

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G722	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/09/2012
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NAME OF PROVIDER OR SUPPLIER REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 645 E BRIDGE ST BROWNSTOWN, IN 47220
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W0000	<p>This visit was for a fundamental annual recertification and state licensure survey.</p> <p>Dates of Survey: February 7, 8 and 9, 2012.</p> <p>Facility number: 004445 Provider number: 15G722 AIM number: 200518250</p> <p>Surveyor: Steven Schwing, Medical Surveyor III.</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 2/16/12 by Ruth Shackelford, Medical Surveyor III.</p>	W0000		

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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W0140	<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. Based on record review and interview for 3 of 4 clients living in the group home (#1, #2 and #3), the facility failed to ensure the clients' checking accounts did not incur service charges.</p> <p>Findings include:</p> <p>A review of the clients' finances was conducted on 2/8/12 at 9:22 AM.</p> <p>-Client #1: Her checking account incurred service charges on 8/8/11, 9/11/11, 10/11/11, 11/8/11, 12/8/11 and 1/10/12 in the amount of \$1.95 each month.</p> <p>-Client #2: His checking account incurred service charges on 8/8/11, 9/11/11, 10/11/11, 11/8/11, 12/8/11 and 1/10/12 in the amount of \$1.95 each month.</p> <p>-Client #3: His checking account incurred service charges on 8/8/11, 9/11/11, 10/11/11 and 11/8/11 in the amount of \$1.95. On 12/8/11 and 1/10/12, the service charges were \$3.95 each month.</p> <p>An interview with the Program Director (PD) was conducted on 2/8/12 at 9:32 AM. The PD indicated she was aware of the on-going service charges. The PD</p>	W0140	<p>Program Director will ensure that all clients accounts are switched to a non-fee (free) checking account. Area Director will review financials quarterly to ensure that no fees are being charged to clients for their checking accounts. Responsible Parties: Program Director, Area Director</p>	03/09/2012			

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	<p>indicated the bank would not waive the service charges. The PD stated she was going to "eventually" switch the checking accounts to a new bank to avoid service charges. The PD indicated the service charges were incurred due to the clients not meeting the minimum account balances required by the bank.</p> <p>9-3-2(a)</p>			
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W0149	<p>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 3 of 18 incident/investigative reports reviewed affecting clients #2 and #4, the facility failed to ensure staff implemented the policies and procedures to prevent abuse and neglect of the clients.</p> <p>Findings include:</p> <p>A review of the facility's incident/investigative reports was conducted on 2/7/12 at 1:06 PM.</p> <p>-On 7/31/11 "between 4:00 and 6:00 PM", former direct care staff #12 was sitting in the living room of the group home eating ice cream. Former direct care staff #13 reported staff #12 stated to client #4, "quit f---ing staring at me!" This incident was reported to administrative staff on 8/1/11 at "about 3:30 PM."</p> <p>-On 7/31/11 at 11:30 AM, former direct care staff #10 told former direct care staff #11 he did not like client #4 but he would provide the best care he could. Client #4 was present when staff #10 told staff #11 this information. This incident was reported to administrative staff on 8/1/11 at 10:30 AM.</p> <p>-On 4/7/11 at 4:00 AM, former direct care staff #9 yelled and cursed at clients #1 and #2 at different times during the</p>	W0149	<p>Program Director will retrain all staff on abuse/neglect policies and prevention. Program Director will retrain all staff on incident reporting and reporting of abuse/neglect in a timely manner. Program Director and Home Manager will complete observations 1x a week for 4 weeks to ensure staff are following policy. Area Director will review observations weekly to ensure that staff are following policy. Responsible Parties: Program Director, Home Manager, Area Director</p>	03/09/2012			

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	<p>morning routine. The incident was reported to the home manager on 4/12/11. Direct care staff #9 quit her job after being suspended on 4/12/11.</p> <p>A review of the facility's Operating Practices - Supervised Group Living Services, dated June 2007, was conducted on 2/7/12 at 1:13 PM. 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>An interview with the Program Director (PD) was conducted on 2/9/12 at 11:47 AM. The PD indicated the staff should report abuse/neglect immediately. The PD indicated the facility should prevent abuse and neglect of the clients.</p> <p>9-3-2(a)</p>						

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W0153	<p>The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures.</p> <p>Based on record review and interview for 4 of 18 incident/investigative reports reviewed affecting clients #1, #2 and #4, the facility failed to ensure staff immediately reported abuse, neglect and an injury of unknown origin to the administrator and to the Bureau of Developmental Disabilities Services (BDDS) within 24 hours, in accordance with state law.</p> <p>Findings include:</p> <p>A review of the facility's incident/investigative reports was conducted on 2/7/12 at 1:06 PM.</p> <p>-On 12/13/11 at 7:30 AM, client #1 was found to have four three inch scratches on her inner left calf of an unknown origin. The facility reported the incident to BDDS on 12/15/11.</p> <p>-On 7/31/11 "between 4:00 and 6:00 PM", former direct care staff #12 was sitting in the living room of the group home eating ice cream. Former direct care staff #13 reported staff #12 stated to client #4, "quit f---ing staring at me!" This incident was reported to administrative staff on 8/1/11 at "about 3:30 PM."</p>	W0153	<p>Program Director will retrain all staff on incident reporting and reporting of incidents in a timely manner to Program Director. Program Director will ensure that all BDDS reports are completed within 24 hours. Area Director will review all incidents reports on a dialy basis to ensure they are being submitted timely. Quality Assurance reviews all incident reports on a weekly basis to ensure they are completed timely. Responsible Parties: Program Director, Area Director, Quality Assurance</p>	03/09/2012			

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	<p>-On 7/31/11 at 11:30 AM, former direct care staff #10 told former direct care staff #11 he did not like client #4 but he would provide the best care he could. Client #4 was present when staff #10 told staff #11 this information. This incident was reported to administrative staff on 8/1/11 at 10:30 AM.</p> <p>-On 4/7/11 at 4:00 AM, former direct care staff #9 yelled and cursed at clients #1 and #2 at different times during the morning routine. The incident was reported to the home manager on 4/12/11. Direct care staff #9 quit her job after being suspended on 4/12/11.</p> <p>An interview with the Program Director (PD) was conducted on 2/9/12 at 11:47 AM. The PD indicated the staff should report abuse/neglect immediately. The PD indicated BDDS reportable incidents should be submitted within 24 hours.</p> <p>9-3-2(a)</p>						

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W0189	<p>The facility must provide each employee with initial and continuing training that enables the employee to perform his or her duties effectively, efficiently, and competently.</p> <p>Based on observation and interview for 3 of 4 clients living in the group home (#1, #2, and #3), the facility failed to ensure staff referred to the Medication Administration Record (MAR) prior to administering liquids through the clients' Gastrostomy (G)-tubes.</p> <p>Findings include:</p> <p>An observation was conducted at the group home on 2/7/12 from 3:59 PM to 5:54 PM. At 4:51 PM, client #1 received 120 cc (cubic centimeter) of cranberry juice followed by a flush of 20 cc water while in the kitchen area of the group home from staff #4. At 5:03 PM, client #3 received 120 cc of cranberry juice followed by a flush of 240 cc of water. At 5:07 PM, client #2 received 50 cc of water, followed by 30 cc of Coke Zero, 120 cc cranberry juice and 100 cc water. Staff #4 administered the liquids to the clients. Staff #4 did not refer to the MAR during the administration of the liquids. The MAR was not present in the kitchen area.</p> <p>An interview with staff #4 was conducted on 2/7/12 at 5:11 PM. Staff #4 indicated she had administered the liquids to the</p>	W0189	<p>Facility Nurse will retrain all staff on medication administration. Program Director and Home Manager will complete med pass observations 1x a week for 4 weeks to ensure that staff are administering medications correctly. Responsible Parties Facility Nurse, Program Director, Home Manager</p>	03/09/2012			

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	<p>clients at the 5:00 PM pass numerous times and knew the amounts to administer. Staff #4 indicated she did not need the MAR to know the amounts to administer.</p> <p>An interview with the nurse was conducted on 2/9/12 at 9:48 AM. The nurse indicated the staff should refer to the MAR prior to administering the liquids to the clients.</p> <p>9-3-3(a)</p>			
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W0249	<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 2 of 2 clients observed to receive their medications during the morning observation (#2 and #3), the facility failed to ensure staff #6 implemented the clients' Gastrostomy Feeding Protocols.</p> <p>Findings include:</p> <p>1) An observation was conducted at the group home on 2/8/12 from 6:25 AM to 8:05 AM. At 6:41 AM, client #2 received his medications (Diazepam, Cerovite, Baclofen, Ferrex, Lactulose, Zegerid, Senna syrup and Infants gas relief) from staff #6. Staff #6 filled a cup with water (no markings on the cup for measurement) and added the liquid and powder medications. Staff #6 mixed the water and the liquid and powder medications in the cup and then poured the mixture into the syringe leading to the G-tube. The staff did not prime the tube with water. Staff #6 then flushed the tube with 60 cc of water and took client #2 out of the med room. Staff #6 observed she</p>	W0249	<p>Facility Nurse will retrain all staff on medication administration and complete client specific training on administering meds via G-tube. Program Director and Home Manager will complete med pass observations 1x a week for 4 weeks to ensure that staff are administering medications correctly. Responsible Parties Facility Nurse, Program Director, Home Manager</p>	03/09/2012			

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	<p>had not administered the medications in pill form. Staff #6 crushed the meds and mixed them with an unmeasured amount of water. Staff #6 administered the pills through the G-tube without first priming the tube with water.</p> <p>A handwritten note, undated, on the med room wall was observed during the med pass. The note indicated for client #2, "Mix crushed meds w/ (with) 10cc - 20cc water, put 20cc water in syringe (keep 10cc in tube), add meds then add 10cc water, use total 250 cc water."</p> <p>A review of client #2's record was conducted on 2/8/12 at 9:53 AM. Client #2's Gastrostomy Feeding Protocol, dated 7/13/11 and signed by the nurse and the physician, indicated the following for the Administration of Medications, "1. Crush or dissolve tablets only as directed by physician prior to administering them through the G-tube. 2. When crushing tablets, use a pill crusher to crush the medications into a fine powder. Clean crusher prior to and after each use. 3. Mix crushed medications with 10cc-20cc of water. 4. Prime tube with water keeping at least 10cc of water in the syringe before adding medications. 5. Add medications (crushed, mixed, or liquid) and then add 10cc more water. 6. Attach feeding tube to button; open clamp</p>			

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	<p>so that medications go in at a rate of less than 5 minutes. 7. Add the remaining water to clear tubing. 8. Never turn your back on the medications. 9. Document."</p> <p>2) An observation was conducted at the group home on 2/8/12 from 6:25 AM to 8:05 AM. At 7:01 AM, staff #6 administered client #3's medications (Acidophilus, Calcium Citrate, Finasteride, Lamotrigine, Lisinopril, Senna-S, Tamsulosin, Carbamazepine, Cerovite, Milk of Magnesia, Polyethylene Glycol, Clonazepam, Furosemide, Lactulose and Potassium Chloride). Prior to administering the meds, staff #6 got a cup full of water (did not measure) from the laundry room sink. Staff #6 added the powder, liquid and crushed meds into the water and mixed it up. Staff #6 poured the mixture into client #3's tube without first priming the tube with water. Staff #6 flushed client #3's tube with 60cc of water.</p> <p>A handwritten note on the med room wall, undated, indicated the following, "Mix crushed meds w/ 10-20cc water, put 20cc water in syringe (keep 10cc in tube), add meds then add 10cc water, use 250cc water total."</p> <p>A review of client #3's Gastostomy Feeding Protocol, dated 8/5/11 and signed</p>						

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	<p>by the nurse and physician, was conducted on 2/8/12 at 10:53 AM. The protocol indicated the following for the administration of medications, "1. Crush or dissolve tablets only as directed by physician prior to administering them through the G-tube. 2. When crushing tablets, use a pill crusher to crush the medications into a fine powder. Clean crusher prior to and after each use. 3. Mix crushed medications with 10cc-20cc of water. 4. Prime tube with water keeping at least 10cc of water in the syringe before adding medications. 5. Add medications (crushed, mixed, or liquid) and then add 10cc more water. 6. Attach feeding tube to button; open clamp so that medications go in at a rate of less than 5 minutes. 7. Add the remaining water to clear tubing. 8. Never turn your back on the medications. 9. Document."</p> <p>An interview with staff #6 was conducted on 2/8/12 at 7:15 AM. Staff #6 indicated the note on the med room wall regarding the procedure to use when administering meds did not work. Staff #6 indicated the clients received the appropriate amount of water during the med pass.</p> <p>An interview with the home manager (HM) was conducted on 2/8/12 at 7:58 AM. The HM indicated the handwritten notes on the med room wall were current</p>						

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	<p>and should be implemented as written.</p> <p>An interview with the nurse was conducted on 2/9/12 at 9:48 AM. The nurse indicated the staff should do a flush prior to administering the meds, per the protocols. The nurse indicated the staff should implement the protocols, as written.</p> <p>9-3-4(a)</p>			
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W0261	<p>The facility must designate and use a specially constituted committee or committees consisting of members of facility staff, parents, legal guardians, clients (as appropriate), qualified persons who have either experience or training in contemporary practices to change inappropriate client behavior, and persons with no ownership or controlling interest in the facility.</p> <p>Based on record review and interview for 4 of 4 clients living in the group home (#1, #2, #3 and #4), the facility failed to ensure the specially constituted committee (Human Rights Committee - HRC) had a designated client representative on the committee, who was appropriate, and/or allowed clients to participate in the HRC meetings/discussions as an HRC member.</p> <p>Findings include:</p> <p>On 2/8/12 at 9:17 AM, a review of the facility's HRC membership documentation, undated, indicated there was no client included in the membership affecting clients #1, #2, #3 and #4.</p> <p>An interview with Administrative staff (AS) #1 was conducted on 2/7/12 at 2:42 PM. AS #1 indicated the HRC did not have a client representative on the committee. AS #1 indicated, in an electronic mail dated 2/9/12 at 10:52 AM, the HRC committee had not had a client representative for "about a year." AS #1 indicated, "We don't have a large number of clients that would be appropriate but we do continue to look for one."</p> <p>9-3-4(a)</p>	W0261	<p>Indiana Mentors HRC committee will ensure that there is a client representative on the committee to assist in approving/disapproving all items sent through HRC. Responsible Party: Area Director</p>	03/09/2012	

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W0263	<p>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 for 1 of 1 client (#4) in the group home with restraint in her Behavior Development Program (BDP), the facility's specially constituted committee (HRC) failed to ensure the BDP was consented to by client #4's guardian prior to implementation.</p> <p>Findings include:</p> <p>A review of client #4's record was conducted on 2/8/12 at 10:21 AM. Client #4's Individual Support Plan (ISP), dated 8/4/11, indicated client #4 had a guardian. Client #4's BDP, dated 8/29/11, indicated she had targeted behaviors of chewing on inappropriate objects (places inedible items in mouth and chews on them; such as clothing, fingers or wood), self-injurious behavior (purposely bangs her elbows on her chair or rubs the back of her head that causes noticeable marking to the body; makes herself sick and vomits) and slapping (defined as attempted or actual purposeful attacks/slaps directed at other people). For self-injurious behavior, the responding to targeted behavior section indicated the following, "If this behavior cannot be redirected and may cause</p>	W0263	<p>Program Director will ensure that any program monitoring change is approved by guardian/HRC prior to implementation. Area Director will review documentation in the home quarterly to ensure all items have received prior approval from guardian/HRC before implementation. Responsible Parties: Program Director Area Director</p>	03/09/2012			

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	<p>moderate or more serious injury, use the minimum amount of physical guidance necessary to stop the behavior (Use agency approved physical intervention techniques)." For slapping, the responding to targeted behavior section indicated the following, "If she pursues and reinitiates physical assault, use the minimum amount of physical guidance necessary to stop the aggression; (Use the techniques taught in the agency-approved crisis intervention)." Client #4's plan did not include a consent from the guardian for the use of the restrictive interventions. The HRC consented to the plan on 9/21/11 without consent from the guardian.</p> <p>An interview with the Program Director (PD) was conducted on 2/9/12 at 11:47 AM. The PD indicated she was unable to locate the consent from client #4's guardian. The PD indicated she sent the plan to be signed but the guardian did not return the signed page of the plan. The PD indicated she did not follow-up with the guardian for the signed consent. The PD indicated she should have ensured written consent was obtained from the guardian.</p> <p>9-3-4(a)</p>			
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W0295	<p>The facility may employ physical restraint only as an integral part of an individual program plan that is intended to lead to less restrictive means of managing and eliminating the behavior for which the restraint is applied.</p> <p>Based on record review and interview for 1 of 1 client (#4) in the home with restraints in her Behavior Development Plan (BDP), the facility failed to ensure the plan indicated the specific interventions needed to address self-injurious behavior and slapping.</p> <p>Findings include:</p> <p>A review of client #4's record was conducted on 2/8/12 at 10:21 AM. Client #4's BDP, dated 8/29/11, indicated she had targeted behaviors of chewing on inappropriate objects (places inedible items in mouth and chews on them; such as clothing, fingers or wood), self-injurious behavior (purposely bangs her elbows on her chair or rubs the back of her head that causes noticeable marking to the body; makes herself sick and vomits) and slapping (defined as attempted or actual purposeful attacks/slaps directed at other people). For self-injurious behavior, the responding to targeted behavior section indicated the following, "If this behavior cannot be redirected and may cause moderate or more serious injury, use the</p>			W0295	<p>Program Director in conjunction with behavior consultant review client #4's BDP to include the specific techniques for staff to use to respond to the targeted behaviors. Program Director will review all other BDP's to ensure they include specific techniques for staff to use to respond to targeted behaviors. Program Director in conjunction with IDT will review BDP's quarterly to ensure they contain the specific techniques for staff to use to respond to targeted behaviors. Responsible Parties: Program Director Behavior Consultant.</p>		03/09/2012

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	<p>minimum amount of physical guidance necessary to stop the behavior (Use agency approved physical intervention techniques)." For slapping, the responding to targeted behavior section indicated the following, "If she pursues and reinitiates physical assault, use the minimum amount of physical guidance necessary to stop the aggression; (Use the techniques taught in the agency-approved crisis intervention)." The plan did not indicate the specific techniques staff were to use to respond to the targeted behaviors.</p> <p>An interview with the Behavior Consultant (BC) was conducted on 2/9/12 at 12:01 PM. The BC indicated the Regional Director or Program Director should have added an addendum to the plan indicating the types of interventions the staff could implement to address the targeting behaviors. The BC indicated having the specific intervention in the plan would clarify to the staff the hold to use. The BC indicated the intervention staff should use would be to hold client #4's arms down to her sides. The BC indicated this information was not part of the plan.</p> <p>9-3-5(a)</p>			
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W0331	<p>The facility must provide clients with nursing services in accordance with their needs.</p> <p>Based on observation, record review and interview for 1 of 2 sampled clients (#4), nursing services failed to ensure staff notified the nurse of client #4's refusals to eat.</p> <p>Findings include:</p> <p>An observation was conducted at the group home on 2/8/12 from 6:25 AM to 8:05 AM and 11:06 AM to 11:28 AM. During the observations, client #4 refused to eat breakfast and lunch. At 7:28 AM, client #4 was assisted in her wheelchair to the dining room table for breakfast. Client #4 refused to feed herself but did take 5 bites of toast with jelly staff #6 put up to her mouth. At 11:06 AM at the group home, client #4 refused to get up off the couch to eat lunch. She continued to refuse to eat until the observation ended at 11:28 AM. During the observation, staff #14 indicated client #4 had not been eating well at lunch time for one week.</p> <p>An interview with the Program Director (PD) was conducted on 2/9/12 at 11:47 AM. The PD indicated she was aware client #4 had not been eating well the past 2 days; she indicated it was possible the length of time was longer. The PD</p>	W0331	<p>Facility Nurse in conjunction with Program Director will update client #4's dining plan to include notifying nurse of refusals to eat. Facility Nurse will retrain all staff on updated dining plan for client #4. Program Director and Nurse will review all other dining plans to ensure they are appropriate and will retrain all staff if any changes are made to those dining plans. Program Director and Home Manager will complete mealtime observations 1x week for 4 weeks to ensure that all dining plans are being implemented correctly. Responsible Parties: Facility Nurse, Program Director, Home Manager</p>	03/09/2012			

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	<p>indicated she had not contacted the nurse in regard to client #4's decreased appetite. The PD indicated she was not sure if anyone else contacted the nurse. The PD indicated client #4 typically had a good appetite.</p> <p>An interview with the nurse was conducted on 2/9/12 at 9:48 AM. The nurse indicated she had not been contacted in regard to client #4's lack of appetite. The nurse indicated client #4 recently had a change in the consistency of her food from a regular diet to mechanical soft #2. The nurse indicated client #4 may not like the recent change. The nurse indicated client #4 typically did not eat well at breakfast routinely. The nurse indicated the staff should have contacted her in regard to the change of appetite.</p> <p>9-3-6(a)</p>				