

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G304	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 04/02/2015
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NAME OF PROVIDER OR SUPPLIER TRANSITIONAL SERVICES SUB LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 4812 W SR 45 BLOOMINGTON, IN 47401
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W 000 Bldg. 00	<p>This visit was for a fundamental annual recertification and state licensure survey.</p> <p>Survey dates: March 31, April 1 and 2, 2015</p> <p>Facility number: 000823 Provider number: 15G304 AIM number: 100249090</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9.</p>	W 000		
W 104 Bldg. 00	<p>483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility.</p> <p>Based on observation and interview for 6 of 6 clients living in the group home (#1, #2, #3, #4, #5 and #6), the governing body failed to exercise operating direction over the facility by failing to ensure the couch in the living room was in good condition.</p> <p>Findings include:</p> <p>Observations were conducted at the group home on 3/31/15 from 3:23 PM to</p>	W 104	<p>The living room couch has been replaced. A checklist has been developed and will be completed at least weekly by the Home Manager to ensure that the needs identified for the home are monitored and corrected as required on an ongoing basis. The Program Director will review and follow up with the Home Manager to ensure the home is in good repair and comfortable for all clients. This checklist will be reviewed with the Area Director at least monthly at the Program</p>	05/02/2015

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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W 120 Bldg. 00	<p>5:59 PM and 4/1/15 from 6:02 AM to 7:29 AM. During the observations, the living room couch's wooden frame was broken. The middle of the bottom of the couch sagged in the front and the back. The cushions of the couch were sunken in to the depressed area. When the couch was pulled away from the wall, the wooden frame of the couch was broken and protruding from the back of the couch. This affected clients #1, #2, #3, #4, #5 and #6.</p> <p>On 3/31/15 at 4:08 PM, the Home Manager indicated a new couch was ordered.</p> <p>On 3/31/15 at 4:08 PM, the Program Director (PD) stated she was "not aware it was as bad as it is." The PD indicated the couch needed to be replaced.</p> <p>9-3-1(a)</p> <p>483.410(d)(3) SERVICES PROVIDED WITH OUTSIDE SOURCES The facility must assure that outside services meet the needs of each client. Based on record review and interview for 6 of 6 clients (#1, #2, #3, #4, #5 and #6), the facility failed to ensure the outside services met the needs of the clients by</p>	W 120	<p>Director/ Area Director meeting. Responsible Party: Home Manager, Program Director, Area Director</p> <p>The Program Director will be retrained to complete day program observations at least monthly and review that all current client program plans are</p>	05/02/2015

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	<p>failing to conduct observations at the day programs to ensure the services met the needs of the clients.</p> <p>Findings include:</p> <p>On 3/31/15 at 1:02 PM, a review of client #1's record at day program #2 was conducted. The record contained an Individual Support Plan (ISP) dated 2/11/14, a Behavior Support Plan (BSP) dated 1/21/12, a Risk Management Assessment and Plan (RMAP) dated 4/30/10 and Physician's Orders (PO's) dated January 2011.</p> <p>On 3/31/15 at 1:11 PM, the Day Program Manager (DPM) indicated she had not observed the group home staff at the day program conducting observations. The DPM indicated she had not met the current Program Director of the group home. The DPM indicated she had not seen the Home Manager at the day program in over one year. The DPM indicated she had client #1's current program plans however she did not provide documentation of the program plans for review.</p> <p>On 4/1/15 at 10:43 AM client #1's record was reviewed. Client #1's current ISP was dated 2/13/15. The current BSP was dated 11/25/14. The current RMAP was</p>		<p>available for immediate review. The Program Director and Area Director will meet monthly to review day program observations and ensure program plans are monitored. Responsible Party: Program Director, Area Director</p>				

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	<p>dated 2/16/15. The current PO's were dated 1/5/15.</p> <p>On 3/31/15 at 4:36 PM, the Program Director (PD) indicated she had not conducted observations at day program #2.</p> <p>On 4/1/15 at 12:58 PM, the facility did not provide documentation indicating observations were conducted at day programs #1, #2 and #3 during the past 12 months. This affected clients #1, #2, #3, #4, #5 and #6.</p> <p>On 3/31/15 at 4:15 PM, the Home Manager (HM) indicated it was the HM and Program Director's responsibility to conduct observations at the day programs monthly. On 3/31/15 at 4:48 PM, the HM had a document signed by a day program #2 staff indicating the receipt of client #1's current RMAP, PO's and BSP. The document was dated 12/5/14. The HM indicated she was unsure why the documentation was not in client #1's record at the day program. The HM indicated the documentation should be in his record. The HM stated her most recent visit to day program #2 was "around December 2014."</p> <p>On 4/1/15 at 12:58 PM, the Area Director (AD) indicated the PD and HM should be</p>			

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W 125 Bldg. 00	<p>checking during their monthly visits to the day programs to ensure the programs had the clients' current program plans.</p> <p>On 4/1/15 at 12:58 PM, the PD indicated she had not conducted an observation at day program #2. The PD indicated although she conducted observations at day program #1, she did not document her observations. The PD indicated observations should be conducted monthly at each day program.</p> <p>9-3-1(a)</p> <p>483.420(a)(3) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must allow and encourage individual clients to exercise their rights as clients of the facility, and as citizens of the United States, including the right to file complaints, and the right to due process.</p> <p>Based on observation, record review and interview for 1 of 3 clients in the sample (#5), the facility failed to ensure client #5 had the right to due process in regard to restricting his access to his candy.</p> <p>Findings include:</p> <p>An observation was conducted at the group home on 3/31/15 from 3:23 PM to</p>	W 125	The staff in the home were retrained on 4/16/15 on not implementing a restriction on Client #5 from his candy as desired and not imposing restrictions on other clients not approved in the clients' individuals program plans. Observations will be completed four times per week for four weeks, two times per week for four weeks and then at least monthly ongoing to ensure	05/02/2015

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	<p>5:59 PM. At 4:43 PM, client #5 asked staff #9 for a piece of candy. Staff #9 told client #5 he had his candy for the day and would need to wait until tomorrow morning to get more. At 5:16 PM, client #5 asked staff #9 for a piece of candy. Staff #9 indicated he gave client #5 four pieces of candy earlier. Staff #9 did not give client #5 candy at 4:43 PM and 5:16 PM when client #5 asked for his candy.</p> <p>On 4/1/15 at 11:08 AM, a review of client #5's record was conducted. There was no documentation in client #5's 2/13/15 Individual Support Plan (ISP) or 2/16/15 Risk Management Assessment and Plan indicating the need to lock up client #5's candy.</p> <p>On 4/1/15 at 1:09 PM, the Program Director (PD) indicated there was no plan for client #5's candy to be locked up. The PD indicated the candy belonged to client #5 and should not be restricted. The PD indicated if the facility was going to restrict client #5's access to his candy, there needed to be a plan.</p> <p>On 4/1/15 at 1:10 PM, the Area Director indicated there was no plan for client #5's candy to be locked up and his candy should not be restricted.</p> <p>9-3-2(a)</p>		clients have access to their desired items as requested. Person Responsible: Home Manager, Program Director				

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W 149 Bldg. 00	<p>483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. Based on record review and interview for 4 of 6 incident/investigative reports reviewed affecting clients #1, #3 and #6, the facility neglected to implement its policies and procedures to prevent client to client abuse.</p> <p>Findings include:</p> <p>On 3/31/15 at 11:15 AM, a review of the facility's incident/investigative reports was conducted and indicated the following:</p> <ol style="list-style-type: none"> On 2/28/15 at 8:00 PM, a client visiting the group home for potential placement hit and then pushed client #6 to the floor. Client #6 was not injured. On 3/21/15 at 8:15 AM, client #1 reported a client visiting the group home for potential placement punched him on the arm and leg when they were in the basement. Client #1 was not injured. On 3/21/15 at 8:15 AM, a client visiting the group home for potential 	W 149	<p>The staff in the home were retrained on 4/16/15 on keeping clients engaged to prevent opportunities for client to client abuse to occur. Physical interventions were reviewed at this training as a refresher. Observations will be completed four times per week for four weeks, two times per week for four weeks and then at least monthly ongoing to monitor client interactions. Person Responsible: Home Manager, Program Director</p>	05/02/2015

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	<p>placement kicked client #3 in the genitals from behind. Client #3 indicated he was not injured.</p> <p>4. On 3/21/15 at 9:40 PM, a client visiting the group home for potential placement punched client #3 on the arm. Client #3 was pushed by the visiting client. Client #3 was not injured.</p> <p>On 4/1/15 at 1:05 PM, the Area Director (AD) indicated client to client aggression was abuse and should be prevented. The AD indicated the facility had a policy and procedure prohibiting abuse of the clients. The AD indicated there had been no incidents of client to client abuse at the group home until a client visiting the home for potential placement engaged in client to client aggression. The AD indicated the group home clients did not retaliate toward the visiting client. The AD indicated the staff should prevent client to client aggression.</p> <p>On 4/1/15 at 1:05 PM, the Program Director (PD) indicated client to client aggression was abuse and should be prevented. The AD indicated the facility had a policy and procedure prohibiting abuse of the clients.</p> <p>The facility's policy and procedures related to abuse and neglect were</p>			

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W 249	<p>reviewed on 3/31/15 at 11:21 AM. The facility's Quality and Risk Management policy dated April 2011 indicated, "Indiana MENTOR promotes a high quality of service and seeks to protect individuals receiving Indiana MENTOR services through oversight of management procedures and company operations, close monitoring of service delivery and through a process of identifying, evaluating and reducing risk to which individuals are exposed." The Human Rights policy, dated April 2011, indicated, in part, "The following actions are prohibited by employees of Indiana MENTOR: abuse, neglect, exploitation or mistreatment of an individual including misuse of an individual's funds; or violation of an individual's rights." The policy indicated, "Indiana MENTOR programs maintain a written list of rights, which take into account the requirements of applicable laws, regulations, and purchasing agencies. This list of rights should include, but is not limited to: e. Ensure the clients are not subjected to physical, verbal, sexual, or psychological abuse or punishment...".</p> <p>9-3-2(a)</p> <p>483.440(d)(1) PROGRAM IMPLEMENTATION</p>			

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Bldg. 00	<p>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, interview and record review for 4 of 4 clients observed to receive their medications (#1, #2, #3 and #4), the facility failed to ensure staff implemented the clients' medication administration training objectives.</p> <p>Findings include:</p> <p>Observations were conducted at the group home on 3/31/15 from 3:23 PM to 5:59 PM and 4/1/15 from 6:02 AM to 7:29 AM. On 3/31/15 at 5:27 PM, client #4 received his medications from staff #9. Client #4 was not asked to identify and state the purpose of a diabetes medication. On 3/31/15 at 5:34 PM, client #2 received one medication from staff #9. Client #2 was not asked to state the name, purpose and at least two side effects of his prescribed medication. On 3/31/15 at 5:40 PM, client #1 received his medications from staff #9. Client #1 was not asked to identify the name and purpose of two behavioral medications.</p> <p>On 3/31/15 at 5:33 PM, staff #9 indicated</p>	W 249	<p>The staff in the home were retrained on 4/16/15 on implementing medication administration training objectives during all med passes. Observations will be completed four times per week for four weeks, two times per week for four weeks and then at least monthly ongoing to ensure objectives are implemented at all opportunities. Person Responsible: Home Manager, Program Director</p>	05/02/2015

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	<p>the clients' medication training objectives were implemented during the morning and bedtime medication passes. Staff #9 indicated he did not implement the clients' medication goals at 5:00 PM.</p> <p>On 4/1/15 at 6:24 AM, client #3 received his medications from staff #8. During the medication pass, client #3 was not asked to identify the names and purpose of his medications.</p> <p>On 4/1/15 at 10:43 AM, a review of client #1's record was conducted. Client #1's Individual Support Plan, dated 2/13/15, indicated he had a medication training objective. The training objective indicated, "Daily at med time, [client #1] will identify and state the purpose of two of his behavioral meds...."</p> <p>On 4/2/15 at 12:12 PM, a review of client #2's medication goal was conducted. Client #2's medication training objective, as indicated in his 1/2/15 ISP, indicated, "Daily, during his medication pass, [client #2] will state the names of his prescribed medications, the purpose of each medication, and at least two side effects of each medications...."</p> <p>On 4/2/15 at 12:12 PM, a review of client #3's medication goal was conducted. Client #3's medication training objective,</p>			

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W 323 Bldg. 00	<p>as indicated in his 12/30/14 ISP, indicated, "Daily, during medication administration times, [client #3] will identify the name of a medication that he is taking and state the purpose...."</p> <p>On 4/1/15 at 11:00 AM, a review of client #4's record was conducted. Client #4's 12/30/14 ISP indicated his medication administration training objective was to identify and state the purpose of a diabetes medication...."</p> <p>On 4/1/15 at 11:47 AM, the Area Director (AD) indicated the clients' medication training objectives should be implemented at every medication pass. The AD stated, "Every time you do meds."</p> <p>9-3-4(a)</p> <p>483.460(a)(3)(i) PHYSICIAN SERVICES The facility must provide or obtain annual physical examinations of each client that at a minimum includes an evaluation of vision and hearing. Based on record review and interview for 1 of 3 clients in the sample (#1), the facility failed to ensure he had an annual examination of his vision.</p>	W 323	All Home Managers and Program Directors will be retrained by the Area Director on 4/23/15 on completing the Monthly Nursing To Do List for clients in the home and return it to the Nurse by the requested date each	05/02/2015

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	<p>Findings include:</p> <p>On 4/1/15 at 10:43 AM, a review of client #1's record was conducted. Client #1's most recent vision exam, dated 3/19/14, indicated, "Small cataracts (no change). Monitor cataracts. RTC (Return To Clinic) 1 yr (year)." Client #1's Medical Component, dated 2/24/15 and completed by the Registered Nurse, indicated, in part, "Had annual vision exam in 3/2014 with new RX (prescription), recommended to wear glasses at work, to return in 1 year to monitor small cataracts. Cataracts not changed from last year." There was no documentation in client #1's record indicating a one year follow-up appointment was held or scheduled.</p> <p>On 4/2/15 at 11:21 AM, the Registered Nurse (RN) indicated the staff failed to make the appointment. The RN indicated she completed a list every month and the staff missed scheduling a follow-up appointment. The RN stated, "We didn't get it done."</p> <p>9-3-6(a)</p>		<p>month. Program Directors will review the To Do List with the Home Managers by the 10th of each month to ensure completion prior to returning to the Nurse. Client #1 has a vision exam scheduled for 5/20/15. Client #1's glasses have been located and the client will be encouraged to wear his glasses and keep them in good repair by participating in training documented on a training objective sheet. The Home Manager and Program Director will review the objective at least monthly to ensure glasses are available for use and in good repair. Person Responsible: Home Manager, Program Director</p>	

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W 331 Bldg. 00	<p>483.460(c) NURSING SERVICES</p> <p>The facility must provide clients with nursing services in accordance with their needs. Based on observation, interview and record review for 2 of 3 clients in the sample (#1 and #4), the facility's nursing services failed to ensure client #4's diabetic orders were clear on how to administer Novolog and staff implemented client #1's foot cream as ordered.</p> <p>Findings include:</p> <p>1. An observation was conducted at the group home on 3/31/15 from 3:23 PM to 5:59 PM. At 5:27 PM, client #4 received Novolog (for diabetes) by injection from staff #9 after staff checked his blood sugar (66).</p> <p>When staff #9 was asked what amount of Novolog he was to administer if client #4's blood sugar was greater than 250, staff #9 indicated client #4's blood sugar had never been that high. Staff #9 did not answer the question if the sliding scale included a base dose and additional insulin or if the dose was just the sliding scale indicated amount.</p> <p>A review of client #4's record was conducted on 4/1/15 at 11:00 AM. Client #4's Medication Administration Record</p>			W 331	<p>The Nurse made changes to Client #4's Medication Administration Record for his diabetic order in regards to his sliding scale of insulin. The change to the MAR has been sent to the Pharmacy to ensure the order is clear on future MARs so it will be administered correctly per physicians orders. Staff in the home were retrained by the Nurse on 4/13/15, 4/16/15 and 4/17/15 on Medication Administration Procedures. This included administering all prescribed medications as ordered by the physician. Observations will be completed four times per week for four weeks, two times per week for four weeks and then at least monthly ongoing during medication passes at various times to ensure medications are passed correctly. Persons Responsible: Home Manager, Program Director</p>		05/02/2015

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	<p>(MAR), dated April 2015, indicated he was to receive Novolog Flexpen: 10u (units) subq (injection) before meals after fingersticks. The MAR indicated "Take blood sugar (fingersticks) before each meal - give Novolog per sliding scale: if BS (blood sugar) (greater than) 250 give 4u, if (greater than) 300 give 8u, if (greater than) 350 give 12u. If any BS (greater than) 500 give 12u & call nurse. Nurse will notify doctor." The MAR did not indicate if the sliding scale was in addition to the 10 units or in place of the 10 units.</p> <p>On 4/1/15 at 11:53 AM, the Registered Nurse (RN) indicated client #4's orders needed to be clarified. The RN indicated client #4's insulin orders had changed several times over the past few months. The RN indicated she needed to ensure the order stated the sliding scale was in addition to the base dose of 10 units. The RN stated she "didn't catch" the information was not on the MAR.</p> <p>On 4/1/15 at 12:02 PM, the Area Director indicated client #4's Novolog orders needed to be clarified.</p> <p>On 4/1/15 at 12:08 PM, the Program Director (PD) indicated client #4's Novolog order needed to be clarified. The PD indicated client #4 was to receive</p>			

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	<p>10 units as the base dose and the sliding scale was in addition to the base dose.</p> <p>2. An observation was conducted at the group home on 3/31/15 from 3:23 PM to 5:59 PM. At 5:40 PM, client #1 received foot cream (Amit/Gaba/Keta/Keto/Lido in Lipoderm) from staff #9. Staff #9 applied the cream to client #1's feet and rubbed it in for 7 seconds on each foot.</p> <p>On 4/1/15 at 10:43 AM, a review of client #1's record was conducted. The Physician's Order, dated 12/9/14, indicated, "Amit/Gaba/Keta/Keto/Lido in Lipoderm. Apply and rub in well 1-2 pumps (1-2 grams) to affected area 3-4 times a day. Massage in for 1-2 minutes."</p> <p>On 4/1/15 at 11:47 AM, the Area Director indicated the staff should follow the physician's orders for applying the cream.</p> <p>On 4/1/15 at 11:50 AM, the Registered Nurse (RN) indicated the staff should implement the physician's order for client #1's cream. The RN stated, "That's not nearly long enough" when informed the staff rubbed the cream on client #1's feet for 7 seconds. The RN indicated, "They aren't doing it correctly."</p>			

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W 436 Bldg. 00	<p>9-3-6(a)</p> <p>483.470(g)(2) SPACE AND EQUIPMENT 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 2 clients in the sample with adaptive equipment (#1), the facility failed to ensure client #1 had his glasses to wear.</p> <p>Findings include:</p> <p>Observations were conducted at the group home on 3/31/15 from 3:23 PM to 5:59 PM and 4/1/15 from 6:02 AM to 7:29 AM. During the observations, client #1 was not observed to wear glasses. On 4/1/15 at 7:22 AM, client #1 indicated he lost his glasses and did not have them to wear. Staff #2 stated to staff #5 to write a note in the communication book for the evening staff to look for client #1's glasses "he was supposed to wear."</p> <p>On 4/1/15 at 10:43 AM, a review of client #1's record was conducted. Client #1's Medical Component, dated 2/24/15</p>	W 436	<p>Client #1 has a vision exam scheduled for 5/20/15. Client #1's glasses have been located and the client will be encouraged to wear his glasses and keep them in good repair by participating in training documented on a training objective sheet. The Home Manager and Program Director will review the objective at least monthly to ensure glasses are available for use and in good repair. Person Responsible: Home Manager, Program Director</p>	05/02/2015

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W 488 Bldg. 00	<p>and completed by the Registered Nurse (RN), indicated, in part, "Had annual vision exam in 3/2014 with new RX (prescription), recommended to wear glasses at work, to return in 1 year to monitor small cataracts. Cataracts not changed from last year." The vision exam recommending client #1 wear glasses to work was not located in client #1's record. Client #1's 2/13/15 Individual Support Plan (ISP) indicated, in part, "Assessment of ability to care for glasses: Needs verbal assistance to clean and care for glasses." The ISP indicated in the Vision Difficulties section, "Wears glasses."</p> <p>On 4/1/15 at 11:56 AM, the RN indicated client #1 needed glasses. The RN indicated client #1 wore glasses when he wanted to wear them and should have them if he wanted to wear them.</p> <p>On 4/1/15 at 12:56 PM, the Program Director indicated client #1 should have his glasses to wear.</p> <p>9-3-7(a)</p> <p>483.480(d)(4) DINING AREAS AND SERVICE The facility must assure that each client eats in a manner consistent with his or her</p>			

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	<p>developmental level.</p> <p>Based on observation and interview for 2 of 3 clients in the sample (#1 and #5), the facility failed to ensure the clients served themselves during dinner.</p> <p>Findings include:</p> <p>An observation was conducted at the group home on 3/31/15 from 3:23 PM to 5:59 PM. At 5:43 PM, the clients were prompted to the table. Client #3 served client #5's beef brisket and mashed potatoes. Staff #14 served client #5's green beans. Staff #9 cut up client #1's beef. Staff #14 poured client #5's milk. There was no redirection from staff to client #3 to allow client #5 to serve himself. There was no training from staff to clients #1 and #5 during the observation.</p> <p>On 4/1/15 at 10:43 AM, a review of client #1's record was conducted. Client #1's Individual Support Plan, dated 2/13/15, indicated, in part, "Assessment of dining skills: Independent."</p> <p>On 4/1/15 at 11:08 AM, a review of client #5's record was conducted. Client #5's 2/13/15 Individual Support Plan indicated, in part, "Assessment of dining skills: Good but may need hand over hand assistance with pouring some things</p>	W 488	<p>The staff in the home were retrained on 4/16/15 on clients being encouraged to serve themselves during all meals. Observations will be completed four times per week for four weeks, two times per week for four weeks and then at least monthly ongoing to monitor clients serving themselves during meals with the least amount of assistance. Person Responsible: Home Manager, Program Director</p>	05/02/2015

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	<p>due to legal blindness."</p> <p>On 4/1/15 at 1:02 PM, the Program Director indicated the clients should be serving themselves with assistance, if needed.</p> <p>On 4/1/15 at 1:02 PM, the Area Director indicated the clients should be serving themselves with assistance, if needed.</p> <p>9-3-8(a)</p>				