STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G792	A. BUILDING 00 B. WING	01/07/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENCHMARK HUMAN SERVICES	9285 W CR 950 N ELIZABETHTOWN, IN 47232

(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 pre-determined full recertification and state licensure survey. This visit included a Covid-19 focused infection control survey. Survey dates: 1/3/22, 1/4/22, 1/5/22, 1/6/22 and 1/7/22. Facility Number: 012528 Provider Number: 15G792 AIMS Number: 201017060 These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review of this report completed by #15068 on 1/19/22.	W 0000		
W 0104 Bldg. 00	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 for 2 of 2 sampled clients (#1 and #2) and 1 additional client (#3), the governing body failed to exercise general policy, budget, and operating direction over the facility to ensure 1) the living room floor was maintained in good repair and 2) client #1's toilet was securely fastened to the floor. Findings include: Observations were conducted on 1/3/22 from 3:05 PM to 6:21 PM and on 1/4/22 from 7:08 AM to 9:37 AM. During observation on 1/3/22 at 4:18 PM, multiple sections of wood laminate flooring had depressions and raised areas	W 0104	This citation affected all clients within the home. Communication with the contractor was not being documented on a work order but communicated verbally. Work orders were completed by the Director for the identified issues. Managers and staff received training on the work order process and documentation. Work orders will be completed as issues are identified and a complete walkthrough of the home will be completed monthly through the Environmental Checklist. Identified	02/06/2022

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

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	noticeable when walked over. The area spanned multiple sections of wood laminate flooring in the main pathway from the common living area going toward the bathroom between clients #2 and #3's bedrooms. The damaged flooring spanned a four foot wide by 5 foot long area. At 4:20 PM, staff #1 was asked about the damaged flooring. Staff #1 stated, "It's because [client #1] will pick at it". As staff #1 responded, client #3 stated, "She'll [client #1] pull it up". Staff #1 then stated, "Yeah, she's a strong little thing". Staff #1 indicated the damaged flooring had been reported as a needed area of repair. On 1/4/22 at 8:57 AM, the Team Leader (TL) was asked about the damaged flooring in the living room and if a work order for repair could be provided for review. The TL stated, "The last one (work request) I sent I had the floor". The TL was asked if the wood laminate flooring was glued and secured to the floor. The TL stated, "It's been separated. It's not as sound as it should be". The TL was asked if the home had any other areas where the flooring was not secure. The TL indicated the only other area not secure was client #1's toilet in her bathroom adjacent to her bedroom. At 9:12 AM, client #1's toilet was looked at, but no visible damage was noticeable. The TL was asked to describe how the toilet was damaged and not secure to the floor. The TL grabbed the side of the toilet and moved it side to side 5 to 6 inches both directions, to demonstrate how the toilet was not securely attached to the floor. On 1/4/22 at 12:52 PM, the Home Manager (HM) was interviewed. The HM was asked about the work order history for the damaged living room flooring and the loose toilet in client #1's bathroom. The HM indicated a need to repair the		issues on the Environmental Checklist will also be communicated to maintenance using a documented work order. All maintenance needs will be communicated with the contractor through a work order. A walkthrough will be completed by the Director to ensure that all needed repairs have been addressed. The work orders and Environmental Checklist will be monitored by the Director for compliance.	

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	living room flooring had been requested, that she was unsure about a request to repair client #1's toilet and stated, "I'll see where I can find those (work orders)". No work order history was available for review. On 1/5/22 at 3:30 PM, the Vice President (VP) was interviewed. The VP was asked about the damaged flooring in the common living area, the loose toilet in client #1's bathroom, and if a work order history could be provided for review. The VP indicated no documented work order history was able to be located and/or available for review. The VP indicated the process to make a request for this region of services had been identified as communication sent to the Home Manager who communicated with the maintenance repair person. The VP indicated she had spoken with the maintenance repair person to obtain the work order history, but none could be provided to her. The VP indicated the maintenance repair person confirmed communication about the need to repair the living room floor had been communicated, but not the loose toilet in client #1's bathroom. The VP stated, "He (maintenance repair person) is going to get estimates. He was not aware of the toilet". The VP indicated the maintenance repair person was going to the home to assess both the living room flooring and client #1's loose toilet. The VP indicated the home should be maintained and in good repair. 9-3-1(a)			
W 0149 Bldg. 00	483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit			

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	mistreatment, neglect or abuse of the client. Based on record review and interview for 1 of 2 sampled clients (#2) and 1 additional client (#3), the facility failed to implement its policy and procedures for prohibiting abuse, neglect, exploitation, mistreatment and/or violation of individual's rights to prevent a pattern of client-to-client physical aggression between clients #2 and #3. Findings include: On 1/4/22 at 11:38 AM, a review of the facility's Bureau of Developmental Disabilities Services (BDDS) incident reports submitted during the open survey was conducted. The review indicated the following which affected clients #2 and #3: -BDDS incident report dated 8/5/21 indicated, "[Client #3] went after [Client #2] hitting her on the head and grabbing her hair and tried to talk (sic) away a bowl from her. Staff quickly stepped in and separated the two of them [client #2] was assessed for injury and none were noted (sic). Plan to resolve: Staff will continue to follow all BSP (Behavior Support Plans) and keep the clients safe and maintain social distancing". Investigation Summary dated 8/5/21 indicated, "Brief summarization of the initial allegation: [Client #3] hit [client #2] and pulled her hair. Disposition of the Investigation: ... Peer to Peer Substantiated ... Recommendation/Corrective Actions: All three staff in the home are new. They will be retrained on staff positioning in order to help ensure safety of all clients in home. This will be completed by 8/24/21. Staff will also follow BSP's and assist with maintaining social distancing in the home".	W 0149	This deficient practice could affect all clients within the home. All staff have been retrained on the Benchmark Abuse and Neglect policy with special emphasis on Peer to Peer aggression. Staff have also completed a post test for Peer to Peer aggression. The staff have been retrained on prevention strategies and the BSP's for clients 2 and 3. The house manager/BC will complete twice weekly observations in the home for 30 days or more as needed to ensure that the training related to decreasing the likelihood of Peer to Peer aggression has been effective. These observations will be documented on Home Visit Forms which will be monitored by the Director for compliance. The team will debrief any incidences of Peer to Peer Aggression to ensure strategies are effective and BSP's will be revised as needed.	02/06/2022

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	-BDDS incident report dated 9/18/21 indicated, "[Client #3] was going into the med room after getting a spoon for her drink. She was walking by her housemate, [client #2], who was throwing something away in the trash. [Client #2] made a comment to [client #3] as she passed which upset her. [Client #3] turned toward her housemate, hit her in the nose one time and continued into the med room and took her meds. [Client #2] began to bleed from her nose and staff assisted her to stop the bleeding. After taking meds [client #3] returned to her seat. [Client #2] had no other issues at this time. Plan to Resolve: A formal investigation is currently underway to evaluate what occurred and what can better prevent these incidents in the future. An injury report was completed for [client #2] and she will continue to be monitored for any further injury or related distress. [Client #3] will continue to follow her behavior plan and attend counseling to help resolve further issues related to these types of incidents". Investigation Summary dated 9/18/21 indicated, "Brief summarization of the initial allegation: [Client #3] punched [client #2] in the face causing a bloody nose. Disposition of the Investigation: Substantiated ... Recommendation/Corrective Actions: Staff person that went outside during the med (medication) pass will receive corrective action due to failing to follow previous instructions and training on staff positioning". -BDDS incident report dated 9/28/21 indicated, "On 09/28/2021 [client #2] was yelling and screaming causing the roommates to get aggravated, staff then took [client #2] outside to calm her down and the other roommates. Staff closed the door and [client #2] went to open the			

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	door and [client #3] ran over to the door and grabbed it to keep her from shutting the door, [client #3] ended up punching [client #2] in the head. [Client #2] grabbed [client #3's] hair and pushed her to the ground. [Client #2] then grabbed [client #3's] hands and pinched them. Staff separated them. Staff had [client #3] go into her room to calm down and she did ... Both [client #2] and [client #3] was (sic) observed for marks, none was seen. Plan to Resolve: Staff will continue to follow BSP". Investigation Summary dated 9/28/21 indicated, "Brief summarization of the initial allegation: [Client #3] and [client #2] got into a fight. Disposition of the Investigation: Substantiated ... Recommendation/Corrective Actions: Staff appeared to follow the BSP's of both clients and intervened as quickly as possible. Staff will continue to follow BSP's and attempt to keep all clients safe". -BDDS incident report dated 11/6/21 indicated, "On 11/05/2021 at 3:50 PM staff took [client #3] outside to pull the trash cans up to the house. [Client #3] came in and went straight to the living room where [client #2] was sitting at and started hitting her. Staff was right behind [client #3] was but (sic) [client #3] in a one arm standing one arm [physical intervention] for 30 sec (HRC (Human Rights Committee) approved) to redirect her away from [client #2]. [Client #3] then went to her room to calm down. Both [client #3] and [client #2] were both assessed for injury (sic) and none were noted. Plan to Resolve: Staff will continue to follow all BSP's and try to safely keep call (sic) clients separated". Investigation Summary dated 11/6/21 indicated, "Brief summarization of the initial allegation:			

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	[Client #3] was outside with staff bringing trash cans up to the garage. When she entered the home, her staff were (sic) behind her. [Client #3] went into the home and attempted to take something from her housemate [client #2]. When [client #2] did not let go of the item, [client #3] hit [client #2] in the face. Disposition of the Investigation: Peer to Peer Substantiated ... Recommendation/Corrective Actions: Staff need to position themselves between clients when possible to reduce the likelihood of Peer-to-Peer aggression". -BDDS incident report dated 12/18/21 indicated, "[Client #3] left personal Items on the table. [Client #2] tried to move item out of her way at the dinner table, [client #3] got mad (sic) told [client #2] to not touch her stuff and [client #2] said something that escalated [client #3] and she hit [client #2] in the right eye. Staff moved in to separate clients [client #3] went to her (sic) room and [client #2] continued to sit at the table. Plan to Resolve: Staff will continue to follow all BSP's and try to safely keep all clients separated". Investigation Summary dated 12/24/21 indicated, "Disposition of the Investigation: Peer to Peer Substantiated ... Recommendation/Corrective Actions: The manager notified the administrator of an incident of Peer-to-Peer aggression between [client #3] and [client #2] ... Analysis and Findings: There were (sic) no violation of rights and physical aggression is addressed in each of the individuals BSPs. Staff indicate that they were in the vicinity of the dining room but not within proximity to stop the initial peer to peer aggression. They were able to get between the two individuals quickly and stop the second attempt of peer to peer aggression. The			

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	investigator assigned the BC (Behavior Clinician) and the House Manager to complete additional training with staff on how to manipluate (sic) the environment to maximize safety and increase their capability to prevent peer to peer aggression". On 1/5/22 at 3:30 PM, the Vice President (VP) and Qualified Intellectual Disability Professional (QIDP) were interviewed. The VP and QIDP were asked about the pattern of client-to-client physical aggression between clients #2 and #3. The VP and QIDP indicated awareness of a pattern between clients #2 and #3 aggression was known. The VP stated, "The investigations have shown some staff positioning issues ... We know it's (pattern of aggression) an issue". The VP and QIDP indicated further review of clients #2 and #3 behavior supports due to a pattern of aggression was in process. The VP was asked about the implementation of the Abuse, Neglect, and Exploitation policy and if it should be implemented at all times. The VP stated, "It should". On 1/5/22 at 4:45 PM, the 5/17/21 ANE policy was reviewed. The ANE policy indicated, "Benchmark Human Services (Benchmark) does not tolerate abuse, neglect, or exploitation in any form by any person. Benchmark strives to be proactive in preventing incidents of abuse, neglect, and exploitation (A-N-E) against the individuals served". 9-3-2(a)			
W 0262 Bldg. 00	483.440(f)(3)(i) PROGRAM MONITORING & CHANGE The committee should review, approve, and monitor individual programs designed to			

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	manage inappropriate behavior and other programs that, in the opinion of the committee, involve risks to client protection and rights. Based on observation, record review and interview for 2 of 2 sampled clients (#1 and #2), the facility failed to ensure clients #1 and #2's restrictive intervention for locking their bedroom closet doors was reviewed, approved and monitored as an aspect of each of their program support needs. Findings include: Observations were conducted on 1/3/22 from 3:05 PM to 6:21 PM and on 1/4/22 from 7:08 AM to 9:37 AM. The observations indicated both clients #1 and #2 had closets within their individual bedrooms and both were locked by use of a pad lock. On 1/3/21 at 5:13 PM, client #1 was in her bedroom sitting on an area rug while the Home Manager assisted with finding puzzle pieces. While client #1 and the Home Manager worked to put a puzzle together, a metal bracket on client #1's closet doors with a pad lock was observed. On 1/4/22 at 8:21 AM, client #2 indicated she wanted to show the surveyor her room. While in client #2's bedroom, a metal clasp with a pad lock was hanging from client #2's closet doors. Staff #6 was asked why clients #1 and #2's bedroom closet doors were pad locked. Staff #6 stated, "I'm guessing it's because she'll (client #1) rip things out of them. [Client #2], I'm not sure". On 1/4/22 at 9:12 AM, the Team Leader (TL) was interviewed. The TL was asked why clients #1 and #2's bedroom closet doors had pad locks	W 0262	This deficient practice affected clients 1 and 2. The BC has reviewed all the Behavior Support Plans in relation to restrictions within the home to ensure there are no unapproved restrictions being implemented. The Residential Director will complete an Environmental Checklist at the home to further ensure that no unapproved restrictions are being implemented. Staff received training on the process for restrictions including assessments of safety issues, plan revision, IDT, Guardian and Human Rights Committee Approval. The Manager/BC will complete twice weekly home visits for 30 days or more as needed to monitor for unapproved restrictions within the environment. These observations will be documented on Home Visit Forms which will be monitored by the Director for compliance.	02/06/2022

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	on them. The TL indicated items kept in the closet were personal items in storage like seasonal clothing. The TL was asked if the use of a pad lock on clients #1 and #2's bedroom closet denying access was approved and part of their program plans. The TL stated, "I think so". On 1/4/22 at 12:52 PM, the Home Manager (HM) was interviewed. The HM was asked what the purpose of the pad locks on clients #1 and #2's bedroom closets was for. The HM stated, "From what I'm told both will destroy all their clothes". The HM was asked if the locking of clients #1 and #2's bedroom closet doors was part of their plans and approved as a restrictive intervention. The HM stated, "It's supposed to be in the restrictive interventions of their BSP's (Behavior Support Plan's)". The HM reviewed both clients #1 and #2's BSP's and then stated, "I don't see it. [Vice President] said she could go over this with you". On 1/5/22 at 10 AM, client #1's record was reviewed. The record indicated the following: Behavior Support Plan dated 11/1/20 through 10/31/21 indicated, "Justification of Restrictive Procedures According to the Group Home Individual Support Plan Assessment inclusive of collateral data, historical and current record reviews, current environmental observations, and current staff interviews the following precautionary restrictions are necessary in the current living environment: 1. This BSP calls for he (sic) use of [behavioral intervention] physical intervention techniques ... 2. [Client #1] is currently prescribed medication for symptoms management related to her psychiatric diagnose (sic).			

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	3. Knives and sharps- Due to [client #1's] history of aggression, sharps such as knives and scissors will be kept in an upper kitchen cabinet and out of sight for her and other's safety ... 4. Door and Window Alarms- Due to a lack of personal safety skills and [client #1's] need for 24 hour supervision his (sic) home will be equipped with alarms on the doors and windows to alert staff if anyone enters or leaves the building. 5. In order to maintain consistent climate control for client health and comfort, and to prevent damage to the equipment, thermostats will have lockable covers placed over them. 6. Due to the possibility of damage associated with a history of aggression and to protect from access to potentially dangerous items, such as cords, the entertainment center in the main living area and in his room will have a Plexiglas covering over the TV and associated electrical equipment. 7. Required Level of Supervision: [Client #1's] requires a supervision level of 24 hours, seven days per week, with a minimum staff to client ratio of 3 staff to 4 clients during normally awake hours. Overnight ratio is minimally 2 staff to 4 clients. During instances where 1:1 staff is required, the staff member responsible to supervise [client #1] will not also be responsible for supervising anyone else. [Client #1's] staff is directed to be 'in close enough proximity to provide safety.' The staff members must be aware of [client #1's] location at all times". Client #1's BSP did not indicate the restriction of locking personal items within her bedroom closet and/or the use of a pad lock to prevent client #1's access within her bedroom closet. On 1/5/22 at 10:52 AM, client #2's record was			

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	reviewed. The record indicated the following: -Behavior Support Plan (BSP) dated 3/1/21 through 2/28/22 indicated, "Justification of Restrictive Procedures According to the Group Home Individual Support Plan Assessment inclusive of collateral data, historical and current record reviews, current environmental observations, and current staff interviews the following precautionary restrictions are necessary in the current living environment: 1. Psychotropic Medication: [Client #2] takes psychotropic medication due to mental health and behavior problems ... 2. In order to further ensure a safe and secure environment, video monitoring will be installed and in use in public areas of the group home. 3. Due to a history of and the risk of elopement and lack of pedestrian skills, [client #2] resides in home equipped with alarms on the doors and windows to notify staff when someone enters or exits the home. 4. Sharps are locked up when not in use. This is to ensure that [client #2] does not use sharps as weapons when she is being physically aggressive. [Client #2] will have access to sharps such as knives, scissors, etc. when she needs them, provided that she is not upset or agitated at the time. 5. Due primarily to [client #2's] housemate's issues with PICA (indiscriminate eating habits) and lack of safety skills, hygiene products are locked up. They are available to her when she requests or is prompted to engage in her hygiene routine. The items are used with staff supervision and assistance as needed. 6. Due to [client #2's] housemate's history PICA and lack of safety skills, bleach and other household cleaning products are locked up when not in use. [Client #2] is allowed access to these			

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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
	items when she requests or is involved in cleaning activities. Staff will assist and supervise as needed to ensure safety. 7. Due to [client #2's] seizure history and housemate's lack of safety skills and the risks associated with the operation of certain kitchen appliances and breakable cookware, these items will be kept in a secure area in the kitchen. [Client #2] will have access to the items when she requests and they are needed for food preparation. These items will be used only with staff supervision, until such time [client #2] is able to use them in a safe manner. 8. Due to [client #2's] history of physical aggression and property destruction the Activity closet will be kept locked to limit access to potentially dangerous items such as scissors, pencils, pens, small craft items such as beads, etc. She will have supervised access to the activity items at scheduled times and when she requests them for an appropriate use. 9. In order to maintain consistent climate control for client health and comfort, and to prevent damage to the equipment, thermostats will have lockable covers placed over them. 10. Due to the possibility of damage associated with a history of property damage and to protect from access to potentially dangerous items, such as cords, the entertainment center in the main living area will have a Plexiglas covering over the TV (television) and associated electronic equipment. 11. [Client #2] should always be seated in a location on the van or any vehicle to prevent access to the dash, the emergency brake, and the driver. 12. [Client #2] may be required to make restitution for breaking other people's property. 13. Due to a peer's history of PICA, all battery operated devices, e.g. remote controls, CD			

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	15G792	A. BUILDING 00 B. WING	01/07/2022

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	players, etc. (unless the battery compartments require a screw be removed in order to open it) will be kept in a secure location when not in use. Staff will maintain possession of remote controls during use". Client #2's BSP did not indicate the restriction of locking personal items within her bedroom closet and/or the use of a pad lock to prevent client #2 access within her bedroom closet. On 1/5/22 at 3:30 PM, the Vice President (VP) and Qualified Intellectual Disability Professional (QIDP) were interviewed. The VP and QIDP were asked about the pad locks located on clients #1 and #2's bedroom closet doors and the indication by staff that seasonal clothing items were maintained within their closets to ensure the clothing would not be lost and/or destroyed. The VP indicated awareness of locks on clients #1 and #2's bedroom closet was not known until the day prior. The VP stated, "It's not in their plans. The only closets we have approval to lock are in the common area. All of the keys are on the key chain for the medication administration room, that's the staffs'. We can go through due process (approval), I'll look into that". 9-3-4(a)			
W 0442 Bldg. 00	483.470(i)(1)(i) EVACUATION DRILLS The facility must hold evacuation drills to ensure that all personnel on all shifts are trained to perform assigned tasks. Based on record review and interview for 2 of 2 sampled clients (#1 and #2) and 1 additional client (#3), the facility failed to ensure all staff received training on emergency drills and evacuations.	W 0442	This deficient practice affected all clients within the home. All staff have completed a training drill to ensure their understanding of how to evacuate the home in case of	02/06/2022

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	Findings include: On 1/4/21 at 8:32 AM, client #3 was asked about evacuation drills and where the designated meeting location outside was located. Client #3 stated, "I don't know. I don't know that I've ever done one". On 1/4/21 at 8:50 AM, the Team Leader (TL) and staff #6 were interviewed about evacuation drills and client #3 not being aware of the designated meeting location outside and/or if she has completed a drill. The TL stated, "I know I've taken her (client #3) out before". Staff #6 indicated she did not know the meeting location and stated, "I've not done one (drill)". The TL stated, "We should have done one". Staff training for evacuation drills was then requested for review. No staff training for evacuation drills was provided for review. On 1/5/21 at 12:25 PM, the Home Manager (HM) was interviewed. The HM was asked about staff training for evacuation drills. The HM stated, "I made a note for myself and [TL] to go through them (evacuation procedures) with the PRNs (as needed staff). I went over it with [staff #6]". The HM indicated she would ensure new staff and PRN staff were involved in the completion of evacuation drills. The HM indicated further follow up was needed. On 1/5/22 at 3:30 PM, the Vice President (VP) was interviewed. The VP was asked about staff training for the completion of evacuation drills and informed no documentation was made available for review. The VP stated, "It should be		fire. This has been documented as a training drill and will be monitored by the Director for compliance. All staff should participate in drills as scheduled. New staff will participate in a training drill during their house orientation. This will be documented as a “training” drill and kept in the fire drill file. Review of all new hire training will be completed monthly by the director to monitor compliance.	

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	on the department training sheet. If she (staff #6) has been there, she should know. If they're telling you they don't know, then it (previous training documentation) doesn't matter". The VP indicated further follow up was needed to ensure all staff working at the home with clients #1, #2 and #3 knew the emergency plan for evacuation drills. 9-3-7(a)			
W 0475 Bldg. 00	483.480(b)(2)(iv) MEAL SERVICES Food must be served with appropriate utensils. Based on observation, record review and interview for 1 of 2 sampled clients (#1), the facility failed to ensure client #1 used her high sided divided plate during her evening meal per her dining plan. Findings include: An observation was conducted on 1/3/22 from 3:05 PM to 6:21 PM. At 5:55 PM, client #1 exited her bedroom and entered the kitchen in preparation of her evening meal. At 5:57 PM, staff #1 obtained a paper plate and plastic cup and prepared client #1's evening meal. Client #1 consumed her chopped Salisbury steak, mashed potatoes, green beans and pasta from a paper plate, her fruit from the fruit cup and drank her juice from a plastic disposable cup. At 6:05 PM, client #1 began eating her meal from the paper plate. At 6:13 PM, client #1 held her fruit cup up to her mouth, then placed her finger inside it and when unsuccessful to get a piece of fruit, client #1 attempted to use her coated spoon to place it inside the small plastic fruit cup. Unsuccessful with the spoon, client #1 picked the fruit cup up	W 0475	All staff received additional training on the adaptive equipment needs of the clients and the use of disposable tableware. The staff have also reviewed the dining plans for the clients to ensure their understanding of its use. The training has been documented on a Record of Training form for the staff. The manager will complete meal observations twice weekly for 30 days or more as needed to ensure that staff are using and offering appropriate adaptive equipment and that will be documented on the Home Visit Form. The forms will be monitored by the Director to ensure compliance.	02/06/2022

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	to her mouth as if drinking pieces of the fruit from the small plastic fruit cup. The Home Manager verbally prompted client #1 to use her coated spoon rather than her hands to get a piece of fruit. Client #1 had consumed most all of her supper and at 6:17 PM, client #1 threw her plastic disposable cup and then threw her paper plate. Both staff #1 and the Home Manager provided verbal redirection and calmed client #1 and her peers. On 1/5/22 at 10 AM, client #1's record was reviewed. The record indicated the following: -Dining Plan dated 12/8/21 indicated, "Name: [Client #1] ... Dining Adaptive Equipment: High sided divided plate with coated spoon, clothing protector, may use cup with handles". -Physician's Order dated 12/23/21 indicated, "Dietary Orders: ... Use high sided plate with coated spoon. May use cup with handles". On 1/5/22 at 10:42 AM, the Nurse was interviewed. The Nurse was asked about client #1's use of a paper plate and disposable plastic cup during the evening meal and what client #1's adaptive support needs during meals should be. The Nurse stated, "Yeah, they need to follow the doctor's orders. We'll need to fix that". On 1/5/22 at 3:30 PM, the Vice President (VP) and Qualified Intellectual Disability Professional (QIDP) were interviewed. The VP and QIDP were asked about staff following client #1's dining plan and the use of a high sided divided plate. The VP and QIDP indicated staff should implement client #1's dining support plan. The VP stated, "Right, I'll work with them on that".			

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	9-3-8(a)			