STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G626	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 10/26/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEAK COMMUNITY SERVICES INC	1141 19TH ST LOGANSPORT, IN 46947

(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) COMPLETION DATE
W0000	This visit was for the annual recertification and state licensure survey. Dates of survey: October 24, 25, and 26, 2012. Surveyor: Tracy Brumbaugh, Medical Surveyor III/QMRP. Provider Number:: 15G626 Aim Number: 100235380 Facility Number: 001188 These federal deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review was completed on 11/1/12 by Tim Shebel, Medical Surveyor III.	W0000		

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

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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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W0104	483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility. Based on observation and interview, the governing body failed to exercise general direction in a manner that resulted in the facility being well maintained for 6 of 6 clients (clients #1, #2, #3, #4, #5, and #6) which lived in the group home. Findings include: On 10-24-12 from 3:15 p.m. until 5:25 p.m. an observation at the homes of clients #1, #2, #3, #4, #5, and #6 was conducted. Clients #4 and #5's bedroom had 8 dime size brown marks on the ceiling and brown, black and red marks on the wall between the closet and the wall with the light switch. The ceiling vent in the living room was covered in dust for clients #1, #2, #3, #4, #5, and #6. On 10-24-12 at 3:30 p.m. an interview with client #4 stated the brown stains on the ceiling were "poop." On 10-25-12 at 11:30 a.m. an interview with the Qualified Mental Retardation Professional indicated the walls, vents, and ceiling should be cleaned and he was unaware of what the stains were on the ceiling in clients #4 and #5's bedroom.	W0104	**W104 – Governing Body** Peak Community Services is committed to ensuring the individuals served that the residence is well maintained. The items in the home noted in the survey as needing repair have been repaired or replaced as required to meet the standards of an ICF/DD residence. The residence coordinator will be retrained in the use of the facility maintenance log to ensure that items in need of repair are documented to notify maintenance staff. Peak Community Services QDDP and Residential Director will observe for items in disrepair or other maintenance items once per month during an observation at the home during the time period of 12.01.12 to 11.30.13. Completion Date: 11.25.12 Persons Responsible: Megan Horton, Acting Residential Coordinator; Courtney Glasson, QDDP, Rick Phelps, Director of Residential Services	11/25/2012

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	9-3-1(a)			

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W0157	483.420(d)(4) STAFF TREATMENT OF CLIENTS If the alleged violation is verified, appropriate corrective action must be taken. Based on record review and interview the facility failed 1 of 3 sampled client's (client #6) to hold an Interdisciplinary Team meeting following a display of harmful behaviors. Findings include: On 10-24-12 at 1:45 p.m. a review of the facility's Bureau of Developmental Disabilities (BDDS) reports was conducted. The reports indicated the following: -A BDDS report dated 9-2-12 for client #6 indicated he threatened to stab and kill his staff and housemates then went to the Emergency Room. -A BDDS report dated 5-30-12 for client #6 indicated he was kicking the railing on the porch, hitting the mailbox, screaming and swearing at staff, he threw a package of meat at staff, and grabbed a knife and lunged staff. Client #6 was transported by the police to Four County Counseling Center. -A BDDS report dated 6-29-12 for client #6 indicated he was throwing his body against the wall, hitting his head on the wall, punched the soap dispenser, approached staff screaming with his fists raised and he threw punches at staff. The	W0157	**W 157 Staff Treatment of Clients** *Peak Community Services is committed to ensuring that if an alleged violation is verified the appropriate* action must be taken. To that end the Peak Community Services IDT has a procedure in place that calls for the IDT to meet within days of an incident that requires the use of Crisis Prevention techniques. Client # 6's Behavior Support Plan has been reviewed and is scheduled for a revision by an outside Behavior Specialist, Raina Dailey of Opportunities for Positive Growth. Peak Community Services QDDP will convene a meeting with the IDT within 24 hours of a BDDS incident report containing references to harmful behaviors. This meeting will review the current behavior support plan to ascertain if the plan needs modifying and will include written minutes of the meeting for distribution to the team. Persons Responsible: Courtney Glasson, QDDP; Rick Phelps, Director of Residential Services; Connie English, Director of Support and Quality Assurance.	11/25/2012

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	police were called but staff transported client #6 to Four County Counseling Center where he was admitted. -A BDDS report dated 7-19-12 for client #6 indicated he started yelling at staff and threatening his housemates. Client #6 became more aggressive and the police were called. Client #6 went to Four County Counseling Center. On 10-26-12 at 11:00 a.m. the Behavior Management Policy (no date available) was reviewed. The Behavior Management Policy indicated individuals receiving services who began to display harmful behaviors will meet with the Interdisciplinary Team (IDT) to develop a program to assist the individual with controlling or ending undesired behaviors. The Behavior Management Policy also indicated efforts would be made to modify maladaptive or problem behaviors and would replace them with appropriate behaviors. On 10-25-12 at 11:30 a.m. an interview with the Qualified Mental Retardation Professional indicated the last update to client #6's behavior plan was 5-29-12 and the Interdisciplinary Team (IDT) had not met to discuss client #6's recent behavioral episodes. 9-3-2(a)			

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W0227	483.440(c)(4) INDIVIDUAL PROGRAM PLAN The individual program plan states the specific objectives necessary to meet the client's needs, as identified by the comprehensive assessment required by paragraph (c)(3) of this section. Based on observation, record review, and interview, the facility failed for 1 of 3 sampled clients (client #1) to ensure he had a toileting goal to assist him with his night time incontinentcy. Findings include: On 10-24-12 from 3:15 p.m. until 5:25 p.m. an observation at the home of client #1 was conducted. Clients #1's bedroom had a strong odor. Client #3's bed sheets were wet/stained and smelled of urine. On 10-24-12 at 3:40 p.m. an interview with the House Manager indicated the smell in client #1's bedroom was urine from client #1 wetting his bed due to refusing to get up and use the restroom through the night. On 10-25-12 at 8:00 a.m. a record review for client #1 was conducted. The Individualized Support Plan (ISP) dated 12-7-11 did not have a toileting goal/objective. On 10-25-12 at 11:30 a.m. an interview	W0227	**W227 Individual Program Plan** Peak Community Services through the IDT system seeks to ensure that specific objectives necessary to meet the client's needs are identified by a comprehensive assessment. Client # 1's Individual Support Plan has been updated to include a toileting goal to assist with his night time incontinency. Peak Community Services QDDP through the IDT process will review the other individuals served ISP's to ascertain if specific objectives needed to deliver the needed services in order to meet the client's needs as identified by the functional comprehensive assessment are contained within the ISP. This review will occur monthly starting 12.01.12 and run through 11.30.13. Person Responsible: Courtney Glasson, QDDP	11/12/2012

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	with the Qualified Mental Retardation Professional indicated client #1 did wet his bed through the night and there was no goal/objective in his ISP to assist him with it. 9-3-4(a)			

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W0249	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. Based on observation, record review, and interview, the facility failed for 3 of 3 clients (clients #1, #2, and #6) who were observed during a medication administration, to ensure medication goals were implemented as written. Findings include: On 10-25-12 from 6:35 a.m. until 6:53 a.m. a medication administration for clients #1, #2, and #6 was conducted. Direct care staff (DCS) #6 punched out client #1's medications for him and asked him to get his medication box. DCS #6 did not ask client #1 if he was carrying his medication list. DCS #6 punched client #2's medications out for him, she asked him to get his box out and she asked his if he wanted a straw. DCS did not ask client #2 if he was carrying his medication list. DCS #6 punched out client #6's medication and she asked him to get his box out. DCS #6 did not ask client #6 to name his medications and why it was prescribed. DCS #6 did not	W0249	**W 249 Program Implementation** Peak Community Services is committed to ensuring the individuals served receive a continuous active treatment program consisting of needed interventions and services… DSP staff in the residence and day program will receive retraining on Client's # 1, 2 and 6's medication goals as well as the use of prompts to ensure that Clients # 1, 2, and 6 receives a continuous active treatment program. DSP's in the home and the day program will be retrained on the definition of continuous active treatment including the use of prompts and other teaching techniques to ensure that all residents receive a continuous active treatment program. Such training will include the use of role play, question and answer session and direct observation by a Peak Community Services QDDP.	11/25/2012

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	know why client #6's was prescribed his Benztropine, Atorvastatin for cholestoral, Invega, Olanzapine, or his Escitalopram. DCS #6 did know why client #6 took his Aspirin for blood, Clonazapam for depression, Tabavite for nutrition, Vitamin D-3 nutrition, and Vitamin E for nutrition. On 10-25-12 at 8:00 a.m. a record review for client #1 was conducted. The Individualized Support Plan (ISP) dated 12-7-11 indicated client #1 had a goal/objective to carry his medication list. On 10-25-12 at 10:00 a.m. a record review for client #2 was conducted. The ISP dated 5-9-12 indicated client #2 had a goal/objective to carry his medication list. On 10-25-12 at 10:45 a.m. a record review for client #6 was conducted. The ISP dated 8-17-12 indicated client #6 had a goal/objective to name 1 of his medications and why is was prescribed. On 10-25-12 at 11:30 a.m. an interview with the Qualified Mental Retardation Professional indicated medication goals for clients #1, #2, and #6 should be implemented at all times of opportunity. 9-3-4(a)		Peak Community Services QDDP and the Director of Residential Services will observe staff for the proper administration of a continuous active treatment program once per month during an observation at the home during the time period of 11.28.12 until 04.28.12 The Director of Residential Services will counsel the Residential Coordinator on the importance of active treatment/goal management. Persons Responsible: Courtney Glasson, QDDP; Rick Phelps, Director of Residential Services, Megan Horton, Acting Residential Coordinator.	

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W0254	483.440(e)(2) PROGRAM DOCUMENTATION The facility must document significant events that contribute to an overall understanding of the client's ongoing level and quality of functioning. Based on record review and interview, the facility failed for 3 of 3 sampled clients (clients #1, #2, and #3) to ensure the Qualified Mental Retardation Professional (QMRP) quarterlies were completed to evaluate their Individualized Support Plan progress. Findings include: On 10-25-12 at 8:00 a.m. a record review for client #1 was conducted. The QMRP quarterlies indicated there were no quarterlies available for review for 3-12 or 12-11. On 10-25-12 at 10:00 a.m. a record review for client #2 was conducted. The QMRP quarterlies indicated there were no quarterlies available for review for 2-12 or 11-11. On 10-25-12 at 9:00 a.m. a record review for client #3 was conducted. The QMRP indicated there were no quarterlies available for review for 3-12 and 12-11. On 10-25-12 at 11:30 a.m. an interview with the QMRP indicated only 2	W0254	**W254 – Program Documentation** Peak Community Services is committed to ensuring that it documents significant events that contribute to an overall understanding of the client's ongoing level and quality of functioning. Client's 1, 2, 3 now have quarterlies for the last two quarters in accordance with the regulations. The individual responsible for the missing documentation is no longer employed by Peak Community Services. To monitor this situation going forward the Director of Support and Quality Assurance will monitor the residence assigned QDDP's monthly paperwork to assure that it is completed and covers the areas as needed by regulations. This monitoring will take place for 9 months starting 11.28.12. Persons responsible: Courtney Glasson, QDDP; Connie English, Director of Support and Quality Assurance.	11/25/2012

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	quarterlies for clients #1, #2, and #3 were available for review. The QMRP indicated QMRP quarterlies should be completed every 3 months to evaluate the progress of clients #1, #2, and #3. 9-3-4(a)			

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W0268	483.450(a)(1)(i) CONDUCT TOWARD CLIENT These policies and procedures must promote the growth, development and independence of the client. Based on observation and interview, the facility failed for 2 of 3 sampled clients (clients #1 and #3) to ensure urinary incontinent pads on furniture weren't visible and the smell of urine was not present in the home. Findings include: On 10-24-12 from 3:15 p.m. until 5:25 p.m. an observation at the home of clients #1 and #3 was conducted. Client #3 sat on a chair with with a urinary incontinent pad on it. The pad remained on the chair for the entire observation. Clients #1 and #3's room had a strong odor. Client #3's bed sheets were wet/stained and smelled of urine. On 10-24-12 at 3:40 p.m. an interview with the House Manager indicated the urinary incontinent pads for client #3 were so he didn't have an accident on the furniture. The House Manager also indicated the smell in clients #1 and #3's bedroom was urine from client #1 wetting his bed due to refusing to get up and use the restroom. On 10-25-12 an interview with the	W0268	**W268 – Conduct Toward Client** Peak Community Services is committed to ensuring that its policies and procedures promote the growth, development and independence of the clients served. Procedures dealing with clients 1 and 3's urinary incontinence have been updated and staff has been trained on the new procedure. Peak Community Services QDDP, Acting Residential Coordinator and the Residential Director will formally observe that the new procedure is being carried out once per month during an observation at the home during the time period of 12.01.12 to 11.30.13. The procedure will be observed informally every time that they are in the residence. Persons Responsible: Megan Horton, Acting Residential Coordinator Courtney Glasson, QDDP Rick Phelps, Director of Residential Services	11/12/2012

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	Qualified Mental Retardation Professional indicated having urinary pads on the furniture and the smell of urine did not promote dignity and respect for clients #1 and #3 and the problem should be fixed. 9-3-4(a)			

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W0331	483.460(c) NURSING SERVICES The facility must provide clients with nursing services in accordance with their needs. Based on observation, record review, and interview, the facility failed for 1 of 3 sampled clients (client #1) to ensure the nursing quarterlies addressed client #1's dry skin and urinary incontinency. Findings include: On 10-25-12 at 8:00 a.m. a record review for client #1 was conducted. The nursing quarterlies dated 7-9-12, 4-30-12, 1-22-12 and 10-1-11 did not indicate client #1's urinary incontinency during sleeping hours or dry skin and scalp had been addressed. On 10-24-12 at 4:45 p.m. an interview with direct care staff #2 indicated client #1 has had urinary incontinency and dry skin and scalp for as long as she has worked with him. On 10-25-12 at 11:30 a.m. an interview with the Qualified Mental Retardation Professional indicated the nursing quarterlies did not address client #1's dry skin or his urinary incontinency which had been a problem for at least 6 to 8 months. 9-3-6(a)	W0331	**W331 – Nursing Services** Peak Community Services is committed to ensuring that nursing services include services that meet the needs of the individuals served. Peak Community Services IDT has met and compiled a protocol for the nurse to follow when the nursing quarterlies are completed by the nursing staff. The nurse will be in-serviced on these protocols and will follow them for future quarterly assessments. A new nursing assessment form will be utilized, starting 12.01.12 to include all health/ medical events of the quarter. The nurse and Residential Director will meet and discuss the new form and protocol, emphasizing a more comprehensive documentation of health and medical events by the nurse. The QDDP and Acting Residential Coordinator will review the quarterly assessments upon receipt and ascertain if all health and medical events are addressed. If not, an addendum will be added to include missing events. Person Responsible: Courtney Glasson, QDDP; Megan Horton,	11/12/2012

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			Acting Residential Coordinator.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G626	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 10/26/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEAK COMMUNITY SERVICES INC	1141 19TH ST LOGANSPORT, IN 46947

(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) COMPLETION DATE
W0340	483.460(c)(5)(i) NURSING SERVICES Nursing services must include implementing with other members of the interdisciplinary team, appropriate protective and preventive health measures that include, but are not limited to training clients and staff as needed in appropriate health and hygiene methods. Based on observation, record review, and interview, the facility failed for 1 of 3 clients (client #6) observed during medication administration, to ensure direct care staff #6 didn't touch the medication with her bare hands. Findings include: On 10-25-12 from 6:47 a.m. until 6:53 a.m. an observation of the medication administration for client #6 was conducted. Direct care staff #6 (DCS) punched out client #6's Escitalopram (DCS #6 was unsure of what the medication was for), she dropped the pill on the counter, then picked it up with her bare hands. Client #6 took his medication. On 10-26-12 at 10:30 a.m. the Living in the Community: Medication Administration Manual, dated 2004, was reviewed. The manual for medication administration indicated, "Remove the medication ordered from the container and put it in a paper cup ...without	W0340	**W340 – Nursing Services** Peak Community Services is committed to ensuring that nursing services include implementing with other members of the interdisciplinary team appropriate protective and preventive health measures that include training clients and staff in appropriate health and hygiene methods. All Peak staff that dispenses medications has Core A and Core B training. The staff that dispensed the medication incorrectly for client # 6 is no longer employed by Peak Community Services. DSP staff in the residence will be retrained by the Director of Residential Services in the proper medication dispensing protocol as outlined in the Peak Community Services Standard Operating Procedures. To monitor the corrective action Peak Community Services Acting Residential Coordinator and the Director of Residential Services will include medication dispensing times	11/25/2012

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	touching the medication. On 10-25-12 at 11:30 a.m. an interview with the Qualified Mental Retardation Professional indicated Med Core A and B should be followed and DCS #6 should not pick up a pill from the counter, touch the pill with her bare hands then administer it to client #6. 9-3-6(a)		in their routine residence observations that are conducted at random times during the month. This monitoring will take place from 11/28/12 through 05/28/13. Persons Responsible: Megan Horton, Acting Residential Coordinator Rick Phelps, Director of Residential Services	

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W0381	483.460(l)(1) DRUG STORAGE AND RECORDKEEPING The facility must store drugs under proper conditions of security. Based on observation and interview the facility failed for 3 of 3 clients (clients #1, #2, and #6) who were observed during medication administration, to ensure the controlled substances were double locked. Findings include: On 10-25-12 from 6:35 a.m. until 6:53 a.m. an observation of the medication administration for clients #1, #2, and #6 was conducted. Client #2 was administered his Vimpat for seizures and his Phenobarbital for seizures. At 6:40 a.m. direct care staff (DCS) #6 indicated client #2's Vimpat and Phenobarbital were both controlled substances and were kept in an unlocked box in a locked closed. Client #1 was administered his Lorazepam for mood. At 6:45 a.m. DCS #6 indicated client #1's Lorazepam was a controlled substance and it was not double locked. Client #6 was given his Clonazepam for depression. DCS #6 indicated client #6's Clonazepam was a controlled substance and it was not kept double locked. On 10-26-12 at 11:30 a.m. an interview with the Qualified Mental Retardation Professional indicated clients #1, #2, and	W0381	**W381 – Drug Storage and Recordkeeping** Peak Community Services is committed to providing the individuals served with the highest level of medication security by ensuring that client's 1, 2, and 6's controlled substances are double locked as called for in the medication storage protocol. The staff that failed to double lock the controlled substances for clients # 1, 2 and 6 is no longer employed by Peak Community Services. DSP staff in the residence will be retrained in the proper medication dispensing protocol as outlined in the Peak Community Services Standard Operating Procedures including the procedure to double lock controlled substances. To monitor the corrective action Peak Community Services QDDP staff, the Director of Residential Services, and the Acting Residential Coordinator will include medication dispensing times in their routine residence observations that are conducted at random times during the month. This monitoring will take place from 11/28/12 through 05/28/13.	11/25/2012

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	#6's controlled medications should be kept double locked. 9-3-6(a)		Persons Responsible: Megan Horton, Acting Residential Coordinator Courtney Glasson, QDDP Rick Phelps, Director of Residential Services	

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W0484	483.480(d)(3) DINING AREAS AND SERVICE The facility must equip areas with tables, chairs, eating utensils, and dishes designed to meet the developmental needs of each client. Based on observation, record review, and interview, the facility failed for 6 of 6 clients (clients #1, #2, #3, #4, #5, and #6) to ensure they were offered a full set of silverware at supper time. Findings include: On 10-24-12 from 3:15 p.m. until 5:25 p.m. an observation at the home of clients #1, #2, #, #4, #5, and #6 was conducted. Clients #1, #2, #3, #4, #5, and #6 had potatoes, pork roast, carrots, bread and butter. Direct care staff #3 assisted client #3 with cutting his potatoes up with a fork. Client #5 put his butter on his bread with a fork. On 10-25-12 at 11:30 a.m. an interview with the Qualified Mental Retardation Professional indicated a full set of silverware should be offered at supper time. 9-3-8(a)	W0484	**W484 – Dining Areas and Service** Peak Community Services is committed to ensuring that each individual served is involved in meal preparation and understand that at meal time a full set of silverware is needed for every meal regardless of what food is served during the meal. Residential staff have be retrained on client's # 1,2,3,4,5,6, need for a full set of silverware as to enable each client to reach their maximum independence level when it comes to their abilities at meal time. Residential staff has also been retrained on meal preparation as a whole and the regulations that state that all clients must be involved in meal preparation and serves themselves as independently as possible as well as the need for a full set of silverware regardless of the food served at meal time. To monitor the corrective action Peak Community Services Acting Residential Coordinator will include meal time issues in their routine residence observations that are conducted at random times during the month.	11/25/2012

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			The Director of Residential Services will perform quarterly observations for DSP's interacting appropriately with clients and allowing highest levels of independence as appropriate including offering them the use of a full set of silverware at supper time. Persons Responsible: Megan Horton, Acting Residential Coordinator Rick Phelps, Director of Residential Services Courtney Glasson, QDDP	