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W 227	INDIVIDUAL PROGRAM PLAN CFR(s): 483.440(c)(4) The individual program plan states the specific objectives necessary to meet the client's needs, as identified by the comprehensive assessment required by paragraph (c)(3) of this section. This STANDARD is not met as evidenced by: Based on observation, review of records and interview the person centered plan (PCP) failed to have sufficient training objectives or interventions for 3 of 4 sampled clients (#1, #4 and #6). The findings are: A. The PCP for client #1 failed to include training to address exercise. For example: Review of records for client #1 on 4/21/21 revealed a dietary progress note dated 11/9/20 that specified a weight loss, 1800 calorie, heart healthy diet. Further review of the 11/2020 progress note revealed the recommendation to encourage increased physical activity as developmentally feasible. Subsequent record review revealed no ideal body weight available for client #1. Review of nursing assessments for client #1 revealed the client to weigh 190 lbs in 6/20 and 197 lbs in 12/20. Continued review of records for client #1 on 4/21/21 revealed a PCP dated 8/14/19. Review of client #1's PCP revealed no training objective relative to increased exercise. Interview with the interim facility qualified intellectual disabilities professional (QIDP) on 4/22/21 verified client #1 did not have a current	W 227		

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

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exercise goal. Continued interview with the QIDP verified client #1 should have a program to address the recommendation of the need for increased physical activity.

B. The PCP for client #4 failed to include training to address exercise. For example:

Review of records for client #4 revealed a nutritional assessment dated 2/17/20. Review of the 2/2020 nutritional assessment for client #4 revealed the client to weigh 208.8 lbs with a desired body weight of 128-156 lbs. Continued review of the 2/2029 nutritional assessment revealed: Client #4 is above his desired body weight range and is noted to be obese as evidenced by a BMI of 34.8 kg/Ms. Further review revealed client #4 has gained 9.6 lbs and additional weight gain is not beneficial at this time. Additional review of the 2/2020 nutritional assessment revealed a recommended diet change was ordered on 1/10/21 for client #4 of a whole consistency, weight loss 1800 calorie, low cholesterol diet.

Continued review of records for client #4 on 4/21/21 revealed a PCP dated 2/24/20. Review of client #4's PCP revealed training objectives relative to household chores, rate of eating, socialization and set place setting. Continued review of client #4's record revealed no training objective relative to exercise or physical activity.

Interview with the interim QIDP verified client #4 is prescribed a restricted diet due to weight gain. Continued interview with the QIDP revealed client #4 could benefit from an exercise goal due to health concerns resulting in a restricted calorie diet.

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W 227	Continued From page 2 C. The PCP for client #6 failed to include training to address exercise. For example: Review of records for client #6 revealed a nutritional assessment dated 2/16/21. Review of the 2/2021 nutritional assessment for client #6 revealed the client to weigh 185 lbs with a desired body weight of 135-145 lbs. Continued review revealed client #6 is above the desired weight range, is currently obese and a diet change of ground consistency, weight loss 1800 low heart healthy, thin liquid diabetic diet is recommended. Additional review revealed the need to continue to encourage increased physical activity as developmentally feasible. Additional comments included client #6 has gained 14.5 lbs in 11 months and has elevated glucose. Interview with the interim facility qualified intellectual disabilities professional (QIDP) on 4/22/21 verified client #6 did not have a current exercise goal. Continued interview with the QIDP verified client #6 should have a program to address the recommendation of the need for increased physical activity.	W 227		
W 249	PROGRAM IMPLEMENTATION CFR(s): 483.440(d)(1) 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.	W 249		

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This STANDARD is not met as evidenced by:
Based on observation, interview and record review, the interdisciplinary team failed to assure consistent interventions to support needs identified in the person centered plans (PCPs) for 3 of 4 sampled clients (#1, #2 and #4) and 2 non-sampled clients (#3 and #5). The findings are:

A. The team failed to ensure 2 of 4 training objectives were implemented as prescribed for client #2. For example:

1. The team failed to implement a feeding objective for client #2.

Observation in the group home on 4/21/21 at 5:05 PM revealed client #2 to participate in the dinner meal. Continued observation revealed client #2 to sit in his wheelchair at the end of the dining table and for staff B to sit beside client #2. Further observation revealed staff B to feed client #2 the dinner meal without offering any option to the client to feed himself.

Review of records for client #2 on 4/22/21 revealed a PCP dated 1/25/21. Review of client #2's PCP revealed the objectives relative to communication, brush teeth, assist with feeding and leisure. Continued review of client #2's training objective to assist with feeding revealed an implementation date of 9/20/19. Further review revealed client #2 will assist with feeding with a procedure of: Staff will scoop client #2's food onto a spoon, place clients hand over staff's hand and raise prepared spoon to his mouth.

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Subsequent review of client #2's feeding objective revealed if client #2 refuses hand over hand after several attempts, staff will assist in feeding client #2. A review of prescribed training frequency revealed training is to occur at the breakfast and dinner meal with five trials conducted at each meal.

Interview with the interim QIDP verified client #2's feeding objective remains current. Continued interview with the interim QIDP verified client #2's feeding objective should have been implemented as prescribed during the dinner meal.

2. The team failed to implement a leisure objective for client #2.

Observations in the group home on 4/22/21 from 7:00 AM to 8:00 AM revealed client #2 to sit in his wheelchair in the living room, facing the window and holding a sippy cup. Continued observations revealed client #2 to remain in the living room area unengaged in any leisure or program activity until 8:05 AM. Observation at 8:05 AM revealed staff D to wheel client #2 to the medication closet to receive his morning medication. Further observation from 8:15 AM to 9:45 AM revealed client #2 to sit in a recliner in the living room with a hand held football and to fall asleep.

Review of records for client #2 on 4/21/21 revealed a PCP dated 1/25/21. Continued review of client #2's PCP revealed the objectives relative to communication, brush teeth, assist with feeding and leisure. Review of client #2's leisure objective revealed when enjoying leisure time, staff will offer two or more leisure activities for client #2 to choose between. Continued review of 9/2019 leisure objective revealed training may

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take place in the living room, at the dining room table or anytime there is leisure time.

Interview with the interim qualified intellectual disabilities professional (QIDP) confirmed client #2's training objectives are current and client #2 should have been offered leisure options as prescribed in the training objective.

B. The team failed to ensure interventions relative the behavior support plan (BSP) were implemented as prescribed for client #1. For example:

Observation in the group home on 4/22/21 at 7:05 AM revealed client #1 to take a shower in a back hallway bathroom of the group home. Continued observation revealed client #1 to return to his bedroom after his shower. Further observation revealed client #1 to remain in his room until 7:55 AM then exit his bedroom to participate in morning medication administration and to return to his bedroom at 8:03 AM. Subsequent observation revealed client #1 to remain in his room until observations ended at 9:50 AM. The facility home manager (HM) was observed to visually check on client #1 at various times without offering or encouraging the client to engage in any activity outside of his bedroom.

Review of records for client #1 on 4/22/21 revealed a diagnosis history of Moderate intellectual disability, autism, anxiety and disruptive behavior. Continued record review revealed a PCP dated 8/14/19. Review of client #1's PCP revealed a BSP dated 4/23/20 with identified target behaviors of refusing to cooperate, AWOL and behavior outbursts. A review of prevention measures relative to client

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#1's behavior plan revealed the need for staff to encourage and support client #1's participation in activities of daily living. A review of reinforcement procedures of the BSP revealed client #1 enjoys social interaction, praise and attention.

Interview with the interim QIDP verified client #1 should have been offered opportunities to participate in daily living activities outside of his bedroom during the 4/22/21 survey observation period. Continued interview with the interim QIDP verified client #1's BSP was not followed with not offering client #1 active treatment opportunities during the morning of 4/22/21.

C. The team failed to ensure interventions relative the behavior support plan (BSP) were implemented as prescribed for client #4. For example:

Observations in the group home on 4/21/21 revealed a monitor device on the bedroom wall of client #4. Continued observation revealed no chime or alarm to sound with the entering or exiting of client #4 or staff from the client's bedroom.

Review of records for client #4 on 4/21/21 revealed a PCP dated 2/24/20. Continued review of records for client #4 on 4/21/21 revealed a BSP dated 11/12/20 with identified target behaviors of physical aggression, social isolation, inappropriate food acquisition and property destruction. Continued review of the current BSP for client #4 revealed interventions to include: a chime will be placed on the bedroom door to alert staff the client may be taking clothing to the garbage.

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Interview with the facility HM on 4/21/21 revealed the monitor in client #4's bedroom did not work as it was used for another client before client #4 moved into the facility. Continued interview with the HM on 4/21/21 verified client #4 had no bedroom door chime. Further interview with the facility HM verified client #4 continued to need close staff supervision due to behaviors related to improper care of clothing.

Interview with the interim QIDP on 4/22/21 verified a chime should have been placed on client #4's bedroom door as prescribed in the BSP for the client. Continued interview with the interim QIDP verified client #4's BSP had not been implemented as prescribed by not implementing intervention procedures identified by the interdisciplinary team as needed to support behavior management.

D. The team failed to ensure interventions relative the behavior support plan (BSP) were implemented as prescribed for client #3. For example:

Observations in the group home on 4/21/21 revealed an alarm on the bedroom door of client #3. Continued observation revealed no chime or alarm to sound with the entering or exiting of client #3 or staff from the client's bedroom.

Review of records for client #3 on 4/22/21 revealed a PCP dated 3/2/21. Continued review of records for client #3 revealed a BSP dated 9/26/19 with identified target behaviors of activity refusal, property destruction, verbal aggression, self injurious behavior, physical aggression, stealing, wandering and inappropriate touching of others. Further review of client #3's BSP

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revealed the client to have a history of engaging in inappropriate sexual touching of other males; A door alert is placed on the bedroom door to alert staff he is entering and exiting his bedroom.

Interview with client #3 on 4/21/21 revealed the door chime on his bedroom door was not working and he thought it needed batteries. Continued interview with client #3 revealed the bedroom door chime had not worked in a while and was used for staff to monitor him.

Interview with the facility HM on 4/21/21 revealed he was unaware the bedroom chime for client #3 was not working. Continued interview with the facility HM revealed he would submit a work order to have the door chime batteries changed. Further interview with the facility HM revealed the chime was needed due to behaviors of client #3 relative to inappropriate touch. Interview with the interim QIDP verified the chime on the bedroom door of client #3 should be implemented as in the behavior plan.

E. The team failed to ensure interventions relative the behavior support plan (BSP) were implemented as prescribed for client #5. For example:

Observations in the group home on 4/21/21 revealed an alarm on the bedroom door of client #5. Continued observation revealed no chime or alarm to sound with the entering or exiting of client #5 or staff from the client's bedroom.

Review of records for client #5 on 4/22/21 revealed a PCP dated 2/11/21. Continued review of records for client #5 revealed a BSP dated 3/13/20 with identified target behaviors of

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W 249	Continued From page 9 non-compliance, tantrum behavior, physical aggression, property destruction, socially inappropriate behavior and AWOL. Further review of client #5's BSP revealed client #5 has demonstrated recurring problems with approaching people and attempting to make inappropriate physical contact. A door alert is placed on the bedroom door to alert staff he is entering and exiting his bedroom. Interview with the facility HM on 4/21/21 revealed he was unaware the bedroom chime for client #5 was not working. Continued interview with the facility HM revealed he would submit a work order to have the door chime batteries changed. Further interview with the facility HM revealed the chime was needed due to behaviors of client #5 relative to inappropriate touch. Interview with the interim QIDP verified the chime on the bedroom door of client #5 should be implemented as prescribed in the behavior plan.	W 249		
W 288	MGMT OF INAPPROPRIATE CLIENT BEHAVIOR CFR(s): 483.450(b)(3) Techniques to manage inappropriate client behavior must never be used as a substitute for an active treatment program. This STANDARD is not met as evidenced by: Based on observations, record review, and interviews, the facility failed to assure techniques to manage inappropriate behavior were not used as a substitute for an active treatment program for 1 of 3 sampled clients (#4). The finding is: Observations at the group home on 4/21/21 from	W 288		

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4:30 PM to 5:45 PM revealed both hallway bathrooms in the facility to have no hand soap. Continued observations revealed various clients (#1, #3, #4, #5, #6) to be prompted by staff to wash their hands before dinner. Further observations revealed various clients (#1, #3, #4, #5, #6) to enter the kitchen area where staff A provided a few drops of hand soap into the hands of each client. Additional observations revealed clients to enter the hallway bathrooms to wash their hands then exit to sit at the dining table. Subsequent observations revealed the hand soap supply for both facility bathrooms to be stored on the kitchen counter.

Observations in the medication room of the group home on 4/22/21 revealed a white board with a written note which indicated: Client #4 is over using his toothpaste, its in his medication basket when he needs to use it.

Review of records for client #4 on 4/22/21 revealed a person centered plan (PCP) dated 2/24/20. Review of client #4's PCP revealed a behavioral support plan (BSP) dated 11/12/20. Review of the BSP for client #4 revealed target behaviors of physical aggression, social isolation, inappropriate food acquisition and property destruction. Further review of client #4's PCP and BSP revealed no target behaviors relative to misuse of hygiene items.

Interview with Staff A and Staff C on 4/21/21 confirmed hand soap from the hallway bathrooms of the group home are stored on the kitchen counter. Continued interview with Staff C revealed hand soap products are not kept in either bathroom of the facility because client #4 misuses and wastes the soap without staff

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W 288	Continued From page 11 supervision. Interview with interim qualified intellectual disability professional (QIDP) on 4/22/21 revealed hand soap in the facility should not be kept in the kitchen. The QIDP subsequently verified client #4's toothpaste should not be kept locked in the medication room as no formal interventions have been implemented to address the inappropriate use of hygiene products by client #4.	W 288		
W 368	DRUG ADMINISTRATION CFR(s): 483.460(k)(1) The system for drug administration must assure that all drugs are administered in compliance with the physician's orders. This STANDARD is not met as evidenced by: Based on observation, record review and interview, the facility failed to assure all drugs were administered without error for 1 non-sampled client (#5). The finding is: Observation in the group home on 4/22/21 at 9:00 AM revealed client #9 to participate in morning medication administration. Continued observation of the medication administration for client #9 revealed all prescribed medications, in pill or tablet form, to be punched by the client with hand over hand assistance into a medication cup. Further observation revealed staff E to mix yogurt with all medications in the medication cup and client #9 to take all medications whole in yogurt. Review of records on 4/22/21 for client #9 revealed physician orders dated 2/5/21. Review of the current physician orders revealed	W 368		

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W 368	Continued From page 12 medications for client #9 should be crushed with applesauce, pudding or yogurt. Interview with the facility nurse on 4/22/21 verified client #9 should have all medication, in the form of a pill or tablet, crushed as in physician orders.	W 368		
W 436	SPACE AND EQUIPMENT CFR(s): 483.470(g)(2) 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 team as needed by the client. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure adaptive equipment was furnished and in good repair for 2 of 4 sampled clients (#2 and #4) and 1 non-sampled client (#3). The findings are: A. The facility failed to ensure timely repairs or the replacement of eyeglasses for client #4. For example: Observations in the group home throughout the 4/21-22/21 survey revealed client #4 to engage in various activities in the group home such as: playing basketball, participating in the dinner meal and clean up, wiping the dining table, sweeping the dining area, laundry, participating in medication administration and leisure activity. At no point during observations did the surveyor observe staff to prompt client #4 to wear eyeglasses.	W 436		

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Review of the records for client #4 on 4/21/21 revealed a person centered plan (PCP) dated 2/24/20. Review of PCP revealed a prescription for glasses to help with focus. Further review of records revealed client #4 is able to see without his glasses but is encouraged to wear them to prevent further eye damage. Additional review of client #4's record revealed an eye exam completed on 2/3/20. Subsequent review of records revealed a vision diagnosis of myopia and difficulty seeing distant objects clearly.

Interview with the facility nurse on 4/21/21 revealed eyeglasses for client #4 had been broken and she was unsure how long they had been broken. Continued interview with the facility nurse revealed she was unaware until the current survey date that client #4's glasses had been broken. Further interview with the facility nurse verified client #4's glasses should have been repaired or replaced after they were broken due to a prescribed need.

B. The facility failed to ensure timely repairs or the replacement of eyeglasses for client #3. For example:

Observations in the group home throughout the 4/21-22/21 survey revealed client #3 to engage in various activities in the group home such as watching television, puzzle activity, dinner and clean up, mopping the kitchen floor, medication administration, making a phone call and to participate in online zoom classes. At no point during observations did the surveyor observe staff to prompt client #3 to wear eyeglasses.

Review of the records for client #3 on 4/22/21

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revealed a person centered plan (PCP) dated 3/2/21. Review of client #3's PCP revealed a prescription for eyeglasses. Continued review of the PCP revealed client #3 currently wears glasses to help focus his eyes and should be encouraged to wear them during awake hours. Further review of records revealed client #3's eyeglasses are kept with him in a case and he has a soft cloth to clean them with. Additional review of client records revealed a medical consult dated 1/30/20. Review of the 1/2020 consult revealed cataract in both eyes, right esotropia and right amblyopia.

Interview with the facility nurse on 4/21/21 revealed eyeglasses for client #3 had been broken and she was unsure how long they had been broken. Continued interview with the facility nurse revealed she was unaware until the current survey date that client #3's glasses had been broken. Further interview with the facility nurse verified client #3's glasses should have been repaired or replaced after they were broken due to a prescribed need.

C. The facility failed to ensure the wheelchair for client #2 was in good repair. For example:

Observations in the group home during the 4/21-22/21 survey revealed client #2 to ambulate with staff assistance while seated in a wheelchair. Continued observation of client #2 throughout survey observations on 4/21-22/21 revealed client #2's feet to hang off the foot rests of the wheel chair and the client to wear socks with no shoes. Further observation of client #2's wheelchair revealed the foot strap to be missing from the right side footrest.

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W 436	Continued From page 15 Review of records for client #2 on 4/22/21 revealed adaptive equipment to include a manual wheelchair. Continued review of records for client #2 revealed a physical therapy (PT) assessment dated 2/9/21. Review of the current PT evaluation revealed footrests help protect the clients' feet when being pushed. Continued review of the PT evaluation revealed the straps on the footrests are not holding his heels on the footrests. He needs something better to keep feet positioned as he is dropping his feet behind his foot rests; He is at risk to injure his feet when they are allowed to fall back behind the footrests. Subsequent review of the 2/2021 PT evaluation revealed client #2's wheelchair is customized to meet his needs, but modifications due to wear and tear are needed. Additional review revealed staff need to make sure his feet remain on the footrest. A review of recommendations of the current PT evaluation revealed the client should wear shoes when he is out of bed to get more traction for mobility and to support foot safety. Interview with the facility nurse on 4/22/21 revealed client #2 was recently assessed in a wheelchair clinic for repairs related to his wheelchair although the date of the assessment was unknown. Continued interview with the facility nurse and interim QIDP revealed there was no documentation available regarding planned repairs for client #2's wheelchair or repairs conducted with the recent wheelchair clinic evaluation.	W 436		
W 460	FOOD AND NUTRITION SERVICES CFR(s): 483.480(a)(1) Each client must receive a nourishing,	W 460		

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W 460	Continued From page 16 well-balanced diet including modified and specially-prescribed diets. This STANDARD is not met as evidenced by: Based on observations, record review and interview, the facility failed to provide a prescribed diet for 2 sampled clients (#1 and #4) and 1 non sampled client (#6). The findings are: A. The facility failed to provide a prescribed diet for client #4. For example: Observation in the group home on 4/21/21 at 5:00 PM revealed client #4 to participate in the dinner meal which consisted of pork chops, mashed potatoes, broccoli, water and unsweetened tea. Continued observation revealed client #4 to fix his plate with minimum assistance. Further observation revealed staff D to encourage client #4 to obtain two porkchop servings and to scoop mashed potatoes and broccoli onto his plate using a large serving spoon. Observation of the serving spoon used during the dinner meal revealed no serving size measurement. Additional observations revealed client #4 to request a second helping of mashed potatoes and to scoop a large unmeasured serving onto his plate. Review of the dinner menu on 4/21/21 revealed the menu to consist of 3 oz BBQ porkchops, 1/2 cup of mashed potatoes, 1/2 cup broccoli, water and unsweetened tea. Review of records for client #4 revealed a nutritional assessment dated 2/17/20. Review of the 2/2020 nutritional assessment for client #4 revealed the client to weigh 208.8 lbs with a desired body weight of 128-156 lbs. Continued review of the nutritional	W 460		

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assessment revealed: Client #4 is above his desired body weight range and is noted to be obese as evidenced by a BMI of 34.8 kg/Ms. Client has gained 9.6 lbs and additional weight gain is not beneficial at this time. Additional review of the 2/2020 nutritional assessment revealed a recommended diet change was ordered on 1/10/21 for client #4 of a whole consistency, weight loss 1800 calorie, low cholesterol diet.

Interview with the facility interim qualified intellectual disabilities professional (QIDP) on 4/22/21 verified the menu in the group home should be followed at all meals. Continued interview with the QIDP verified staff should have measured the amount of each menu item served to each client. The QIDP subsequently verified the serving sizes should have been measured to ensure each prescribed diet was followed.

B. The facility failed to provide a prescribed diet for client #6. For example:

Observations in the group home on 4/21/21 at 5:00 PM revealed client #6 to participate in the dinner meal which consisted of pork chops, mashed potatoes, broccoli, water and unsweetened tea. Continued observation revealed client #6 to fix his plate with minimum assistance. Further observation revealed staff D to encourage client #6 to obtain two porkchop servings and to scoop mashed potatoes and broccoli onto his plate. Observation of the serving spoon used during the dinner meal revealed no serving size measurement. Additonal observations revealed client #6 to request a second helping of mashed potatoes and the

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home manager (HM) to indicate client #6 can have more vegetables.

Review of the dinner menu for the group home on 4/21/21 revealed the menu to consist of 3 oz BBQ porkchops, 1/2 cup of mashed potatoes, 1/2 cup broccoli, water and unsweetened tea. Review of records for client #6 revealed a nutritional assessment dated 2/16/21. Review of the 2/2021 nutritional assessment for client #6 revealed the client to weigh 185 lbs with a desired body weight of 135-145 lbs. Continued review revealed client #6 is above the desired weight range, is currently obese and a diet change of ground consistency, weight loss 1800 low heart healthy, thin liquid diabetic diet is recommended. Additional review revealed the need to continue to encourage increased physical activity as developmentally feasible. Additional comments included client has gained 14.5 lbs in 11 months and ha elevated glucose.

Interview with the interim QIDP on 4/22/21 verified the menu in the group home should be followed at all meals. Continued interview with the QIDP verified staff should have measured the amount of food items served for each client and provided the amount specified on the dinner menu. The QIDP subsequently verified the serving sizes should have been measured to ensure each prescribed diet was followed.

C. The facility failed to provide a prescribed diet for client #1. For example:

Observations in the group home on 4/21/21 at 5:00 PM revealed client #1 to participate in the dinner meal which consisted of pork chops, mashed potatoes, broccoli, water and

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unsweetened tea. Continued observation revealed client #1 to fix his plate with minimum assistance. Further observation revealed staff D to encourage client #1 to obtain two porkchop pieces and scoop mashed potatoes and broccoli onto his plate using a large serving spoon. Observation of the serving spoon used during the dinner meal revealed no serving size measurement. Additional observations revealed client #1 to request second helping of mashed potatoes and to scoop a large unmeasured serving into his plate.

Review of the dinner menu for the group home on 4/21/21 revealed the menu to consist of 3 oz BBQ porkchops, 1/2 cup of mashed potatoes, 1/2 cup broccoli, water and unsweetened tea. Continued review of records for client #1 on 4/2121 revealed a dietary progress note dated 11/9/20 that specified a weight loss 1800 calorie heart healthy diet. Further review of the 11/2020 progress note revealed the recommendation to encourage increased physical activity as developmentally feasible. Additional review of client #1's record revealed a nursing assessment dated 7/9/20. Review of the 7/2020 nursing assessment revealed the client to weigh 190 lbs in 6/20, 223 lbs in 9/2020 and 197 lbs in 12/20. Further review revealed client #1's diet needs to be followed as prescribed.

Interview with the interim QIDP on 4/22/21 verified the menu in the group home should be followed at all meals. Continued interview with the QIDP verified staff should have measured the amount of food items served for each client and provided the amount specified on the dinner menu. The QIDP subsequently verified the serving sizes should have been measured to

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W 460	Continued From page 20 ensure each prescribed diet was followed.	W 460		