STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G745	A. BUILDING 00 B. WING	04/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RES CARE SOUTHEAST INDIANA	16611 SIMA GRAY RD HENRYVILLE, IN 47126

(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
W 0000 Bldg. 00	This visit was for a fundamental annual recertification and state licensure survey. This visit was done in conjunction with the PCR (Post Certification Revisit) to the investigation of complaint #IN00219614. Dates of Survey: 4/17/17, 4/18/17, 4/19/17 and 4/21/17. Facility Number: 011663 Provider Number: 15G745 AIMS Number: 200902020 These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review of this report completed by #15068 on 5/16/17.	W 0000		
W 0149 Bldg. 00	483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement			

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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	written policies and procedures that prohibit mistreatment, neglect or abuse of the client. Based on record review and interview for 2 of 2 sampled clients (A and B), plus one additional client (C), the facility failed to implement their policy and procedures to report allegations of abuse and injuries during restraint to the Bureau of Developmental Disabilities Services (BDDS) and failed to investigate allegations of abuse for clients A, B and C. The facility failed to implement their policy and procedures to investigate an allegation of neglect (insufficient staffing) for clients A, B and C. Findings include: 1. Observations were conducted at the group home on 4/17/17 from 3:45 PM through 6:30 PM. Clients A, B and C were observed throughout the observation period. At 4:15 PM client C was observed to have 3 to 4 small bruises on his upper arms. Client C indicated the bruises were from being placed in YSIS (You're Safe I'm Safe). At 6:00 PM HM (House Manager) #1 indicated client C had some small bruises on his arm due to being put in YSIS. The facility's BDDS/Incident Reports (IR) were reviewed on 4/18/17 at 12:49 PM. The review indicated the following:	W 0149	**W149:** The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. **Corrective Action: (Specific):** The QA Coordinator will be re-trained on the completion of investigations for all allegations of abuse, neglect or mistreatment. **How others will be identified: (Systemic):** The Program Manager will review incident reports for the home with QA at least twice weekly for the next 30 days then at least weekly thereafter to ensure that incidents requiring an investigation have an investigation initiated timely and the peer review will review investigations at least weekly to ensure that investigations are thorough. **Measures to be put in place:** The QA Coordinator will be re-trained on the completion of investigations for all allegations of abuse, neglect or mistreatment. **Monitoring of Corrective Action:** The Program Manager will review incident reports for the home with QA at least twice weekly for the next 30 days then at least weekly thereafter to	05/21/2017

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	IR report dated 2/12/17 indicated, "[Client C] threw his plate at staff. When staff arrived [Client C] jumped out of his chair and swung at staff. Staff used 2 man YSIS to get [client C] to his room. [Client C] may have bruising in the wrist areas due to YSIS and hitting and kicking staff." The review indicated client C's 2/12/17 incident of injury due to a YSIS hold was not reported to BDDS within 24 hours of the facility's knowledge. IR report dated 3/18/17 indicated, "[Client A] was in living room talking to staff. [Client A] brandished a home made weapon at staff saying he was going to use the weapon on another client. Staff confiscated the weapon." The review indicated the incident of client to client aggression was not reported to BDDS within 24 hours of the facility's knowledge. IR report dated 3/27/17 indicated, "[Client B] was cussing and picked up what looked like a stick. Staff took it away at which point [client B] got physically aggressive with staff. He got in staff's face and grabbed them. Staff attempted to redirect. [Client B] was put in a 2 man hold. Possible bruising on wrist from 2 man YSIS." The review indicated client B's 3/27/17 incident of		ensure that incidents requiring an investigation have an investigation initiated timely and the peer review will review investigations at least weekly to ensure that investigations are thorough. **Completion date: 5/21/2017**	

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	injury due to a YSIS hold was not reported to BDDS within 24 hours of the facility's knowledge. IR report dated 4/6/17 indicated, "[Client B] went into the kitchen and started grabbing appliances throwing them on the ground. YSIS was used. Possible bruising from YSIS on both wrists." The review indicated client B's 4/6/17 incident of injury due to a YSIS hold was not reported to BDDS within 24 hours of the facility's knowledge. IR report dated 4/7/17 indicated, "Staff did YSIS on [Client C] sitting in his recliner. One staff on either side holding his wrist. Talked to him and got him to calm down after 20 minutes. May have possible bruising to both arms and lower wrist." The review indicated client C's 4/7/17 incident of injury due to a YSIS hold was not reported to BDDS within 24 hours of the facility's knowledge. IR report dated 4/9/17 indicated, "[Client B] threw items from his room at staff. Pounded on the plexiglass cover of his television and attempted to hit staff. Placed in a 2 man YSIS, verbal redirection. Possible bruising from YSIS." (Location of possible bruising was not indicated.) The review indicated client B's 4/9/17 incident of injury due to			

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	a YSIS hold was not reported to BDDS within 24 hours of the facility's knowledge. IR report dated 4/9/17 indicated, "Staff did a one man YSIS (Your Safe I'm Safe Hold). Staff and [client A] fell to the floor and hit the kitchen table after [client A] shoved staff. Another staff ran over to aid. [Client A] was put into a 2 man YSIS. [Client A] said he bit his lip during the incident. Possible bruising from YSIS and on back from the fall. [Client A] has bruised knuckles." The review indicated client A's 4/9/17 incident of injury due to a YSIS hold was not reported to BDDS within 24 hours of the facility's knowledge. IR report dated 4/10/17 indicated, "Staff used YSIS on [client B] after several minutes [client B] calmed down only to start up again. He did this 4 consecutive times before remaining calm. Possible bruising on arms." The review indicated client B's 4/10/17 incident of injury due to a YSIS hold was not reported to BDDS within 24 hours of the facility's knowledge. 2. BDDS (Bureau of Developmental Disabilities Services) reports were reviewed on 4/18/17 at 12:49 PM. BDDS reports dated 3/29/17 indicated, "The			

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	ESN 2 (Extensive Special Needs) home located at [address] is required to have 3 staff on shift from 2:00 PM to 10:00 PM when all 4 individuals are present. On 3/28/17 local BDDS service coordinator completed a routine home visit and noted there was (sic) only 2 staff members present in the home, with all 4 individuals present. The home was out of staffing ratio for approximately 1 hour, from 2 PM to 3 PM. There was staff scheduled to work, he was running late from a scheduled training course at the core office. There were no injuries or incidents reported as a result of the home being out of ratio." PM (Program Manager) #1 was interviewed on 4/19/17 at 1:45 PM. PM #1 indicated allegations of abuse, neglect and mistreatment should be reported to BDDS within 24 hours of the facility knowledge of the allegation. PM indicated all allegations of abuse should be investigated. ResCare 1/2016 Abuse, Neglect, Exploitation, Mistreatment or Violation of Individual Rights policy was reviewed on 4/19/17 at 12:36 PM. ResCare Policy indicated, "All allegations of occurrences of abuse, neglect, exploitation, mistreatment or violation of an Individual's rights shall be reported to the			

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	appropriate authorities through the appropriate supervisory channels." 9-3-2(a)			
W 0153 Bldg. 00	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 observation, record review and interview for 8 of 11 allegations of abuse, neglect or mistreatment reviewed, the facility failed to ensure allegations of abuse/mistreatment regarding clients A, B and C were reported to BDDS (Bureau of Developmental Disabilities Services) within 24 hours of the facility's knowledge of the allegations in accordance with state law. Findings include: Observations were conducted at the group home on 4/17/17 from 3:45 PM through 6:30 PM. Clients A, B and C were observed throughout the observation period. At 4:15 PM client C was observed to have 3 to 4 small bruises	W 0153	**W153:** The facility must ensure that all allegations of mistreatment, neglect, 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. **Corrective Action: (Specific):** The QA Coordinator will be re-trained on reporting all allegations of abuse, neglect or mistreatment as well as injuries of unknown source to the administrator and/or other officials in accordance with state law.	05/21/2017

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	on his upper arms. Client C indicated the bruises were from being placed in YSIS (You're Safe I'm Safe). At 6:00 PM HM (House Manager) #1 indicated client C had some small bruises on his arm due to being put in YSIS. The facility's Incident Reports (IR) were reviewed on 4/18/17 at 12:49 PM. The review indicated the following: IR report dated 2/12/17 indicated, "[Client C] threw his plate at staff. When staff arrived [Client C] jumped out of his chair and swung at staff. Staff used 2 man YSIS to get [client C] to his room. [Client C] may have bruising in the wrist areas due to YSIS and hitting and kicking staff." The review indicated client C's 2/12/17 incident of injury due to a YSIS hold was not reported to BDDS within 24 hours of the facility's knowledge. IR report dated 3/18/17 indicated, "[Client A] was in living room talking to staff. [Client A] brandished a home made weapon at staff saying he was going to use the weapon on another client. Staff confiscated the weapon." The review indicated the incident of client to client aggression was not reported to BDDS within 24 hours of the facility's knowledge.		**How others will be identified: (Systemic):** The QA Manager and the Program Manager will review incident reports at least twice weekly for the next 30 days and then at least weekly thereafter to ensure that all allegations of abuse, neglect, mistreatment and injuries of unknown origin are reported to the administrator and other officials in accordance with state law. **Measures to be put in place):** The QA Coordinator will be re-trained on reporting all allegations of abuse, neglect or mistreatment as well as injuries of unknown source to the administrator and/or other officials in accordance with state law. **Monitoring of Corrective Action:** The QA Manager and the Program Manager will review incident reports at least twice weekly for the next 30 days and then at least weekly thereafter to ensure that all allegations of abuse, neglect, mistreatment and injuries of unknown origin are reported to the administrator and other officials in accordance with state law.	

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	IR report dated 3/27/17 indicated, "[Client B] was cussing and picked up what looked like a stick. Staff took it away at which point [client B] got physically aggressive with staff. He got in staff's face and grabbed them. Staff attempted to redirect. [Client B] was put in a 2 man hold. Possible bruising on wrist from 2 man YSIS." The review indicated client B's 3/27/17 incident of injury due to a YSIS hold was not reported to BDDS within 24 hours of the facility's knowledge. IR report dated 4/6/17 indicated, "[Client B] went into the kitchen and started grabbing appliances throwing them on the ground. YSIS was used. Possible bruising from YSIS on both wrists." The review indicated client B's 4/6/17 incident of injury due to a YSIS hold was not reported to BDDS within 24 hours of the facility's knowledge. IR report dated 4/7/17 indicated, "Staff did YSIS on [Client C] sitting in his recliner. One staff on either side holding his wrist. Talked to him and got him to calm down after 20 minutes. May have possible bruising to both arms and lower wrist." The review indicated client C's 4/7/17 incident of injury due to a YSIS hold was not reported to BDDS within 24 hours of the facility's knowledge.		**Completion date: 05/21/2017**	

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IR report dated 4/9/17 indicated, "[Client B] threw items from his room at staff. Pounded on the plexiglass cover of his television and attempted to hit staff. Placed in a 2 man YSIS, verbal redirection. Possible bruising from YSIS." (Location of possible bruising was not indicated.)The review indicated client B's 4/9/17 incident of injury due to a YSIS hold was not reported to BDDS within 24 hours of the facility's knowledge.

IR report dated 4/9/17 indicated, "Staff did a one man YSIS (You're Safe I'm Safe Hold). Staff and [client A] fell to the floor and hit the kitchen table after [client A] shoved staff. Another staff ran over to aid. [Client A] was put into a 2 man YSIS. [Client A] said he bit his lip during the incident. Possible bruising from YSIS and on back from the fall. [Client A] has bruised knuckles." The review indicated client A's 4/9/17 incident of injury due to a YSIS hold was not reported to BDDS within 24 hours of the facility's knowledge.

IR report dated 4/10/17 indicated, "Staff used YSIS on [client B] after several minutes [client B] calmed down only to start up again. He did this 4 consecutive times before remaining calm. Possible

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	bruising on arms." The review indicated client B's 4/10/17 incident of injury due to a YSIS hold was not reported to BDDS within 24 hours of the facility's knowledge. PM (Program Manager) #1 was interviewed on 4/19/17 at 1:45 PM. PM #1 indicated allegations of abuse, neglect and mistreatment should be reported to BDDS within 24 hours of the facility knowledge of the allegation. 9-3-1(b)(5) 9-3-2(a)			
W 0154 Bldg. 00	483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated. Based on record review and interview for 9 of 11 allegations of abuse, neglect or injuries of unknown origin reviewed, the facility failed to ensure a thorough investigation of an alleged allegation of neglect (insufficient staffing) regarding clients A, B and C. The facility failed to investigate allegations of abuse for clients A, B and C. Findings include:	W 0154	**W154:** The facility must have evidence that all alleged violations are thoroughly investigated. **Corrective Action: (Specific):** The QA Coordinator will be re-trained on the completion of investigations for all allegations of abuse, neglect or mistreatment.	05/21/2017

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	1. BDDS (Bureau of Developmental Disabilities Services) reports were reviewed on 4/18/17 at 12:49 PM. BDDS reports dated 3/29/17 indicated, "The ESN 2 (Extensive Special Needs) home located at [address] is required to have 3 staff on shift from 2:00 PM to 10:00 PM when all 4 individuals are present. On 3/28/17 local BDDS service coordinator completed a routine home visit and noted there was (sic) only 2 staff members present in the home, with all 4 individuals present. The home was out of staffing ratio for approximately 1 hour, from 2 PM to 3 PM. There was staff scheduled to work, he was running late from a scheduled training course at the core office. There were no injuries or incidents reported as a result of the home being out of ratio." Staff time cards were reviewed on 4/18/17 at 4:00 PM. Staff time cards indicated the home was under ratio on the following days: 1st shift (6:00 AM through 2:00 PM) was run with one staff and 3 clients (A, B and C) on 4/9/17 from 6:00 AM through 7:00 AM. 1st shift was run with 2 staff and 3 clients on 3/21/17, 3/22/17, 3/24/17, 4/10/17 and 4/16/17. 2nd shift (2:00 PM through 10:00 PM) was run with 2 staff and 3 clients on 3/17/17, 3/18/17, 3/19/17, 3/20/17, 3/21/17, 3/22/17, 3/23/17, 3/24/17,		**How others will be identified: (Systemic):** The Program Manager will review incident reports for the home with QA at least twice weekly for the next 30 days then at least weekly thereafter to ensure that incidents requiring an investigation have an investigation initiated timely and the peer review will review investigations at least weekly to ensure that investigations are thorough. **Measures to be put in place:** The QA Coordinator will be re-trained on the completion of investigations for all allegations of abuse, neglect or mistreatment. **Monitoring of Corrective Action:** The Program Manager will review incident reports for the home with QA at least twice weekly for the next 30 days then at least weekly thereafter to ensure that incidents requiring an investigation have an investigation initiated timely and the peer review will review investigations at least weekly to ensure that investigations are thorough.	

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	4/1/17, 4/2/17, 4/5/17, 4/7/17, 4/12/17 and 4/16/17. Third shift (10:00 PM through 6:00 AM) was run with one staff and 3 clients on 3/17/17, 3/18/17, 3/19/17, 3/22/17, 3/23/17, 3/24/17 and 4/13/17. 2. IR (incident report) dated 2/12/17 indicated, "[Client C] threw his plate at staff. When staff arrived [Client C] jumped out of his chair and swung at staff. Staff used 2 man YSIS (You're Safe I'm Safe) to get [client C] to his room. [Client C] may have bruising in the wrist areas due to YSIS and hitting and kicking staff." IR report dated 3/18/17 indicated, "[Client A] was in living room talking to staff. [Client A] brandished a home made weapon at staff saying he was going to use the weapon on another client. Staff confiscated the weapon." IR report dated 3/27/17 indicated, "[Client B] was cussing and picked up what looked like a stick. Staff took it away at which point [client B] got physically aggressive with staff. He got in staff's face and grabbed them. Staff attempted to redirect. [Client B] was put in a 2 man hold. Possible bruising on wrist from 2 man YSIS."		**Completion date: 5/21/2017**	

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	IR report dated 4/6/17 indicated, "[Client B] went into the kitchen and started grabbing appliances throwing them on the ground. YSIS was used. Possible bruising from YSIS on both wrists." IR report dated 4/7/17 indicated, "Staff did YSIS on [Client C] sitting in his recliner. One staff on either side holding his wrist. Talked to him and got him to calm down after 20 minutes. May have possible bruising to both arms and lower wrist." IR report dated 4/9/17 indicated, "[Client B] threw items from his room at staff. Pounded on the plexiglass cover of his television and attempted to hit staff. Placed in a 2 man YSIS, verbal redirection. Possible bruising from YSIS." (Location of possible bruising was not indicated.) IR report dated 4/9/17 indicated, "Staff did a one man YSIS (Your Safe I'm Safe Hold). Staff and [client A] fell to the floor and hit the kitchen table after [client A] shoved staff. Another staff ran over to aid. [Client A] was put into a 2 man YSIS. [Client A] said he bit his lip during the incident. Possible bruising from YSIS and on back from the fall. [Client A] has bruised knuckles."			

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	15G745	A. BUILDING 00 B. WING	04/21/2017

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	IR report dated 4/10/17 indicated, "Staff used YSIS on [client B] after several minutes [client B] calmed down only to start up again. He did this 4 consecutive times before remaining calm. Possible bruising on arms." Review of the above IRs did not indicate the allegations of abuse and/or client to client aggression were investigated. Program Manager (PM) #1 was interviewed on 4/19/17 at 1:45 PM. PM #1 indicated the home should have 3 staff on 1st shift, 3 staff on 2nd shift and 2 staff on overnight shift. PM #1 indicated the home was fully staffed, however staff would call off or not show up to shift. PM #1 indicated all allegations of abuse, neglect or mistreatment should be investigated thoroughly. 9-3-2(a)			
W 0186 Bldg. 00	483.430(d)(1-2) DIRECT CARE STAFF The facility must provide sufficient direct care staff to manage and supervise clients in			

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	accordance with their individual program plans. Direct care staff are defined as the present on-duty staff calculated over all shifts in a 24-hour period for each defined residential living unit. Based on record review and interview for 2 of 2 sampled clients (A and B), plus 1 additional client (C), the facility failed to provide 3 staff on first and second shifts and 2 staff on third shift for the Extensive Special Needs (ESN) home. Findings include: BDDS (Bureau of Developmental Disabilities Services) reports were reviewed for clients A, B and C on 4/18/17 at 12:49 PM. BDDS reports dated 3/29/17 indicated, "The ESN 2 (Extensive Special Needs) home located at [address] is required to have 3 staff on shift from 2:00 PM to 10:00 PM when all 4 individuals are present. On 3/28/17 local BDDS service coordinator completed a routine home visit and noted there was only 2 staff members present in the home, with all 4 individuals present. The home was out of staffing ratio for approximately 1 hour, from 2 PM to 3 PM. There was staff scheduled to work, he was running late from a scheduled training course at the core office. There were no injuries or incidents reported as a	W 0186	**W186:** The facility must provide sufficient direct care staff to manage and supervise clients in accordance with their individual program plans. **Corrective Action: (Specific):** The Residential Manager will be re-trained on ensuring that staffing ratios are consistent with the scheduled hours for the home. **How others will be identified: (Systemic):** The Area Supervisor will review the schedule for the home with the Residential Manager at least three times weekly for the next 30 days then at least weekly thereafter to ensure that staffing ratios are consistent with the scheduled hours for the home and verifying that all shifts have staff scheduled. The Area Supervisor will send a copy of the schedule to the Program Manager for review at least weekly for the next 30 days and HR will continue active recruiting for any open staffing positions.	05/21/2017

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	result of the home being out of ratio." Staff time cards were reviewed on 4/18/17 at 4:00 PM. Staff time cards indicated the home was under ratio on the following days: 1st shift (6:00 AM through 2:00 PM) was run with one staff and 3 clients (A, B and C) on 4/9/17 from 6:00 AM through 7:00 AM. 1st shift was run with 2 staff and 3 clients on 3/21/17, 3/22/17, 3/24/17, 4/10/17 and 4/16/17. 2nd shift (2:00 PM through 10:00 PM) was run with 2 staff and 3 clients on 3/17/17, 3/18/17, 3/19/17, 3/20/17, 3/21/17, 3/22/17, 3/23/17, 3/24/17, 4/1/17, 4/2/17, 4/5/17, 4/7/17, 4/12/17 and 4/16/17. Third shift (10:00 PM through 6:00 AM) was run with one staff and 3 clients on 3/17/17, 3/18/17, 3/19/17, 3/22/17, 3/23/17, 3/24/17 and 4/13/17. Program Manager (PM) #1 was interviewed on 4/19/17 at 1:45 PM. PM #1 indicated the home should have 3 staff on 1st shift, 3 staff on 2nd shift and 2 staff on overnight shift. PM #1 indicated the home was fully staffed, however staff would call off or not show up to shift. 9-3-3(a)		**Measures to be put in place:** The Residential Manager will be re-trained on ensuring that staffing ratios are consistent with the scheduled hours for the home. **Monitoring of Corrective Action :)** The Area Supervisor will review the schedule for the home with the Residential Manager at least three times weekly for the next 30 days then at least weekly thereafter to ensure that staffing ratios are consistent with the scheduled hours for the home and verifying that all shifts have staff scheduled. The Area Supervisor will send a copy of the schedule to the Program Manager for review at least weekly for the next 30 days and HR will continue active recruiting for any open staffing positions. **Completion date: 5/21/2017**	

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W 0192 Bldg. 00	483.430(e)(2) STAFF TRAINING PROGRAM For employees who work with clients, training must focus on skills and competencies directed toward clients' health needs. Based on observation, interview and record review for 1 additional client (C), the facility failed to ensure facility staff were adequately trained on how to administer a client's medications. Findings include: Observations were conducted at the	W 0192	**W192:** For employees, who work with clients, training must focus on skills and competencies directed toward clients' health needs. **Corrective Action: (Specific):**	05/21/2017

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	group home on 4/17/17 from 3:45 PM through 6:30 PM. Client C was observed in the home throughout the observation period. At 3:45 PM staff #1 was seated outside on the patio smoking a cigarette. Staff #1 indicated this was the first time he had worked at this home so he did not know the clients. Upon entering the home at 4:00 PM staff #2 indicated he had only worked in the home for 2 weeks. Staff #2 indicated none of the staff in the home were qualified to pass medications. Staff #2 indicated staff #3 was on an outing with client A. Staff #2 indicated staff #3 could not pass medications either. At 4:30 PM staff #2 indicated he did not think clients received 4 PM medications. Client C indicated he received several medications at 4:00 PM. Staff #2 tried to call HM (House Manager) #1. Staff #2 indicated HM #1 did not answer his call. At 4:50 PM staff #1 called another ESN home located next door to see if someone could come pass medications. At 5:00 PM staff from another home arrived and passed client C's 4:00 PM medications which consisted of Loperamide (diarrhea), Gabapentin (seizures) and Lithium (bipolar). At 5:30 PM HM #1 arrived at the home. Client C's April Medication Administration Record (MAR) was reviewed on 4/17/17 at 4:15 PM. Client		The Residential Manager will be retrained on ensuring that there is adequate staff in the home that has been trained on medication administration so medications can be administered timely and without error. **How others will be identified: (Systemic):** The nurse will review all staff working at the home to ensure that they have all been trained on medication administration and are qualified to administer medications timely and without error. The Area Supervisor will follow up with the Residential manager and the nurse at least weekly to ensure that all new staff and staff working in the home are qualified to administer medications timely and without error. **Measures to be put in place:** The Residential Manager will be retrained on ensuring that there is adequate staff in the home that has been trained on medication administration so medications can be administered timely and without error. **Monitoring of Corrective Action :)** The nurse will review all staff working at the home to ensure	

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	C's April MAR indicated client C was to receive Gabapentin Capsule 300 mg (milligram), Loperamide Capsule 2 mg and Lithium Carbonate 150 mg at 4:00 PM medication pass. HM #1 was interviewed on 4/17/17 at 5:30 PM. HM #1 indicated the 3 staff working in the home had not finished their medication training. HM #1 indicated the staff should call another house for medication pass and have someone else come to the home. QIDP (Qualified Intellectual Disabilities Professional) #1 was interviewed on 4/19/17 at 1:45 PM. QIDP #1 indicated staff should be deployed in a manner where someone who was trained to pass medications worked on each shift. PM (Program Manager) #1 was interviewed on 4/19/17 at 1:45 PM. PM #1 indicated medications should be given according to orders. PM #1 indicated the staff should call another house to pass medications if they are unable to. 9-3-3(a)		that they have all been trained on medication administration and are qualified to administer medications timely and without error. The Area Supervisor will follow up with the Residential manager and the nurse at least weekly to ensure that all new staff and staff working in the home are qualified to administer medications timely and without error. . **Completion date: 5/21/2017**	