Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL005-020	A. BUILDING: ______ B. WING ______	10/08/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUMMIT SUPPORT SERVICES OF ASHE, INC - ARK	342 LONG STREET JEFFERSON, NC 28640

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 000	INITIAL COMMENTS An annual and complaint survey was completed on 10/8/21. The complaints were substantiated (#NC00180518 and #NC00181037). Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .5600C Supervised Living for Adults with Developmental Disability.	V 000		
V 108	27G .0202 (F-I) Personnel Requirements 10A NCAC 27G .0202 PERSONNEL REQUIREMENTS (f) Continuing education shall be documented. (g) Employee training programs shall be provided and, at a minimum, shall consist of the following: (1) general organizational orientation; (2) training on client rights and confidentiality as delineated in 10A NCAC 27C, 27D, 27E, 27F and 10A NCAC 26B; (3) training to meet the mh/dd/sa needs of the client as specified in the treatment/habilitation plan; and (4) training in infectious diseases and bloodborne pathogens. (h) Except as permitted under 10a NCAC 27G .5602(b) of this Subchapter, at least one staff member shall be available in the facility at all times when a client is present. That staff member shall be trained in basic first aid including seizure management, currently trained to provide cardiopulmonary resuscitation and trained in the Heimlich maneuver or other first aid techniques such as those provided by Red Cross, the American Heart Association or their equivalence for relieving airway obstruction. (i) The governing body shall develop and implement policies and procedures for identifying,	V 108		

Division of Health Service Regulation

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

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V 108	Continued From page 1 reporting, investigating and controlling infectious and communicable diseases of personnel and clients. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure that staff members were trained in cardiopulmonary resuscitation (CPR) and First Aid affecting 3 of 3 (Staff #1, Staff #2, Staff #3) audited staff. The findings are: Review on 9/17/21 of Staff #1's personnel record revealed: -hire date of 9/17/15; -CPR/First Aid certification dated 4/1/21; -The training was online and did not include a hands on component. Review on 9/15/21 of Staff #2's personnel record revealed: -hire date of 3/5/07; -CPR/First Aid certification dated 4/1/21; -The training was online and did not include a hands on component. Review on 9/15/21 of the Qualified Professional's (QP) personnel record revealed: -hire date of 03/30/15; -CPR/First Aid certification dated 4/1/21; -The training was online and did not include a hands on component. Interview on 9/21/21 with the QP revealed: -the CPR/First Aid certification is an online only course;	V 108		

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V 108	Continued From page 2 -prior to the COVID-19 pandemic, they had a staff member providing CPR with a hands-on component.	V 108		
V 118	27G .0209 (C) Medication Requirements 10A NCAC 27G .0209 MEDICATION REQUIREMENTS (c) Medication administration: (1) Prescription or non-prescription drugs shall only be administered to a client on the written order of a person authorized by law to prescribe drugs. (2) Medications shall be self-administered by clients only when authorized in writing by the client's physician. (3) Medications, including injections, shall be administered only by licensed persons, or by unlicensed persons trained by a registered nurse, pharmacist or other legally qualified person and privileged to prepare and administer medications. (4) A Medication Administration Record (MAR) of all drugs administered to each client must be kept current. Medications administered shall be recorded immediately after administration. The MAR is to include the following: (A) client's name; (B) name, strength, and quantity of the drug; (C) instructions for administering the drug; (D) date and time the drug is administered; and (E) name or initials of person administering the drug. (5) Client requests for medication changes or checks shall be recorded and kept with the MAR file followed up by appointment or consultation with a physician.	V 118		

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V 118	Continued From page 3	V 118		

This Rule is not met as evidenced by:
Based on record reviews, interviews and observations, the facility failed to ensure that medications were administered to a client only on the written order of a physician and that medications administered were recorded immediately after administration affecting 2 of 3 audited clients (Client #2 and Client #3). The findings are:

Cross Reference: 10A NCAC 27G .0209(h) Medication Errors (Tag 120). Based on record reviews, the facility failed to report medication errors immediately to a physician or pharmacist affecting 3 or 3 audited clients (Client #1, Client #2, Client #3).

Review on 9/14/21 of client #2's record revealed:
-admission date of 12/5/16;
-diagnoses of Intellectual Disability, Gastroesophageal Reflux disease (GERD), Obstructive Sleep Apnea.

Review on 9/15/21 of physician orders for Client #2 included:
-lorazepam 0.5 milligram (mg) tablet (sleep), take 1 tablet in the morning ordered 6/2/21;
-omeprazole 20 mg (GERD), take 1 capsule daily ordered 12/17/20;
-fluoxetine 20 mg (depression) capsule, take one capsule daily ordered 6/2/21.

Review on 9/15/21 of client #2's MAR revealed:
-Staff #1 initials are crossed out on 7/19/21 for the lorazepam 0.5 milligrams;
-Staff #1 initials are crossed out on 7/19/21 for

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V 118	Continued From page 4 omeprazole 20 mg; -Staff #1 initials are crossed out on 7/19/21 for fluoxetine 20 mg. Interview on 9/15/21 with Non-audited staff revealed: -she wasn't sure what happened with Client #2's MAR for 7/19/21 for the lorazepam 0.5 mg am dose, omeprazole 20 mg or fluoxetine 20 mg doses. Review on 9/14/21 of Client #3's record revealed: -admission date of 10/01/10; -diagnoses of Major Depressive Disorder Single Episode, Frontal Lobe Syndrome, Dementia without Behavior, Encephalopathy, Organic Personality, Partial Epilepsy without Intractable, and Viral Encephalitis. Review on 9/14/21 of physician orders for Client #3 included: -docusate 100 mg (constipation) take 2 capsules by mouth at 8:00 am ordered on 3/9/212; -escitalopram 20 mg (depression) take 1 tablet by mouth at bedtime ordered on 3/9/21. Review on 9/14/21 of Client #3's MAR revealed: -docusate was documented as administered as ordered on 7/12/21, 8/19/21, and 9/13/21. Review on 9/22/21 of the electronic health record for Client #3 revealed: -entry on 7/13/21: medication error occurred on 7/12/21 for docusate 100 mg, 2 capsules at 8:00 am; -manager popped client's morning medication and noticed one docusate capsule was still in the pack; - only one capsule was administered to client on 7/13/21.	V 118		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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V 118	Continued From page 5	V 118		

Review on 9/22/21 of the electronic health record for Client #3 revealed:
-entry on 8/19/21: medication error discovered on 8/19/21 at 4:00 pm that client did not receive full 8:00 am dose of docusate 100 mg 2 capsules at 8:00 am;
-staff only gave one capsule and missed giving client the second dose.

Review on 9/22/21 of the electronic health record for Client #3 revealed:
-entry on 9/14/21: medication error on 9/13/21;
-Client #3 did not get full dose of docusate 100 mg 2 capsules at 8:00 am;
-only one capsule was administered on 9/13/21.

Observation on 9/15/21 at 3:05 pm in the facility office revealed:
-Non-audited Staff was looking through MARs with a second Non-audited Staff;
-they were discussing blanks on the MAR and looking at the calendar in an attempt to determine who was working on the dates that were not initialed;
-the second Non-audited Staff initialed for a past date.

Interview on 9/30/21 with Non-audited staff revealed:
-when there are missing initials on the MAR, staff put a sticky note on the MAR and call the staff back in to initial the missing dates;
-staff initials the bubble pack for the medication when they "pop the pill" to administer the medication;
-if the pill was still in the pack and a dose was missed, they documented it as a medication error and called the pharmacist, administrator on call, and staff.

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V 118	Continued From page 6 Due to the failure to accurately document medication administration it could not be determined if clients received their medications as ordered by the physician. Review on 10/6/21 of 1st Plan of Protection written by the Qualified Professional (QP) and dated on 10/6/21 revealed: What immediate action will the facility take to ensure the safety of the consumers in your care? "Admin (Administrataive) staff will send a communication this afternoon to the Ark via FAX and Scom (electronic comminication) regarding the citations and the need for staff to focus and pay close attention to what they are doing when giving medications. In particular, staff will be instructed to always initial the MAR immediately after giving a medication Staff will be instructed to highlight any medications on the MAR which need to be given in "two's" in a different color. Also staff will be instructed to draw an arrow on the pill packs connecting one pill with the other when 2 pills need to be given at once. Also staff will be reminded to document any med error on the back of the MAR in addition to completing a GER (electronic record). When a medication is administered, the pill packs will be compared to the MAR. When a pill is popped, staff will initial the pill packet. When a medication is given to a client, the MAR will be initialed by staff. In the event that staff misses initialing the MAR, a new form was generated to track documentation errors. The staff who discovers the documentation error will fill out that form and give it to the QP over that group home. The staff who committed the documentation error will document the error on the back of the MAR, sign and date.	V 118		

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V 118	Continued From page 7	V 118		

This form will be sent out via FAX this afternoon. Future actions will include updating the med (medication) administration and med error policy to reflect recent changes in the way med errors are reported in Therap (electronic health record) and how documentation errors are reported. Also policies regarding the handling of med errors and supervision of staff will be reviewed and revised. Staff will receive comprehensive training on medication administration, medication errors, and disciplinary action ASAP (as soon as posible)."

Describe your plans to make sure the above happens.
"We have contracted with an RN (Registered Nurse), [contracted registered nurse name] and she will review the MARS on a quarterly basis and provide ongoing instruction to staff regarding any issues she finds. QPs and Director will randomly visit the Ark to look at the MARS and check for any discrepancies in GER (electronic record) and MAR as well as other documentation issues. As soon as QP [sister facility QP] returns from vacation next week, we will set up a time for med administration and med error training for group home staff. We will begin updating policies to reflect changes and will submit changes to the Summit Board of Directors for approval. A "checklist" of all necessary actions will be created and QPs/Director will check items off the list as actions are completed. Results of ongoing random MAR checks will be documented in the Ark Meeting Notes on the Company server and staff supervision will be documented in supervision notes."

Review on 10/7/21 of the revised Plan of Protection written by the QP and dated 10/7/21 revealed:

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V 118	Continued From page 8 What immediate action will the facility take to ensure the safety of the consumers in your care? "Admin staff will send a communication this afternoon to the Ark via FAX and Scom (electronic communication) regarding the citations and the need for staff to focus and pay close attention to what they are doing when giving medications. (Completed 10/6/21 by the QP) In particular, staff will be instructed to always initial the MAR immediately after giving a medication Staff will be instructed to highlight any medications on the MAR which need to be given in "two's" in a different color. Also staff will be instructed to draw an arrow on the pill packs connecting one pill with the other when 2 pills need to be given at once. Also staff will be reminded to document any med error on the back of the MAR in addition to completing a GER (electronic record). When a medication is administered, the pill packs will be compared to the MAR. When a pill is popped, staff will initial the pill packet. When a medication is given to a client, the MAR will be initialed by staff. In the event that staff misses initialing the MAR, a new form was generated to track documentation errors. The staff who discovers the documentation error will fill out that form and give it to the QP over that group home. The staff who committed the documentation error will document the error on the back of the MAR, sign and date. This form will be sent out via FAX this afternoon. Future actions will include updating the med administration and med error policy to reflect recent changes in the way med errors are reported in Therap (electronic health record) and how documentation errors are reported. Also policies regarding the handling of med errors and supervision of staff will be reviewed and revised. Revision of policies will be completed by QPs/Director by 10/19/21 when the Summit	V 118		

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	MHL005-020	A. BUILDING: ______ B. WING ______	10/08/2021

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V 118	Continued From page 9	V 118		

Board meets. Staff will receive comprehensive training on medication administration, medication errors, and disciplinary action by 10/28/21 or possibly earlier."

Describe your plans to make sure the above happens.
"We have contracted with an RN, (Registered Nurse), [contracted registered nurse name] and she will review the MARS on a quarterly basis and provide ongoing instruction to staff regarding any issues she finds. QPs and Director will randomly visit the Ark to look at the MARS and check for any discrepancies in GER (electronic health record note) and MAR as well as other documentation issues. This will begin the week of 10/11/21. As soon as QP [sister facility QP] returns from vacation next week, we will set up a time for med administration and med error training for group home staff and this will be completed by 11/5/21 or possibly earlier. We will begin updating policies to reflect changes and will submit changes to the Summit Board of Directors for approval on 10/19/21. A "checklist" of all necessary actions will be created by 10/12/21 and QPs/Director will check items off the list as actions are completed. Results of ongoing random MAR checks will be documented in the Ark Meeting Notes by 10/21/21 on the Company server and staff supervision will be documented in monthly supervision notes starting in October by 10/29/21."

This facility serves 6 adult clients whose diagnoses included of Intellectual Disability, Gastroesophageal Reflux disease (GERD), Obstructive Sleep Apnea, Major Depressive Disorder, Frontal Lobe Syndrome, Dementia without Behavior, Encephalopathy, Organic Personality, Partial Epilepsy without Intractable

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V 118	Continued From page 10	V 118		

and Viral Encephalitis. The clients were prescribed lorazepam, omeprazole, fluoxetine, docusate, escitalopram, and amlodipine. Documentation on Client #2's MAR had initials marked out for 3 medications lorazepam, omeprazole, fluoxetine) for 1 day with no other staff initials for that day. Client #3 was only given a half dose of docusate on 3 different days. The facility had 6 medication errors that were not documented as required and not immediately reported to the physician or pharmacist. Additionally, any blanks on the MAR that were missing staff initials were addressed, sometimes days later, by instructing a staff person who had worked on that shift to initial the blanks on the MAR. Because of the blanks on the MAR, it could not be determined if medications were administered as ordered. This deficiency constitutes a Type B rule violation. If the violation is not corrected within 45 days, an administrative penalty of $200.00 per day will be imposed for each day the facility is out of compliance beyond the 45th day.

V 123 — 27G .0209 (H) Medication Requirements — V 123

10A NCAC 27G .0209 MEDICATION REQUIREMENTS
(h) Medication errors. Drug administration errors and significant adverse drug reactions shall be reported immediately to a physician or pharmacist. An entry of the drug administered and the drug reaction shall be properly recorded in the drug record. A client's refusal of a drug shall be charted.
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V 123	Continued From page 11	V 123		

This Rule is not met as evidenced by:
Based on record reviews, the facility failed to report medication errors immediately to a physician or pharmacist affecting 3 or 3 audited clients (Client #1, Client #2, Client #3). The findings are:

Review on 9/15/21 of Client #1's record revealed:
-admission date of 8/9/78;
-diagnoses of Conduct Disorder, Mild Mental Retardation, High Triglycerides;

Review on 9/15/21 of physician orders for Client #1 included:
-amlodipine 5 milligrams one tablet by mouth daily ordered 8/9/21.

Review on 9/22/21 of the electronic health record for Client #1 revealed:
-entry on 8/29/21: medication error discovered on 8/29/21 at 2:40 pm;
-the foil was broken on the pill pack for 9/5/21 for amlodipine 5 mg and the tablet was missing;
-staff called the Qualified Professional (QP) as soon as they discovered the missing pill;
-no evidence that the facility contacted the pharmacy or the physician.

Review on 9/15/21 of Client #2's MAR revealed:
-Staff #1's initials on the date of 7/19/21 were marked out for lorazepam 0.5 mg;
-Staff #1's initials on the date of 7/19/21 were marked out for omeprazole 20 mg;
-Staff #1's initials on the date of 7/19/21 were marked out for and fluoxetine 20 mg;
-no other indication on the MAR that the medications were given;

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V 123	Continued From page 12	V 123		

-no evidence staff contacted the pharmacy or the physician.

Review on 9/15/21 of Client #3's MAR revealed:
-no evidence the escitalopram 20 mg was administered as ordered for 8/16/21 and 8/17/21;
-no evidence staff contacted the pharmacy or the physician.

Interview on 9/30/21 with Non-audited Staff revealed:
-until recently they had not been documenting missed initials as medication errors;
-recently received an electronic communication from the QP to document missing initials as a medication error;
-she thought people were getting confused about when to write error on the MAR if they initial in wrong space and document on back. She is going to follow up with the QP about the process for this;
-she thinks everyone needs some retraining on medication documentation.

Review on 10/5/21 of the facility's Medications and Medication Administration policy dated 6/25/19 revealed:
"-A medication error is defined as:
-1. Any error that reaches the client, specifically:
-Missed (omitted) medication
-Incorrect dose administered
-Wrong medication administered
-Given without following specific physician's instructions
-Incorrect time of administration, i.e. more than an hour before or after the scheduled time of administration
-Missing dose(s) of medication
-Administering outdated medications"

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 123	Continued From page 13 2. "Document error in Medication Administration Record (MAR) -Signed but did not administer a medication -Did not sign -Did not count or sign off on controlled medications. Any employee of Summit Support Services who is responsible for a medication administration error will review the Medication Error Report form with their supervisor or designee and documentation will be made in the supervision record". This deficiency is cross referenced into 10A NCAC 27G .0209 (c) Medication Administration (V118) for a Type B violation and must be corrected within 45 days.	V 123		
V 289	27G .5601 Supervised Living - Scope 10A NCAC 27G .5601 SCOPE (a) Supervised living is a 24-hour facility which provides residential services to individuals in a home environment where the primary purpose of these services is the care, habilitation or rehabilitation of individuals who have a mental illness, a developmental disability or disabilities, or a substance abuse disorder, and who require supervision when in the residence. (b) A supervised living facility shall be licensed if the facility serves either: (1) one or more minor clients; or (2) two or more adult clients. Minor and adult clients shall not reside in the same facility. (c) Each supervised living facility shall be licensed to serve a specific population as designated below: (1) "A" designation means a facility which	V 289		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL005-020	A. BUILDING: ____ B. WING ____	10/08/2021

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V 289	Continued From page 14 serves adults whose primary diagnosis is mental illness but may also have other diagnoses; (2) "B" designation means a facility which serves minors whose primary diagnosis is a developmental disability but may also have other diagnoses; (3) "C" designation means a facility which serves adults whose primary diagnosis is a developmental disability but may also have other diagnoses; (4) "D" designation means a facility which serves minors whose primary diagnosis is substance abuse dependency but may also have other diagnoses; (5) "E" designation means a facility which serves adults whose primary diagnosis is substance abuse dependency but may also have other diagnoses; or (6) "F" designation means a facility in a private residence, which serves no more than three adult clients whose primary diagnoses is mental illness but may also have other disabilities, or three adult clients or three minor clients whose primary diagnoses is developmental disabilities but may also have other disabilities who live with a family and the family provides the service. This facility shall be exempt from the following rules: 10A NCAC 27G .0201 (a)(1),(2),(3),(4),(5)(A)&(B); (6); (7)(A),(B),(E),(F),(G),(H); (8); (11); (13); (15); (16); (18) and (b); 10A NCAC 27G .0202(a),(d),(g)(1)(i); 10A NCAC 27G .0203; 10A NCAC 27G .0205 (a),(b); 10A NCAC 27G .0207 (b),(c); 10A NCAC 27G .0208 (b),(e); 10A NCAC 27G .0209[(c)(1) - non-prescription medications only] (d)(2),(4); (e)(1)(A),(D),(E);(f);(g); and 10A NCAC 27G .0304 (b)(2),(d)(4). This facility shall also be known as alternative family living or assisted family living (AFL).	V 289		

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V 289	Continued From page 15 This Rule is not met as evidenced by: Based on interviews, the facility failed to operate within its scope to provide residential services to individuals diagnosed with developmental disabilities and who require supervision when in the residence affecting 3 of 3 clients (Client #1, Client #2, Client #3). The findings are: Review on 9/17/21 of Staff #1's personnel record revealed: -Hire date of 9/17/15. Interview on 9/15/21 with the Qualified Professional (QP) revealed: -Staff #1 asked the Executive Director (ED) if she could bring her newborn with her during her shift if needed, as long as she had a family member with her to babysit the baby; -the ED talked with the Board of Directors who approved staff to bring her baby; -the facility conducted a background and Health Care Registry Personnel (HCPR) check on the staff member's father; -the facility "has always allowed staff to bring in their family at times so the clients can interact with other people"; -only the baby and Staff #1's father spent the night. Attempted interview on 9/15/21 with Client #1 revealed: -he had no response when asked about a baby being in the home. Attempted interview on 9/15/21 with Client #2	V 289		

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V 289	Continued From page 16	V 289		

revealed:
-he was more interested in talking about the recent death of his brother and didn't answer questions about a baby being in the home.

Attempted interview on 9/15/21 with Client #3 revealed:
-she was very agitated and escalated to anger outbursts and stated she wanted to die and talked about God;
-she was not able to follow a conversation.

Interview on 9/20/21 with Staff #1 revealed:
-she made a request to administration and received their approval to bring her baby and her father to babysit with her on shift;
-the baby and her father only spent one night at the facility from Saturday morning to Sunday evening;
-when her father is at the facility, he and the baby stay in the staff bedroom and she thought clients did not know he was there;
-she did bring the baby out to common area of the facility, but her father stayed in the staff bedroom;
-she attempted to get shift coverage by another staff if she was without childcare but "there has been time or two" she brought the baby with her on shift;
-she has not had an emergency with a client while she had the baby and her father at the facility.

Interview on 9/28/21 with the Executive Director (ED) revealed:
-Staff #1 requested to bring her baby to the facility to stay with her while she worked;
-the baby and father only stayed over one night;
-the facility completed a background and an HCPR check on Staff #1's father prior to him staying at the facility;

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V 289	Continued From page 17 -the staff member's schedule changed and she no longer needs to bring her baby to the facility.	V 289		