. Ongoing, the Program Director will complete IST meetings as required. Completion Date: 7-29-2012 Responsible Party: Program Director and Area Director	07/25/2012

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	Services discussed this issue with staff and reminded him not to get too relaxed in monitoring [client #1] although we have not seen many behavior issues to date. Director also discussed with staff the greater potential for [client #1] to elope in the future due to today's incident." 2. On 10/21/11 "Staff asked [client #1] to put his toothbrush and toothpaste away in his locker. [Client #1] ran out the back door and into the office suite next door where he stole and drank coffee and ate coffee grounds. Staff redirected [client #1] back to the day program suite." Under Plan to Resolve, it indicated "Staff was retrained not to request [client #1] to independently put away items in his locker and maintain line of sight." 3. On 2/3/12 client #1 "ran out the back door of the day program and into another suite next door. Staff ran behind him and met him in the other suite. Staff redirected [client #1] back to the [name of] suite. [Client #1] did not steal any food or drink during his elopement. . . ." Under Plan to Resolve it indicated "Continue to follow [client #1]'s behavior plan to deal with behaviors such as elopement and stealing. Keep [client #1] in line of sight at all times. Communicate all behaviors issues with team for			

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	support." 4. On 2/17/12 client #1 ran out the back door of the day program and into a neighboring suite at the office park. Staff ran after client #1 and brought him back to the day program. He did not steal anything to drink. Under Plan to Resolve it indicated "Continue to follow strategies in [client #1]'s behavior plan to prevent and deal with elopement." Review on 6/19/12 at 9:00 AM of client #1's records was conducted. Client #1's Behavior Development Program (BDP) dated 12/11/10, indicated he had target behaviors of runs/wanders away, excessive drinking, and food stealing. The BDP indicated an "One-On-One Staffing and Preventing AWOL (leaving area) which included: Prevent Inappropriate Exit. Monitor [client #1] closely whenever he appears upset. He often chooses to exit without notice when he is upset. Try to monitor [client #1] discreetly so you do not agitate him further. Accordingly, periodically make visual contact and make sure you know where he is at all times until he calms down. . . ." Client #1's revised BDP dated 1/20/12 didn't include the one-on-one staffing to prevent AWOL and had the same wording on how to prevent inappropriate exit as in the			

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	12/11/10. In client #1's records there was no evidence the IDT (Interdisciplinary Team) discussed client #1's AWOL with the day program after any of the incidents. Interview on 6/19/12 at 12:30 PM with day program (DP) staff #1 was conducted. He indicated staff are to monitor client #1 to make sure he doesn't leave facility and not to drink too much. DP staff #1 indicated a staff 's attention was elsewhere when the above incidents happened. DP staff #1 indicated client #1 hasn't had any incidents since he has been one-on-one. Interview on 6/22/12 at 4:30 PM with the AD (Area Director) was conducted. The AD indicated there was no information on the IDT meetings regarding the above-mentioned incidents. 9-3-1(a)			

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W0149	483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. Based on record review and interview, the facility failed to implement their abuse/neglect policy by not reporting to BDDS (Bureau of Developmental Disabilities Services) timely for 5 of 35 reportable incident reports reviewed. Findings include: Review on 6/18/12 at 2:10 PM of the BDDS reportable incident reports included the following late reports: 1. An incident on 6/24/11, reported 7/6/11, indicated "While on transport from day program, [client #3] became agitated. She bit [client #4] on the thigh and hit [former client #8] and [client #2] with an open hand. No one was injured seriously, [client #4] had a small bruise on her thigh from the bite mark. Staff intervened and helped [client #3] calm down, the transport continued with not (sic) further issues." Under the Plan to Resolve it indicated "Monitor [client #3]'s aggression, monitor for further incidents. . .Retrain staff on incident reporting. . .Consider corrective action for involved staff due to late reporting."	W0149	The new Program Director will be trained on Indiana MENTOR's policy and procedure for reporting all incident within 24 hours. Ongoing, the Home Manager or Program Director will complete random Active Treatment observations three times per week for the first four weeks, and then once a week on going to ensure that all incidents are reported in a timely manner. Completion Date: 7-25-2012 Responsible Party: Home Manager and Program Director	07/25/2012

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	2. An incident on 6/27/11, reported 7/6/11, indicated "During transport from the group home, [client #3] bit [client #6] on the back leaving a small red mark. She also hit [client #4], [client #5] and [former client #8]. No one was injured. [Client #3] had just gotten on the van, staff intervened and moved [client #3] to an area of the van where she was sitting away from her peers." Under Plan to Resolve it indicated "Investigate incident . . .monitor [client #3]'s behaviors for patterns of aggression/agitation. . .corrective action for staff for late reporting. . .retrain all staff on incident reporting/timelines." 3. An incident on 8/27/11, reported 8/29/11, indicated client #5 and former client #8 were "discovered together in the bathroom. They were both undressed, but they were not touching one another or physically interacting. Staff assisted [client #5] with dressing and supervised [former client #8] dressing and had [former client #8] go to another room. Staff kept them from being alone together in their bedroom the rest of the evening." Under Plan to Resolve it indicated "Incident will be investigated. . .Staff are suspended due to late reporting. . .staff will monitor [former client #8] and [client #5] frequently when alone in their bedroom together. . .Incidents of a similar			

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	nature will be monitored and additional safeguards put into place if necessary." 4. An incident on 9/23/11, reported 9/26/11, indicated client #2 "was agitated on the van ride, he was sitting in his preferred seat and no peers were sitting next to him. [Client #5] was in the seat in front of [client #2] with [staff #1]. [Client #2] began hitting, scratching at and biting at [client #5]. [Staff #1] intervened and [client #2] then began hitting and biting at her. [Client #5] was bitten on the middle of his back, which left only teeth marks and required no first aid. He also sustained a small (about 1/2 inch) scratch on his right forehead, near his hairline. When staff returned to the group home, she washed the scratch and treated it with antibiotic ointment." Under the Plan to Resolve it indicated "Investigate the incident . . .retrain staff on-call procedures. . .review van protocols with staff." 5. An incident on 10/21/11, reported 10/24/11, at day program indicated "Staff asked [client #1] to put his toothbrush and toothpaste away in his locker. [Client #1] ran out the back door and into the office suite next door where he stole and drank coffee and ate coffee grounds. Staff redirected [client #1] back to the day program suite. Program coordinator			

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	[former program director] immediately to inform her of the incident and notified [client #1]'s residential staff upon pickup." Under Plan to Resolve, it indicated "Staff was retrained not to request [client #1] to independently put away items in his locker and maintain line of sight." Review on 6/21/12 at 11:20 AM of the facility's abuse/neglect policy entitled "Quality and Risk Management" dated 4/11, indicated a reportable incident such as listed above was to be reported "within twenty-four (24) hours of: (a) the occurrence of the incident; or (b) the reporter becoming aware of or receiving information about an incident." Interview on 6/20/12 at 2:38 PM with the Area Director (AD) was conducted. The AD indicated the policy on when to report reportable incidents was within 24 hours of the incident. 9-3-2(a)			

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W0153	483.420(d)(2) STAFF TREATMENT OF CLIENTS The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures. Based on record review and interview, the facility failed to report to BDDS (Bureau of Developmental Disabilities Services) timely for 5 of 35 reportable incident reports reviewed, in accordance with State law. Findings include: Review on 6/18/12 at 2:10 PM of the BDDS reportable incident reports included the following late reports: 1. An incident on 6/24/11, reported 7/6/11, indicated "While on transport from day program, [client #3] became agitated. She bit [client #4] on the thigh and hit [former client #8] and [client #2] with an open hand. No one was injured seriously, [client #4] had a small bruise on her thigh from the bite mark. Staff intervened and helped [client #3] calm down, the transport continued with not (sic) further issues." Under the Plan to Resolve it indicated "Monitor [client #3]'s aggression, monitor for further incidents. . .Retrain staff on incident reporting. .	W0153	The new Program Director will be trained on Indiana MENTOR's policy and procedure for reporting all incidents within a 24 hour period. Ongoing, the Home Manager or Program Director will complete random Active Treatment observations three times per week for the first four weeks, and then once a week on going to ensure that all incidents are reported in a timely manner. Completion Date: 7-25-2012 Responsible Party: Home Manager and Program Director	07/25/2012

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	.Consider corrective action for involved staff due to late reporting." 2. An incident on 6/27/11, reported 7/6/11, indicated "During transport from the group home, [client #3] bit [client #6] on the back leaving a small red mark. She also hit [client #4], [client #5] and [former client #8]. No one was injured. [Client #3] had just gotten on the van, staff intervened and moved [client #3] to an area of the van where she was sitting away from her peers." Under Plan to Resolve it indicated "Investigate incident . . .monitor [client #3]'s behaviors for patterns of aggression/agitation. . .corrective action for staff for late reporting. . .retrain all staff on incident reporting/timelines." 3. An incident on 8/27/11, reported 8/29/11, indicated client #5 and former client #8 were "discovered together in the bathroom. They were both undressed, but they were not touching one another or physically interacting. Staff assisted [client #5] with dressing and supervised [former client #8] dressing and had [former client #8] go to another room. Staff kept them from being alone together in their bedroom the rest of the evening." Under Plan to Resolve it indicated "Incident will be investigated. . .Staff are suspended due to late reporting. . .staff			

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	will monitor [former client #8] and [client #5] frequently when alone in their bedroom together. . .Incidents of a similar nature will be monitored and additional safeguards put into place if necessary." 4. An incident on 9/23/11, reported 9/26/11, indicated client #2 "was agitated on the van ride, he was sitting in his preferred seat and no peers were sitting next to him. [Client #5] was in the seat in front of [client #2] with [staff #1]. [Client #2] began hitting, scratching at and biting at [client #5]. [Staff #1] intervened and [client #2] then began hitting and biting at her. [Client #5] was bitten on the middle of his back, which left only teeth marks and required no first aid. He also sustained a small (about 1/2 inch) scratch on his right forehead, near his hairline. When staff returned to the group home, she washed the scratch and treated it with antibiotic ointment." Under the Plan to Resolve it indicated "Investigate the incident . . .retrain staff on-call procedures. . .review van protocols with staff." 5. An incident on 10/21/11, reported 10/24/11, at day program indicated "Staff asked [client #1] to put his toothbrush and toothpaste away in his locker. [Client #1] ran out the back door and into the office suite next door where he stole and drank			

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	coffee and ate coffee grounds. Staff redirected [client #1] back to the day program suite. Program coordinator [former program director] immediately to inform her of the incident and notified [client #1]'s residential staff upon pickup." Under Plan to Resolve, it indicated "Staff was retrained not to request [client #1] to independently put away items in his locker and maintain line of sight." Interview on 6/20/12 at 2:38 PM with the Area Director (AD) was conducted. The AD indicated reportable incidents were to be reported within 24 hours of the incident. 9-3-2(a)			

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W0252	483.440(e)(1) PROGRAM DOCUMENTATION Data relative to accomplishment of the criteria specified in client individual program plan objectives must be documented in measurable terms. Based on record review and interview, the facility failed for 1 of 4 sampled clients (client #1) by not ensuring client #1's individual support plan objectives were being documented on a regular basis. Findings include: Review on 6/19/12 at 9:00 AM of client #1's records was conducted and included client #1's monthly reviews from 9/11 to 4/12 of his program plan objectives. There was no monthly review for May, 2012, in client #1's records at the time of this review. The following monthly reviews indicated on the objectives listed "There was no data collected for this objective this month," and "It is unknown why there was no data available for this month." 1. September, 2011: Wash hands before meds; indicate choice of drink; engage in physical activity for 15 minutes; will choose the quarter when presented with a variety of coins; will wash both his arms; twice daily will brush teeth and gums; will use the restroom every 2 hours; and dirty laundry placed in appropriate place.	W0252	All staff will be retrained on completing and properly documenting all goals. The Home Manager will complete two weekly observations to ensure that all staff are completing the objectives correctly with the clients. The Home Manager will be retrained on completing documentation reviews weekly. Along with the observations, the Home Manager will also complete weekly random documentation reviews to ensure that all staff are completing the documentation to record the completion of the objectives. The Program Director will review all documentation reviews and completed observations to ensure that they are being completed correctly by both the staff and the Home Manager. Ongoing, the Area Director will complete random quarterly audits to ensure that all documentation is being completed and correctly. Completion Date: 7-25-2012 Responsible Party: Home Manager , Program Director, and Area Director	07/25/2012

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	2. October, 2011: Twice daily will brush his teeth and gums. 3. January, 2012: Will choose the quarter when presented with a variety of coins; will wash both arms; and twice daily will brush his teeth and gums. 4. February, 2012: Will choose the quarter when presented with a variety of coins; will wash both arms, and twice daily will brush his teeth and gums. 5. March, 2012: Will choose the quarter when presented with a variety of coins. 6. April, 2012: Twice daily will brush his teeth and gums; will choose a quarter when presented with a variety of coins; and will wash both his arms. Interview on 6/20/12 at 2:38 PM with the AD (Area Director) was conducted. She indicated staff should always record the data when running a goal formally. 9-3-4(a)			

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(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
W0263	483.440(f)(3)(ii) PROGRAM MONITORING & CHANGE The committee should insure that these programs are conducted only with the written informed consent of the client, parents (if the client is a minor) or legal guardian. Based on record review and interview, the facility failed for 4 of 4 sampled clients (clients #1, #2, #3, and #4) by not obtaining the written informed consent of the guardian or healthcare representative before the HRC (Human Rights Committee) approved clients' restrictive programs. Findings include: Review on 6/19/12 at 9:00 AM of client #1's records was conducted. Client #1's ISP (Individual Support Plan) dated 8/15/11 indicated client #1 had a healthcare representative (HCR). Client #1's BDP (Behavior Development Program) dated 1/20/12 indicated he was on the following behavior medications: 4 mg (milligrams) Risperidone, 1500 mg divalproex, and .2 mg Clonidine. Client #1's BDP did not have HCR consent but the HRC approved it on 6/6/12. Review on 6/19/12 at 9:45 AM of client #2's records was conducted. Client #2's ISP dated 8/15/11 indicated he had a guardian. Client #2's BDP dated 1/28/12 indicated he was on the following	W0263	The new Program Director will be trained on the correct process for retrieving the appropriate approvals for the Behavior Support Plans. Ongoing, the new Program Director will correctly retrieve the approvals for all future Behavior Support Plans from the Guardian/Health Care Representative first, then once received, will get the appropriate approval from the Human Rights Committee, before implementing. Ongoing, the Area Director will complete random quarterly audits to ensure that all of the proper approvals are in place from the IDTs. Completion Date: 7-25-2012 Responsible Party: Home Manager , Program Director, and Area Director	07/25/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G618	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 06/25/2012

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	behavior medications: 20 mg (milligrams) Olanzapine, .2 mg Clonidine, and 2 mg Guanfacine ER. Client #2's BDP did not have guardian consent but the HRC approved it on 2/9/12. Review on 6/19/12 at 10:00 AM of client #3's records was conducted. Client #3's ISP dated 10/15/11 indicated she had a healthcare representative. Client #3's BDP dated 8/3/11 indicated she was on the following behavior medications: 10 mg (milligrams) Risperidone, 3 mg Haloperidol, 1500 mg valproic acid, 10 mg diazepam (PRN) as needed, and 0.125 mg of triazolam (PRN). Client #3's BDP did not have HCR consent but the HRC approved it on 10/12/11. Review on 6/19/12 at 10:25 AM of client #4's records was conducted. Client #4's ISP dated 11/12/11 indicated she had a healthcare representative. Client #4's BDP dated 12/9/11 indicated she was on the following behavior medications: 2 mg (milligrams) Risperidone, 1200 mg oxcarbazepine, 2 mg clonazepam, 30 mg propranolol, and .25 mg of triazolam (PRN). Client #4's BDP did not have HCR consent but the HRC approved it on 2/9/12. Interview on 6/20/12 at 3:05 PM with the			

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	AD (Area Director) was conducted. The AD indicated the healthcare representative or the guardian would need to give their consent and then it would be reviewed and approved by the Human Rights Committee. 9-3-4(a)			

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W0322	483.460(a)(3) PHYSICIAN SERVICES The facility must provide or obtain preventive and general medical care. Based on record review and interview, the facility failed for 1 of 4 sampled clients (client #3) by not ensuring she had a pap/pelvic exam. Findings include: Review on 6/19/12 at 10:00 AM of client #3's records was conducted. Her ISP (Individual Support Plan) dated 10/15/11 indicated she was 26 years of age. There was no pap/pelvic exam in her file. There was no doctor recommendation in her file to indicate whether she needed one or not or when her last one was. Her annual physical dated 12/21/11 did not indicate a recommendation for her to get a pap. Interview on 6/22/12 at 4:30 PM with the AD (Area Director) was conducted. The AD indicated she could not find out anything about whether client #3 has had a pap or not. 9-3-6(a)	W0322	Client #3 completed her annual PAP on 2-3-2012. See Attachment 1. Ongoing, the Director of Nursing will complete random quarterly audits to ensure that all proper medical care is followed up on and documented correctly. Completion Date: 7-29-2012 Responsible Party: Program Nurse and Director of Program Nursing	07/25/2012

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W0323	483.460(a)(3)(i) PHYSICIAN SERVICES The facility must provide or obtain annual physical examinations of each client that at a minimum includes an evaluation of vision and hearing. Based on record review and interview, the facility failed for 1 of 4 sampled clients (client #2) by not ensuring the physician screened his hearing at his annual physical. Findings include: Review on 6/19/12 at 9:45 AM of client #2's records was completed. Client #2's last hearing evaluation was on 4/5/05. Client #2's annual physical was on 7/20/11 and it did not indicate his hearing was screened. Interview on 6/20/12 at 2:38 PM with the AD (Area Director) was conducted. The AD indicated the client's physician would formally check the hearing and vision at the annual physical, and then if further evaluations are needed/recommended, they they would refer the client out as needed. 9-3-6(a)	W0323	The Director of Nursing will retrain the Program Nurse on the ensuring that all components of the physical exams are completed. Ongoing, the Director of Nursing will complete random quarterly audits to ensure that all proper medical care is followed up on and documented correctly. Completion Date: 7-29-2012 Responsible Party: Program Nurse and Director of Program Nursing	07/25/2012

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W0440	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 8 of 8 clients (clients #1, #2, #3, #4, #5, #6, #7, and #8) who resided in the group home from July, 2011 to June, 2012, by not conducting evacuation drills at least one per shift per quarter, or every 90 days, in the past year. Findings include: Review on 6/19/12 at 8:55 AM of the facility's evacuation drills was conducted for the period of 7/1/11 to 6/19/12. During first shift (6:00 AM to 2:00 PM), there were no drills run from 7/2/11 to 2/9/12. During third shift (10:00 PM to 6:00 AM), there were no drills run from July, 2011 to March 11, 2012. Interview on 6/20/12 at 3:05 PM with the AD (Area Director) was conducted. The AD indicated evacuation drills were to be conducted one per shift per quarter. 9-3-7(a)	W0440	All Direct Support Professionals will receive a retraining every other month to ensure that they understand the importance of completing the monthly fire drills. The retraining will include reviewing a copy of the Fire Drill Schedule. Ongoing, the Direct Support Professionals will complete one fire drill per month (or more as needed) according to the schedule to ensure that the health and safety of the client's needs are met. Ongoing, all completed fire drill reports will be turned in to and reviewed by Quality Assurance for accuracy and thoroughness of each drill. Completion Date: 7-25-2012 Responsible Party: Home Manager	07/25/2012

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