

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G230	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/26/2013
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NAME OF PROVIDER OR SUPPLIER REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1221 WARREN DR LAFAYETTE, IN 47905
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W000000	<p>This visit was for an extended recertification and state licensure survey.</p> <p>Dates of survey: August 21, 22, 23 and 26, 2013.</p> <p>Facility Number: 000754 Provider Number: 15G230 AIMS Number: 100243370</p> <p>Surveyor: Claudia Ramirez, RN</p> <p>The following federal deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 9/9/13 by Ruth Shackelford, QIDP.</p>	W000000		

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 that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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W000140	<p>483.420(b)(1)(i) CLIENT FINANCES</p> <p>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.</p> <p>Based on observation, record review and interview, for 1 of 4 sample clients (client #4), the facility failed to maintain an accurate accounting system for the client's personal fund account.</p> <p>Findings include:</p> <p>On 08/22/13 at 3:48 PM client #4's personal fund account was reviewed with the QIDP (Qualified Intellectual Disabilities Professional). Client #4's current petty cash balance indicated client #4 had a balance of \$26.30. A money count with the QIDP indicated client #4 had \$19.30. Client #4's petty cash funds were off a total of \$7.00. The QIDP indicated client #4's funds did not balance.</p> <p>Client #4's records were reviewed on 08/22/13 at 3:15 PM. Client #4's ISP (Individual Support Plan) dated 01/30/13 indicated client #4 was not able to independently handle his money and required assistance.</p> <p>On 08/23/13 at 3:50 PM an interview was</p>	W000140	<p>The facility ensures a system is in place that assures a full and complete accounting of clients' personal funds. The Program Director will be retrained on Mentor policy regarding client funds. The Program Director will review all client funds at least monthly, and will document this on the monthly review. The Home Manager will be retrained on Mentor policy regarding client funds. The Home Manager will check all client accounts, at least weekly to ensure that all funds are appropriately accounted for, and balanced, per policy and regulation. The Home Manager will document this weekly, on the Home Manager weekly checklist. This checklist will be submitted to the Program Director for review and corrective action, if needed. The Home Manager will retrain direct support staff to follow procedure regarding utilizing client cash. This will include counting all client cash at the beginning, and the end of each shift, to ensure that all cash on hand is accounted for. Persons Responsible: Area Director, Program Director, Home Manager Completion Date: 9/25/13</p>	09/25/2013			

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	<p>conducted with the QIDP (Qualified Intellectual Disabilities Professional). The QIDP indicated the agency was responsible for assisting client #4 with his funds as he was not independent with his money and required assistance. She further indicated client funds should balance.</p> <p>9-3-2(a)</p>			

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W000263	<p>483.440(f)(3)(ii) PROGRAM MONITORING & CHANGE The committee should insure that these programs are conducted only with the written informed consent of the client, parents (if the client is a minor) or legal guardian.</p> <p>Based on record review and interview, the facility failed to obtain the health care representative (HCR) or guardian's (GU) approval before implementation of a Behavioral Support Plan for 3 of 4 sampled clients (clients #1, #2 and #4) with restrictive programs.</p> <p>Findings include:</p> <p>1. Client #1's records were reviewed on 08/22/13 at 9:16 AM. Client #1's BSP dated 01/30/13 indicated client #1's behaviors included resistance, agitation, inappropriate touching, false reporting, physical aggression and intentional falling. The BSP contained an undated attachment named, "Medication Management." The Medication Management document indicated she was on the following medications for the behaviors: Fluoxetine (anti-depressant), Risperidone (anti-psychotic) and Donepezil (dementia). The BSP did not indicate written informed consent was obtained from client #1's GU for the BSP.</p>	W000263	<p>The facility ensures that all programs are conducted, only after obtaining written, informed consent of the client, parents or legal guardian. The Area Director will retrain the Program Director on policy and procedure regarding ensuring that client/parent/guardian approval is obtained, for all programs, and plans pertaining to the client. The Area Director will review all program plan documentation, at least quarterly, to ensure that appropriate signatures have been obtained. This will be documented on the Area Director checklist. Persons Responsible: Area Director, Program Director Completion Date: 9/25/13</p>	09/25/2013	

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	<p>On 08/23/13 at 10:00 AM an interview was conducted with the Program Director (PD). The PD indicated client #1's BSP was not signed by the GU.</p> <p>2. Client #2's records were reviewed on 08/22/13 at 9:50 AM. Client #2's BSP dated 12/20/12 indicated client #2's behaviors included physical aggression, hoarding, SIB (self-injurious behavior), property destruction and agitation. The BSP contained an undated attachment named, "Medication Management." The Medication Management document indicated she was on the following medications for the behaviors: Olanzapine (anti-psychotic), Fluoxetine (anti-depressant) and Donepezil (dementia). The BSP did not indicate written informed consent was obtained from client #2's HCR for the BSP.</p> <p>On 08/23/13 at 10:00 AM an interview was conducted with the Program Director (PD). The PD indicated client #2's BSP was not signed by the HCR.</p> <p>3. Client #4's records were reviewed on 08/22/13 at 3:15 PM. Client #4's BSP dated 01/24/13 indicated client #4's behaviors included resistance, physical aggression, stealing food, property destruction, incontinence, aggressive outbursts and inappropriate nudity. The</p>				

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	<p>BSP contained an undated attachment named, "Medication Management." The Medication Management document indicated he was on the following medications for the behaviors: Mirtazapine Soltab, Risperidone Solution and Clonazepam for mood stabilization. The BSP did not indicate written informed consent was obtained from client #4's HCR for the BSP.</p> <p>On 08/23/13 at 10:00 AM an interview was conducted with the Program Director (PD). The PD indicated client #4's BSP was not signed by the HCR.</p> <p>9-3-4(a)</p>				

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W000285	<p>483.450(b)(2) MGMT OF INAPPROPRIATE CLIENT BEHAVIOR Interventions to manage inappropriate client behavior must be employed with sufficient safeguards and supervision to ensure that the safety, welfare and civil and human rights of clients are adequately protected.</p> <p>Based on record review and interview for 1 of 4 sample clients (client #4), the facility failed to ensure implementation of restraints did not cause injury to the client. The facility failed to ensure safeguards were put in place to ensure the protection of the client during use of restraints.</p> <p>Findings include:</p> <p>The facility's BDDS (Bureau of Developmental Disabilities Services) reports and investigations were reviewed on 08/21/13 at 2:30 PM. The BDDS reports indicated the following:</p> <p>A BDDS report dated 01/16/13 for an incident dated 01/15/13 at 6:15 PM indicated: "[Client #4] had been acting agitated for most of the evening and was unable to express why. [Client #1] and [client #4] were sitting in the living room when [client #4] got up quickly and moved toward [client #1] and began hitting her. Staff immediately intervened</p>	W000285	The facility ensures that management of inappropriate client behaviors must be employed with sufficient safeguards and supervision to ensure the safety of the clients. All staff in the home will receive retraining on Physical Intervention Alternatives. Staff will demonstrate, during training, that they are aware and able to facilitate safe usage of interventions that may be necessary for safely managing client behaviors. Staff will receive annual retraining on Physical Intervention Alternatives, at least annually. The Program Director will request an IDT review, of recommendations resulting from any BDDS report filed, resulting from the useage of restraint of any client. The Program Director will submit recommendations to the team for review and possible further review of support plans or protocols currently in place. The Program Director will note any such incident report, as well as recommendations requested in the monthly review. At any time that an injury occurs, to a client, because of a restraint utilized, an IDT meeting will be requested, to	09/25/2013	

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	<p>and prompted [client #4] to stop and he did not. Staff then used approved PIA (Physical Interventions Alternatives) techniques and held [client #4's] arms to his side. Staff then lost her footing after [client #4] began trying to hit staff and fell causing [client #4] to also fall. [Client #4] was assisted up and checked for injury and a small red mark was found on [client #4's] forehead. Staff were advised to monitor [client #4's] vitals....Staff were also advised to use caution when dealing with intense behaviors to prevent this from happening again."</p> <p>On 08/23/13 at 10:00 AM an interview was conducted with the Program Director (PD). The PD indicated if the restraint was applied correctly client #4 should not have been injured.</p> <p>9-3-5(a)</p>		<p>review the incident in question and to provide input regarding possible review or change in support plans or protocols in place, if needed. The Program Director will note any such meeting and recommendations in team meeting notes, as well as in the monthly review form. Mentor supervisors will complete an active treatment observation, at least once weekly. Any necessary interventions observed will be noted on the observation form. In addition, the supervisor on site, will provide immediate retraining in the event that the staff may require it. Persons Responsible: Agency PIA trainer, Program Director Completion Date: 9/25/13</p>		

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W000289	<p>483.450(b)(4) MGMT OF INAPPROPRIATE CLIENT BEHAVIOR</p> <p>The use of systematic interventions to manage inappropriate client behavior must be incorporated into the client's individual program plan, in accordance with §483.440(c)(4) and (5) of this subpart.</p> <p>Based on record review and interview, the facility failed to clearly define the specific techniques utilized in the Behavior Support Plan (BSP) for 3 of 4 sample clients (clients #2, #3 and #4), as a part of the clients' treatment plans.</p> <p>Findings include:</p> <p>1. Client #2's records were reviewed on 08/22/13 at 9:50 AM. Client #2's BSP dated 12/20/12 indicated client #2's behaviors included physical aggression, hoarding, SIB (self-injurious behavior), property destruction and agitation. The BSP indicated, "...If [client #2] continues to be physically aggressive, staff should block the physically aggressive behavior using Indiana Mentor Physical Interventions Alternatives. Any escorts/restraints should be released a quickly as possible and should be used in conjunction...If a restraint lasts for 10 minutes...This is considered a proactive intervention because it is designed to prevent additional outbursts...." The plan</p>	W000289	The facility ensures the use of systematic interventions to manage inappropriate client behavior, which are incorporated into the client's individual program plan. The Program Director will communicate with the behavior specialist to determine which techniques and interventions are needed to address possible client behaviors. These techniques will be outlined in the clients behavior support plans. The Program Director will retrain direct support staff on updated information in client behavior plans, as related to specific interventions to be used. Responsible Persons: Program Director Completion Date: 9/25/13	09/25/2013	

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	<p>failed to indicate and define specifically what techniques were to be used.</p> <p>On 08/23/13 at 10:00 AM an interview was conducted with the Program Director (PD). The PD indicated client #2's BSP did not state and define the specific techniques for client #2.</p> <p>2. Client #3's records were reviewed on 08/22/13 at 10:10 AM. Client #3's BSP dated 02/20/13 indicated client #3's behaviors included resistance, physical aggression, taking other's property without permission and inappropriate nudity. The BSP indicated, "...If [client #3] continues to be physically aggressive, staff should block the physically aggressive behavior using Indiana Mentor Physical Interventions Alternatives. Any escorts/restraints should be released as quickly as possible and should be used in conjunction...If a restraint lasts for 10 minutes...This is considered a proactive intervention because it is designed to prevent additional outbursts...." The plan failed to indicate and define specifically what techniques were to be used.</p> <p>On 08/23/13 at 10:00 AM an interview was conducted with the Program Director (PD). The PD indicated client #3's BSP did not state and define the specific techniques for client #3.</p>				

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	<p>3. Client #4's records were reviewed on 08/22/13 at 3:15 PM. Client #4's BSP dated 01/24/13 indicated client #4's behaviors included resistance, physical aggression, stealing food, property destruction, incontinence, aggressive outbursts and inappropriate nudity. The BSP indicated, "...If [client #4] continues to be physically aggressive, staff should block the physically aggressive behavior using Indiana Mentor Physical Interventions Alternatives. Any escorts/restraints should be released a quickly as possible and should be used in conjunction...If a restraint lasts for 10 minutes...This is considered a proactive intervention because it is designed to prevent additional outbursts..." The plan failed to indicate and define specifically what techniques were to be used.</p> <p>On 08/23/13 at 10:00 AM an interview was conducted with the Program Director (PD). The PD indicated client #4's BSP did not state and define the specific techniques for client #4.</p> <p>9-3-5(a)</p>			

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W000312	<p>483.450(e)(2) DRUG USAGE 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.</p> <p>Based on record review and interview, the facility failed for 3 of 4 sampled clients (clients #1, #2 and #4) who were on medications related to behaviors, by not ensuring the clients' Behavior Support Plan (BSP) included the medication or an attainable titration plan for the medications in the plan.</p> <p>Findings include:</p> <p>1. Client #1's records were reviewed on 08/22/13 at 9:16 AM. Client #1's BSP dated 01/30/13 indicated client #1's behaviors included resistance, agitation, inappropriate touching, false reporting, physical aggression and intentional falling. The BSP contained an undated attachment named, "Medication Management." The Medication Management document indicated she was on the following medications for the behaviors: Fluoxetine (anti-depressant), Risperidone (anti-psychotic) and Donepezil (dementia). The BSP's medication reduction plan indicated client</p>	W000312	The facility ensures that drugs used for control of inappropriate behavior are used as integral part of a clients; individual program plan. This is directed specifically towards the reduction and eventual elimination of the behaviors that the drugs are utilized for. The Program Director will meet with the behavior consultant to discuss attainable levels of behavior to be met, as indicated in the titration plan. Behavior Plans will be revised to include updated titration plans, which will have criteria of behavior for medication reduction, to be at an attainable level. The Program Director will review titration plans, at least quarterly and as needed, to ensure levels of behavior criteria, in titration plans are reasonable and attainable. The Program Director will submit behavior data, at least quarterly, to the prescribing physician, at the psychiatric medication review, for consultation and possible medication reduction. The facility nurse will track all changes and recommendations in the monthly nurses notes. Persons Responsible: Program Director,	09/25/2013	

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	<p>#1 needed to reduce the behaviors to zero over a 90 day period before the medication would be considered for a decrease. The BSP did not contain an attainable titration plan.</p> <p>On 08/23/13 at 10:00 AM an interview was conducted with the Program Director (PD). The PD indicated client #1's BSP should contain a titration plan that was attainable.</p> <p>2. Client #2's records were reviewed on 08/22/13 at 9:50 AM. Client #2's BSP dated 12/20/12 indicated client #2's behaviors included physical aggression, hoarding, SIB (self-injurious behavior), property destruction and agitation. The BSP contained an undated attachment named, "Medication Management." The Medication Management document indicated she was on the following medications for the behaviors: Olanzapine (anti-psychotic), Fluoxetine (anti-depressant) and Donepezil (dementia). The BSPs medication reduction plan indicated client #2 needed to reduce the behaviors to zero over a 90 day period before the medication would be considered for a decrease. The BSP did not contain an attainable titration plan.</p> <p>On 08/23/13 at 10:00 AM an interview was conducted with the Program Director</p>		<p>Facility NurseCompletion Date: 9/25/13</p>				

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	<p>(PD). The PD indicated client #2's BSP should contain a titration plan that was attainable.</p> <p>3. Client #4's records were reviewed on 08/22/13 at 3:15 PM. Client #4's BSP dated 01/24/13 indicated client #4's behaviors included resistance, physical aggression, stealing food, property destruction, incontinence, aggressive outbursts and inappropriate nudity. The BSP contained an undated attachment named, "Medication Management." The Medication Management document indicated he was on the following medications for the behaviors: Mirtazapine Soltab, Risperidone Solution and Clonazepam for mood stabilization. The BSPs medication reduction plan indicated client #4 needed to reduce the behaviors to zero over a 90 day period before the medication would be considered for a decrease. The BSP did not contain an attainable titration plan.</p> <p>On 08/23/13 at 10:00 AM an interview was conducted with the Program Director (PD). The PD indicated client #4's BSP should contain a titration plan that was attainable.</p> <p>9-3-5(a)</p>			

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NAME OF PROVIDER OR SUPPLIER REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1221 WARREN DR LAFAYETTE, IN 47905
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W000331	<p>483.460(c) NURSING SERVICES The facility must provide clients with nursing services in accordance with their needs.</p> <p>Based on record review and interview, the facility failed for 2 of 4 sampled clients (clients #1 and #2), by not ensuring the clients received updated fall protocols and equipment as prescribed by the physician.</p> <p>Findings include:</p> <p>1. Client #1's records were reviewed on 08/22/13 at 9:16 AM. There were 19 BDDS reports for client #1 regarding falls which occurred on the following dates: 03/20/13, 03/27/13, 05/09/13, 05/16/13, 05/21/13, 05/25/13, 05/27/13 twice, 06/06/13, 06/10/13, 06/19/13, 07/01/13, 07/08/13 twice, 07/05/13, 07/09/13, 07/10/13, 07/11/13 and 07/26/13. Client #1's fall protocol dated 07/05/13 indicated she was at risk for falls and "has had numerous falls while walking and has fallen out of bed. She is leaning to the left, has been more confused and clumsy." The protocol was updated 07/05/13 after a PT (Physical Therapy) evaluation and her record indicated she had 4 falls since that date. The protocol box for "gait belt" was not marked to indicate client #1 used a gait belt. The "walker" box was checked and indicated client #1 used a walker but the plan did not indicate when she was to</p>	W000331	<p>The facility provides clients with nursing services in accordance with their needs. The facility nurse will be retrained to ensure that all protocols are written to include all physician and therapists recommendations. This includes, but is not limited to, what adaptive equipment is needed, and when the individual needs to use it. The Program Director will review protocols for individuals to ensure that they remain accurate and meet the needs of the individuals. The Program Director will indicate any changes needed, in the monthly review. The facility nurse will also document changes needed in the monthly nurses notes. The Program Director will implement a night time protocol, for client number one and for client number two. These protocols will outline what adaptive equipment is needed to decrease or eliminate falls during sleeping hours and to document that clients are being physically checked, every 30 minutes at all times when the clients are in bed. No other clients were affected by the deficient practice, however, the Facility Nurse will review all current protocols in the home, to ensure that each is complete and meets each individual's current needs. The facility nurse will document</p>	09/25/2013			

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	<p>use the walker, how she was to use the walker, or its placement when she was not using it. The protocol indicated client #1's bed had bedrails. The falls of 05/09/13 and 05/21/13 were from her bed. Client #1's record did not contain any documents to indicate she was checked after she went to bed at night.</p> <p>2. Client #2's records were reviewed on 08/22/13 at 9:50 AM. There were 9 BDDS reports for client #2 regarding falls which occurred on the following dates: 10/16/12, 12/09/12, 01/29/13, 02/07/13, 03/20/13, 04/24/13, 05/02/13, 05/09/13, 06/07/13, 07/11/13 and 07/21/13. Client #2's fall protocol dated 06/28/12 indicated she was at risk for falls and "walks rapidly often without regard for objects in her path..." The protocol did not indicate use of a walker, cane, gait belt, bedrails or wheelchair. The protocol indicated she had a bed alarm on her bed. The falls of 10/16/12, 03/20/13 and 07/21/13 were from her bed. A 03/22/13 visit to her Dr indicated client #2 needed full length bedrails (instead of the 1/2 rails she had) . Client #2's record did not contain any documents to indicate she was checked after she went to bed at night.</p> <p>On 08/23/13 at 10:00 AM an interview was conducted with the Registered Nurse (RN). She indicated client #1 had gone</p>		<p>this on the monthly nurses notes. Responsible Persons: Program Director; Facility Nurse Completion Date: 9/25/13</p>				

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	<p>through some neurological changes at the time the falls had started. The RN indicated client #1 had seen her neurologist and PCP (primary care physician) on several occasions during this time and had numerous tests completed in order to determine what was going on with client #1's health. She indicated her Fall Protocol should contain information regarding the gait belt and when/how to use it. She also indicated the protocol should instruct staff how and when to use the walker along with how close it should be to client #1 when she is sitting and not utilizing it for mobility. The RN indicated client #2's fall protocol needed to be updated to identify she now used a gait belt and had side rails. She indicated client #2 at the current time only had half rails and she did not have the full side rails yet as the Dr ordered. She indicated clients #1 and #2 should be routinely checked at night and the bed checks should be documented by the staff.</p> <p>9-3-6(a)</p>			

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W000436	<p>483.470(g)(2) SPACE AND EQUIPMENT</p> <p>The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client.</p> <p>Based on observation, interview and record review for 1 of 1 sample client (client #1), who wore glasses, and 1 additional client (client #8) who wore glasses, the facility failed to provide training to clients #1 and #8 to use their eyeglasses.</p> <p>Findings include:</p> <p>Observations were conducted in the group home on 08/22/13 from 7:00 AM until 8:15 AM and staff #3, #4 and #5 were on duty. Clients #1 and #8 were not wearing their glasses nor were any verbal prompts made to clients #1 and #8 regarding their glasses. At 7:50 AM client #1 was assisted to the kitchen for medication. Client #1 was handed her glasses, and assisted with putting them on by staff #3 who had taken them from a case which he obtained in the medication area. Client #8 received his glasses from a case in the medication area from staff #3 at 8:00 AM.</p> <p>Client #1's record was reviewed on</p>	W000436	<p>The facility ensures that clients maintain, use and make informed choices about the use of dentures, eyeglasses, hearing and other communication aids, braces and devices as identified as a need by the IDT. The Program Director will revise the ISP's for client #1 and client #8 to provide training to use their eye glasses. The training goal will include methodology for teaching client #1 and client #8 to place their glasses in a container in their room, before going to bed, as well as teaching them to safely retrieve the glasses from the container, each morning. Methodology and criteria will be determined and revised as needed, by the Program Director. Staff will be trained on the goal revision, and will document this goal on the goal tracking document. The Program Director will monitor the progress of these goals, and will document revisions and needs on the monthly review. Responsible Party: Program Director Date of completion: 9/25/13</p>	09/25/2013			

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	<p>08/22/13 at 9:16 PM. Client #1's vision examination dated 01/16/13 indicated client #1 was prescribed eyeglasses. Client #1's 05/29/13 ISP (Individual Support Plan) did not indicate a formal training objective for wearing the eyeglasses.</p> <p>Client #8's record was reviewed on 08/22/13 at 4:00 PM. Client #8's 11/02/12 ISP indicated client #8 wore glasses, the ISP did not indicate a formal training objective for wearing the eyeglasses.</p> <p>On 08/23/13 at 10:00 AM an interview was conducted with the Program Director (PD). The PD indicated clients #1 and #8 should have their glasses when they awoken in the mornings and they should not wait until the AM medication pass to get their glasses.</p> <p>9-3-7(a)</p>			