STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G674	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 06/25/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE DESIGNS INC	1922 LIMESTONE DR ELLETTSVILLE, IN 47429

(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
W 0000 Bldg. 00	This visit was for a full annual recertification and state licensure survey. Survey dates: June 22, 23, 24 and 25, 2015 Facility number: 009347 Provider number: 15G674 AIM number: 100239630 These deficiencies also reflect state findings in accordance with 460 IAC 9.	W 0000		
W 0249 Bldg. 00	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, interview and record review for 3 of 3 clients in the sample (#2, #4 and #6) and one additional client (#1), the facility failed to ensure staff implemented the clients' program plans as written for: 1) door alarms for clients #2, #4 and #6, 2) client #2's plan for drinks, 3) client #1's plan for	W 0249	To correct the deficient practice and prevent recurrence,all staff will be re-trained on the training objectives for all individuals living in the home. The QIDP will create environmental cues to support implementation;for example, a reminder near the door to keep alarms on and to take the PRN bag when leaving the home, small dishes to support with	07/24/2015

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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	following his diet, 4) client #1's plan to put food away when not in use, 5) client #4's seizure management plan, and 6) client #6's plan to set a timer as a visual aid for his cigarette schedule. Findings include: 1) An observation was conducted at the group home on 6/22/15 from 3:41 PM to 5:50 PM. At 4:05 PM, the upstairs back door alarm was on and the front door alarm was off. At 4:14 PM when staff #3 entered the front door, the alarm did not sound due to being off. At 4:21 PM, the Network Director (ND) asked staff #3, #5 and #6 to turn on the front door alarm. Staff #3, #5 and #6 did not turn the alarm on. At 5:31 PM when the ND left the group home, the front door alarm was off. At 5:35 PM when the Team Manager left the group home, she prompted staff #5 to turn on the alarm. Staff #5 turned on the front door alarm. An observation was conducted at the group home on 6/23/15 from 6:05 AM to 8:00 AM. The front door alarm was not turned on. At 6:24 AM when staff #3 arrived to the group home, she rang the doorbell. When she entered, she indicated to staff #8 that she did not know if the alarm was on. Staff #8 stated, "Oh, it's off." Neither staff turned		correct portions of food,pre-packaging some snack and breakfast-type foods into individual serving sizes to increase individual independence, etc. Competency-based assessments related to individual plans will be incorporated into regular staff meetings so staff knowledge of plans can be assessed on an ongoing basis. Monitoring will be accomplished through observations by the ND/QIDP, Director of Residential Services (DORS), Quality Assurance Director (QAD), and Director of Support Services (DOSS) 5 times per week for a period of 2 weeks. On an ongoing basis, the ND/QIDP will observe staff in the setting no less than twice weekly. Additionally, the Team Manager is assigned to the home full time, and works alongside direct support staff,providing ongoing support, supervision and training as needed.	

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	on the alarm. The front door alarm was not turned on during the observation at the group home on 6/23/15. On 6/23/15 at 6:05 AM, staff #9 indicated the door alarms were in place for client #5. On 6/23/15 at 6:05 AM, staff #8 indicated the door alarms were in place for client #6. On 6/23/15 at 7:57 AM, staff #3 indicated the door alarms should be on all the time the clients were in the group home. On 6/23/15 at 9:15 AM, the ND indicated the door alarms should be on when the clients were at home. On 6/23/15 at 9:15 AM, the Team Lead indicated the door alarms should be on when the clients were at home. On 6/23/15 at 8:18 AM, client #2's Behavioral Support Plan, dated 10/13/14, indicated, "Door alarms should be activated because darting is an issue. [Client #2] has darted to neighbor's homes and cars to seek out coffee or food...." On 6/24/15 at client #4's Behavioral			

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	Support Plan, dated 9/11/14, indicated, "Door alarms are turned on at night when [client #4] is home... [Client #4] has had darting issues and needs to be attended carefully when outside. Going in and out of the van is the time of his most frequent attempt to dart...." On 6/23/15 at 8:54 AM, client #6's Behavioral Support Plan, dated 5/4/15, indicated, "Door alarms are in place on external doors at the group home to alert staff that a door has been opened." 2) An observation was conducted at the group home on 6/22/15 from 3:41 PM to 5:50 PM. At 4:06 PM, client #2 drank out of a cup left on the dining room table by the Team Manager (TM). The Network Director (ND) redirected client #2 and informed the TM that client #2 drank from her cup. The ND prompted client #2 to get a drink. At 4:09 PM, client #2 threw away the cup. On 6/23/15 at 9:08 AM, the ND indicated client #2 had a plan for drinks to be put away and the plan should be implemented as written. On 6/23/15 at 8:18 AM, a review of client #2's record was conducted. Client #2's Behavioral Support Plan, dated 10/13/14, indicated, "Fluids should be			

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	locked up and staff should not have drinks out while working on the floor due to [client #2] being diagnosed with Psychogenic Polydipsia, which is a self-stimulatory behavior where [client #2] will drink fluids to the point of vomiting and could also cause a seizure and death. [Client #2's] fluid intake should be closely monitored to ensure electrolytes stay within normal range. He may have 100 ounces of liquid per day...." 3) On 6/23/15 from 6:05 AM to 8:00 AM, an observation was conducted at the group home. At 6:50 AM, client #1 served himself from the pan on the stove. Client #1 served himself three scrambled eggs and made two pieces of toast for breakfast. Client #1 poured 3-4 cups of cold, dry cereal into his bowl. At 7:17 AM, client #1 went back into the kitchen and prepared himself an instant package of oatmeal. Client #1 was not redirected or prompted to follow the menu serving sizes. Client #1 was not prompted to take a good amount of food or he could do better next time. Client #1 was not informed of how to stay healthy as indicated in his plan. On 6/24/15 at 12:52 PM, a review of client #1's Behavioral Support Plan, dated 3/12/15, indicated, in part, "There			

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	are two areas of concerns in regard to [client #1]. His anxiety/agitation and an obsession with food. [Client #1's] obsession with food really interferes with his ability to be independent. He will seek out food at any time and will open all the kitchen cabinets looking for extra food or if he is out he will go into offices seeking out food. If [client #1] insists on taking food, staff should talk with him about the effects of going over his daily diet. [Client #1] has high cholesterol, high blood pressure and a family history of heart disease. If he still insists on taking extra food staff should ask [client #1] to then only take a 'good amount' and put the food in a dish and sit at the table. Tell [client #1] that he should follow his meal plan to stay healthy and if he does not follow it tell [client #1] that 'he can do better next time' and explain that certain foods (mainly fatty) foods will cause him harm and may lead to heart problems. Otherwise [client #1] will take a whole container and eat it all as fast as he can in secret. (Use this as a teachable moment.)...." On 6/23/15 at 9:08 AM, the Network Director indicated the staff should have implemented client #1's plan as written. On 6/24/15 at 11:05 AM, the Team Lead indicated client #1's plan should have			

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	been implemented as written. On 6/24/15 at 11:06 AM, the Team Manager indicated client #1's plan should have been implemented as written. 4) On 6/23/15 from 6:05 AM to 8:00 AM, an observation was conducted at the group home. At 6:50 AM, client #1 served himself from the pan on the stove. Client #1 served himself three scrambled eggs and made two pieces of toast for breakfast. Client #1 poured 3-4 cups of cold, dry cereal into his bowl. At 7:17 AM, client #1 went back into the kitchen and prepared himself an instant package of oatmeal. During the observation, the cereal, bread, packets of instant oatmeal and cooked eggs were left out on the counter and the scrambled eggs were in a pan on the stove. On 6/24/15 at 12:52 PM, a review of client #1's Behavioral Support Plan, dated 3/12/15, indicated, in part, "Again [client #1] enjoys eating food, however, he has been diagnosed with hypertension, high cholesterol, and is on a 1500 calorie diet. [Client #1] needs to (sic) monitored when in the kitchen because he will steal food as well as eating to the point of vomiting. [Client #1] can be sneaky in the kitchen and will attempt to shove food in his mouth when others are not			

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	looking or sneak extra snacks into his room. Excess food should be kept out of sight locked in the garage refrigerator and freezer or in the storage room when not in use...." On 6/24/15 at 10:41 AM, the Team Lead indicated the food should be locked up as indicated in client #1's plan except when being prepared for a meal. On 6/24/15 at 10:41 AM, the Team Manager indicated the food should be locked up as indicated in client #1's plan except when being prepared for a meal. 5) Confidential interview (CI) #1 indicated client #4 had two seizures, one at the day program and one on his way home from the day program, on 6/22/15. CI #1 indicated the LifeDesigns nurse was contacted by LifeDesigns staff. CI #1 indicated the day program staff should have contacted the nurse. CI #1 indicated the day program staff should have administered client #4's PRN (as needed) medication for seizures. CI #1 indicated the day program staff did not implement client #4's seizure plan as written. CI #1 indicated the LifeDesigns staff (#5 and #6) failed to administer client #4's PRN medication due to failing to take his PRN bag with them during transport from the day program to the group home. CI #1			

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	indicated staff #5 and #6 failed to implement client #4's plan as written. CI #1 indicated this was not the first time staff #5 and #6 failed to take client #4's PRN bag with them during transport. On 6/23/15 at 9:15 AM, the Network Director indicated the day program staff failed to notify the nurse, client #4's mom (guardian) and LifeDesigns staff when client #4 had a seizure. The ND indicated the LifeDesigns staff failed to take client #4's PRN bag with them during transport. The ND indicated client #4's PRN medication should have been given by the LifeDesigns staff during transport but the medication was in the bag at the group home. The ND indicated client #4's plan for seizures should have been implemented as written. On 6/24/15 at 11:01 AM, a review of client #4's Seizure Protocol for [client #4] - Staff Guidelines was conducted. The plan, dated 10/26/13, indicated, "Current Orders: Diastat 20 mg (milligrams), Klonopin 0.5 mg PO (by mouth)/PRN (as needed): give one tablet as directed after 1 seizure if GREATER THAN ONE MINUTE or if found disoriented and seizure activity is suspected." The plan indicated, "Use of VNS (Vagus Nerve Stimulation) magnet generator			

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	stimulation: A. When staff sees [client #4] beginning to have a seizure, they are to swipe the magnet over the left side of his chest where the VNS generator is located under the skin, from shoulder to sternum ONE time. This will stimulate the VNS for 60 seconds. [Client #4] might cough or clear his throat, this is a normal response to the VNS stimulation. After stimulation, [client #4's] seizure should subside or decrease in intensity... C. Staff will then page the Nurse/Nurse On-call to notify him/her of the seizure activity and of the magnet swipe and the result. Staff will also notify the QMRP (Qualified Mental Retardation Professional) of this information via voicemail... Use of Klonopin 0.5 mg/PRN for seizure activity: A. Staff should follow steps A through D as stated above. After one seizure (greater than) 1 minute. B. After first seizure if greater than one minute: staff may administer Klonopin 0.5 mg PO/PRN...." On 6/24/15 at 10:41 AM, the Team Lead (TL) indicated the staff were trained to take the PRN bag with them during transport. The TL indicated the bag was recently moved from the downstairs office to the upstairs cabinet where the van keys were located in order to make it easier for the staff to remember to take it with them. The TL indicated client #4's			

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	plan should be implemented as written. On 6/24/15 at 10:44 AM, the Team Manager indicated client #4's plan should be implemented as written. On 6/24/15 at 2:22 PM, the nurse indicated client #4's two seizures on 6/22/15 were both one minute in length. The nurse indicated the staff did not follow the plan. The nurse indicated the staff contacted the Medical Coordinator but not the nurse. The nurse indicated client #4 should have received his PRN medication immediately following the second seizure. The nurse indicated client #4 was administered the medication as soon as he arrived to the group home. The nurse indicated staff #5 and #6 were going to be retrained and given written warnings for failing to follow client #4's plan. The nurse indicated staff #5 and #6 failed to take the PRN bag with them on 6/23/15 in addition to 6/22/15. 6) On 6/22/15 from 3:41 PM to 5:50 PM, an observation was conducted at the group home. At 4:02 PM when client #6 indicated to staff he wanted to go out to smoke, client #6 was prompted to set the stove timer to 90 minutes. Client #6 set the timer on the stove for 90 minutes. At 4:18 PM when client #6 asked to smoke,			

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	the Network Director prompted client #6 to check his timer. The ND also offered client #6 activities to engage in until the timer went off indicating it was time to smoke. At 5:22 PM, client #6 asked for a cigarette. Client #6 was redirected to check the timer. On 6/22/15 at 5:22 PM, staff #6 indicated client #6 was on a schedule to smoke his cigarettes every 90 minutes. On 6/23/15 from 6:05 AM to 8:00 AM, an observation was conducted at the group home. At 6:57 AM, client #6 asked staff #8 for a cigarette. Staff #8 used a key to access the locked pantry to get client #6's cigarette. At 7:02 AM when client #6 came into the group home from smoking, he was not prompted to set a timer. At 7:26 AM, client #6 asked staff #9 for a cigarette. Staff #9 stated to client #6 he had just smoked a cigarette "not too long ago." Staff #9 did not prompt client #6 to set a timer or to check the timer. At 7:42 AM, client #6 asked staff #9 for a cigarette. Staff #9 got client #6 a cigarette. Staff #8, who was near staff #9, stated the staff "encourage" client #6's 90 minute cigarette schedule. Staff #9 indicated client #6 was leaving soon for the day program so the staff gave him another cigarette.			

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	On 6/23/15 at 8:54 AM, a review of client #6's record was conducted. Client #6's 6/23/15 Nursing Care Plan did not address smoking. Client #6's Individualized Support Plan, dated 5/4/15, indicated, "[Client #6] will increase his health and wellness by building skills to quit smoking. [Client #6] has been working on taking a break of at least an hour between each cigarette, with the hopes of eventually stopping smoking completely. [Client #6] will smoke multiple packs of cigarettes in one day, when he finishes one he would start to smoke another right away. 1. [Client #6] will go out for a smoke break, once her (sic) returns inside he will set a timer for an hour and a half. 2. Staff will prompt [client #6] to pick an activity or task to complete to help redirect his attention from smoking. If [client #6] does not smoke another cigarette before the timer goes off the goal is considered completed." On 6/23/15 at 9:15 AM, the Network Director indicated client #6's plan for smoking should be implemented as written for setting the timer after he smokes a cigarette. 9-3-4(a)			

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W 0356 Bldg. 00	483.460(g)(2) COMPREHENSIVE DENTAL TREATMENT The facility must ensure comprehensive dental treatment services that include dental care needed for relief of pain and infections, restoration of teeth, and maintenance of dental health. Based on record review and interview for 1 of 3 clients in the sample (#2), the facility failed to ensure recommended dental care was completed. Findings include: On 6/23/15 at 8:18 AM, a review of client #2's record indicated he had a dental appointment on 3/9/15. The Medical Appointment Record indicated, "Moderate-heavy generalized plaque build up. Moderate periodontitis (inflammation of the tissue around the teeth, often causing shrinkage of the gums and loosening of the teeth). Recommend that [client #2] come in every 4 months for cleanings. [Client #2] was jerking more than usual today - seemed very anxious. He might benefit from going to a dentist that offers sedation. [Client #2] still needs a crown on lower right (#30)." There was no documentation the client #2 received a crown on his lower right tooth. On 6/24/15 at 10:31 AM, the Medical	W 0356	To correct the deficient practice, an appointment has been scheduled for client #2 on 7/15/15. To ensure no others were affected by the deficient practice, the ND/ QIDP or nurse will review appointment records for all other individuals to ensure any necessary follow up was completed . To ensure the deficient practice does not continue, staff who support individuals with medical appointments will be re-trained on the process for appointment documentation, as well as communication following the appointment of any necessary follow-up, medication changes, etc. Ongoing monitoring will be accomplished through the Team Manager weekly report, which includes information and follow up for all appointments that occurred each week. Additionally, the ND/QIDP completes a monthly report for each individual living in the home that includes a grid of all medical appointments and any needed follow up. The nurse also reviews medical appointment information on a regular basis, and monitors to ensure follow up	07/24/2015

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Coordinator (MC) indicated on 6/23/15 she scheduled an appointment for client #2 to have the crown in July 2015. The MC indicated she was unsure why an appointment was not previously scheduled. The MC indicated an appointment should have been scheduled sooner. 9-3-6(a)		is completed.	
W 0440 Bldg. 00	483.470(i)(1) EVACUATION DRILLS The facility must hold evacuation drills at least quarterly for each shift of personnel. Based on record review and interview for 5 of 6 clients living in the group home (#1, #2, #3, #4 and #5), the facility failed to conduct quarterly evacuation drills for each shift. Findings include: On 6/22/15 at 3:42 PM, a review of the facility's evacuation drills was conducted. There was no evacuation drill conducted during the day shift (6:00 AM to 2:00 PM) from 7/13/14 to 12/16/14. During the night shift (10:00 PM to 6:00 AM), there was no evacuation drill conducted from 11/20/14 to 3/22/15. This affected clients #1, #2, #3, #4 and #5. On 6/22/15 at 3:55 PM the Network	W 0440	To correct the deficient practice, a drill schedule has been posted. Staff will be provided additional training related to the timeframes in which drills must be completed, including a clarification that the requirement of “quarterly” means every 90 days (as opposed to once per calendar quarter). To ensure the deficient practice does not continue, the Team Manager will complete a weekly report that summarizes events for each customer in the home, including completed drills, as well as any needed follow up. The Team Manager, ND/QDDP will meet weekly at the home to review current status of individuals living in the home, support needs of staff and to ensure follow up related to any identified issues or concerns.The ND/QDDP will complete a quarterly Quality	07/24/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G674	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 06/25/2015
NAME OF PROVIDER OR SUPPLIER LIFE DESIGNS INC		STREET ADDRESS, CITY, STATE, ZIP CODE 1922 LIMESTONE DR ELLETTSVILLE, IN 47429	

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	Director indicated the facility should conduct one evacuation drill per shift per quarter. 9-3-7(a)		Assurance Review to ensure all drills in the home are current. The QA review is submitted to the DRS, as well as the Quality Assurance Director for tracking and trending purposes. The QAD report is submitted to the CEO to be included as part of the monthly report to the LifeDesigns Board of Directors.	
W 0460 Bldg. 00	483.480(a)(1) FOOD AND NUTRITION SERVICES Each client must receive a nourishing, well-balanced diet including modified and specially-prescribed diets. Based on observation, record review and interview for 2 of 3 non-sampled clients (#1 and #5), the facility failed to ensure staff implemented the serving sizes on the menu as written. Findings include: On 6/23/15 from 6:05 AM to 8:00 AM, an observation was conducted at the group home. At 6:50 AM, client #1 served himself from the pan on the stove three scrambled eggs and made two pieces of toast for breakfast. Client #1 poured 3-4 cups of cold, dry cereal into his bowl. At 7:17 AM, client #1 went back into the kitchen and prepared himself an instant package of oatmeal. Client #1 was not redirected or prompted to follow the menu serving sizes.	W 0460	To correct the deficient practice and prevent recurrence,all staff will be re-trained on individual plans related to meals/ eating,menus, serving sizes, etc. Smaller bowls will be purchased for the home, and some foods, such as cereal and snack foods, will be packaged into individual serving sizes to support individuals to be more independent with serving themselves. Monitoring will be accomplished through observations, including mealtime observations, by the ND/QIDP, Director of Residential Services (DORS),Quality Assurance Director (QAD), and Director of Support Services (DOSS) 5 times per week for a period of 2 weeks. On an ongoing basis, the ND/QIDP will observe staff in the setting no less than twice weekly. Additionally, the Team Manager is assigned to the home full time,	07/24/2015

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	15G674		06/25/2015

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	At 6:55 AM, client #5 served herself 3-4 scrambled eggs and two pieces of toast. Client #5 served herself 3-4 cups of cold cereal into her bowl. Client #5 added barbeque sauce to her eggs. At 7:03 AM after eating her first serving of eggs, client #5 served herself an additional 3-4 scrambled eggs. Client #5 was not redirected or prompted to follow the menu serving sizes. On 6/23/15 at 6:20 AM, a review of the menu, dated 2/23/10 week 3, indicated the following: cranberry juice, egg, hot or cold cereal, toast skim milk, coffee, jelly and margarine. The menu, posted on the wall between the dining room and kitchen, did not include serving sizes. At 7:17 AM, staff #8 and #9 indicated they did not know where the menu was located with the serving sizes. At 7:40 AM, staff #3 was able to locate the menu with the serving sizes. The menu indicated, "1 egg, 1/2 cup hot or 3/4 cup cold cereal, 1 slice of toast and 1 cup of milk." On 6/23/15 at 7:37 AM, staff #3 indicated client #1 was on a regular diet. Staff #3 indicated client #5 was on an 1800 calorie diet. On 6/23/15 at 7:40 AM, staff #3 indicated the menu should be implemented as written in regard to serving sizes.		and works alongside direct support staff, providing ongoing support, supervision and training as needed.	

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	On 6/24/15 at 10:38 AM, a review of client #1's Group Home Quarterly Nutrition Assessment, dated 5/8/15, was reviewed. Client #1 was on a regular diet. The dietician indicated his diet was "as menued." On 6/24/15 at 10:37 AM, a review of client #5's Group Home Quarterly Nutrition Assessment, dated 5/8/15, was reviewed. Client #5's current diet was 1500 calorie, no concentrated sweets and low fat diet. On 6/23/15 at 9:08 AM, the Network Director indicated the staff should prompt the clients to follow the menu and their diet orders. The ND indicated the staff should know where the menus were located with the serving sizes. On 6/24/15 at 11:05 AM, the Team Lead indicated the clients should be prompted to follow the serving sizes on the menu and their diets. On 6/24/15 at 11:06 AM, the Team Manager indicated the clients should be prompted to follow the serving sizes on the menu and their diets. On 6/24/15 at 2:30 PM, the nurse indicated the clients should be prompted			

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	to follow the serving sizes on the menu. 9-3-8(a)			