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THOMAS S DECATUR HOME	7559 DECATUR DRIVE FAYETTEVILLE, NC 28303

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E 015	Subsistence Needs for Staff and Patients CFR(s): 483.475(b)(1) §403.748(b)(1), §418.113(b)(6)(iii), §441.184(b)(1), §460.84(b)(1), §482.15(b)(1), §483.73(b)(1), §483.475(b)(1), §485.542(b)(1), §485.625(b)(1) [(b) Policies and procedures. [Facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated every 2 years [annually for LTC facilities]. At a minimum, the policies and procedures must address the following: (1) The provision of subsistence needs for staff and patients whether they evacuate or shelter in place, include, but are not limited to the following: (i) Food, water, medical and pharmaceutical supplies (ii) Alternate sources of energy to maintain the following: (A) Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions. (B) Emergency lighting. (C) Fire detection, extinguishing, and alarm systems. (D) Sewage and waste disposal. *[For Inpatient Hospice at §418.113(b)(6)(iii):] Policies and procedures. (6) The following are additional requirements for hospice-operated inpatient care facilities only. The policies and procedures must address the following: (iii) The provision of subsistence needs for	E 015		

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

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hospice employees and patients, whether they evacuate or shelter in place, include, but are not limited to the following:
(A) Food, water, medical, and pharmaceutical supplies.
(B) Alternate sources of energy to maintain the following:
(1) Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions.
(2) Emergency lighting.
(3) Fire detection, extinguishing, and alarm systems.
(C) Sewage and waste disposal.
This STANDARD is not met as evidenced by:
Based on observation, policy review and staff interviews, the facility failed to ensure emergency provisions for subsistence needs for staff and clients included adequate food and water as identified in the emergency preparedness (EP) plan. This potentially affected all clients (#1, #2, #3, #4 and #5) residing in the home. The finding is:

During observations in the home on 5/8/23, surveyor looked into the container which contained their emergency food consisting of: fruit cups (26); Vienna sausage (18); a 12 pack box of crackers; 2 cartons of powered milk; tuna (10 cans); toaster pasties (24) and chicken breast (12 cans). Further observations revealed there were no bottles of water.

Review on 5/9/23 of the facility's EP plan dated 2022 - 2023, did not have specific information on emergency food storage policy or identify a rotation schedule to ensure the food's freshness.

During an interview on 5/8/23, Staff A stated the

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E 015	Continued From page 2 contents of the container was all of the emergency food in the home. When asked if the food was enough for both clients and staff during an emergency, Staff A stated "No". During an interview on 5/9/23, the Qualified Intellectual Disabilities Professional (QIDP) confirmed that the food in the container was all of the emergency food in the home. Further interview revealed it would not be enough food for both the clients and staff for three days.	E 015		
W 159	QIDP CFR(s): 483.430(a) Each client's active treatment program must be integrated, coordinated and monitored by a qualified intellectual disability professional who- This STANDARD is not met as evidenced by: Based on record reviews and interview, the facility failed to ensure the Qualified Intellectual Disabilities Professional (QIDP) completed Individual Program Plan (IPP) meetings at least annually, implemented goals for newly admitted client and monitored data collection for all identified programs. This affected 5 of 5 audit clients (#1, #2, #3, #4 and #5). The findings are: A. Record review on 5/8/23 of client #4's record revealed he was admitted to the home on 3/31/22. Further review revealed client #4 did not have an IPP completed. Record review on 5/8/23 of client #5's record revealed he was admitted to the home on 11/14/22. Further review revealed client #5 did not have an IPP completed. During an interview in 5/8/23, the QIDP confirmed	W 159		

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both clients #4 and #5 did not have an IPP within 30 days of their admission to the facility. Further interview revealed it is the QIDP's responsibility to ensure IPP's are completed for newly admitted clients.

B. Review on 5/8/23 of client #4's record revealed he does not have any training goals. Further review revealed client #4 was admitted to the facility on 3/31/22.

During an interview on 5/9/23, the QIDP revealed he has not implemented any new goals for client #4. Further interview revealed the QIDP is responsible for ensuring client #4 has training goals.

The QIDP failed the ensure data for program goals were taken as prescribed:

C. Review on 5/8/23 of client #1's goals: turning off light; unhooking pants; walking up stairs and appropriate table manners was missing for the entire months of March and April 2023 and for the month of May (2023) from the 1st thru 8th. Further review revealed there were no data sheets in the book for client #1.

Review on 5/8/23 of client #2's goals: appropriate table manners; putting placemats on table, put folded clothes in drawer and hand washing was missing for the entire months of March and April 2023 and for the month of May (2023) from the 1st thru 8th. Further review revealed there were no data sheets in the book for client #2.

Review on 5/8/23 of client #3's goals: combing hair; identifying letters and making a cracker

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W 159	Continued From page 4 sandwich was missing for the entire months of March and April 2023 and for the month of May (2023) from the 1st thru 8th. Further review revealed there were no data sheets in the book for client #3. Review on 5/8/23 of client #5's goals: bathing; toileting and appropriate table manners was missing for the entire months of March and April 2023 and for the month of May (2023) from the 1st thru 8th. Further review revealed there were no data sheets in the book for client #5. During an interview on 5/8/23, Staff A confirmed that data was missing for goals for clients #1, #2, #3 and #5. Staff A also confirmed there were no data sheets in the books for the clients. During an interview on 5/9/23, the QIDP confirmed there were no data collected for clients #1, #2, #3 and #5. The QIDP also acknowledged there were no data sheets in the books for the clients. Further interview revealed it is the QIDP's responsibility to ensure data is collected and data sheets are kept in the books. The QIDP also stated it was his oversight that the data sheets are missing.	W 159		
W 195	ACTIVE TREATMENT SERVICES CFR(s): 483.440 The facility must ensure that specific active treatment services requirements are met. This CONDITION is not met as evidenced by: The team failed to: ensure clients' Individual Program Plans (IPP's) were completed (W226);	W 195		

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W 195	Continued From page 5 ensure objectives are developed necessasry to meet the needs of the clients (W227); ensure that each client received a continuous active treatment program, which includes aggressive, consistent implementation of a program of specialized and generic training and treatment directed towards the acquisition of the behaviors necessary for the client to function with as much self-determination and independence as possible (W249); ensure that data was collected with the frequency as prescribed by clients written formal programs (W252) and failed to ensure new objectives were considered in a timely manner (W258). The cumulative effect of these systemic practices resulted in the facility's failure to provide statutorily mandated active treatment services to the clients.	W 195		
W 196	ACTIVE TREATMENT CFR(s): 483.440(a)(1) Each client must receive a continuous active treatment program, which includes aggressive, consistent implementation of a program of specialized and generic training, treatment, health services and related services described in this subpart, that is directed toward: (i) The acquisition of the behaviors necessary for the client to function with as much self determination and independence as possible; and (ii) The prevention or deceleration of regression or loss of current optimal functional status. This STANDARD is not met as evidenced by: Based on observations, record review and confirmed by interviews with staff, the facility	W 196		

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W 196	Continued From page 6 failed to provide an aggressive implementation of specialized treatment to 5 of 5 audit clients (#1, #2, #3, #4 and #5) in the areas of dining, communication, leisure and choice making. The findings include: A. Cross reference W226. The facility failed to ensure the individual program plan (IPP) is prepared within 30 days of admission for 2 of 5 audit clients (#4 and #5). B. Cross reference W227. The facility failed ensure objectives are developed necessary to meet the needs for 2 of 5 audit clients (#1 and #4). C. Cross reference W249. The facility failed to ensure 2 of 5 audit clients (#4 and #5) received a continuous active treatment program consisting of needed interventions and services as identified in the Individual Program Plan (IPP) in the area of meal preparation. D. Cross reference W252. The facility failed to ensure ensure data relative to the accomplishment of the criteria specified in the clients' individual program plan and ensure objectives are documented in measurable terms for 4 of 5 audit clients (#1, #2, #3 and #5). E. Cross reference W258. The qualified intellectual disabilities professional (QIDP) failed to ensure new objectives were considered in a timely manner for 1 of 5 audit clients (#4).	W 196		
W 210	INDIVIDUAL PROGRAM PLAN CFR(s): 483.440(c)(3) Within 30 days after admission, the	W 210		

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W 210	Continued From page 7 interdisciplinary team must perform accurate assessments or reassessments as needed to supplement the preliminary evaluation conducted prior to admission. This STANDARD is not met as evidenced by: Based on record review and interviews, the facility failed to obtain needed initial assessments for 1 of 5 audit clients (#5). The finding is: Review on 5/8/23 of client #5's record revealed he had not received Speech, Physical Therapy (PT) and Occupational Therapy (OT) Evaluations. Further review revealed client #5 was admitted to the facility on 11/14/22. During an interview on 5/9/23, the Qualified Intellectual Disabilities Professional (QIDP) confirmed client #5 does not have Speech, PT and OT evaluations.	W 210		
W 214	INDIVIDUAL PROGRAM PLAN CFR(s): 483.440(c)(3)(iii) The comprehensive functional assessment must identify the client's specific developmental and behavioral management needs. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure two newly admitted clients (#4 and #5) had a psychological assessment completed within 30 days of admission. The findings are: A. Review on 5/8/23 of client #4's record revealed he was admitted to the facility on 3/31/22. Further review indicated client #4's psychological assessment was completed by another agency on 11/1/19.	W 214		

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W 214	Continued From page 8 B. Review on 5/8/23 of client #5's record revealed he was admitted to the facility on 11/14/22. Further review indicated client #5's psychological assessment was completed by another agency on 11/1/19. During an interview on 5/9/23, the Qualified Intellectual Disabilities Professional (QIDP) confirmed both clients #4 and #5 did not have current/updated psychological assessments that were completed within 30 days of admission. Further review revealed the QIDP is the person who is responsible to ensure psychological assessments are completed for newly admitted clients.	W 214		
W 221	INDIVIDUAL PROGRAM PLAN CFR(s): 483.440(c)(3)(v) The comprehensive functional assessment must include auditory functioning. This STANDARD is not met as evidenced by: Based on record review and interviews, the facility failed to ensure an auditory examination for 1 of 5 audit clients (#5). The finding is: Review on 5/8/23 of client #5's record revealed he had not received an auditory examination. Further review revealed client #5 was admitted to the facility on 11/14/22. During an interview on 5/8/23, the Qualified Intellectual Disabilities Professional (QIDP) confirmed client #5 has not received an auditory examination. Further interview revealed he is not sure why client #5 never received his auditory examination.	W 221		
W 226	INDIVIDUAL PROGRAM PLAN CFR(s): 483.440(c)(4)	W 226		

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W 226	Continued From page 9 Within 30 days after admission, the interdisciplinary team must prepare, for each client, an individual program plan. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure each client received an individual program plan (IPP) within thirty days after admission. This affected 2 of 5 audit clients (#4 and #5). The findings are: A. Record review on 5/8/23 of client #4's record revealed he was admitted to the home on 3/21/22. Further review revealed client #4 did not have an IPP completed. B. Record review on 5/8/23 of client #5's record revealed he was admitted to the home on 11/14/22. Further review revealed client #5 did not have an IPP completed. During an interview in 5/8/23, the Qualified Intellectual Disabilities Professional (QIDP) confirmed both clients #4 and #5 did not have a IPP within 30 days of their admission to the facility. Further interview revealed it is the QIDP's responsibility to ensure IPP's are completed for newly admitted clients.	W 226		
W 248	INDIVIDUAL PROGRAM PLAN CFR(s): 483.440(c)(7) A copy of each client's individual plan must be made available to all relevant staff, including staff of other agencies who work with the client, and to the client, parents (if the client is a minor) or legal guardian. This STANDARD is not met as evidenced by: Based on record reviews and interviews, the	W 248		

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W 248	Continued From page 10 facility failed to ensure current Individual Program plans (IPP's) and Behavior Intervention Programs (BIP's) were available to all relevant staff. This affected 5 of 5 audit clients (#1, #2, #3, #4 and #5). The findings are: During observations in the home during the survey on 5/8 - 9/23, the surveyor noticed five binders located in the home which were kept inside of container. Upon further examination the surveyor noticed there was no updated or current IPP's or BIP's in the binders for clients #1. #2, #3. #4 and #5. During interview on 5/8/23, Staff A and B both confirmed there are no current or updated IPP's or BIP's for them to review for clients #1, #2, #3, #4 and #5. During and interview on 5/8/23, the Qualified Intellectual Disabilities Professional (QIDP) confirmed the binders for clients #1, #2, #3, #4 and #5 did not contain current or updated IPP's and BIP's. Additonal interview revealed it is the QIDP's responsibility to ensure all relevant staff have access to the IPP's and BIP's of all the clients residing in the home.	W 248		
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 observations, record reviews and interviews, the facility failed to ensure 2 of 5 audit clients (#4 and #5) received a continuous active treatment program consisting of needed interventions and services as identified in the Individual Program Plan (IPP) in the area of meal preparation. The finding is:

A. During observations in the home on 5/8/23 from 9:28am until 11:35am, client #5 was observed to be in his bedroom either watching television or sleeping. Further observations revealed client #4 was sitting in the living room area looking at the television until 10:30am, at which time is when he left for school. Clients #4 and #5 did not have a IPP.

B. During observations in the home on 5/8/23 from 4:05pm until 5:22pm, client #5 was observed in his bedroom watching his television. Further observations revealed staff talking to client #5 about what he was watching on the television. Additonal observations revealed client #4 was seen sitting in the dining room area from 4:05pm until 5:22pm. The television was on and every so often client #4 would look at it. Clients #4 and #5 were never offered any activities to participate in. Client #4 did not have goals,

C. During evening observations in the home on 5/8/23, Staff C was observed using an electric can opener, putting contents of food into pots and stirring food on the stove. Further observations revealed client #4 sitting in the living room and looking at Staff C while they prepared dinner. At

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W 249	Continued From page 12 no time was client #4 given the opportunity to participate in meal preparation. D. During evening observations in the home on 5/8/23, client #5 was observed in his bedroom watching television. Further observations revealed Staff C was using an electric can opener, pouring contexts of the can into a pot and stirring. Additional observations revealed Staff C opening a box of instant mashed potatoes, pouring it into a pot and stirring. Client #5 was never given the opportunity to participate in meal preparation. E. During morning observations in the home on 5/9/23 at 6:55am, clients #4 and #5 were sitting in the living room. Further observations revealed the television was on. Clients #4 and #5 were never offered any activities to participate in. During an interview on 5/8/23, Staff C stated he should have had clients #4 and #5 participate in meal preparation. During an interview on 5/9/23, the Qualified Intellectual Disabilities Professional (QIDP) revealed Staff C should have had client #4 assist with meal preparation. Further interview revealed client #4 has the skills to prepare a simple salad. The QIDP stated client #5 should have been allowed to participate in meal preparation. During an interview on 5/11/23, management staff stated clients #4 and #5 should have had IPP's written for them. The management staff also revealed client #4 should have had goals written for me.	W 249		
W 252	PROGRAM DOCUMENTATION	W 252		

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W 252	Continued From page 13 CFR(s): 483.440(e)(1) Data relative to accomplishment of the criteria specified in client individual program plan objectives must be documented in measurable terms. This STANDARD is not met as evidenced by: Based on observations, record review and interviews, the facility failed to ensure 4 of 5 audit clients (#1, #2, #3, and #5) data for their goals was documented. The findings are: A. Review on 5/8/23 of client #1's goals: turning off light; unhooking pants; walking up stairs and appropriate table manners was missing for the entire months of March and April 2023 and for the month of May (2023) from the 1st thru 8th. Further review revealed there were no data sheets in the book for client #1. B. Review on 5/8/23 of client #2's goals: appropriate table manners; putting placemats on table, put folded clothes in drawer and hand washing was missing for the entire months of March and April 2023 and for the month of May (2023) from the 1st thru 8th. Further review revealed there were no data sheets in the book for client #2. C. Review on 5/8/23 of client #3's goals: combing hair; identifying letters and making a cracker sandwich was missing for the entire months of March and April 2023 and for the month of May (2023) from the 1st thru 8th. Further review revealed there were no data sheets in the book for client #3.	W 252		

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W 252	Continued From page 14 D. Review on 5/8/23 of client #5's goals: bathing; toileting and appropriate table manners was missing for the entire months of March and April 2023 and for the month of May (2023) from the 1st thru 8th. Further review revealed there were no data sheets in the book for client #5. During an interview on 5/8/23, Staff A confirmed that data was missing for goals for clients #1, #2, #3 and #5. Staff A also confirmed there were no data sheets in the books for the clients. During an interview on 5/9/23, the Qualified Intellectual Disabilities Professional (QIDP) confirmed there were no data collected for clients #1, #2, #3 and #5. The QIDP also acknowledged there were no data sheets in the books for the clients. Further interview revealed it is the QIDP's responsibility to ensure data is collected and data sheets are kept in the clients's books.	W 252		
W 258	PROGRAM MONITORING & CHANGE CFR(s): 483.440(f)(1)(iv) The individual program plan must be reviewed at least by the qualified mental retardation professional and revised as necessary, including, but not limited to situations in which the client is being considered for training towards new objectives. This STANDARD is not met as evidenced by: Based on record review and staff interview, the facility failed to ensure training towards new objectives was considered in a timely manner for 1 of 5 audit clients (#4). The finding is: Review on 5/8/23 of client #4's record revealed he does not have any training goals. Further	W 258		

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W 258	Continued From page 15 review revealed client #4 was admitted to the facility on 3/31/22. During an interview on 5/9/23, the Qualified Intellectual Disabilities Professional (QIDP) revealed he has not implemented any new goals for client #4. Further interview revealed the QIDP is responsible for ensuring client #4 has training goals.	W 258		
W 263	PROGRAM MONITORING & CHANGE CFR(s): 483.440(f)(3)(ii) The committee should insure that these programs are conducted only with the written informed consent of the client, parents (if the client is a minor) or legal guardian. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure restrictive programs were only conducted with the written informed consent of a legal guardian. This affected 2 of 5 audit clients (#2 and #4). The findings are: A. Review on 5/8/23 of client #2's Behavior Intervention Program (BIP) updated 2023 revealed it was last signed by her guardian on 3/24/22. Further review revealed there was not a current BSP consent signed by her guardian. B. Review on 5/8/23 of client #2's Behavior Intervention Program (BIP) revealed it was last signed by his guardian on 3/31/22. Further review revealed there was not a current BSP consent signed by his guardian. During an interview on 5/9/23, the Qualified Intellectual Disabilities Professional (QIDP) confirmed both clients #2 and #4 BIP's have	W 263		

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W 263	Continued From page 16 expired. The QIDP reported it is their reasonability to ensure that consents are signed by the guardians.	W 263		
W 340	NURSING SERVICES CFR(s): 483.460(c)(5)(i) Nursing services must include implementing with other members of the interdisciplinary team, appropriate protective and preventive health measures that include, but are not limited to training clients and staff as needed in appropriate health and hygiene methods. This STANDARD is not met as evidenced by: Based on observations, documentation and interview, nursing services failed to ensure that staff were sufficiently trained in the disposal of medications and the administering of as needed medications. This affected 2 of 4 audit clients (#2 and #4) The findings are: A. During medication administration observations in the home on 5/9/23 at 7:08am, one of client #4's pills fell on the floor while he was putting them into his mouth. Further observations revealed the medication technician picking up the pill and placing it on the table in the medications room. Additional observations revealed at 7:13am, the medication technician handed the pill to another staff and told them to go flush it down the toilet. During an immediate interview, the medication technician revealed she was trained not to leave the medication room and that is the reason why she gave the pill to another staff person to dispose of. During an interview on 5/9/23, the Qualified	W 340		

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W 340	Continued From page 17 Intellectual Disabilities Professional (QIDP) stated that two staff are to dispose of pills. The second staff is there as a witness. B. During medication administration observations in the home on 5/9/23 at 7:16am, client #2 consumed Hydroxyzine 25mg. During an interview on 5/9/23, the medication technician stated she gave client #2 the Hydroxyzine due to the fact she was having behaviors. Review on 5/9/23 of client #2's Behavior Intervention Program (BIP) data sheet revealed the box for 8am on 5/9/23 was checked for self injurious behaviors. Further review revealed no other boxes with times were checked. During an interview on 5/9/23, the QIDP confirmed the BIP data sheet was checked for 8am; indicating client #2 had a behavior during that time frame. The QIDP did not understand why client #2 was given Hydroxyzine at 7:16am for behaviors that had not yet occurred. Further interview revealed the nurse should have also been called prior to the medicine being given.	W 340		
W 351	COMPREHENSIVE DENTAL DIAGNOSTIC SERVICE CFR(s): 483.460(f)(1) Comprehensive dental diagnostic services include a complete extraoral and intraoral examination, using all diagnostic aids necessary to properly evaluate the client's condition not later than one month after admission to the facility (unless the examination was completed within twelve months before admission).	W 351		

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W 351	Continued From page 18 This STANDARD is not met as evidenced by: Based on record review and interviews, the facility failed to ensure a dental examination for 1 of 5 audit clients (#5). The finding is: Review on 5/8/23 of client #5's record revealed he he had dental appointment on 12/27/22. Further review revealed client #5 refused to be examined by the dentist. Additonal review revealed another dental appointment has not been rescheduled. Client #5 was admitted to the facility on 11/14/22. During an interview on 5/8/23, the Qualified Intellectual Disabilities Professional (QIDP) stated another dental appointment had not be rescheduled for client #5. The QIDP stated he had only followed up with the dentist once since client #5 refused to be examined by the dentist.	W 351		
W 460	FOOD AND NUTRITION SERVICES CFR(s): 483.480(a)(1) Each client must receive a nourishing, well-balanced diet including modified and specially-prescribed diets. This STANDARD is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to ensure each client received a nourishing, well balanced diet including modified specially prescribed diet as prescribed. This affected 2 of 5 audit clients (#2 and #4). The findings are:	W 460		

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W 460	Continued From page 19 A, During dinner observations in the home on 5/8/23, client #2 received two extra pieces of chicken. Review on 5/8/23 of the facility's diet orders dated 12/13/22 revealed client #2 is to receive seconds of one fruit or one vegetable only. B. During dinner observations in the home on 5/8/23, client #4 received two extra pieces of chicken and another scoop of mashed potatoes. Review on 5/8/23 of the facility's diet orders dated 12/13/22 revealed client #4 is to receive seconds of one fruit or one vegetable only. During an interview on 5/8/23, Staff C stated he gave client #2 the two extra pieces of chicken because she never eats. During the interview the surveyor showed Staff C the diet orders and he said it was correct and he should have followed them. Staff C reported he gave client #4 the two extra pieces of chicken and the extra scoop of mashed potatoes "just because" he felt like it. During an interview on 5/9/23, the Qualified Intellectual Disabilities Professional (QIDP) stated staff have been trained to follow clients #2 and #4 diet orders. Further interview revealed the diet orders are current and up to date.	W 460		
W 484	DINING AREAS AND SERVICE CFR(s): 483.480(d)(3) The facility must equip areas with tables, chairs, eating utensils, and dishes designed to meet the developmental needs of each client. This STANDARD is not met as evidenced by: Based on observations and interviews, the facility	W 484		

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W 484	Continued From page 20	W 484		

failed to ensure staff were sufficiently trained in the implementation of adaptive dining equipment for 1 of 5 audit clients (#1). The finding is:

During lunch observations in the home on 5/8/23, client #1 was observed not using a plate guard. Further observations revealed client #1 leaning over his plate and shoveling his meal into his mouth. At no time was client #1 provided with his plate guard.

During dinner observations in home on 5/8/23, client #1 was observed using his plate guard. Further observations revealed the plate guard was facing away from the way he was scooping his food. Additional observations revealed client #1 was leaning over his plate and shoveling his meal into his mouth. At no time was client #1's plate guard repositioned to assist him with eating correctly.

During an interview on 5/9/23, Staff C reported he knew to place the plate guard on client #1's plate guard, however had not been inserviced on the proper placement of it.

During an interview on 5/9/23, the Qualified Intellectual Disabilities Professional (QIDP) stated the plate guard needs to be on the on the opposite side of his plate while he is scooping his food.