DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	15G786	A. BUILDING 00 B. WING	04/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
PATHFINDER SERVICES INC	1570 JESSUP STREET HUNTINGTON, IN 46750

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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 an extended annual recertification (Client Protections) and state licensure survey. Dates of Survey: 4/15, 4/16, 4/17, 4/18, 4/19, 4/22, and 4/23/2024. Facility number: 012414 Provider Number: 15G786 AIMS Number: 200998980 These federal deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review of this report completed by #15068 on 5/8/24.	W 0000		
W 0149 Bldg. 00	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 2 of 55 BDS (Bureau of Disability Services) reports reviewed and 1 of 5 investigations reviewed, the facility failed to implement the agency's abuse, neglect, and exploitation (ANE) policy and procedures to protect clients #3 and #6 regarding AWOL (absent without leave) behaviors from further ANE and to thoroughly investigate client #3's fall during substantiated staff to client neglect which resulted in significant injuries. Findings include: The facility's BDS reports were reviewed on 4/15/24 at 1:59 PM.	W 0149	W149: Staff Treatment of Clients -Facility admits failure to complete investigate as per organizational policy and identified in W149. Going forward, staff will ensure the safety of all individuals as trained per their plans and organization policy. Staff retrained in Abuse, Neglect and Exploitation (ANE), as well as trained upon hire and annually as required and report any suspected incidents. Faulty alarm was replaced, and an alarm shift check was implemented. BSP amendment made to include	05/30/2024

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Melissa Rogers	ADRS	06/27/2024

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 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 disclo 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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	1. The BDS report dated 12/26/23 indicated client #3 had ambulated out the back door while staff was not watching her. Client #3 was able to travel a block to a stop sign in her pajamas on 12/26/23 before being found by a community member. The community member walked the block to the group home to see if client #3 belonged to the group home before she called the police as client #3 was nonverbal and couldn't tell her where she lived. A staff member took her personal car to where client #3 had ambulated to return her to the group home safely. The investigation dated 2/13/24 was reviewed on 4/18/24 at 4:37 PM and indicated staff were suspended. The investigation indicated faulty door alarms were replaced and modifications to the home would be completed to ensure the safety of the clients. The investigation indicated a fence for the yard was completed and there was discussion of moving the closets in the front hallway to allow a pass-through window enabling staff to monitor the front door while in the kitchen. Client #3's 7/12/23 BSP (Behavior Support Plan) was reviewed on 4/16/24 at 3:00 PM and indicated, "It is very important to always watch [client #3] as she has a strong tendency to wander off." Client #3's ISP (Individualized Support Plan) dated 8/8/23 indicated, "[client #3] wanders the house occasionally seemingly randomly. Staff are to monitor her when she is up ... There are chimes on the doors as well to alert staff if someone exits/enters in order to maintain [client #3's] safety as she has a history of elopement ...[Client #3] has 24/7 staffing and supports." 2. The 8/17/23 BDS report was reviewed on 4/15/24 at 1:59 PM and indicated client #6 had been sitting in an empty transit vehicle from 2:26		"leaving staff supervision". Transit retraining completed by staff. Oversight on Relias training completion by GHM and ADRS to be completed monthly. Agency staff will follow ANE policies as written/trained and complete any investigations in a timely manner. 05/30/2024	

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	PM to 2:48 PM when another transit vehicle driver spotted client #6 knocking on the back door of the vehicle for help getting out of the vehicle. The other transit driver found the keys to the transit in the cup holder of the vehicle and opened the front door for client #6 to disembark and assisted him into the day program building to ask the day program staff if he was part of their program. The investigation dated 8/30/23 was reviewed on 4/18/24 at 4:37 PM. The investigation indicated, "Pathfinder needs to continue to develop teamwork and communication in connection department through staff meetings and teaching moments as they come up; the substitute information sheets located in each room need to be updated to keep all clients safe; the QIDP (Qualified Intellectual Disabilities Professional) should have been notified when high-risk plans needed updating and client #6's plans should be amended to include elopement, and that mini bus keys should not be left in the transit vehicles for client safety." Client #6's 4/28/23 BSP was reviewed on 4/15/24 at 1:59 PM and indicated, "staff will do their best to take [client #6] out when he requests a cigarette at day service." Client #6's ISP dated 5/19/23 indicated, "[Client #6] continues living ... in a supported group living facility with 24/7 staffing availability and supports ... there are door alarms in place at his home installed ... to alert staff if someone enters/exits the home so staff can ensure their safety." An interview with the LPN (Licensed Practical Nurse) on 4/19/24 at 10:28 AM indicated client #3 should be in staff's line of sight and client #6 has typical supervision. The LPN indicated clients #3 and #6 had no pedestrian safety skills. The LPN			

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stated, "[client #3] eloped due to a faulty alarm on the back door and staff inattention to [client #3] in the home." The LPN stated, "this was neglect as staff failed to know where [clients #3 and #6] were."

An interview with the ADRS (Assistant Director of Residential Services) on 4/19/24 at 1:34 PM indicated client #3 should be in staff's line of sight as she has no pedestrian safety skills. The ADRS indicated clients #3 and #6 had no pedestrian safety skills. The ADRS indicated client #3 eloped due to a faulty alarm on the back door and staff inattention to client #3 in the home. The ADRS stated, "this was neglect as staff failed to know where [clients #3 and #6] were."

3. The 8/24/23 BDS report was reviewed on 4/17/24 at 1:00 PM and indicated, "[client #3] presented to the emergency department with complaints of a fall. [Client #3] was 2.5 feet high on a transit lift in her wheelchair, and DSP (Direct Support Professional) staff accidentally pushed her off the lift while falling along with her. DSP staff thought the lift was up, it was not and sitting flush on the ground. [Client #3's] face went onto the pavement. [Client #3's] mom was with [client #3] in the ER (emergency room) and let hospital staff know that [client #3] acted as if she was in pain....there is approximately a 2 cm (centimeter) laceration (cut) of the right side of the tongue from the lateral aspect to the near midline. This is gaping (wide open). [Client #3] has a 1.5 cm (centimeter) superficial (surface) laceration over the left lower lip... does not affect the vermilion border (edge of the lip). Multiple other small abrasions over the face... will require surgical repair and admission to the hospital."

The investigation report dated 9/11/23 was

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	reviewed 4/17/24 at 12:00 PM and indicated client #3 had a fall out of the transit (mini bus) on 8/23/23. The report indicated, "staff was assisting individual off the lift. While the lift was on the ground, she thought it was up on the deck. [Staff #6] did not check if it was in proper placement and [staff #6] pushed individual into the area where the lift would be if it was up. Individual fell to ground with [staff #6] alongside her. [Staff #6] had scrapes up the front of her legs and a bruise blooming on her upper/middle back. EMS (Emergency Medical Staff) was notified, [staff #6] refused transport to hospital." The ADRS's (Assistant Director of Residential Services) investigation notes regarding client #3's fall dated 8/23/23 indicated, ..."[staff] didn't double check the lift was at the height of the transit door. [Client #3] fell a distance of about 2.5 feet, face first. This resulted in soft tissue injuries to her face and body, and a tongue laceration that required surgical repair." ... "[LPN] submitted a BDDS (sic) report regarding the accident." The investigation notes indicated staff error of assuming the lift was up led to the hospitalization and serious injury of client #3. An interview with the LPN (Licensed Practical Nurse) on 4/19/24 at 10:28 AM indicated at the time of client #3's fall from the transit, she was not initially notified. The LPN indicated after the incident no changes or policies for nursing were needed. The LPN stated, "the client's fall resulted in serious injury was attributed to staff error, not following the policy and constituted neglect." An interview with the ADRS on 4/19/24 at 1:34 PM indicated the retraining of staff was delayed until 9/14/23 because of coordination of schedules between staff and trainers. The ADRS indicated			

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	modifications to the transit would void the warranty of the transit so the company who made the transit cautioned them to not change or add anything for safety. The ADRS indicated staff retraining was the corrective measure. The ADRS stated, "the client's fall resulting in serious injury was attributed to staff error, and not following the policy which constituted neglect." The ANE (Abuse, Neglect and Exploitation) policy reviewed 4/15/24 at 1:59 PM dated 7/20/22 indicated, "The prevention of serious incidents and abuse, neglect and exploitation, is the priority." 9-3-2(a)			
W 0154 Bldg. 00	483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated. Based on record review and interview for 1 of 5 investigations reviewed for client #3, the facility failed to complete a thorough investigation of an allegation of neglect. Findings include: The facility's BDS reports were reviewed on 4/15/24 at 1:59 PM. The 8/24/23 BDS (Bureau of Disability Services) and indicated, "[client #3] presented to the emergency department with complaints of a fall. [Client #3] was 2.5 feet high on a transit lift in her wheelchair, and DSP (Direct Support Professional) staff accidentally pushed her off the lift while falling along with her. DSP staff thought the lift was up, it was not and sitting flush on the ground. [Client #3's] face went onto the pavement. [Client	W 0154	W154: Staff Treatment of Clients -Organization will ensure annual review of all policies and procedures are completed. In addition, to be approved by CEO and Chief Habilitation Officer to ensure efficacy. Further, all incidents are reviewed by the Continuous Improvement Department to ensure organizational policies are in compliance. Staff completed re-training in Abuse, Neglect and Exploitation (ANE). Staff also complete training upon hire and annually as required and report any suspected incidents as per policy. Oversight on Relias training	05/30/2024

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	#3's] mom was with [client #3] in the ER (emergency room) and let hospital staff know that [client #3] acted as if she was in pain....there is approximately a 2 cm (centimeter) laceration (cut) of the right side of the tongue from the lateral aspect to the near midline. This is gaping (wide open). [Client #3] has a 1.5 cm (centimeter) superficial (surface) laceration over the left lower lip... does not affect the vermilion border (edge of the lip). Multiple other small abrasions over the face... will require surgical repair and admission to the hospital." The investigation report dated 9/11/23 was reviewed 4/17/24 at 12:00 PM and indicated client #3 had a fall out of the transit (mini bus) on 8/23/23. The report indicated, "staff was assisting individual off the lift. While the lift was on the ground, she thought it was up on the deck. [Staff #6] did not check if it was in proper placement and [staff #6] pushed individual into the area where the lift would be if it was up. Individual fell to ground with [staff #6] alongside her. [Staff #6] had scrapes up the front of her legs and a bruise blooming on her upper/middle back. EMS (Emergency Medical Staff) was notified, [staff #6] refused transport to hospital." The investigation did not contain any recommendations or corrective action to prevent recurrence. The ADRS's (Assistant Director of Residential Services) investigation notes regarding client #3's fall dated 8/23/23 indicated, ..."[staff] didn't double check the lift was at the height of the transit door. [Client #3] fell a distance of about 2.5 feet, face first. This resulted in soft tissue injuries to her face and body, and a tongue laceration that required surgical repair." ... "[LPN] submitted a BDDS report regarding the accident." The investigation notes indicated staff error of		completion by GHM and ADRS to be completed monthly. Agency staff will follow ANE policies as written/trained and complete any investigations in a timely manner. 05/30/2024	

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	assuming the lift was up led to the hospitalization and injury of client #3. An interview with the LPN (Licensed Practical Nurse) on 4/19/24 at 10:28 AM indicated at the time of client #3's fall from the transit, she was not initially notified. The LPN indicated after the incident no changes or policies for nursing were needed. The LPN stated, "the client's fall resulted in serious injury was attributed to staff error, not following the policy and constituted neglect." An interview with the ADRS on 4/19/24 at 1:34 PM indicated the retraining of staff was delayed until 9/14/23 because of coordination of schedules between staff and trainers. The ADRS indicated modifications to the transit would void the warranty of the transit so the company who made the transit cautioned them to not change or add anything for safety. The ADRS indicated staff retraining was the corrective measure. The ADRS stated, "the client's fall resulting in serious injury was attributed to staff error, and not following the policy which constituted neglect." The ADRS stated, "the corrective action plan should have been completed, the safety committee should have met and training issues preventing needed staff retraining should have occurred before 9/14/24." 9-3-2(a)			
W 0436 Bldg. 00	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			

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	team as needed by the client. Based on observation, record review, and interview, for 1 additional client (#4) with adaptive equipment, the facility failed to ensure client #4's physician prescribed CPAP (machine to help with sleep apnea) was in the group home and available for client #4's use. Findings include: An observation was completed on 4/15/24 from 3:39 PM to 5:40 PM at the group home. At 4:15 PM, client #4 indicated she was missing her CPAP machine. When asked about her CPAP machine, client #4 indicated her CPAP machine was at her mom's house and hadn't been brought to the group home. Client #4 denied any complaints of tiredness, or difficulty breathing while sleeping from not having or using the CPAP machine. At 4:33 PM, the house manager (HM) indicated client #4 doesn't have her CPAP machine in the group home and refuses to wear it when she does have access to it. HM indicated the nurse was aware of the client's refusal to wear the CPAP machine as ordered by the physician. Client #4's record was reviewed on 4/16/24 at 4:08 PM. Client #4's HRP (High Risk Plan) dated 9/7/23 indicated, "[Client #4] utilizes a CPAP machine nightly. Staff will assure [client #4] puts this on at night and removes every morning. Staff will assist [client #4] with cleaning procedures ...." An interview with the LPN (Licensed Practical Nurse) on 4/19/24 at 10:28 AM indicated client # 4 should have been following the MD (Medical Doctor) order. The LPN stated, "I have not been at the house and do not know if she has it (the CPAP machine) or been following it (the MD orders)." The LPN indicated staff are required to	W 0436	W436 Staff will ensure individuals' adaptive equipment is available for use per physician order. Staff will review equipment across all group homes to ensure adaptive equipment is available for use per physician order. Adaptive equipment will be assessed upon move-in and monthly to ensure it remains in place and in working order. Oversight on completion by GHM and LPN to be completed monthly. 06/15/2024	06/15/2024

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	prompt client #4 to use it each night but if she refuses to wear it, it is her choice. The LPN indicated if it was at the mom's house, then the client isn't utilizing it per the physician's order as she should have been. The LPN indicated there is a tracking form to be utilized by the group home staff. An interview with the ADRS (Assistant Director of Residential Services) on 4/19/24 at 1:34 PM indicated the group home staff are to prompt client #4 to wear her CPAP machine nightly. When asked how client #4 is to utilize it nightly when it is currently located at her mom's home, the ARDS indicated she isn't utilizing the CPAP machine according to the MD office and this should have been noticed when tracking her usage in the IMAR (the computer charting system of the facility). The ARDS indicated client #4 should have the prescribed CPAP available to her. 9-3-7(a)			
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 1 of 3 sampled clients (#2), the facility failed to follow the client's prescribed diet. Findings include: An observation was completed on 4/16/24 from 5:27 AM to 7:38 AM. Client #2 was not offered a lactose-free milk option at breakfast. She consumed an 8 oz (ounce) glass of whole milk at breakfast.	W 0460	W460 -Staff to follow physician recommended substitutions per individuals' prescribed diets. QIDP completed a retraining on individual prescribed diet on 06/10/2024. Please see attached signature sheet for reference. Staff will review individuals' prescribed diets annually and as needed to ensure nutritional needs are met per individuals' plan.	06/15/2024

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	Client #2's record was reviewed on 4/16/24 at 3:45 PM. Client #2's PO (Physician Order) dated 1/3/24 indicated her diet is ground meats, bite sized, with a diagnosis of lactose intolerance. Client #2's quarterly nutrition assessment dated 2/28/24 indicated client #2 should be "provided calcium fortified milk replacement to promote bone health... her diet is bite size, ground meat, lactose intolerant." An interview with the LPN (Licensed Practical Nurse) on 4/19/24 at 10:28 AM indicated a lactose free alternative should have been available at meal time for client #2. An interview with the ADRS (Assistant Director of Residential Services) on 4/19/24 at 1:34 PM indicated a lactose alternative should have been available at meal time for client #2. 9-3-8(a)		Upon hire, staff are trained on individual plans and nutritional health needs. QIDP and GHM provided training for physician recommended substitutions to ensure individuals' continued health and safety. LPN clarified diet information with PCP and noted there are no sensitivities to lactose. Lactose intolerance has been removed from individual's record per PCP on 06/10/2024. Oversight completed weekly by GHM, signed off on Weekly Residential Supports Observation Checklist. Please see attached for review. Also, registered dietician reviews individual needs quarterly by observation and report. 06/15/2024	
W 0474 Bldg. 00	483.480(b)(2)(iii) MEAL SERVICES Food must be served in a form consistent with the developmental level of the client. Based on observation, record review, and interview for 1 of 3 sampled clients (client #2), the facility failed to ensure client #2's modified diet texture was prepared at the recommended consistency. Findings include: On 4/15/24 from 3:39 PM to 5:40 PM, client #2 was observed in the group home. At 3:55 PM, the HM (house manager) indicated client #2 was on a regular diet, small bite size pieces and had to be	W 0474	W 474 -Staff to follow physician recommended substitutions per individuals' prescribed diets. QIDP completed a retraining on individual prescribed diet on 06/10/2024. Please see attached signature sheet for reference. Staff will review individuals' prescribed diets annually and as needed to ensure nutritional needs are met per individuals' plan and staff trainings are current.	06/15/2024

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	monitored. At 4:57 PM, client #2 was provided Beef Stew. The staff did not cut the 1.5 inch meat cubes into small bite size pieces. Client #2 ate the stew. On 4/16/24 from 5:27 AM to 7:38 AM, client #2 was observed in the group home. At 6:52 AM client #2 was provided a preset divided plate with bite size pieces of breakfast burrito (made with sausage, eggs, peppers and cheese wrapped in a tortilla), a toaster strudel, mandarin oranges and an 8 oz (ounce) glass of whole milk. The burrito had been cut with kitchen scissors to be smaller pieces but the meat was not a ground consistency. On 4/16/24 from 9:20 AM to 12:20 PM, client #2 was observed in the facility owned day program. At 12:05 PM, client #2 was observed with a 2 cup plastic storage container with beef stew in it that was neither cut up or a ground consistency. Client #2's record was reviewed on 4/16/24 at 3:45 PM. Client #2's ISP (Individual Support Plan) dated 9/8/23 indicated "Lactose intolerance. Per guardian, her food should be bite sized. Ground meats to avoid choking. Staff to monitor [client #2] while eating." Client #2's nutritional assessment dated 2/28/24 indicated client #2 should be "provided calcium fortified milk replacement to promote bone health... her diet is bite size, ground meat, lactose intolerant." Client #2's 8/3/23 Dining/Dysphasia risk plan indicated client #2 "has lactose intolerance; staff should be trained on lactose free products and assure [client #2] does not drink dairy products or consume dairy foods. Per guardian, her food		Upon hire, staff are trained on individual plans and nutritional health needs. QIDP and GHM provided training for physician recommended substitutions to ensure individuals' continued health and safety. LPN clarified diet information with PCP and noted there are no sensitivities to lactose. Lactose intolerance has been removed from individual's record per PCP on 06/10/2024. Individual has a speech therapy appointment scheduled on 07/01/2024 at PHH. Staff retrained on meal preparation safety on 05/24/2024. Oversight completed weekly by GHM, signed off on Weekly Residential Supports Observation Checklist. Please see attached for review. Also, registered dietician reviews individual needs quarterly by observation and report. 06/15/2024	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G786	A. BUILDING 00 B. WING	04/23/2024

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	should be bite sized. Ground meats to avoid choking. Staff to monitor client #2 while eating." The January 2019 IDDSI (International Dysphagia Diet Standards International) regulations reviewed on 4/19/24 at 3:15 PM, followed by the facility indicated ground meat (minced) is, "Meat served finely minced or chopped to 4 mm (millimeters) lump size served in a thick, smooth, non-pouring sauce or gravy * Fish served finely mashed or chopped to 4mm lump size served in a thick, smooth, non-pouring sauce or gravy." Client #2's 1/3/24 physician's order indicated "Dietary Orders: Ground meats, bite sized, lactose intolerance." An interview with the LPN (Licensed Practical Nurse) on 4/19/24 at 10:28 AM indicated client #2's food should have been given a hamburger like texture when it was cut up. The meat should have been pureed with a blender or food chopper (mechanically altered) to reach ground consistency. The LPN stated, "[client #2] is a choking risk and the risk is increased when the foods aren't mechanically altered before eating the food." An interview with the ADRS (Assistant Director of Residential Services) on 4/19/24 at 1:34 PM stated, "[client #2's] food should have been mechanically altered, and needed to be more finely cut than using a pair of kitchen scissors." 9-3-8(a)			
W 0488 Bldg. 00	483.480(d)(4) DINING AREAS AND SERVICE The facility must assure that each client eats in a manner consistent with his or her			

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	developmental level. Based on observation and interview, for 3 of 3 sampled clients (#1, #2, and #3) and 3 additional clients (#4, #5 and #6), the facility failed to ensure clients #1, #2, #3, #4, #5 and #6 had the opportunity to participate in meal preparation. Findings include: On 4/16/24 from 5:27 AM to 7:38 AM, clients #1, #2, #3, #4, #5 and #6 were observed at the group home. During the observation periods, clients #1, #2, #3, #4, #5 and #6 were not encouraged to prepare or serve their meals. At 6:00 AM, the DSP (Direct Support Professional) #3 cooked breakfast and prepared 6 preset dishes of toaster strudel, breakfast burritos, mandarin oranges and 5 glasses of 2% milk and 1 glass of whole milk. DSP #3 set the plates and glasses of milk on the countertop in the kitchen. From 6:25 AM to 7:11 AM, clients #1, #2, #3, #4, #5 and #6 came into the dining room at different times, sat at their place where a plate of preset food and a preset glass of milk had been provided and ate their food. An interview with the HM (House Manager) on 4/16/24 at 6:52 AM indicated each client should have been given the choice to assist with meal preparation with appropriate client-based tasks based on their ability, need and ISPs (Individual Support Plan). An interview with the ADRS (Assistant Director of Residential Services) on 4/19/24 at 1:34 PM indicated staff should talk clients through meal preparation, use hand over hand techniques to complete meal preparation and use the clients' goals to guide them in assisting the preparation of the meals in the home.	W 0488	W488 Residents will be given the choice to participate in meal preparation to the best of their ability. Staff will offer individuals the opportunity to participate in meal preparation. Staff at each group home will be trained upon hire and annually on client engagement in meal preparation skills per their Individual Support Plan (ISP). Oversight completed ongoing by QIDP and ADRS to ensure individuals are engaging in meal preparation skills per their ISP. 06/15/2024	06/15/2024

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