

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G807	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	(X3) DATE SURVEY COMPLETED 04/06/2022
NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES ADEPT		STREET ADDRESS, CITY, STATE, ZIP COD 213 W WATER ST CENTERVILLE, IN 47330		
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W 0000 Bldg. 00	<p>This visit was for a pre-determined full recertification and state licensure survey. This visit included the investigation of complaint #IN00376550.</p> <p>Complaint #IN00376550: Unsubstantiated, due to lack of sufficient evidence.</p> <p>This visit was in conjunction with the PCR (post certification revisit) to the PCR completed on 2/17/22 to the investigation of complaints #IN00366881 and #IN00368229 completed on 12/16/21.</p> <p>This visit was in conjunction with the PCR to the investigation of complaint #IN00370933 completed on 2/17/22.</p> <p>Survey Dates: April 4, 5 and 6, 2022.</p> <p>Facility Number: 012632 Provider Number: 15G807 AIMS Number: 201065000</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review of this report completed by #15068 on 4/18/22.</p>	W 0000		
W 0189 Bldg. 00	<p>483.430(e)(1) STAFF TRAINING PROGRAM</p> <p>The facility must provide each employee with initial and continuing training that enables the employee to perform his or her duties effectively, efficiently, and competently.</p> <p>Based on observation, record review and interview for 1 non-sampled client (D), the facility</p>	W 0189	<p>CORRECTION: <i>The facility must provide each</i></p>	05/06/2022

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

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosed days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	<p>failed to ensure staff were competently trained and properly implemented client D's dining plan.</p> <p>Findings include:</p> <p>On 4/4/22 from 6:00 AM to 8:20 AM, an observation was conducted at the group home. At 7:55 AM, client D washed her hands and started eating breakfast. Breakfast was biscuits and gravy, bacon and yogurt. Throughout the meal, client D took a bite, put her fork down, paused for 10 seconds then repeated the process with each bite. Client D took drinks as needed. Staff #4 sat next to client D throughout the meal and would prompt client D if she attempted to take a bite prior to chewing and swallowing her food.</p> <p>On 4/4/22 from 4:00 PM to 6:15 PM, an observation was conducted at the group home. At 5:55 PM, client D washed her hands and went to the table for dinner. Dinner was oven fried chicken, carrots, cream style corn, and a roll with butter and pudding. Staff #2 sat diagonally across the table from client D throughout the meal. Client D took a bite of food, put her utensil down, paused, took a drink, paused again then repeated the process until her food was gone. Throughout the meal, staff #2 provided constant redirection for client D to follow her dining plan, take sips of her drink between bites, the pause between bites wasn't long enough, etc. Client D became frustrated and stated, "I just want to eat" over and over again. Client D asked for more to drink and staff #2 stated, "No, you're on a fluid restriction". Client D was crying and emotional throughout the meal.</p> <p>On 4/5/22 at 11:00 AM, a focused review of client D's record was conducted. Client D's record indicated client D had an annual swallow</p>		<p><i>employee with initial and continuing training that enables the employee to perform his or her duties effectively, efficiently, and competently.</i> Through observation the governing body has determined that this deficient practice affected all clients. Specific corrections include: All facility staff will be retrained by the nurse regarding proper implementation of client D's dining plan. Through observation, the governing body determined that this deficient practice did not affect additional clients.</p> <p>PREVENTION: A management staff will be present, supervising active treatment during no less than five active treatment sessions per week, on varied shifts to assist with and monitor implementation of dining plans. Members of the Operations Team 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, until all staff demonstrate competence. After this period of enhanced administrative monitoring and support, the Executive Director and Regional Director will determine the level of ongoing support needed at the facility. Current Operations Team</p>	

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	<p>evaluation on 6/1/21. The recommendations from the evaluation were, "Thin liquids with flow restrictive cup as needed, regular diet (chopped/ground to bite size pieces as needed), feeding strategies (counting while chewing as needed)".</p> <p>Client D's 9/16/21 Dining Plan indicated the following: "Behavior Concerns: [Client D] has a tendency to rush at mealtime and not properly chew her food. After each bite [client D] should count to 10 and take a sip of fluid as needed. [Client D] will pocket her food and rushes when drinking fluids. Food Texture: Regular diet, chopped/ground to bite size pieces as needed.... Specific Skills to Maintain/Acquire: Staff should sit with [Client D] during all meals and provide prompts and assistance as needed. Encourage [client D] to slow down and chew her food and count to ten between bites and follow with a sip of fluid from restrictive flow cup if needed (sic)".</p> <p>On 4/4/22 at 5:10 PM, client D was interviewed. Client D stated her meal plan was to "Take a bite, put my fork down, count to 10, take a drink, pause, take another bite". Client D indicated the staff were not consistent with implementing her plan.</p> <p>On 4/5/22 at 4:05 PM, the QIDPM (Qualified Intellectual Disabilities Professional Manager), QIDP (Qualified Intellectual Disabilities Professional), AS (Area Supervisor), QAM (Quality Assurance Manager), LPN (Licensed Practical Nurse) and the PM (Program Manager) were interviewed. The AS indicated client D was at risk for choking due to eating fast and not chewing her food. The AS indicated client D was on a fluid restriction at one time. The LPN indicated client D was not on a fluid restriction</p>			<p>members received training from the QIDP Manager to assure a clear understanding of administrative monitoring as defined below.</p> <ul style="list-style-type: none"> · 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 <p>Administrative support at the home will include assuring staff dining plans as written.</p> <p>RESPONSIBLE PARTIES: QIDP, Area Supervisor, Residential Manager, Direct Support Staff, Operations Team, Regional Director</p>

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W 0249 Bldg. 00	<p>and she should have been given more to drink. The LPN indicated client D's plan said she should take a drink between bites if needed. The AS indicated client D required redirection to follow her plan during every meal. The AS and the QIDP indicated staff needed to be retrained on client D's meal plan so staff were consistent with implementing the plan as written.</p> <p>9-3-3(a)</p> <p>483.440(d)(1) PROGRAM IMPLEMENTATION As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan.</p> <p>Based on observation, record review and interview for 1 of 2 clients in the sample (A) and 1 additional client (D), the facility failed to ensure staff implemented clients A and D's program plan training objectives during formal and informal opportunities.</p> <p>Findings include:</p> <p>1. On 4/4/22 at 8:25 AM, the AS (Area Supervisor) was interviewed. The AS indicated client A was restricted from internet access and social media. The AS indicated client A was discharged from a mental health facility on 3/29/22 and she was placed at a hotel until her discharge date of 4/8/22. The AS stated client A "has been putting stuff all over [social media sites]". The AS stated, "She (Client A) posted on [social media] to pray for her last night. Guys have been</p>		W 0249	CORRECTION: <i>As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan.</i> Specifically, through observation, the governing body has determined this deficient practice could have affected all clients who live at the facility. All facility staff will receive additional training toward aggressive and consistent implementation of each	05/06/2022

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	<p>messaging her right and left".</p> <p>On 4/5/22 at 12:45 PM, client A's record was reviewed. Client A's 2/9/22 BSP (Behavior Support Plan) indicated, "Restrictions:... Internet and Social Media Access- NO ACCESS at Present Time- To reduce opportunities for her to communicate with whom she is not to have communication with, including those she knows and unknown individuals who could put her into danger and her housemates. [Client A] has a history of giving out her address to strangers online...."</p> <p>On 4/4/22 at 4:45 PM, client A was interviewed. Client A indicated she was restricted from the internet and social media. Client A indicated she had been on social media since she has been staying at the hotel. When asked how she had access to social media, client A stated, "It's free wifi at the hotel. I just have to call the front desk and get the password". Client A indicated staff working with her knew she was on social media.</p> <p>On 4/5/22 at 4:05 PM, the QIDPM (Qualified Intellectual Disabilities Professional Manager), QIDP (Qualified Intellectual Disabilities Professional), AS (Area Supervisor), QAM (Quality Assurance Manager), LPN (Licensed Practical Nurse) and the PM (Program Manager) were interviewed. The QIDP and the AS indicated client A was restricted from the internet and social media. The AS stated, "We tried to block the internet from her room. She found a way to get on it. She was calling the front desk to get the password". When asked how she was able to access social media when she had 1:1 staffing in the hotel room, the AS stated, "The staff that was with her let her do it".</p>		<p>client's current prioritized learning objectives, and behavior support strategies, and safety restrictions. Additionally, all staff will be trained regarding that all formal programs including but not limited to token reward systems must be incorporated into approved plans prior to implementation.</p> <p>PREVENTION: A management staff will be present, supervising active treatment during no less than five active treatment sessions per week, on varied shifts to assist with and monitor implementation of prioritized learning objectives, as well as assuring behavior supports and safety restrictions are implemented as written. Members of the Operations Team 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, until all staff demonstrate competence. After this period of enhanced administrative monitoring and support, the 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 to assure a clear understanding of administrative monitoring as</p>	

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	<p>2. On 4/4/22 from 4:00 PM to 6:15 PM an observation was conducted at the group home. At 5:10 PM, client D showed the surveyor her bedroom. Client D had a container with tokens in it on her bookshelf. Client D indicated she earned the tokens by completing her goals and helping with things around the group home. Client D stated, "They (staff) keep forgetting to give them (tokens) to me. I haven't got any since [former staff #6] left". Client D indicated she should get the tokens at the end of the day when she gets her evening medication. Client D stated, "It's been a really long time". Client D indicated she enjoys trading her tokens in for prizes. There was an undated document called Rules for Tokens and Ribbons hanging on client D's wall. The document indicated the following: "1. Staff will be responsible for passing out tokens. 2. Tokens will be given every time individual is compliant with program, taking medications, and etc. 3. Each time an individual displays a target/precursor behavior, the individual will give a token back to staff...."</p> <p>On 4/5/22 at 11:00 AM a focused review of client D's record was conducted.</p> <p>Client D's 6/1/19 (revised 6/4/21) BSP (Behavior Support Plan) indicated the following Token Reinforcement Program:</p> <p>"1. Each individual will have a clear container with a lid in her room with her name on it. 2. Staff will have a supply of tokens on their person at all times for each of the individuals. The tokens will be a specific color for each individual, which will match the color of the lid on the container. 3. The staff will be responsible for giving a token to the individual when she is cooperative either</p>		<p>defined below.</p> <ul style="list-style-type: none"> • 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 <p>Administrative support at the home will include:</p> <ul style="list-style-type: none"> • Assuring staff implement prioritized learning objectives at all reasonable opportunities. • Assuring behavior support strategies and safety restrictions are implemented as written. • Assuring formal programs including but not limited to token reward systems are incorporated into approved plans prior to implementation. <p>RESPONSIBLE PARTIES: QIDP, Residential Manager, Direct Support Staff, Operations Team, Regional Director</p>	

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	<p>independently or with prompts to complete her individual programming goals/objectives/ expectations: this includes taking medication/treatments as ordered, attending day service as scheduled, participating in positive health and safety choices, demonstration of skill acquisition, etc.</p> <p>4. The token is to be given to the individual immediately for positive actions with the staff explaining what the action was that earned the token. Immediate reinforcement for positive and socially appropriate behaviors is the reason tokens must/should be carried by staff. The token is to be given by the staff who observed the positive action....</p> <p>9. Each time an individual displays a precursor/target behavior, the individual will give a token back to the staff by handing it to the staff. This is to help the individual learn personal responsibility for their own actions and to see they are responsible for what is occurring. If the individual refuses to return a token, no further tokens may be earned until the token is returned. Only tokens will be subject to return. Ribbons will not be subject to return.</p> <p>10. The point of immediacy is for the individual to learn positive behavior equals positive reinforcement. Therefore, token rewards and/or returns occur on the shift on which the action occurred...."</p> <p>On 4/4/22 at 5:52 PM, staff #3 was interviewed. Staff #3 stated, "They get tokens when they do goals or when they help around the house. They get them at the end of the day. Sometimes they gets marks (due to behavior) and lose a token though. We have been missing some (tokens) with everything that has been going on with [client A]. We need to get better". Staff #3 stated, "[Client D] earns them (tokens) then may</p>			

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W 0262 Bldg. 00	<p>lose them (tokens) and at the end of the day she doesn't get any". Staff #3 indicated she doesn't explain to the clients why tokens are earned or lost. Staff #3 stated, "Sometimes she (client D) gets them after she's asleep and she doesn't know it".</p> <p>On 4/5/22 at 4:05 PM, the QIDPM, QIDP, AS, QAM, LPN and the PM were interviewed. The AS stated, "We have tokens that they get for completing goals and if they do something that isn't asked of them. They earn the tokens, turn them in for ribbons then turn the ribbons in for snacks or an outing with preferred staff". The AS and the QIDP indicated the tokens should be awarded to the clients immediately after they are earned and the program should be implemented consistently.</p> <p>9-3-4(a)</p> <p>483.440(f)(3)(i) PROGRAM MONITORING & CHANGE The committee should review, approve, and monitor individual programs designed to manage inappropriate behavior and other programs that, in the opinion of the committee, involve risks to client protection and rights. Based on observation, record review and interview for 1 of 2 clients in the sample (A), the facility failed to obtain HRC (Human Rights Committee) approval regarding client A's restrictive BSP (Behavior Support Plan). Findings include: On 4/4/22 from 6:00 AM to 8:20 AM and 4:00 PM to 6:15 PM, observations were conducted at the group home. Each time someone opened the front</p>	W 0262	<p>CORRECTION: <i>The committee should review, approve, and monitor individual programs designed to manage inappropriate behavior and other programs that, in the opinion of the committee, involve risks to client protection and rights.</i> Specifically, the QIDP has obtained Human Rights Committee Approval for client A's</p>	05/06/2022

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	<p>door and two back doors an alarm sounded.</p> <p>On 4/5/22 at 12:45 PM, client A's record was reviewed. Client A's 2/9/22 BSP indicated she was prescribed the following psychotropic medications: Depakote (for behavior), Invega (for attention deficit hyperactivity disorder), Zoloft (for behavior) and Hydroxyzine (for behavior). The BSP indicated client A had the following restrictions: enhanced supervision (1:1) to prevent elopement; access to writing utensils and paper only under direct observation and supervision of a staff member; no access to the internet and social media; removal of personal items from her bedroom until behaviors stabilize; direct supervision during phone calls with her adoptive mother; restricted from sharps, chemicals and lighters; soft helmet and mitts during episodes of self injurious behavior and You're Safe, I'm Safe personal safety techniques. Client A's record did not indicate the facility obtained HRC consent prior to implementing client A's restrictive plan.</p> <p>On 4/5/22 at 4:05 PM, the QIDPM (Qualified Intellectual Disabilities Professional Manager), QIDP (Qualified Intellectual Disabilities Professional), AS (Area Supervisor), QAM (Quality Assurance Manager), LPN (Licensed Practical Nurse) and the PM (Program Manager) were interviewed. The QIDP indicated client A's updated BSP has been implemented and the facility did not obtain HRC approval prior to implementing the updated plan. The QIDP indicated the guardian has to approve the plan before it can go through the HRC process. The QIDPM stated, "It should not be implemented without consent".</p> <p>9-3-4(a)</p>		<p>Behavior Support Plan. A review of facility documentation indicated this deficient practice did not affect additional clients.</p> <p>PREVENTION: The QIDP will be retrained regarding the need to obtain Human Rights Committee Approval for all restrictive programs prior to implementation. Retraining will focus on assuring that the QIDP has a clear understanding of what specifically constitutes a restrictive program and proper preparation for presenting program modifications to the committee prior to granting approval to restrictive programs. The agency has established a monthly system of internal audits that review all facility systems including, but not limited to due process and Human Rights Committee Approval for restrictive programs.</p> <p>RESPONSIBLE PARTIES: QIDP, Operations Team, Human Rights Committee, Regional Director</p>	

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W 0312 Bldg. 00	<p>483.450(e)(2) DRUG USAGE be used only as an integral part of the client's individual program plan that is directed specifically towards the reduction of and eventual elimination of the behaviors for which the drugs are employed.</p> <p>Based on record review and interview for 1 of 2 clients in the sample (B), the facility failed to develop an active treatment program for the use of client B's PRN (as needed) psychotropic medications used for behavior control.</p> <p>Findings include:</p> <p>On 4/5/22 at 11:30 AM, client B's record was reviewed and indicated the following:</p> <p>Client B's March 2022 Physician's Orders indicated client B was prescribed Clonazepam .5 mg (milligrams), "Give one tablet by mouth once daily as needed for anxiety" and Haloperidol 1 mg, "Take one tablet every 8 hours as needed for agitation".</p> <p>Discharge records from client B's ED (Emergency Department) visit dated 11/16/21 indicated client B was prescribed Haldol 1 mg PRN (as needed).</p> <p>Client B's 9/21/21 ISP (Individual Support Plan) and client B's 11/29/21 BSP (Behavior Support Plan) did not include an active treatment program for the use of Clonazepam or Haldol as PRN medications.</p> <p>On 4/5/22 at 4:05 PM, the QIDPM (Qualified Intellectual Disabilities Professional Manager), QIDP (Qualified Intellectual Disabilities Professional), AS (Area Supervisor), QAM (Quality Assurance Manager), LPN (Licensed</p>	W 0312	<p>CORRECTION: <i>Drugs used for control of inappropriate behavior must be used only as an integral part of the client's individual program plan that is directed specifically towards the reduction of and eventual elimination of the behaviors for which the drugs are employed.</i> Specifically, the behavioral clinician has incorporated protocols for the use of an agitation PRN (as needed) medication into client B's Behavior Support Plan. A review of facility support plans and current medication orders indicated this deficient practice did not affect additional clients.</p> <p>PREVENTION: The behavioral clinician will be trained regarding the need to assure that active treatment programs are in place to support the reduction and eventual elimination of all currently prescribed psychotropic medications and that the use of all behavior controlling medications is incorporated into clients' behavior support plans. This training will include This training will include the need to incorporate specific</p>	05/06/2022

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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 0501 Bldg. 00	<p>Practical Nurse) and the PM (Program Manager) were interviewed. The QIDP indicated client B could request the PRN or staff could offer it to her. The QIDPM indicated the PRN medication should be included in client B's BSP.</p> <p>9-3-5(a)</p> <p>483.460(a)(4)(ii) COVID-19 Policies and Procedures: Education § 483.460(a)(4)(ii) Before offering COVID-19 vaccine, all staff members are provided with education regarding the benefits and risks and potential side effects associated with the vaccine. Based on observation, record review and interview for 1 of 2 clients in the sample (B) and 2 additional clients (C and D), the facility failed to ensure staff #1 was provided with education regarding the benefits, risks and potential side effects associated with the Covid-19 vaccine.</p>		W 0501	<p>protocols for the use of as needed psychotropic medications into clients' plans.</p> <p>Additionally, members of the Operations Team (comprised of the Executive Director, Operations Managers, Program Managers, Quality Assurance Manager, QIDP Manager, QIDP, Quality Assurance Coordinators, Area Supervisors, Nurse Manager and Assistant Nurse Manager) will incorporate audits of support documents into visits to the facility no less than monthly to assure the plans include active treatment programs designed to reduce and eventually eliminate the use of behavior controlling medications.</p> <p>RESPONSIBLE PARTIES: QIDP, Area Supervisor, Residential Manager, Direct Support Staff, Operations Team, Regional Director</p> <p>CORRECTION: <i>Before offering COVID-19 vaccine, all staff members are provided with education regarding the benefits and risks and potential side effects associated with the vaccine. Specifically, staff #1 will</i></p>	05/06/2022

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

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NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES ADEPT		STREET ADDRESS, CITY, STATE, ZIP COD 213 W WATER ST CENTERVILLE, IN 47330		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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 0504 Bldg. 00	<p>Findings include:</p> <p>An observation was conducted at the group home on 4/4/22 from 6:00 AM to 8:20 AM. Clients B, C and D were observed at the group home. Staff #1 worked throughout the observation.</p> <p>On 4/4/22 at 6:45 AM, staff #1 was interviewed. Staff #1 indicated she did not get the Covid-19 vaccination and she did not plan on getting the vaccination.</p> <p>On 4/5/22 at 2:00 PM, staff #1's employee record was reviewed. The record did not indicate staff #1 received education regarding the benefits, risks and potential side effects associated with the Covid-19 vaccine.</p> <p>On 4/5/22 at 4:05 PM, the QIDPM (Qualified Intellectual Disabilities Professional Manager), QIDP (Qualified Intellectual Disabilities Professional), AS (Area Supervisor), QAM (Quality Assurance Manager), LPN (Licensed Practical Nurse) and the PM (Program Manager) were interviewed. The QIDPM indicated the facility did not have documentation of staff #1 receiving education regarding the Covid-19 vaccination.</p> <p>9-3-3(a)</p> <p>483.460(a)(4)(v) COVID-19 Policies and Procedures: Vaccination § 483.460(a)(4)(v) The client, client's representative, or staff member has the opportunity to accept or refuse COVID-19 vaccine, and change their decision. Based on observation, record review and interview for 1 of 3 employee records reviewed</p>	W 0504	<p>complete the agency's web-based COVID-19 Vaccination education curriculum.</p> <p>PREVENTION: Any unvaccinated staff who are assigned to the facility, will complete the agency vaccine training. Facility Supervisors will follow-up with the Human Resources Department to assure the training has been completed.</p> <p>RESPONSIBLE PARTIES: QIDP, Area Supervisor, Residential Manager, Human Resources Department, Direct Support Staff, Operations Team, Regional Director</p>	05/06/2022

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	<p>(staff #1), the facility failed to ensure staff #1's record included documentation of the Covid-19 vaccination being offered.</p> <p>Findings include:</p> <p>An observation was conducted at the group home on 4/4/22 from 6:00 AM to 8:20 AM. Staff #1 worked throughout the observation.</p> <p>On 4/4/22 at 6:45 AM, staff #1 was interviewed. Staff #1 indicated she did not get the Covid-19 vaccination and she did not plan on getting the vaccination.</p> <p>On 4/5/22 at 2:00 PM, staff #1's employee record was reviewed. The record did not indicate staff #1 was offered and had the opportunity to accept or refuse the Covid-19 vaccination.</p> <p>On 4/5/22 at 4:05 PM, the QIDPM (Qualified Intellectual Disabilities Professional Manager), QIDP (Qualified Intellectual Disabilities Professional), AS (Area Supervisor), QAM (Quality Assurance Manager), LPN (Licensed Practical Nurse) and the PM (Program Manager) were interviewed. When asked if the facility had documentation of staff #1 being offered the Covid-19 vaccination, the QIDPM stated, "Not that we can reproduce. There is a form that should have been done". The QIDPM indicated there should be documentation in staff #1's record indicating the vaccination was offered.</p> <p>9-3-3(a)</p>		<p><i>or staff member has the opportunity to accept or refuse COVID-19 vaccine, and change their decision.</i> Specifically, the facility will offer staff #1 the opportunity to receive the second dose of the COVID-19 vaccine. Documentation of the offer will be added to staff #1's employee file.</p> <p>PREVENTION: Any unvaccinated staff who are assigned to the facility, will be offered an opportunity to receive the COVID-19 vaccine. Facility Supervisors will follow-up with the Human Resources Department to assure documentation of the vaccination offer is maintained.</p> <p>RESPONSIBLE PARTIES: QIDP, Area Supervisor, Residential Manager, Human Resources Team, Direct Support Staff, Operations Team, Regional Director</p>	