

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G074	(X2) MULTIPLE CONSTRUCTION A. BUILDING -- B. WING _____	(X3) DATE SURVEY COMPLETED 12/04/2023
NAME OF PROVIDER OR SUPPLIER EASTER SEALS ARC OF NORTHEAST		STREET ADDRESS, CITY, STATE, ZIP COD 2827 TILLMAN ROAD FORT WAYNE, IN 46816		
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E 0000 Bldg. --	<p>An Emergency Preparedness Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.475.</p> <p>Survey Date: 12/04/23</p> <p>Facility Number: 000618 Provider Number: 15G074 AIM Number: 100233730</p> <p>At this Emergency Preparedness Survey, Easter Seals Arc of Northeast Indiana was found not in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.475</p> <p>The facility has 8 certified beds. All 8 beds are certified for Medicaid. At the time of the survey, the census was 8.</p> <p>Quality Review completed on 12/05/23</p>	E 0000		
E 0004 Bldg. --	<p>403.748(a), 416.54(a), 418.113(a), 441.184(a), 482.15(a), 483.475(a), 483.73(a), 484.102(a), 485.625(a), 485.68(a), 485.727(a), 485.920(a), 486.360(a), 491.12(a), 494.62(a)</p> <p>Develop EP Plan, Review and Update Annually</p> <p>§403.748(a), §416.54(a), §418.113(a), §441.184(a), §460.84(a), §482.15(a), §483.73(a), §483.475(a), §484.102(a), §485.68(a), §485.625(a), §485.727(a), §485.920(a), §486.360(a), §491.12(a), §494.62(a).</p>			

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

TITLE

(X6) DATE

Katlyn Rife

Director of Group Homes

12/21/2023

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 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 disclosed 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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	<p>The [facility] must comply with all applicable Federal, State and local emergency preparedness requirements. The [facility] must develop establish and maintain a comprehensive emergency preparedness program that meets the requirements of this section. The emergency preparedness program must include, but not be limited to, the following elements:</p> <p>(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be [reviewed], and updated at least every 2 years. The plan must do all of the following:</p> <p>* [For hospitals at §482.15 and CAHs at §485.625(a):] Emergency Plan. The [hospital or CAH] must comply with all applicable Federal, State, and local emergency preparedness requirements. The [hospital or CAH] must develop and maintain a comprehensive emergency preparedness program that meets the requirements of this section, utilizing an all-hazards approach.</p> <p>* [For LTC Facilities at §483.73(a):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually.</p> <p>* [For ESRD Facilities at §494.62(a):] Emergency Plan. The ESRD facility must develop and maintain an emergency preparedness plan that must be [evaluated], and updated at least every 2 years.</p> <p>Based on record review and interview, the facility</p>	E 0004	E004	12/22/2023

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E 0006 Bldg. --	<p>failed to establish an Emergency Preparedness Plan (EPP) for the correct facility in accordance with 42 CFR 483.475(b). This deficient practice could affect all occupants.</p> <p>Findings include:</p> <p>Based on records review with the Maintenance Tech #2 on 12/04/23 at 11:20 a.m., the clients moved to this replacement home in August of 2023. The provided EPP had information from the previous home and not the current location.</p> <p>Based on an interview during records review, the Maintenance Tech #2 agreed the EPP in the home was for the old location.</p> <p>This was reviewed with the Maintenance Tech #2 during the exit conference.</p> <p>Plan Based on All Hazards Risk Assessment</p> <p>§403.748(a)(1)-(2), §416.54(a)(1)-(2), §418.113(a)(1)-(2), §441.184(a)(1)-(2), §482.15(a)(1)-(2), §483.475(a)(1)-(2), §483.73(a)(1)-(2), §484.102(a)(1)-(2), §485.625(a)(1)-(2), §485.68(a)(1)-(2), §485.727(a)(1)-(2), §485.920(a)(1)-(2), §486.360(a)(1)-(2), §491.12(a)(1)-(2), §494.62(a)(1)-(2)</p>		<p>The Emergency Preparedness Plan (EPP) for the updated location has been placed in the home. All house staff will be retrained on the changes made to the EPP based on the change in location as well as retrained on where the EPP is stored and can be accessed within the home.</p> <p>Persons Responsible: QIDP/Director of Group Homes Completion Date: 12/22/2023</p> <p>The QIDP of the home will complete an observation to confirm the EPP is in the home, in its designated place. The QIDP will ask the staff present to locate the EPP in order to demonstrate knowledge of where the EPP is stored and can be accessed.</p> <p>Persons Responsible: QIDP/Director of Group Homes Completion Date: 12/22/2023</p>	

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	<p>\$491.12(a)(1)-(2), \$494.62(a)(1)-(2)</p> <p>[(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following:]</p> <p>(1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach.*</p> <p>(2) Include strategies for addressing emergency events identified by the risk assessment.</p> <p>* [For Hospices at §418.113(a):] Emergency Plan. The Hospice must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following:</p> <p>(1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach.</p> <p>(2) Include strategies for addressing emergency events identified by the risk assessment, including the management of the consequences of power failures, natural disasters, and other emergencies that would affect the hospice's ability to provide care.</p> <p>*[For LTC facilities at §483.73(a):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. The plan must do the following:</p>			

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	<p>(1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing residents.</p> <p>(2) Include strategies for addressing emergency events identified by the risk assessment.</p> <p>*[For ICF/IIDs at §483.475(a):] Emergency Plan. The ICF/IID must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following:</p> <p>(1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing clients.</p> <p>(2) Include strategies for addressing emergency events identified by the risk assessment.</p> <p>Based on record review and interview, the facility failed to maintain an emergency preparedness plan (EPP) that was based on and includes a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing clients and included strategies for addressing emergency events identified by the risk assessment in accordance with 42 CFR 483.475(a) (1) and 42 CFR 483.475(a) (2). This deficient practice could affect all occupants.</p> <p>Findings include:</p> <p>Based on records review with the Maintenance Tech #2 on 12/04/23 at 11:20 a.m., the clients moved to this replacement home in August of 2023. The provided Hazardous Vulnerability Assessment (HVA) identified possible hazards from the previous home and not the current</p>	E 0006	<p>E006</p> <p>The Hazard Vulnerability Assessment (HVA) for the updated location has been placed in the home. All house staff will be retrained on the assessment based on the change in location as well as retrained on where the HVA is stored and can be accessed within the home.</p> <p>Persons Responsible: QIDP/Director of Group Homes Completion Date: 12/22/2023</p> <p>The QIDP of the home will complete an observation to confirm the HVA is in the home, in it's designated place. The QIDP will ask the staff present to locate</p>	12/22/2023

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E 0013 Bldg. --	<p>location. Based on an interview during records review, the Maintenance Tech #2 agreed the HVA in the home was for the old location.</p> <p>This was reviewed with the Maintenance Tech #2 during the exit conference.</p> <p>403.748(b), 416.54(b), 418.113(b), 441.184(b), 482.15(b), 483.475(b), 483.73(b), 484.102(b), 485.625(b), 485.68(b), 485.727(b), 485.920(b), 486.360(b), 491.12(b), 494.62(b)</p> <p>Development of EP Policies and Procedures §403.748(b), §416.54(b), §418.113(b), §441.184(b), §460.84(b), §482.15(b), §483.73(b), §483.475(b), §484.102(b), §485.68(b), §485.625(b), §485.727(b), §485.920(b), §486.360(b), §491.12(b), §494.62(b).</p> <p>(b) Policies and procedures. [Facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years.</p> <p>*[For LTC facilities at §483.73(b):] Policies and procedures. The LTC facility must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must</p>		<p>the HVA in order to demonstrate knowledge of where the HVA is stored and can be accessed.</p> <p>Persons Responsible: QIDP/Director of Group Homes Completion Date: 12/22/2023</p>	

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	<p>be reviewed and updated at least annually.</p> <p>*Additional Requirements for PACE and ESRD Facilities:</p> <p>*[For PACE at §460.84(b):] Policies and procedures. The PACE organization must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must address management of medical and nonmedical emergencies, including, but not limited to: Fire; equipment, power, or water failure; care-related emergencies; and natural disasters likely to threaten the health or safety of the participants, staff, or the public. The policies and procedures must be reviewed and updated at least every 2 years.</p> <p>*[For ESRD Facilities at §494.62(b):] Policies and procedures. The dialysis facility must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years. These emergencies include, but are not limited to, fire, equipment or power failures, care-related emergencies, water supply interruption, and natural disasters likely to occur in the facility's geographic area.</p> <p>Based on record review and interview, the facility</p>	E 0013	E013	12/22/2023

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E 0037 Bldg. --	<p>failed to establish Emergency Policies and Procedures for the correct facility in accordance with 42 CFR 483.475(b). This deficient practice could affect all occupants.</p> <p>Findings include:</p> <p>Based on records review with the Maintenance Tech #2 on 12/04/23 at 11:20 a.m., the clients moved to this replacement home in August of 2023. The provided Emergency Preparedness Plan had policies and procedures from the previous home and not the current location. Based on an interview during records review, the Maintenance Tech #2 agreed the Emergency Policies and Procedures in the home was for the old location.</p> <p>This was reviewed with the Maintenance Tech #2 during the exit conference.</p> <p>EP Training Program</p> <p>§403.748(d)(1), §416.54(d)(1), §418.113(d)(1), §441.184(d)(1), §482.15(d)(1), §483.475(d)(1), §483.73(d)(1), §484.102(d)(1), §485.625(d)(1), §485.68(d)(1), §485.727(d)(1), §485.920(d)(1), §486.360(d)(1), §491.12(d)(1), §491.12(d)(1).</p> <p>*[For RNCHIs at §403.748, ASCs at §416.54, Hospitals at §482.15, ICF/IIDs at §483.475,</p>			<p>The Emergency Preparedness Plan (EPP) for the updated location has been placed in the home. All house staff will be retrained on the changes made to the EPP based on the change in location as well as retrained on where the EPP is stored and can be accessed within the home.</p> <p>Persons Responsible: QIDP/Director of Group Homes Completion Date: 12/22/2023</p> <p>The QIDP of the home will complete an observation to conform the EPP is in the home, in its designated place. The QIDP will ask the staff present to locate the EPP in order to demonstrate knowledge of where the EPP is stored and can be accessed.</p> <p>Persons Responsible: QIDP/Director of Group Homes Completion Date: 12/22/2023</p>	

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	<p>HHAs at §484.102, "Organizations" under §485.727, OPOs at §486.360, RHC/FQHCs at §491.12:]</p> <p>(1) Training program. The [facility] must do all of the following:</p> <ul style="list-style-type: none"> (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of all emergency preparedness training. (iv) Demonstrate staff knowledge of emergency procedures. (v) If the emergency preparedness policies and procedures are significantly updated, the [facility] must conduct training on the updated policies and procedures. <p>*[For Hospices at §418.113(d):] (1) Training. The hospice must do all of the following:</p> <ul style="list-style-type: none"> (i) Initial training in emergency preparedness policies and procedures to all new and existing hospice employees, and individuals providing services under arrangement, consistent with their expected roles. (ii) Demonstrate staff knowledge of emergency procedures. (iii) Provide emergency preparedness training at least every 2 years. (iv) Periodically review and rehearse its emergency preparedness plan with hospice employees (including nonemployee staff), with special emphasis placed on carrying out the procedures necessary to protect patients and others. (v) Maintain documentation of all emergency preparedness training. 			

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	<p>(vi) If the emergency preparedness policies and procedures are significantly updated, the hospice must conduct training on the updated policies and procedures.</p> <p>*[For PRTFs at §441.184(d):] (1) Training program. The PRTF must do all of the following:</p> <ul style="list-style-type: none"> (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) After initial training, provide emergency preparedness training every 2 years. (iii) Demonstrate staff knowledge of emergency procedures. (iv) Maintain documentation of all emergency preparedness training. <p>(v) If the emergency preparedness policies and procedures are significantly updated, the PRTF must conduct training on the updated policies and procedures.</p> <p>*[For PACE at §460.84(d):] (1) The PACE organization must do all of the following:</p> <ul style="list-style-type: none"> (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing on-site services under arrangement, contractors, participants, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Demonstrate staff knowledge of emergency procedures, including informing participants of what to do, where to go, and whom to contact in case of an emergency. (iv) Maintain documentation of all training. 			

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	<p>(v) If the emergency preparedness policies and procedures are significantly updated, the PACE must conduct training on the updated policies and procedures.</p> <p>*[For LTC Facilities at §483.73(d):] (1) Training Program. The LTC facility must do all of the following:</p> <ul style="list-style-type: none"> (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected role. (ii) Provide emergency preparedness training at least annually. (iii) Maintain documentation of all emergency preparedness training. (iv) Demonstrate staff knowledge of emergency procedures. <p>*[For CORFs at §485.68(d):](1) Training. The CORF must do all of the following:</p> <ul style="list-style-type: none"> (i) Provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. All new personnel must be oriented and assigned specific responsibilities regarding the CORF's emergency plan within 2 weeks of their first workday. The training program must include instruction in the location and use of alarm systems and signals and firefighting equipment. <p>(v) If the emergency preparedness policies</p>			

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	<p>and procedures are significantly updated, the CORF must conduct training on the updated policies and procedures.</p> <p>*[For CAHs at §485.625(d):] (1) Training program. The CAH must do all of the following:</p> <ul style="list-style-type: none"> (i) Initial training in emergency preparedness policies and procedures, including prompt reporting and extinguishing of fires, protection, and where necessary, evacuation of patients, personnel, and guests, fire prevention, and cooperation with firefighting and disaster authorities, to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. (v) If the emergency preparedness policies and procedures are significantly updated, the CAH must conduct training on the updated policies and procedures. <p>*[For CMHCs at §485.920(d):] (1) Training. The CMHC must provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles, and maintain documentation of the training. The CMHC must demonstrate staff knowledge of emergency procedures. Thereafter, the CMHC must provide emergency preparedness training at least every 2 years.</p> <p>Based on record review and interview, the facility</p>		E 0037	E037
				12/22/2023

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NAME OF PROVIDER OR SUPPLIER EASTER SEALS ARC OF NORTHEAST		STREET ADDRESS, CITY, STATE, ZIP COD 2827 TILLMAN ROAD FORT WAYNE, IN 46816		
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E 0039 Bldg. --	<p>failed to ensure staff were trained in emergency preparedness policies and procedures. The ICF/IID facility must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles; (ii) Provide emergency preparedness training at least every two years; (iii) Maintain documentation of all emergency preparedness training; (iv) Demonstrate staff knowledge of emergency procedures; (v) If the emergency preparedness policies and procedures are significantly updated, the facility must conduct training on the updated policies and procedures in accordance with 42 CFR 483.475(d)(1). This deficient practice could affect all occupants.</p> <p>Findings include:</p> <p>Based on records review with the Maintenance Tech #2 on 12/04/23 at 11:30 a.m., there was no documentation available for review to indicate all facility staff were trained and demonstrate knowledge of the Emergency Preparedness Program (EPP) initially for new staff and every two years for existing staff. Based on an interview at the time of records review, the Maintenance Tech #2 stated documentation for all staff EPP training could not be found during the survey.</p> <p>This was reviewed with the Maintenance Tech #2 during the exit conference.</p> <p>403.748(d)(2), 416.54(d)(2), 418.113(d)(2), 441.184(d)(2), 482.15(d)(2), 483.475(d)(2), 483.73(d)(2), 484.102(d)(2), 485.625(d)(2), 485.68(d)(2), 485.727(d)(2), 485.920(d)(2), 486.360(d)(2), 491.12(d)(2), 494.62(d)(2) EP Testing Requirements</p>		<p>All house staff will be retrained in the Emergency Preparedness Plan (EPP). All house staff will complete an 11 question Emergency Preparedness competency test. Ongoing, the Emergency Preparedness competency test will be completed by all house staff annually.</p> <p>Persons Responsible: QIDP/Director of Group Homes Completion Date: 12/22/2023</p> <p>The QIDP of the home will review the results of all staff's 11 question Emergency Preparedness competency test to ensure staff are answering the questions correctly with a minimum of an 80% success rate.</p> <p>Persons Responsible: QIDP/Director of Group Homes Completion Date: 12/22/2023</p>	

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	<p>§416.54(d)(2), §418.113(d)(2), §441.184(d)(2), §460.84(d)(2), §482.15(d)(2), §483.73(d)(2), §483.475(d)(2), §484.102(d)(2), §485.68(d)(2), §485.625(d)(2), §485.727(d)(2), §485.920(d) (2), §491.12(d)(2), §494.62(d)(2).</p> <p>*[For ASCs at §416.54, CORFs at §485.68, OPO, "Organizations" under §485.727, CMHCs at §485.920, RHCs/FQHCs at §491.12, and ESRD Facilities at §494.62]:</p> <p>(2) Testing. The [facility] must conduct exercises to test the emergency plan annually. The [facility] must do all of the following:</p> <ul style="list-style-type: none"> (i) Participate in a full-scale exercise that is community-based every 2 years; or (A) When a community-based exercise is not accessible, conduct a facility-based functional exercise every 2 years; or (B) If the [facility] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required community-based or individual, facility-based functional exercise following the onset of the actual event. (ii) Conduct an additional exercise at least every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2) (i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, 			(X5) COMPLETION DATE

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	<p>clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.</p> <p>(iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [facility's] emergency plan, as needed.</p> <p>*[For Hospices at 418.113(d):]</p> <p>(2) Testing for hospices that provide care in the patient's home. The hospice must conduct exercises to test the emergency plan at least annually. The hospice must do the following:</p> <p>(i) Participate in a full-scale exercise that is community based every 2 years; or</p> <p>(A) When a community based exercise is not accessible, conduct an individual facility based functional exercise every 2 years; or</p> <p>(B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospital is exempt from engaging in its next required full scale community-based exercise or individual facility-based functional exercise following the onset of the emergency event.</p> <p>(ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following:</p> <p>(A) A second full-scale exercise that is community-based or a facility based functional exercise; or</p> <p>(B) A mock disaster drill; or</p> <p>(C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a</p>			

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	<p>set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.</p> <p>(3) Testing for hospices that provide inpatient care directly. The hospice must conduct exercises to test the emergency plan twice per year. The hospice must do the following:</p> <ul style="list-style-type: none"> (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual facility-based functional exercise; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospice is exempt from engaging in its next required full-scale community based or facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: <ul style="list-style-type: none"> (A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop led by a facilitator that includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the hospice's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the hospice's emergency plan, as needed. 			

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	<p>*[For PRFTs at §441.184(d), Hospitals at §482.15(d), CAHs at §485.625(d):]</p> <p>(2) Testing. The [PRTF, Hospital, CAH] must conduct exercises to test the emergency plan twice per year. The [PRTF, Hospital, CAH] must do the following:</p> <ul style="list-style-type: none"> (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or (B) If the [PRTF, Hospital, CAH] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event. <p style="margin-left: 20px;">(ii) Conduct an [additional] annual exercise or and that may include, but is not limited to the following:</p> <ul style="list-style-type: none"> (A) A second full-scale exercise that is community-based or individual, a facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. <p style="margin-left: 20px;">(iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the [facility's] emergency plan, as needed.</p> <p>*[For PACE at §460.84(d):]</p> <p>(2) Testing. The PACE organization must</p>			(X5) COMPLETION DATE

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	<p>conduct exercises to test the emergency plan at least annually. The PACE organization must do the following:</p> <ul style="list-style-type: none"> (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or (B) If the PACE experiences an actual natural or man-made emergency that requires activation of the emergency plan, the PACE is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event. <ul style="list-style-type: none"> (ii) Conduct an additional exercise every 2 years opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. <ul style="list-style-type: none"> (iii) Analyze the PACE's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the PACE's emergency plan, as needed. <p>*[For LTC Facilities at §483.73(d):]</p> <p>(2) The [LTC facility] must conduct exercises to test the emergency plan at least twice per year, including unannounced staff drills using</p>			

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	<p>the emergency procedures. The [LTC facility, ICF/IID] must do the following:</p> <ul style="list-style-type: none"> (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise. (B) If the [LTC facility] facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the LTC facility is exempt from engaging its next required a full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: <ul style="list-style-type: none"> (A) A second full-scale exercise that is community-based or an individual, facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [LTC facility] facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [LTC facility] facility's emergency plan, as needed. <p>*[For ICF/IIDs at §483.475(d)]:</p> <ul style="list-style-type: none"> (2) Testing. The ICF/IID must conduct exercises to test the emergency plan at least twice per year. The ICF/IID must do the following: <ul style="list-style-type: none"> (i) Participate in an annual full-scale exercise 			

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	<p>that is community-based; or</p> <p>(A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or.</p> <p>(B) If the ICF/IID experiences an actual natural or man-made emergency that requires activation of the emergency plan, the ICF/IID is exempt from engaging in its next required full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event.</p> <p>(ii) Conduct an additional annual exercise that may include, but is not limited to the following:</p> <p>(A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or</p> <p>(B) A mock disaster drill; or</p> <p>(C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.</p> <p>(iii) Analyze the ICF/IID's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the ICF/IID's emergency plan, as needed.</p> <p>*[For HHAs at §484.102]</p> <p>(d)(2) Testing. The HHA must conduct exercises to test the emergency plan at least annually. The HHA must do the following:</p> <p>(i) Participate in a full-scale exercise that is community-based; or</p> <p>(A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise</p>				

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	<p>every 2 years; or.</p> <p>(B) If the HHA experiences an actual natural or man-made emergency that requires activation of the emergency plan, the HHA is exempt from engaging in its next required full-scale community-based or individual, facility based functional exercise following the onset of the emergency event.</p> <p>(ii) Conduct an additional exercise every 2 years, opposite the year the full-scale _____ or functional exercise under paragraph (d)(2)(i) of this section is conducted, _____ that may include, but is not limited to the following:</p> <p>(A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or</p> <p>(B) A mock disaster drill; or</p> <p>(C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.</p> <p>(iii) Analyze the HHA's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the HHA's emergency plan, as needed.</p> <p>*[For OPOs at §486.360]</p> <p>(d)(2) Testing. The OPO must conduct exercises to test the emergency plan. The OPO must do the following:</p> <p>(i) Conduct a paper-based, tabletop exercise or workshop at least annually. A tabletop exercise is led by a facilitator and includes a group discussion, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an</p>			

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	<p>emergency plan. If the OPO experiences an actual natural or man-made emergency that requires activation of the emergency plan, the OPO is exempt from engaging in its next required testing exercise following the onset of the emergency event.</p> <p>(ii) Analyze the OPO's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the [RNHCl's and OPO's] emergency plan, as needed.</p> <p>*[RNCHIs at §403.748]:</p> <p>(d)(2) Testing. The RNHCl must conduct exercises to test the emergency plan. The RNHCl must do the following:</p> <p>(i) Conduct a paper-based, tabletop exercise at least annually. A tabletop exercise is a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.</p> <p>(ii) Analyze the RNHCl's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the RNHCl's emergency plan, as needed.</p> <p>Based on record review and interview, the facility failed to conduct exercises to test the emergency plan at least twice per year. The ICF/IID facility must do the following:</p> <p>(i) Participate in an annual full-scale exercise that is community-based; or</p> <p>a. When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise.</p> <p>b. If the ICF/IID facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the ICF/IID facility is exempt from engaging its next required</p>		E 0039	<p>E039</p> <p>The house supervisor will be retrained on how and when to facilitate a full-scale exercise that is community based.</p> <p>Persons Responsible: QIDP/Director of Group Homes Completion Date: 12/22/2023</p> <p>In addition to the already scheduled drill schedule for 2024, a make up annual full-scale exercise that is community-based</p>	12/22/2023

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	<p>full-scale in a community-based or individual, facility-based full-scale functional exercise for 1 year following the onset of the actual event.</p> <p>(ii) Conduct an additional exercise that may include, but is not limited to the following:</p> <ul style="list-style-type: none"> a. A second full-scale exercise that is community-based or an individual, facility-based functional exercise. b. A mock disaster drill; or c. A tabletop exercise or workshop that is led by a facilitator that includes a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. <p>(iii) Analyze the ICF/IID facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the ICF/IID facility's emergency plan, as needed in accordance with 42 CFR 483.475(d)(2). This deficient practice could affect all occupants.</p> <p>Findings include:</p> <p>Based on records review with the Maintenance Tech #2 on 12/04/23 at 11:35 a.m., the following was not available for review:</p> <ul style="list-style-type: none"> a) No documentation was provided of an annual full-scale exercise within the last 12 months that is community-based, a facility-based functional exercise when a community-based exercise is not accessible, or an actual natural or man-made emergency. The last document drill was conduct on 09/01/22. b) No documentation was provided of an additional annual exercise of choice within the last 12 months: a second full-scale exercise that is community-based, a facility-based functional exercise, a mock disaster drill, a tabletop exercise, 		<p>will be conducted and documented appropriately. During the make up annual full-scale exercise that is community-based, a certified full scale exercise that is community-based trainer will be present to ensure the drill is ran appropriately.</p> <p>Persons Responsible: QIDP/Director of Group Homes Completion Date: 12/22/2023</p> <p>The house supervisor will be retrained on how and when to facilitate a tabletop exercise that will consist of a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.</p> <p>Persons Responsible: QIDP/Director of Group Homes Completion Date: 12/22/2023</p> <p>In addition to the already scheduled drill schedule for 2024, a make up tabletop exercise will be conducted and documented appropriately.</p> <p>Persons Responsible: QIDP/Director of Group Homes Completion Date: 12/22/2023</p> <p>The QIDP will review the drill documentation monthly to ensure that the drills are occurring as scheduled, and documentation is being provided, especially</p>	

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NAME OF PROVIDER OR SUPPLIER EASTER SEALS ARC OF NORTHEAST		STREET ADDRESS, CITY, STATE, ZIP COD 2827 TILLMAN ROAD FORT WAYNE, IN 46816		
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K 0000 Bldg. 03	<p>or a workshop. The last document drill of choice was conducted on 10/12/22.</p> <p>Based on interview at the time of records review, the Maintenance Tech #2 stated there is no documentation of Emergency drills that took place in within the past 12 months.</p> <p>This was reviewed with the Maintenance Tech #2 during the exit conference.</p> <p>A Life Safety Code Recertification Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.470(j).</p> <p>Survey Date: 12/04/23</p> <p>Facility Number: 000618 Provider Number: 15G074 AIM Number: 100233730</p> <p>At this Life Safety Survey, Easter Seals Arc of Northeast Indiana was found not in compliance with Requirements for Participation in Medicaid, 42 CFR Subpart 483.470(j), Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 32, New Residential Board and Care Occupancies.</p> <p>This one-story facility was fully sprinklered. The facility has a fire alarm system with heat detection in the attic and garage, smoke detection in the corridors, sleeping rooms, and common living areas. The facility is protected by an automatic generator. The facility has a capacity of 8 and had a census of 8 at the time of this survey.</p>	K 0000	<p>ensuring that the full scale exercise that is community based, and the tabletop exercise is completed when scheduled.</p> <p>Persons Responsible: QIDP/Director of Group Homes Completion Date: 12/22/2023</p>	

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K S353 Bldg. 03	<p>Calculation of the Evacuation Difficulty Score (E-Score) using NFPA 101A, Alternative Approaches of Life Safety, Chapter 6, rated the facility Prompt with an E-Score of 1.48.</p> <p>Quality Review completed on 12/05/23</p> <p>NFPA 101 Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing 2012 NEW NFPA 13 and 13R Systems All sprinkler systems installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, and NFPA 13R, Standard for the Installation of Sprinkler Systems in Residential Occupancies Up To and Including Four Stories in Height, are inspected, tested and maintained in accordance with NFPA 25, Standard for Inspection, Testing and Maintenance of Water Based Fire Protection System.</p> <p>NFPA 13D Systems Sprinkler systems installed in accordance with NFPA 13D, Standard for the Installation of Sprinkler Systems in One- and Two-Family Dwellings and Manufactured Homes, are inspected, tested and maintained in accordance with the following requirements of NFPA 25:</p> <ol style="list-style-type: none"> 1. Control valves inspected monthly (NFPA 25, section 13.3.2). 2. Gauges inspected monthly (NFPA 25, section 13.2.71). 3. Alarm devices inspected quarterly (NFPA 25, section 5.2.6). 4. Alarm devices tested semiannually (NFPA 25, section 5.3.3). 5. Valve supervisory switches tested semiannually (NFPA 25, section 13.3.3.5). 			

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	<p>6. Visible sprinklers inspected annually ((NFPA 25, section 5.2.1)).</p> <p>7. Visible pipe inspected annually (NFPA 25, section 5.2.2).</p> <p>8. Visible pipe hangers inspected annually (NFPA 25, section 5.2.3).</p> <p>9. Buildings inspected annually prior to freezing weather for adequate heat for water filled piping (NFPA 25, section 5.2.5).</p> <p>10. A representative sample of fast response sprinklers are tested at 20 years (NFPA 25, section 5.3.1.1.1.2).</p> <p>11. A representative sample of dry pendant sprinklers are tested at 10 years (NFPA 25, section 5.3.1.1.15).</p> <p>12. Antifreeze solutions are tested annually (NFPA 25, section 5.3.4).</p> <p>13. Control valves are operated through their full range and returned to normal annually (NFPA 25, section 13.3.3.1).</p> <p>14. Operating stems of OS&Y valves are lubricated annually (NFPA 25, section 13.3.4).</p> <p>15. Dry pipe systems extending into unheated portions of the building are inspected, tested and maintained (NFPA 25, section 13.4.4).</p> <p>A. Date sprinkler system last checked and necessary maintenance provided.</p> <p>_____</p> <p>B. Show who provided the service.</p> <p>_____</p> <p>C. Note the source of the water supply for the automatic sprinkler system.</p> <p>_____</p> <p>32.2.3.5.3, 9.7.5, 9.7.7, 9.7.8, and NFPA 25 Based on record review and interview, the facility failed to ensure 1 of 1 sprinkler systems were tested and/or inspected in accordance with NFPA</p>	K S353	K0353 The maintenance staff will be retrained on completing the	12/22/2023

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K S500 Bldg. 03	<p>25. NFPA 25, Section 5.2.5 states, waterflow alarm and supervisory alarm devices shall be inspected quarterly to verify that they are free of physical damage. An inspection is defined as a visual examination of a system or a portion thereof to verify that it appears to be in operating condition and is free of physical damage. Section 5.3.3.2 states vane-type and pressure switch-type water flow alarm devices shall be tested semiannually. A test is defined as a procedure used to determine the operational status of a component or system by conducting periodic physical checks, such as waterflow tests, fire pump tests, alarm tests, and trip tests of dry pipe, deluge, or pre-action valves. This deficient practice could affect all clients and staff.</p> <p>Findings include:</p> <p>Based on record review with the Maintenance Tech #2 on 12/04/23 at 11:40 a.m., there was no sprinkler inspection documentation for the water flow alarm device available for review for the third quarter of 2023. Based on interview at the time of observation, the Maintenance Tech #2 stated the sprinkler inspection documentation could not be found.</p> <p>This was reviewed with the Maintenance Tech #2 during the exit conference.</p> <p>NFPA 101 Building Services - Other Building Services - Other List in the REMARKS section any LSC Section 32.2.5 and 33.2.5 Building Services that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included</p>		<p>“Monthly Group home Chek Sheet”, including documentation of the sprinkler systems-ensuring gauges on wet pipe sprinkler systems shall be inspected monthly to ensure good condition and normal water supply pressure is being maintained, and valves secured with locks are inspected monthly.</p> <p>Person Responsible: Maintenance Supervisor/Director of Facilities and Property Management Completion Date: 12/22/2023</p> <p>Maintenance Supervisor/Director of Facilities and Property Management will review the “Monthly Group Home Chek Sheet” to ensure documentation of the sprinkler systems including inspections of gauges and valves are being completed monthly.</p> <p>Person Responsible: Maintenance Supervisor/Director of Facilities and Property Management Completion Date: 12/22/2023</p>	

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K S712 Bldg. 03	<p>on Form CMS-2567.</p> <p>Based on record review, observation and interview; the facility failed to maintain a complete written record of monthly generator load testing for 4 of 12 months. LSC 4.5.7 states any building service equipment or safeguard provided to achieve the goals of this Code shall be designed, installed, and approved in accordance with applicable NFPA codes. NFPA 110, Standard for Emergency and Standby Power Systems, 2010 Edition, Section 8.4.2.4 states spark-ignited generator sets shall be exercised at least once a month with the available EPSS load for 30 minutes or until the water temperature and the oil pressure have stabilized. NFPA 110, Section 8.3.4 states a permanent record of EPSS inspections, tests, exercising, operation, and repairs shall be maintained and readily available. This deficient practice affects all clients, staff and visitors.</p> <p>Findings include:</p> <p>Based on record review with the Maintenance Tech #2 on 12/04/23 at 12:15 a.m., the clients moved to this replacement home in August of 2023. No documentation of monthly generator load testing since August of 2023 was available for review. Based on interview at the time of record review, the Maintenance Tech #2 stated the facility has a natural gas emergency generator, the generator is tested monthly, but the tests are not documented.</p> <p>This was reviewed with the Maintenance Tech #2 during the exit conference.</p> <p>NFPA 101 Fire Drills Fire Drills 1. The facility must hold evacuation drills at</p>	K S500	<p>E0500</p> <p>The maintenance staff will be retrained on completing written record of monthly generator load testing.</p> <p>Person Responsible: Maintenance Supervisor/Director of Facilities and Property Management Completion Date: 12/22/2023</p> <p>Maintenance Supervisor/Director of Facilities and Property Management will review the written record of the monthly generator load testing to ensure documentation of generator load testing is being completed.</p> <p>Person Responsible: Maintenance Supervisor/Director of Facilities and Property Management Completion Date: 12/22/2023</p>	12/22/2023

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	<p>least quarterly for each shift of personnel and under varied conditions to:</p> <ul style="list-style-type: none"> a. Ensure that all personnel on all shifts are trained to perform assigned tasks; b. Ensure that all personnel on all shifts are familiar with the use of the facility's emergency and disaster plans and procedures. <p>2. The facility must:</p> <ul style="list-style-type: none"> a. Actually evacuate clients during at least one drill each year on each shift; b. Make special provisions for the evacuation of clients with physical disabilities; c. File a report and evaluation on each drill; d. Investigate all problems with evacuation drills, including accidents and take corrective action; and e. During fire drills, clients may be evacuated to a safe area in facilities certified under the Health Care Occupancies Chapter of the Life Safety Code. <p>3. Facilities must meet the requirements of paragraphs (i) (1) and (2) of this section for any live-in and relief staff that they utilize.</p> <p>42 CFR 483.470(i)</p> <p>Based on record review and interview, the facility failed to conduct evacuation/fire drills at least quarterly for each shift of personnel and under varied conditions for 2 of 12 shifts. This deficient practice affects all staff and clients.</p> <p>Findings include:</p> <p>Based on records review with the Maintenance Tech #2 on 12/04/23 at 12:00 p.m., the following shifts were missing fire drills:</p> <ul style="list-style-type: none"> a) There was no documentation for a second shift fire drill in the third quarter of 2023. b) There was no documentation for a third shift 		K S712	<p>K0712</p> <p>The house supervisor will be retrained on conducting evacuation/fire drills quarterly each shift of personnel and under varied conditions.</p> <p>Persons Responsible: QIDP/Director of Group Homes Completion Date: 12/22/2023</p> <p>In addition to the already scheduled drill schedule for 2024, a make up second shift fire drill will be conducted and documented</p>	12/22/2023

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	<p>fire drill in the third quarter of 2023. Based on interview at the time of record review, the Maintenance Tech #2 stated documentation of the aforementioned fire drills could not be found.</p> <p>This was reviewed with the Maintenance Tech #2 during the exit conference.</p>		<p>appropriately. During the make up second shift fire drill, a certified fire drill trainer will be present to ensure the drill is ran appropriately.</p> <p>Persons Responsible: QIDP/Director of Group Homes Completion Date: 12/22/2023</p> <p>In addition to the already scheduled drill schedule for 2024, a make up second shift fire drill will be conducted and documented appropriately. During the make up second shift fire drill, a certified fire drill will be present to ensure the drill is ran appropriately.</p> <p>Persons Responsible: QIDP/Director of Group Homes Completion Date: 12/22/2023</p>	