STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	15G807	A. BUILDING 00 B. WING	11/25/2024

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COMMUNITY ALTERNATIVES ADEPT	213 W WATER ST CENTERVILLE, IN 47330

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W 0000 Bldg. 00	This visit was for a pre-determined full recertification and state licensure survey. This visit included the investigation of complaint #IN00446149. Complaint #IN00446149: Federal/state deficiency related to the allegation(s) was cited at W149. Survey Dates: November 21, 22 and 25, 2024. Facility Number: 012632 Provider Number: 15G807 AIMS Number: 201065000 These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review of this report completed by #15068 on 12/6/24.	W 0000		
W 0149 Bldg. 00	483.420(d)(1) STAFF TREATMENT OF CLIENTS Based on record review and interview for 1 of 2 sampled clients (A), the facility failed to implement its written policy and procedures to prevent two incidents of client A ingesting non-edible items which required medical intervention. Findings include: On 11/21/24 at 1:05 PM, a review of the facility's incident/investigative reports was conducted and indicated the following: 1. A 10/26/24 Bureau of Disability Services (BDS) report indicated the following incident occurred on 10/25/24 at 6:20 AM: "On the morning of	W 0149	**CORRECTION:** *The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, or abuse of the client.* Specifically, the QIDP/Behavioral Clinician revised the enhanced supervision procedures in client A's Behavior Support plan including switching assigned one to one staff every 30 minutes to facilitate maintaining focus. The QIDP/Behavioral Clinician trained all staff on the plan revisions. Through monitoring	12/21/2024

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Bob Morris	QIDP Manager	12/20/2024

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	10/25/24, [client A] became agitated because she chose not to participate in the company Halloween party the night earlier. Staff offered supportive conversation and coping skills. [Client A] sat up on her bed with her feet on the floor, placing her hands between her legs, sitting calmly. [Client A's] 1:1 (one on one) staff saw [client A] put her hand to her mouth and put something in her mouth. Staff attempted to verbally redirect and block to remove the object from [client A's] mouth, but [client A] was able to swallow the object. Staff notified administrative staff and were prompted to notify emergency services for an evaluation. [Client A] became verbally aggressive but complied with morning hygiene while waiting on emergency transport. EMS (Emergency Medical Services) transported [client A] to the [Hospital] Emergency Department. Initial evaluation through x-ray did not show object in her stomach, but a CT (computed tomography) scan noted a small sharp object further down in the intestinal track (sic). [Client A] was admitted into [Hospital] for further evaluation and treatment. Staff was in communication with Nursing, Area Supervisor, and behavioral clinician during this incident. [Staff #1], [client A's] one to one staff at the time of the incident, has been suspended pending investigation. The Executive Director was notified. Plan to Resolve: [Client A] remains hospitalized. ResCare nursing will remain in communication with the hospital to assure continuity of care. [Client A] has a history of swallowing non-food items addressed in her Behavior Support Plan. The interdisciplinary team met on 10-25-24 to discuss this incident and the adjustments that need to occur to her room and behavior support plan to prevent further swallowing no (sic) food items. ResCare's investigation into the incident is ongoing and [staff #1] will remain suspended		of incident documentation and face to face observation, the governing body determined that this deficient practice did not affect the other clients who reside in the facility. **PREVENTION:** An Area Supervisor or Direct Support Lead will be present, supervising active treatment during no less than five active treatment sessions per week, on varied shifts to assist with and monitor skills training, including but not limited to assuring staff implement behavior supports as written, and that safety equipment functions as required. For the next 30 days, members of the Operations Team (comprised of the Executive Director, Operations Managers, Program Managers, Quality Assurance Manager, QIDP Manager, QIDPs, Quality Assurance Coordinators, Area Supervisors, Assistant Nurse Manager and Nurse Manager) will conduct twice weekly administrative monitoring during varied shifts/times, to assure interaction with multiple staff, involved in a full range of active treatment scenarios, including weekend observations. After 30 days, administrative monitoring will occur no less than weekly until all staff demonstrate competence. After this period of enhanced administrative monitoring and support, the	

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	pending the outcome". A 10/31/24 Investigative Summary indicated the following: "Factual Findings: -[Client A] became agitated approximately twenty minutes after waking up on 10/25/24 (6:20 AM). -[Staff #1] provided one-to-one observation to [client A] on her 8:00 PM-8:00 AM shift on 10/24/24-10/25/24. -[Client A] testified that when she woke up and was angry, [staff #1] was sitting back on the couch in front of her door listening to music on her phone. -[Staff #1] testified that she had been sitting on the couch while [client A] slept but had moved a computer chair in its place before [client A] woke up. -[Staff #2] testified that she could not be certain whether [staff #1] was sitting on the couch or in the computer chair at the time of the incident because she was working on the other side of the house. -[Staff #1] testified that after approximately 30 minutes of agitated behavior, [client A's] actions and body language suggested to her that [client A] was about to swallow something so [staff #1] stood up and walked toward her, but that before she reached her [client A] placed her hand to her mouth and appeared to put something into her mouth. -[Client A] testified that [staff #1] saw her place a		Executive Director and Regional Director will determine the level of ongoing support needed at the facility. Current Operations Team members received training from the QIDP Manager on 12/14/23, to assure a clear understanding of administrative monitoring as defined below. · The role of the administrative monitor is not simply to observe & report. · When opportunities for training are observed, the monitor must step in and provide the training and document it. · If gaps in active treatment are observed the monitor is expected to step in and model the appropriate provision of supports. · Assuring the health and safety of individuals receiving supports at the time of the observation is the top priority. · Review all relevant documentation, providing documented coaching and training as needed. Administrative oversight will include: · Assuring proper implementation of Behavior Support Plans. · Assuring safety equipment functions as required. **RESPONSIBLE PARTIES:** QIDP, Area Supervisor, Direct Support Lead, Direct Support Staff, Operations Team, Regional	

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	staple into her mouth. -[Staff #1] testified that she applied pressure to [client A's] cheeks, attempting to get [client A] to open her mouth. -[Staff #1] testified that she was careful not to apply too much pressure, so as not to hurt her or cause injury from whatever [client A] had swallowed. -[Client A] testified that [staff #1] covered her nose with her hand to get her to open her mouth. -[Staff #1] testified that she did not pace (sic) her hand over [client A's] nose. -[Client A] and [staff #1] both testified that [client A] swallowed the object. -[Client A] identified the object she swallowed as one or two staples that she had exposed by peeling paint off her bed frame. -[Client A] testified that she also swallowed some small pieces of paint. -[Staff #1] testified that she contacted [Direct Support Staff Lead/DSSL] and reported that she believed [client A] had swallowed a nail. -[DSSL] confirmed that [staff #1] reported to the incident to her shortly before 7:00 AM and testified that she instructed [staff #1] to call the nurse and to prepare [client A] for transport to the hospital. -[Staff #1] testified that she did not call the nurse. -[LPN (Licensed Practical Nurse)] testified that		Director	

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	she was not called about the incident and that she found out about it through an email she received at 8:15 AM. -[LPN] testified that she would have instructed staff to take her to the ER (emergency room), if she had been informed. -Hospital records provided to ResCare staff and nursing provide an inconclusive clinical picture of [client A's] medical status. Upon her admission to the hospital, verbal reports from hospital personnel indicated an abdominal CT Scan showed a potentially sharp object in [client A's] upper intestine. [Client A's] X-Ray Abdomen Two-way Upright and KUB (kidney, ureter, bladder) taken 10/26/24 'findings: supine and upright radiograph of abdomen and pelvis. There is no obvious radiopaque evidence of foreign body or free air. Bowel gas pattern demonstrate diffuse ileus (inability of the intestine to contract normally and move waste out of the body) with large and small bowel distention. The Osseous (bone tissue) structures are normal'. [Client A's] Hospital After visit Summary indicated a discharge diagnosis of Encounter for Observation of Suspected Foreign Body Ingestion Ruled Out. -[DSSL] testified that on the 8:00 AM to 8:00 PM shift staff switched out one-to-one responsibilities every 30 minutes. -[Staff #2] testified that with past partners on the 8:00 PM to 8:00 AM shift, she would switch out with the other staff every half hour. She said that currently, however, [staff #1] preferred to handle the one-to-one responsibilities while [staff #2] cleaned and assisted the other individuals with their morning routines.			

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	-[Staff #1] confirmed the current night shift division of labor on her rotation with [staff #2]. -[Staff #1] testified that she remains sitting and does not fall asleep. -[Staff #2] testified that she has observed [staff #1] lying on the couch but has never seen [staff #1] asleep or appearing to be ready to doze off. -At the time of the incident (sic). Eating non-food items was addressed in her Behavior Support Plan. -Per [staff #1's] testimony, when [client A] reached down and appeared to be manipulating her bed, [staff #1] remained seated outside of her door and did not approach [client A] to intervene per enhanced supervision protocols, in [client A's] plan. Conclusion: 1. The evidence substantiates that [client A] swallowed a non-food item that required medical intervention on 10/25/24. 2. The evidence does not substantiate that [client A's] Behavior Support Plan failed to address swallowing non-food items. 3. The evidence does not substantiate that [client A's] one-to-one staff was not present at the time of the incident. 4. The evidence does not substantiate that [staff #1] failed to remain awake and alert while providing one-to-one supervision to [client A] on the night of 10/24/24 through the morning of 10/25/24.			

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	5. The evidence does not substantiate that [staff #1] failed to intervene, per her Behavior Support Plan, when [client A] became agitated and began to escalate on 10/25/24. 6. The evidence substantiates that [staff #1] failed to follow [client A's] one-to-one procedures on 10/25/24. 7. The evidence substantiates that [staff #1] failed to prevent [client A] from swallowing a non-food object while assigned to provide one-to-one supervision on 10/25/24. 8. The evidence substantiates that [staff #1] failed to report to the nurse that [client A] had swallowed a non-food object on the morning of 10/25/24. 9. The evidence substantiates that [client A] failed to follow ResCare Policies and Procedures. 10. The evidence does not substantiate that the facility's staffing level contributed to [client A] swallowing a non-food item on 10/25/24. Recommendations: 1. See Peer Review". An 11/1/24 ResCare Investigation Peer Review indicated the following: "1. Return [staff #1] to work with Progressive Written Corrective Action (7.1 A 21). 2. Revise BSP to include documented room sweeps.			

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	3. Confirm staff training on revised BSP and 1:1 Protocols, keeping common areas clear, not moving couch for nighttime 1:1, 1:1 30 minute rotation. 4. Add Ileus (diagnosed during hospitalization) to [client A's] Comprehensive High-risk Plan. 5. Environmental services to cover outlets and secure any new items that could be broken/swallowed". On 11/22/24 at 3:00 PM, the Qualified Intellectual Disabilities Professional Manager (QIDPM), Operation Support Specialist (OSS), QIDP/Behavior Clinician (QIDP/BC) and the Program Manager (PM) were interviewed. The QIDPM indicated client A was admitted to the hospital for observation after reporting she swallowed non-edible items, possibly staples from her platform bed. The QIDPM indicated the initial x-ray didn't show anything but the CT scan showed probable small foreign objects. The QIDPM stated, the hospital discharge diagnosis was "Encounter for Observation of Suspected Foreign Body Ingestion Ruled Out". The QIDPM indicated client A was discharged from the hospital on 10/27/24. The QIDP/BC indicated client A's one on one protocol wasn't implemented because staff were to switch out every 30 minutes. The QIDP/BC indicated staff #1 should have been closer to client A while she was in bed due to client A being upset prior to the incident occurring. The QIDP/BC indicated client A's BSP wasn't implemented as written. The QIDP/BC indicated client A's BSP was updated to include documented room sweeps and staff were retrained on the updated BSP. 2. A 9/3/24 BDS report indicated the following			

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	incident occurred on 9/2/24 at 9:15 AM: "On the morning of 9/2/24 [client A] became agitated during her morning hygiene routine. Staff offered supportive conversation and offered coping skills. [Client A] (sic) asked her to do her crafts for her coping skill to help her calm. Staff offered supportive conversation while doing crafts to assist with calming. While doing crafts with staff [client A] became agitated for unknown reasons. [Client A] took a plastic [sandwich] bag that her crafting items were in and began to bite off a piece of the bag. Staff attempted to block the attempt but was unsuccessful and she as (sic) able to swallow a small piece of the bag. [Client A] then became tearful stating she had swallowed something earlier that day but did not disclose what she had swallowed. Staff contacted nursing and administrative staff and nursing instructed to take [client A] to [Hospital] for further evaluation. Staff transported [client A] to [hospital] in [city, state]. [Client A] received x-ray's (sic) and (sic) discovered a (sic) unknown foreign object in her esophagus, and required a (sic) endoscopy (exam with a camera) to remove the foreign object. During the examination, [client A] disclosed to staff that she had swallowed the head to her electric toothbrush earlier during her morning hygiene routine. [Client A] was sedated and the toothbrush was removed. [Client A] tolerated the procedure with no issues. After the object was removed and she stabilized after the sedation, she as (sic) discharged back to the site. Plan to Resolve: [Client A] received post incident supportive conversation from the team after the endoscope. The team, including ResCare nursing, will continue to work with the [hospital] team for continuity of care during the recovery process and continue to monitor [client A] for possible issues. The team notified nursing and administrative staff about this procedure. [Client			

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	A] has a history of agitation and swallowing nonfood items that are outlined in her behavioral support plan, which includes her remaining on 1:1 staffing at all times. The team met on 9/3/24 with guardian to discuss the events of this incident and how to prevent further occurrences. A 9/5/24 Investigative Summary indicated the following: "Factual findings:" "Interviews indicate: Staff was following the BSP that day and was providing 1:1 to [client A]. Staff was in the bathroom doorway and had to allow [client A] to put the toothbrush in her mouth to brush her teeth. Staff was providing 1:1 as described in her plan. There is not a more efficient way to brush teeth with a (sic) object large enough to prevent swallowing. [Client A] must place a toothbrush in her mouth to brush teeth. Swallowing non-food objects is addressed in [client A's] Behavior Support Plan. Conclusion: 1. The evidence does not substantiate that staff failed to take measures and follow [client A's] Behavior Support Plan to keep her safe. 2. The evidence does not substantiate that [client A's] BSP failed to reflect her behavior of swallowing small objects and preventative			

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	strategies. 3. The evidence does not substantiate that staff failed to follow 1:1 procedures and small object procedures outline in [client A's] BSP. Recommendations: 1. Getting rid of her electric toothbrush and getting a thicker regular toothbrush to help avoid breaking and swallowing. Inspecting the toothbrush before and after each use. 2. Explore different methods of toothbrushing to reduce the risk of swallowing objects and/or having staff brush her teeth. 3. This will likely increase behaviors so attempting least restrictive first with changing the toothbrush". On 11/22/24 at 12:32 PM and on 11/25/24 at 8:50 AM, client A's record was reviewed. Client A's 11/13/24 BSP indicated the following: Client A had a target behavior of noncompliance with health and safety. Non-compliance with health and safety was defined as "When [client A] refuses to complete ISP (Individual Support Plan) and/or BSP goals/objectives, active treatment or medical/mental health treatments related to her health and safety as outlined in any doctor's (sic) orders. Includes any refusal to complete daily grooming/ hygiene (showering, washing hair, clean clothes d/t (due to) incontinence), refusal to follow menu or not eating or drinking. This will also include eating or drinking things she shouldn't (non food items) and putting items in areas of her body that they			

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	should not be in. Example: Putting things in her ears and nose or swallowing things that she should not be eaten. [Client A] often does this so that she can goto (sic) the ER. Restrictions: "Modified Enhanced Supervision (MES)/Small objects: To protect [client A] from placing herself at risk of harm all small objects, smaller than a quarter will be restricted or used only in the supervision of staff (Example: Crafting items, beads and anything that can be put in her ears, nose or throat). [Client A] will also not be permitted to have any small jewelry (Charms, ear rings, necklaces, bracelets) in her possession to avoid her swallowing these items or causing harm to herself. [Client A] will have limited items in her room to avoid her taking things to break and/or swallow that could cause her potential harm. All items in her room will be kept at a minimum and only allow things that are necessary for her daily living (clothes, bedding and furniture (sic). All other items will be stored out of her personal bedroom and be available to her upon request while in the supervision of her 1: 1 staff. [Client A] will have a 1:1 staffing continuously starting 9/14/23, this will include showering, bathroom and staff will move with her throughout the house and watching her sleep with a light on for viewing her at all times throughout the night. This includes crafting and supplies. All crafting items must be accounted for when [client A] is done with her crafting (for example 5 crayons put out 5 put back). All beads and small items are to be counted and small items she makes must be put up for her until she is able to have access to these items again. [Client A] will remain on 1:1 until a (sic) IDT (Interdisciplinary Team) meeting is set and 1:1 is lifted. Please be aware of small items in the common areas and all things that can be			

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	broken into smaller pieces to be swallowed. Always scan the common areas of the home for swallowing dangers. Update 10-27-24 Room Checklist form and Clothing/Common area protocol: -Staff is to document daily on the Room checklist form, all areas of the room for missing wood, screws or nails on walls, on her bed frame, baseboards, flooring and outlet covers. Any missing screws, nails and wood must be documented on form and supervisor and QIDP notified immediately upon findings. -While [client A] is in behavior and disrobes, keep her removed clothing with her but out of reach while in active behavior. Once [client A] has calmed prompt her every 5 minuets (sic) to redress. [Client A] will eat her clothing while in active behavior. -If [client A] rips her clothing, remove all pieces of her ripped clothing, and get them out of the room immediately. Call for fellow staff to remove the torn pieces if necessary. [Client A] will eat clothing that will cause bowel obstructions. -Also, keep small items out of common areas of the home to prevent [client A] (sic) grabbing items and swallowing. Example: pens, staff belongings, keys and other small items that can be broken. MES for target behaviors: There will be times [client A] is demonstrating target behaviors while on 1:1 MES. During these times the protocol goes as follows and still includes 1:1 staffing. Modified Enhanced Supervision Protocols: When [client A] demonstrates she may be a threat to herself (through the expression of suicidal			

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	15G807	A. BUILDING 00 B. WING	11/25/2024

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	ideations or other high intensity displays of behaviors), supervision will move from Modified Enhanced Supervision to Enhanced Supervision protocols. During these displays, [client A] needs the support and heightened supervision protocols that Enhanced Supervision provide; these specific measures are to be implemented when [client A] is potentially a threat to herself or others while at home and in the community. MES means that [client A] is on Enhanced Supervision and not able to enter the community. The MES protocol (when implemented) will be evaluated every 2-hours by the RM (Residential Manager)/AS/QIDP and Behaviorist.... 1: 1 Protocol: [Client A] is 1:1 until further notice. This means that you should always be with [client A] and follow her as she moves through the home, during waking hours. This includes the bathroom. You must always keep [client A] in your sight and as close to her as possible without causing agitation, and at her side no exceptions. For example, if [client A] is sitting on the couch, you should be beside her or sitting in front of her. Place yourself so you are able to prevent grabbing and swallowing things. [Client A] is quick, stay as close as possible to her. During sleeping hours, you should be placed in her room placing yourself so that you are able to prevent her picking at herself or bed/ bedding/clothing, and so you have quick access to [client A] in case of these events. Low lighting or lights on so that you can always see [client A] and her hands. Also, prompt [client A] to put her hands outside her blankets so that you can always see her hands. Position yourself around her room as she moves through the night to adjust the view of [client A] and her hands if needed. Staff should be switching out every 30 minutes with another staff during the day and			

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	night shift to avoid staff burn out during 1:1 with [client A]. Staff will not move any Livingroom (sic) furniture into [client A's] bedroom or outside her bedroom door, at any time and must use dining room chairs that must be in her room next to her while she sleeps.... Strategies to decrease: [Client A] should be closely monitored for Non-compliance w/ (with) health and safety when she becomes upset or angry. Staff will ask [client A] her reason for non compliance. Ask [client A] if she will accompany staff to another private area of the house so they can talk. Ask [client A] how staff can help with the situation. Staff will utilize active listening skills by repeating back what one believes she stated. Acknowledge problem and work with [client A] to find a solution to the problem". Client A's hospital 10/27/24 discharge summary indicated client A was admitted to the hospital on 10/25/24 and discharged on 10/27/24. "Principle (sic) Admission Diagnosis: Encounter for observation for suspected ingested foreign body ruled out. Discharge Diagnoses- Principle (sic) Problem: Encounter for observation for suspected ingested foreign body ruled out". "Patient was upset at the group home workers last night and ingested small piece of paper and screws from her bed frame. She present to the ED (emergency department) today due to right upper quadrant abdominal pain and nausea. She denies vomiting. Per group home worker, patient had a small bowel movement this morning while she was in CT scan. She was evaluated by psych tree arch due to concerns for possible suicidality, but per Psychiatry note, her behaviors were not due to self-harm, but more due to impulse control disorder. Psychiatry recommended patient be			

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	discharged back to group home following medical rule out. CT of the abdomen and pelvis indicated multiple hyperdense metallic foreign bodies in the distal small bowel without free air.... Case was discussed with GI (gastrointestinal) who recommended NPO (nothing by mouth) while patient was experiencing pain with serial KUB. She was admitted for ingested foreign body". On 11/22/24 at 3:00 PM, the QIDPM, OSS, QIDP/BC and the PM were interviewed. The PM and QIDP/BC indicated staff didn't check the electric toothbrush to ensure all parts with there when she returned her hygiene basket to staff. The QIDP/BC indicated client A's supervision at the time of the incident was one to one and client A hadn't had any recent incidents of ingesting nonedible items. The PM indicated staff were in the bathroom with client A when the incident occurred but they didn't see client A ingest the head of the toothbrush. The PM indicated client now uses a manual toothbrush with a thick handle. The QIDPM indicated the facility had an abuse neglect policy which prohibits abuse, neglect, exploitation and mistreatment of the clients and it should be implemented as written. The agency's Abuse, Neglect, Exploitation, Mistreatment Operating Standard dated 2/26/18 was reviewed on 11/25/24 at 9:45 AM and indicated the agency "strictly prohibited abuse, neglect, exploitation, mistreatment, or violation of an Individual's rights". "ResCare staff actively advocate for the rights and safety of all individuals. All allegations or occurrences of abuse, neglect, exploitation, mistreatment shall be reported to the appropriate authorities through the appropriate supervisory channels and will be thoroughly investigated			

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	under the policies of RESCARE, Rescare, and local, state and federal guidelines." This federal tag relates to complaint #IN00446149. 9-3-2(a)			
W 0356 Bldg. 00	483.460(g)(2) COMPREHENSIVE DENTAL TREATMENT Based on record review and interview for 1 of 2 sampled clients (A), the facility failed to ensure client A was provided with timely dental services. Findings include: On 11/22/24 at 12:32 PM and on 11/25/24 at 8:50 AM, client A's record was reviewed. Client A's record indicated she had a dental examination on 1/26/24 and the following recommendation was made. "Pt. (patient) needs deep cleaning on upper teeth. Antibiotic and mouthwash called to pharmacy. Return appointment date: March 5th, 2024 1:30 PM". There was no documentation indicating the follow-up appointment was completed. On 11/22/24 at 3:00 PM, the Qualified Intellectual Disabilities Professional Manager (QIDPM), Operation Support Specialist (OSS), QIDP/Behavior Clinician (QIDP/BC) and the Program Manager (PM) were interviewed. The PM indicated follow up appointments should be completed as recommended. The QIDP/BC indicated client A attended the appointment on 6/6/24 according to the calendar. The QIDPM indicated the dentist would be called to obtain the record of visit for the appointment and the information would be provided.	W 0356	**CORRECTION:** *The facility must ensure comprehensive dental, treatment services that include dental care, needed for relief of pain and infections, restoration of teeth, and maintenance of dental health.* Specifically, the facility nurse scheduled recommended dental follow-up for client A. A review of facility documentation indicated this deficient practice did not affect additional clients. **PREVENTION:** · The Facility nurse will complete monthly audits of all charts and turn in the audits to the Nurse Manager for review. · The Nurse Manager will review issues revealed in audits with the Executive Director and Department heads weekly for follow-up. · The Executive Director and will follow-up with the Nurse Manager as needed to address issues raised through audits, incident reports or other concerns brought to management attention.	12/21/2024

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	On 11/25/24 at 12:19 PM, the following email was sent to the Surveyor from the QIDPM, "[PM] spoke with the dentist office and the appointment needed to be rescheduled for 12/06/24, at 11 AM". 9-3-6(a)		Members of the Operations Team (comprised of the Executive Director, Operations Managers, Program Managers, Quality Assurance Manager, QIDP Manager, QIDPs, Quality Assurance Coordinators, Area Supervisors, Assistant Nurse Manager and Nurse Manager) and nursing staff will incorporate medical chart reviews into their formal audit process, which will occur no less than monthly to assure that medical follow-along including but not limited to recommended follow-up examinations and procedures take place as required. **RESPONSIBLE PARTIES:** QIDP, Area Supervisor, LPN, Direct Support Lead, Direct Support Staff, Operations Team, Regional Director	