STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G723	A. BUILDING 00 B. WING	02/19/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RES CARE COMMUNITY ALTERNATIVES SE IN	13009 HORIZON DR MEMPHIS, IN 47143

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W 0000 Bldg. 00	This visit was for a pre-determined full annual recertification and state licensure survey. This visit included a Covid-19 focused infection control survey. This visit was in conjunction with the investigation of Complaint #IN00344804. Dates of survey: 2/15/21, 2/16/21, 2/17/21, 2/18/21 and 2/19/21. Facility Number: 004615 Provider Number: 15G723 AIMS Number: 200528230 These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review of this report completed by #15068 on 3/8/21.	W 0000		
W 0140 Bldg. 00	483.420(b)(1)(i) CLIENT FINANCES The facility must establish and maintain a system that assures a full and complete accounting of clients' personal funds entrusted to the facility on behalf of clients. Based on record review and interview for 2 of 2 sampled clients (A and B) and 2 additional clients (C and D), the facility failed to ensure a full and complete accounting of the clients' personal funds entrusted to the facility. Findings include: On 2/16/21 at 2:30 PM, a review of the Bureau of Developmental Disabilities Services (BDDS) incident reports and accompanying Investigative	W 0140	The Facility will retrain staff on the standard of maintaining the system of accounting for client's funds entrusted to the facility. All receipts for the purchases must be returned to the facility and identify which client funds were spent on. The Residential Manager will conduct weekly reviews of the Client Financial Record's to ensure all	03/21/2021

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

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	Summaries was completed. The reports indicated: BDDS report dated 12/10/20 indicated, "It was reported [client D] had $184.00 left from a spend down. [Client D] requested funds to make a purchase. Staff got the money from the desk and gave [client D] $7.00 and told [client D] that was all the money in the envelope. Resident Manager looked through the desk and could not locate the remaining $177.00". Investigation summary dated 12/9/20 through 12/16/20 indicated, "An investigation was initiated after the business department did not receive receipts and/or remaining funds to account for [client D's] $600.00 check. It was reported $184.00 was left unaccounted for ... Factual Findings: [Client D] received a $600 check on 10/20 (2020), [former staff #3] picked the check up and took [client D] to spend the funds. [Former staff #3] returned to the ResCare Core Office on 10/20 (2020) and met with the business department to turn in receipts and cash. There was $184.48 remaining when the funds were counted ... [Former staff #3] attempted to give the remaining funds to the business department but was told he would need to get a money order, so the funds could be redeposited. [Former staff #3] did not get a money order on 10/20. He put the funds in his glove box of his car and planned to get the money order the next day. Before [former staff #3] could get the money order, [client D] was asking for his money and [former staff #3] put the funds in the desk drawer (in the home). Per [client D], when he received the remaining funds, there was only $7 and some change, which he used to purchase cigarettes. [Former Area Supervisor] spoke with staff, all of whom stated they did not take [client		transactions have been recorded and account is balanced. The Program Manager will in-service the Area Supervisor, Residential Manager and Direct Support Lead on the use of client finance book. All employees will be trained on the revised standard and disciplinary action will be given if the standard is not followed. The Facility will ensure that the abuse neglect and exploitation policy is followed. Persons Responsible: Program Manager, Area Supervisor, Residential Manager, Direct Support Lead, QA, Business Manager, Area Supervisor, QIDP, Residential Manager, and DSP.	

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	D] back out to spend the remaining funds. [Client D] denies spending the funds, other than $7. Review of finance log and receipts shows there is $176.90 unaccounted for. Conclusion: It is unsubstantiated [client D] spent the remaining funds, totaling $176.90. Recommendations: 1) Reimburse [client D] $176.90. 2) IDT (Interdisciplinary Team Meeting) to discuss use of P-cards (debit card). 3) Purchase a drop box for [group home]. 4) Audits to be completed 5 times weekly by RM (Residential Manager). 5) Retrain staff on finances". On 2/17/21 at 12:45 PM, the Qualified Intellectual Disability Professional (QIDP) was interviewed. The QIDP was asked about client D's missing money. The QIDP indicated it was not able to be determined if client D had spent the money on vaping supplies or if the money was actually missing, but it had been investigated and client D had been reimbursed. When asked to review clients A, B, C and D's financial ledgers for cash on hand the QIDP stated, "There are none here. It's all done on a P-card (a single debit card that includes clients A, B, C and D's personal funds). That's at the office". The QIDP was asked how client A, B, C and D's personal funds were itemized for accounting. The QIDP indicated accounting was maintained at the office and staff returned receipts after purchases to the office. The QIDP was asked if financial ledgers for clients A, B, C and D were maintained and available for review at the home. The QIDP stated, "Nope, It's at the office in the P-card book". On 2/17/21 at 3:03 PM, the Interim Associate Director (IAD) was interviewed. The IAD was asked about client D's missing money and the accounting system used for client A, B, C and D's			

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	personal funds. The IAD indicated the incident with client D's missing $176.90 had occurred and stated, "That sounds right". The IAD indicated client D had been reimbursed for the missing personal funds and financial accounting RFMS (Resident Financial Management System) forms could be provided for review for each of the clients. The IAD was asked about financial ledgers and accounting for clients A, B, C and D's personal funds brought back to the home. The IAD stated, "The house should have had a running ledger". The IAD was asked about the use of a P-card. The IAD stated, "It's like an escrow (temporary deposit of funds) account". On 2/17/21 at 3:24 PM, a review of clients A, B, C and D's RFMS accounting during the period of 2/1/21 through 2/17/21 was completed. The review indicated the following for each of the clients: Client A's RFMS accounting indicated a balance of $86.21, with no debit or withdrawal activity. No ledger was available in the home for review to compare the balance of client A's personal funds. Client B's RFMS accounting indicated "No transaction of file". Client B's date of admission was 12/21/20 and pending financial processes to be established. No ledger was available in the home for review to compare the balance of client B's personal funds. Client C's accounting indicated a balance of $1,904.19, with no debit or withdrawal activity. No ledger was available for review in the home to compare the balance of client C's personal funds.			

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	Client D's accounting indicated a balance of $837.16. On 12/24/20 a debit withdrawal transaction was listed as iPod for a total of $340.00. No ledger was available for review in the home to compare the balance of client D's personal funds. On 2/19/21 at 10:00 AM, the Interim Program Manager (IPM) was interviewed. The IPM was asked about client A, B, C and D's accounting of personal funds. The IPM stated, "I developed a finance book for that home". The IPM indicated the new Area Supervisor was trained and the "existing" staffing at the home will receive training. The IPM indicated the home used a P-card with $50.00 a month added and stated, "I don't think the staff was tracking that properly. It was not done (accounting of client A, B, C and D's personal funds)". 9-3-2(a)			
W 0149 Bldg. 00	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 for 5 of 21 incidents affecting clients A, C and D, the facility failed to implement its policy and procedures for prohibiting abuse, neglect, exploitation, mistreatment or violation of an individual's rights to prevent 1) client A's elopement on 1/2/21, 2) former staff #1 sleeping while on duty on 11/28/20 while clients A, C and D were present at the home and the use of inappropriate language toward client A, 3) missing Oxycodone (pain medication) 5-325 mg (milligrams) for client D and 5) a lack of financial accounting for client D's personal	W 0149	The Program Manager will ensure the Area Supervisor and Residential Manager retrain staff on the Abuse, Neglect and Exploitation Policy and disciplinary action will be given if the policy is not followed. Area Supervisor and Residential Manager will ensure that the Abuse, Neglect and Exploitation Policy is followed.	03/21/2021

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	funds. Findings include: On 2/16/21 at 2:30 PM, a review of the Bureau of Developmental Disabilities Services (BDDS) incident reports and accompanying Investigative Summaries was completed. The reports indicated: 1) BDDS report dated 1/3/21 indicated, "It was reported [client A] become upset and exited the home. Staff was unable to follow, and police were contacted for assistance. Police located [client A] 1 mile from the home. Police transported [client A] home". Investigation summary dated 1/2/21 indicated, "Briefly describe the incident and any sustained injury if any. [Client A] wanted more food but per his dining plan is on portion control. When staff told [client A], he could not have anything else, [client A] walked out the front door and kept walking though staff was attempting to verbally redirect him. Non-emergency police were contacted for assistance and brought [client A] back to the residence. There were no injuries reported .... Interview staff involved... [Former staff #1] - [Client A] got mad over food and ran out the front door and down the road. I called law enforcement and they brought him back. I couldn't follow him because there were other clients at home ... Was there sufficient staff at the time of the incident? No". 2) BDDS report dated 12/1/20 indicated, "Staff [staff #8] reported that when she arrived to work on 11/28/20, staff [former staff #1] was sleeping on the couch and that [client D] was outside. [Client A] and [client C] were still in bed		Monitoring of Corrective Action: The Program Manager, Area Supervisor and Residential Manager will ensure all incidents of possible abuse, neglect and exploitation are reported to the QA department. Persons Responsible: Program Manager, Area Supervisor, Residential Manager, Direct Support Lead	

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	sleeping. [Staff #8] reported [former staff #1] slept for 1 ½ hours after [staff #8] arrived and when he woke up he clocked out and left". Investigation summary dated 12/1/20 through 12/2/20 indicated, "An investigation was initiated after allegations were received of staff, [former staff #1], sleeping on the clock. [Former staff #1] was already on administrative leave due to unrelated allegations and remains suspended pending investigation outcome ... Conclusion: It is substantiated [former staff #1] was asleep on 11/28. Recommendations: 1) Term [former staff #1]. 2) Retrain ANE (Abuse, Neglect and Exploitation Policy) with all staff. 3) Review Bill of Rights and Grievance (policy) with all clients. 4) [Staff #8] retrained on ANE including neglect (sleeping)". BDDS report dated 11/29/20 indicated, "It was reported by a housemate of [client A's] that staff [former staff #1] is verbally abusive to [client A]. Housemate reported [former staff #1] frequently swears at [client A]." Investigation summary dated 11/29/20 through 12/2/20 indicated, "An investigation was initiated after [client D], client, reported staff [former staff #1] yells and curses at his housemate [client A] ... Conclusion: It is substantiated [former staff #1] yelled at [client A]. It is substantiated [former staff #1] cursed at [client A]". 3) BDDS report dated 2/4/21 indicated, "It was reported by staff that during med (medication) audits staff found there were 8 missing Oxycodone 5-325 mg pills prescribed to [client D]. Medication was prescribed as a PRN (as needed) following a dental procedure".			

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	Investigation summary dated 2/4/21 through 2/10/21 indicated, "An investigation was initiated after it was reported [client D] was missing 8 Oxycodone, the audit sheet had been tampered with/removed, and initials for administration were falsified. There were no staff suspended as result of this allegation, however, on 2/5 (2021) staff [former staff #2] reported when he was training with staff [staff #3], he witnessed her pop a pill, from a bubble pack, state it dropped on the floor, then [staff #3] put the pill in her mouth and swallowed it. This was [former staff #2's] first day on the job and he was unaware of who or how to report this at the time. [Former staff #2] reported the allegations once returning to work and being advised of how to report. Staff member, [staff #3], was placed on administrative leave pending investigation. Conclusion: 1) It is substantiated 8 Oxycodone of [client D's] are unaccounted for. 2) It is unable to be determined what happened to the pills at this time. 3) It is unable to be determined, at this time, if staff [staff #3] took clients medications from the home. Conclusion and recommendations will be updated after final interview is completed". 4) BDDS report dated 12/10/20 indicated, "It was reported [client D] had $184.00 left from a spend down. [Client D] requested funds to make a purchase. Staff got the money from the desk and gave [client D] $7.00 and told [client D] that was all the money in the envelope. Resident Manager looked through the desk and could not locate the remaining $177.00". Investigation summary dated 12/9/20 through 12/16/20 indicated, "An investigation was initiated after the business department did not receive receipts and/or remaining funds to account for [client D's] $600.00 check. It was			

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	reported $184.00 was left unaccounted for ... Factual Findings: [Client D] received a $600 check on 10/20 (2020), [former staff #3] picked the check up and took [client D] to spend the funds. [Former staff #3] returned to the ResCare Core Office on 10/20 (2020) and met with the business department to turn in receipts and cash. There was $184.48 remaining when the funds were counted ... [Former staff #3] attempted to give the remaining funds to the business department but was told he would need to get a money order, so the funds could be redeposited. [Former staff #3] did not get a money order on 10/20. He put the funds in his glove box of his car and planned to get the money order the next day. Before [former staff #3] could get the money order, [client D] was asking for his money and [former staff #3] put the funds in the desk drawer (in the home). Per [client D], when he received the remaining funds, there was only $7 and some change, which he used to purchase cigarettes. [Former Area Supervisor] spoke with staff, all of whom stated they did not take [client D] back out to spend the remaining funds. [Client D] denies spending the funds, other than $7. Review of finance log and receipts shows there is $176.90 unaccounted for. Conclusion: It is unsubstantiated [client D] spent the remaining funds, totaling $176.90. Recommendations: 1) Reimburse [client D] $176.90. 2) IDT (Interdisciplinary Team Meeting) to discuss use of P-cards (debit cards). 3) Purchase a drop box for [group home]. 4) Audits to be completed 5 times weekly by RM (Residential Manager). 5) Retrain staff on finances". On 2/19/21 at 9:52 AM, the Interim Associate Director (IAD) was interviewed. The IAD was asked about the above noted incident history. The IAD indicated the incidents of elopement, staff			

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	sleeping on duty and the use of inappropriate language, the missing medications and the missing personal funds had occurred. The IAD indicated those incidents were examples of where the implementation of the Abuse, Neglect and Exploitation (ANE) policy had not occurred. The IAD stated, "That's fair. I get that" and indicated the ANE policy should be implemented at all times. On 2/19/21 at 10:00 AM, the Interim Program Manager (IPM) was interviewed. The IPM was asked about the above noted incident history. The IPM indicated the incidents of elopement, staff sleeping on duty and the use of inappropriate language, the missing medications and the missing personal funds were examples of where the implementation of the Abuse, Neglect and Exploitation (ANE) policy had not occurred. The IPM stated, "We can in-service the existing staff there. I've not seen any current implementation (ANE policy) issues other than the missing medication. I did develop a finance book for the home. I trained how I understood with the new Area Supervisor". The IPM indicated implementation of the ANE policy should occur at all times and in-servicing with the existing staffing at the home on the implementation of the ANE policy would be reviewed. On 2/19/21 at 10:22 AM, the Quality Assurance Manager (QAM) was interviewed. The QAM was asked about the above noted incident history. The QAM indicated the incidents of elopement, staff sleeping on duty and the use of inappropriate language, the missing medications and the missing personal funds had occurred. The QAM indicated those incidents were examples of where the implementation of the ANE policy had not occurred. The QAM stated, "Yes, there needs			

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	to be enough staffing to implement the program plans". The QAM indicated the ANE policy should be implemented at all times. On 2/17/21 at 4:22 PM, the ANE policy dated 10/16/20 was reviewed. The ANE policy indicated, "ResCare strictly prohibits abuse, neglect, exploitation, mistreatment, or violation of an Individual's rights". 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 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 1 of 1 incident/investigative reports reviewed affecting client A, the facility failed to ensure there was sufficient direct care staff to manage and supervise client A according to his program plans. Findings include: Observation was completed on 2/15/21 from 11:45 AM to 1:02 PM. Present at the home were clients A, B, C and D along with staff #7. Clients A and C were in the dining area, client B was in his room and client D was in the living room. During the observation the clients were preparing for their noon meal of chicken with pasta and carrots.	W 0186	1.The Program Manager will conduct a weekly meeting to project needs and plan coverage for open shifts. All Area Supervisors in the New Albany Program and All ESN Direct Support Leads, and Residential Managers will attend if available. 2.ResCare New Albany Operation has brought in staff from out of town and, increased wages for DSPs outside of the ESN System including paid travel time bonuses, and mileage. 3.Human Resources has made filling ESN Open shifts a priority, this will continue until vacancies	03/21/2021

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	-At 12:03 PM staff #7 was interviewed. Staff #7 was asked about staff supports at the home. Staff #7 stated, "We're supposed to have 3 here and 2 at night. Today is because of weather. The 2 guys are usually here. It's pretty rare that just 1 person is here. We don't have a Home Manager at this time. We have a new Area Supervisor". Staff #7 was asked about elopement incidents at the home. Staff #7 indicated both client A and client B had elopement target behaviors identified in their behavior support plans. Staff #7 indicated he was not present when client A eloped from the home on 1/2/21. -At 12:23 PM, clients A, B and C sat down at the dining room table and began eating their noon meal. Client D was in the living room finishing a time limited game on his phone and then joined the group in the dining room at 12:30 PM. -At 12:45 PM, clients A, C and D began cleaning the dining area following their meal. Client B returned to his room after taking his plate and utensils to the kitchen sink. On 2/16/21 at 2:30 PM, a review of the Bureau of Developmental Disabilities Services (BDDS) incident reports and accompanying Investigative Summaries was completed. The reports indicated: BDDS report dated 1/3/21 indicated, "It was reported [client A] become upset and exited the home. Staff was unable to follow, and police were contacted for assistance. Police located [client A] 1 mile from the home. Police transported [client A] home". Investigation summary dated 1/2/21 indicated,		are filled. 4.The Area Supervisor will coordinate with ESN Residential Managers to ensure shift coverage. The unfilled shift will be reported to the Program Manager. 5.DSP Base pay has been increased to $13 and hour to help fill staffing vacancies, additional bonuses are being provided for qualified staff. 6.A weekly report is being provided to the hiring manager that will identify open positions and forecast staff gains and losses. Persons Responsible: Program Manager, Human Resource, Quality Assurance, Area Supervisor, Behavior Clinician, QIDP, Residential Manager, and DSP.	

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	15G723	A. BUILDING 00 B. WING	02/19/2021

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	"Briefly describe the incident and any sustained injury if any. [Client A] wanted more food but per his dining plan is on portion control. When staff told [client A], he could not have anything else, [client A] walked out the front door and kept walking through staff was attempting to verbally redirect him. Non-emergency police were contacted for assistance and brought [client A] back to the residence. There were no injuries reported .... Interview staff involved... [Former staff #1] - [Client A] got mad over food and ran out the front door and down the road. I called law enforcement and they brought him back. I couldn't follow him because there were other clients at home ... Was there sufficient staff at the time of the incident? No". On 2/17/21 at 3:03 PM, the Interim Associate Director (IAD) was interviewed. The IAD was asked about client A's incident of elopement on 1/2/21 and the staffing levels at the home. The IAD indicated the home operated with 12-hour shift, 7 AM to 7 PM (Day Shift) and 7 PM to 7 AM (Evening Shift). The IAD was asked if the staffing ratio had been maintained at the home and during client A's elopement. The IAD indicated that staffing ratio had not been maintained. The IAD stated, "We've taken corrective action to address that. We're putting a DSL (Direct Support Lead) in each home. We've hired 2 RMs (Residential Managers). The old system was an RM in each house and an Area Supervisor. We're increasing management at the homes". On 2/17/21 at 1:33 PM, client A's record were reviewed. The record indicated the following: -Individual Support Plan (ISP) dated 1/11/21 indicated, "[Client A] requires supervision to			

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	ensure basic ADL's (Adult Daily Living Skills) are completed. [Client A] has several health concerns at this moment that require 24- hour supervision and care. [Client A] needs help through verbal prompting and assistance when evacuating the residence during emergencies. The interdisciplinary team recommends that [client A] have supervision while participating in community activities due to his current diagnoses and inappropriate behaviors as well as health and safety issues ...". -Behavior Support Plan (BSP) dated 9/18/20 indicated, "Target Behaviors: ... Elopement: any occurrence of leaving the area with the intent to escape staff supervision at home or in community ... Reactive Procedures: ... Elopement: Verbally redirect him back to his side of the house. Engage him in a preferred activity with the staff in his area. If he is attempting to leave the area, request that he go for a walk with staff and/or go to an area away from the source of what may be frustrating/bothering him. If he continues to attempt to leave or does leave, immediately follow him and continue to redirect him back to the assigned area or an area where you can problem solve with him. If he complies provide abundant praise and work with him on what if bothering him. If he does not comply, immediately notify the AS (Area Supervisor) and BC (Behavior Clinician) of the incident. If while at the home, he is attempting to leave and is walking in the neighborhood or toward [name of road], staff will block him from going that direction. If the behavior persist and he gets to the end of the driveway, staff will implement YSIS (You're Safe I'm Safe) starting with one-person physical redirection. If the behavior persist staff will implement the two-person			

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	physical redirection. If necessary, the two person lift is applicable only for elopement and other behaviors displayed that are life threatening. If [client A] displays any other target behavior, follow the reactive procedure for that behavior ...". On 2/17/21 at 3:39 PM, staffing time records were reviewed for the date of 1/2/21, the date of client A's elopement. The staffing coverage indicated the following: -Former staff #1 clocked in on 1/2/21 at 7:19 AM and clocked out at 7:17 PM for the day shift. -Staff #7 clocked in for his evening shift on 1/1/21 and clocked out at 7:38 AM on 1/2/21. Staff #7 clocked back in during the evening hours of 1/2/21 at 7:16 PM. -Staff #6 clocked in for her evening shift on 1/1/21 and clocked out at 7:20 AM on 1/2/21. Staff #6 clocked back in during the evening hours of 1/2/21 at 6:52 PM. The staffing coverage on 1/2/21, the date of client A's elopement, was 1 staff during the day shift hours of 7 AM to 7 PM and 2 staff during the evening shift between the hours of 7 PM to 7 AM. On 2/18/21 at 2:41 PM, the undated Reimbursement Guidelines for the 24 hour Extensive Support Needs Residences were reviewed. The record indicated, "Individuals living in residences under this category must be supervised at all times and the staffing pattern at full capacity should be a minimum of: three (3) staff on the day shift; three (3) staff on the evening shift; and two (2) staff on the night shift".			

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	From observation, interviews with staff and a record review of the previous 3 weeks of time records, the use of 2 staff members scheduled during the 8 AM to 8 PM day shift was indicated. On 2/19/21 at 10:00 AM, the Interim Program Manager (IPM) was interviewed. The IPM was asked about the above staffing coverage at the home on the day of client A's elopement on 1/2/21 and if day shift hours were between 7 AM to 7 PM. The IPM stated, "Yes, [IAD] and I are going to look at the scheduling. I don't like the 12 hours really. If we have call-ins, it's hard to staff for 12 hours". The IPM indicated two additional Residential Managers and a new Area Supervisor had been hired to add additional oversight to help ensure staffing coverage. The IPM indicated the home should have maintained a staffing coverage of 3 staff on day shift. 9-3-3(a)			
W 0440 Bldg. 00	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 for 2 of 2 sampled clients (A and B), and 2 additional clients (C and D), the facility failed to conduct quarterly evacuation drills for each shift of personnel. Findings include: On 2/17/21 at 1:58 PM, a review of the facility's evacuation drills was completed. The facility failed to provide documentation for evacuation drills conducted during the months of January 2021, December 2020, November 2020, October 2020, September 2020 and August	W 0440	1.All staff at the home will be re-trained on conducting evacuation drills quarterly on all shifts. The Residential Manager will review all drills to ensure all required drills area conducted. The Program Manager will train the Area Supervisor and the Area Supervisor will train all facility staff. 1.The Area Supervisor will visit the home at least monthly to ensure the drills are in the home	03/21/2021

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	2020. This affected clients A, B, C and D. On 2/17/21 at 2:30 PM, the Qualified Intellectual Disabilities Professional (QIDP) was interviewed. The QIDP was asked how often evacuation drills should be completed at the home. The QIDP indicated one evacuation drill per shift per quarter. The QIDP indicated evacuation drills had not been completed from August 2020 through January 2021. On 2/17/21 at 2:31 PM, staff #4 was interviewed. Staff #4 was asked if evacuation drills from August 2020 through January 2021 were available for review. Staff #4 stated, "I'll be honest, I don't think we've completed them (evacuation drills)". Staff #4 indicated no evacuation drills could be provided for review for the period of August 2020 through January 2021. On 2/19/21 at 9:52 AM, the Interim Associate Director (IAD) was interviewed. The IAD indicated the Qualified Intellectual Disabilities Professional had shared information about missing evacuation drills at the home. The IAD stated, "We're missing some". On 2/19/21 at 10:00 AM, the Interim Program Manager (IPM) was interviewed. The IPM was asked about missing evacuation drills. The IPM indicated she was new to this home and unaware of any issues with the home's evacuation drills being completed. The IPM stated, "I didn't know anything about missing evacuation drills". On 2/19/21 at 10:22 AM, the Quality Assurance Manager (QAM) was interviewed. The QAM was asked about missing evacuation drills for review at the home. The QAM indicated the IAD had		and up to date. 1.The Residential Manager will submit monthly drills to the QA Department upon completion. The QA Department will notify the Area Manager and Program manager if the facility has not performed monthly drills as required. 1.The Area supervisor will ensure drills are completed as required. 1.The program manager will conduct random monthly inspections to ensure drills are being completed as required. **Persons Responsible:** Program Manager, Area Supervisor, Residential Manager, Direct Support Lead, DSP, QA	

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	contacted him about copies to provide for review, but it was determined the home was missing evacuation drills and additional copies of completed drills could not be provided for review. 9-3-7(a)			