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E 004	Develop EP Plan, Review and Update Annually CFR(s): 483.475(a) §403.748(a), §416.54(a), §418.113(a), §441.184(a), §460.84(a), §482.15(a), §483.73(a), §483.475(a), §484.102(a), §485.68(a), §485.542(a), §485.625(a), §485.727(a), §485.920(a), §486.360(a), §491.12(a), §494.62(a). The [facility] must comply with all applicable Federal, State and local emergency preparedness requirements. The [facility] must develop establish and maintain a comprehensive emergency preparedness program that meets the requirements of this section. The emergency preparedness program must include, but not be limited to, the following elements: (a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be [reviewed], and updated at least every 2 years. The plan must do all of the following: * [For hospitals at §482.15 and CAHs at §485.625(a):] Emergency Plan. The [hospital or CAH] must comply with all applicable Federal, State, and local emergency preparedness requirements. The [hospital or CAH] must develop and maintain a comprehensive emergency preparedness program that meets the requirements of this section, utilizing an all-hazards approach. * [For LTC Facilities at §483.73(a):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually.	E 004		

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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E 004	Continued From page 1 * [For ESRD Facilities at §494.62(a):] Emergency Plan. The ESRD facility must develop and maintain an emergency preparedness plan that must be [evaluated], and updated at least every 2 years. . This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure the Emergency Preparedness (EP) plan was reviewed and updated every two years. The finding is: Review on 9/18/23 of the facility's EP plan revealed the date of their plan was 10/21/19. Further review revealed there was not an updated plan located in the home. During an interview on 9/19/23, the Regional Director (RM) stated she was sure it was updated in 2023.	E 004		
E 037	EP Training Program CFR(s): 483.475(d)(1) §403.748(d)(1), §416.54(d)(1), §418.113(d)(1), §441.184(d)(1), §460.84(d)(1), §482.15(d)(1), §483.73(d)(1), §483.475(d)(1), §484.102(d)(1), §485.68(d)(1), §485.542(d)(1), §485.625(d)(1), §485.727(d)(1), §485.920(d)(1), §486.360(d)(1), §491.12(d)(1). *[For RNCHIs at §403.748, ASCs at §416.54, Hospitals at §482.15, ICF/IIDs at §483.475, HHAs at §484.102, REHs at §485.542, "Organizations" under §485.727, OPOs at §486.360, RHC/FQHCs at §491.12:] (1) Training program. The [facility] must do all of the following:	E 037		

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E 037	Continued From page 2 (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of all emergency preparedness training. (iv) Demonstrate staff knowledge of emergency procedures. (v) If the emergency preparedness policies and procedures are significantly updated, the [facility] must conduct training on the updated policies and procedures. *[For Hospices at §418.113(d):] (1) Training. The hospice must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing hospice employees, and individuals providing services under arrangement, consistent with their expected roles. (ii) Demonstrate staff knowledge of emergency procedures. (iii) Provide emergency preparedness training at least every 2 years. (iv) Periodically review and rehearse its emergency preparedness plan with hospice employees (including nonemployee staff), with special emphasis placed on carrying out the procedures necessary to protect patients and others. (v) Maintain documentation of all emergency preparedness training. (vi) If the emergency preparedness policies and procedures are significantly updated, the hospice must conduct training on the updated policies and	E 037		

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E 037	Continued From page 3 procedures. *[For PRTFs at §441.184(d):] (1) Training program. The PRTF must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) After initial training, provide emergency preparedness training every 2 years. (iii) Demonstrate staff knowledge of emergency procedures. (iv) Maintain documentation of all emergency preparedness training. (v) If the emergency preparedness policies and procedures are significantly updated, the PRTF must conduct training on the updated policies and procedures. *[For PACE at §460.84(d):] (1) The PACE organization must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing on-site services under arrangement, contractors, participants, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Demonstrate staff knowledge of emergency procedures, including informing participants of what to do, where to go, and whom to contact in case of an emergency. (iv) Maintain documentation of all training. (v) If the emergency preparedness policies and procedures are significantly updated, the PACE must conduct training on the updated policies and procedures.	E 037		

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E 037	Continued From page 4	E 037		

*[For LTC Facilities at §483.73(d):] (1) Training Program. The LTC facility must do all of the following:
(i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected role.
(ii) Provide emergency preparedness training at least annually.
(iii) Maintain documentation of all emergency preparedness training.
(iv) Demonstrate staff knowledge of emergency procedures.

*[For CORFs at §485.68(d):](1) Training. The CORF must do all of the following:
(i) Provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles.
(ii) Provide emergency preparedness training at least every 2 years.
(iii) Maintain documentation of the training.
(iv) Demonstrate staff knowledge of emergency procedures. All new personnel must be oriented and assigned specific responsibilities regarding the CORF's emergency plan within 2 weeks of their first workday. The training program must include instruction in the location and use of alarm systems and signals and firefighting equipment.
(v) If the emergency preparedness policies and procedures are significantly updated, the CORF must conduct training on the updated policies and procedures.

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E 037	Continued From page 5 *[For CAHs at §485.625(d):] (1) Training program. The CAH must do all of the following: (i) Initial training in emergency preparedness policies and procedures, including prompt reporting and extinguishing of fires, protection, and where necessary, evacuation of patients, personnel, and guests, fire prevention, and cooperation with firefighting and disaster authorities, to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. (v) If the emergency preparedness policies and procedures are significantly updated, the CAH must conduct training on the updated policies and procedures. *[For CMHCs at §485.920(d):] (1) Training. The CMHC must provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles, and maintain documentation of the training. The CMHC must demonstrate staff knowledge of emergency procedures. Thereafter, the CMHC must provide emergency preparedness training at least every 2 years. This STANDARD is not met as evidenced by: Based on document review and interviews, the facility failed to ensure direct care staff were adequately trained on the facility's emergency preparedness (EP) pan. The finding is:	E 037		

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E 037	Continued From page 6 Review on 9/18/23 of the facility's EP manual (10/21/19) did not include any information regarding training of staff. During an interview on 9/19/23, the Regional Manager (RM) confirmed there were no information included in the EP concerning training of the staff.	E 037		
W 130	PROTECTION OF CLIENTS RIGHTS CFR(s): 483.420(a)(7) The facility must ensure the rights of all clients. Therefore, the facility must ensure privacy during treatment and care of personal needs. This STANDARD is not met as evidenced by: Based on observations and interviews, the facility failed to ensure privacy for 1 of 5 audit clients (#3). The finding is: During evening observations in the home on 9/18/23 at 6:37pm, client #3 was observed sitting on the toilet with the door wide open. Further observations revealed Staff B walking in and then walking out of the bathroom while the door remained open. Additional observations revealed a male client walking by the open bathroom door and looking in while Staff B was also standing there. At 6:39pm, client #3 stood up from the toilet, pulling up her underwear and then her pants, while the door remained open. At no time was the door closed for client #3's privacy while she used the toilet. During an interview on 9/18/23, Staff B revealed ever since she has worked in the home, the bathroom door remains open while client #3 is using the toilet. Staff B confirmed the bathroom	W 130		

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W 130	Continued From page 7 door should be closed while client #3 is using the toilet. Review on 9/19/23 of client #3's Adaptive Behavior Inventory (ABI) dated 11/1/22 revealed she has partial independence with closing the bathroom door for privacy. During an interview on 9/19/23, the management staff stated the bathroom door should be closed while client #3 is using the toilet. Further interview revealed under no circumstances have staff been told to leave the bathroom door open while a client is using the toilet.	W 130		
W 192	STAFF TRAINING PROGRAM CFR(s): 483.430(e)(2) For employees who work with clients, training must focus on skills and competencies directed toward clients' health needs. This STANDARD is not met as evidenced by: Based on observations and interviews, the facility failed to ensure staff were sufficiently trained in reporting medical concerns. This affected 1 of 5 audit clients (#6). The finding is: During observations throughout the survey on 9/18 - 19/23, client #6 was saying "My gums hurt". There where also times where she was yelling how her gums hurt. At no time did any of the staff working in the home ask client #6 about her gums. During an interview on 9/18/23, the medication technician on second shift stated client #6 lies for attention. When asked if she was going to contact the nurse she said "No".	W 192		

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W 192	Continued From page 8 During an interview on 9/19/23, management staff revealed staff should have followed up with client #6 when she was complaining about how her gums where hurting. Further interview revealed staff have been trained to follow up on medical concerns of the clients in the home.	W 192		
W 247	INDIVIDUAL PROGRAM PLAN CFR(s): 483.440(c)(6)(vi) The individual program plan must include opportunities for client choice and self-management. This STANDARD is not met as evidenced by: Based on observations, record review and interviews, the facility failed to ensure 1 of 5 audit clients (#4) was provided the opportunity of choice. The finding is: During morning observations in the home on 9/19/23 at 6:39am, client #4 stood up from his seat and began walking away from the group. Staff C put out her arm at the waist level of client #4 and telling him to "Stop". Client #4 then turned around and sat back down in his chair. At 6:41am, client #4 again stood up from his chair and Staff C told him "Stop" and "No, [Client #4]". Client #4 sat back down. Client again tried to leave the group at 6:42am, Staff C pointed back at the chair where client #4 was sitting. Client #4 sat back down in the chair and crossed his legs. Review on 9/18/23 of client #4's record dated 8/25/22 did not indicate that client #4 was not allowed freedom of movement within his own environment. During an interview on 9/19/23, management staff confirmed client #4 should be allowed	W 247		

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W 247	Continued From page 9 freedom of movement within his environment.	W 247		
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. This STANDARD is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to ensure 5 of 5 audit clients (#2, #3, #4, #5 and #6) received a continuous active treatment program consisting of needed interventions and services as identified in the Individual Program Plan (IPP) in the areas of program guidelines, adaptive equipment, dining, toileting and handwashing. The findings are: A. During observations in the home on 9/18/23 at 5:10pm, Staff A was in the kitchen preparing dinner. Staff A opened a kitchen drawer that contained butter knives. Immediate interview with Staff A revealed butter knives are kept in the drawer and butcher knives are kept in an unsecured kitchen cabinet on a shelf. Review of client #2's Behavior Support Plan (BSP) dated 2/2/23 revealed an objective that by	W 249		

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W 249	Continued From page 10 February 1, 2024 client #2 will exhibit four or fewer challenging behaviors per month for eleven consecutive months. Challenging behaviors are identified as aggressive behavior, severe disruptive behavior, taking things that do not belong to him, failure to make responsible choices and attempted AWOL/actual AWOL. Further review of the BSP revealed client #2 served a year and a half jail sentence after threatening to use a knife on a police officer. The team implemented a restriction of knives at the day program and home that knives will be kept in a secure area. After a knife is used, the knife will be cleaned and returned to the secure area. Client #2 can only use knives under direct staff supervision. Interview on 9/19/23 with Staff F revealed knives are to be kept in a secure area due to client #2's behavior. Staff F took the knives from the unsecured kitchen cabinet and placed them on a shelf in the pantry. Staff F turned the pantry alarm door on and closed the door. Interview on 9/19/23 with management revealed the BSP states secure area but does not specify where the area is or if it is to be locked. However, management acknowledges that a kitchen cabinet shelf is not secure. B. During observations in the home throughout 9/19/23, at no time was client #5 observed wearing a gait belt. During observations at 5:10pm, Staff B was observed assisting client #5 to transfer from her wheelchair to a recliner and at 6:16pm from the recliner back to her wheelchair. A gait belt was not used by Staff B for either transfer.	W 249		

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W 249	Continued From page 11 Review of client #5's Fall Prevention and Safety Guidelines dated 7/29/23 revealed for stand-pivot transfers, provide 1+ minimum assistance and verbal cueing with support of a gait belt for all transfers. Interview on 9/19/23 at 7:50am with Staff F revealed client #5 should wear a gait belt for all transfers. Interview on 9/19/23 with management confirmed a gait belt should be used when transferring client #5. C. During meal observations in the home on 9/18 - 19/23, clients #2, #4 and #6 did not wash their hands prior to eating dinner or breakfast. At no time were clients #2 #4 and #6 given any type of prompts to was their hands. Review on 9/19/23 of client #2's Adaptive Behavior Inventory (ABI) dated 11/1/22 revealed he is independent with washing his hands prior to meals. Review on 9/19/23 of client #4's ABI dated 1/10/22 revealed he has partial independence with washing his hands prior to meals. Review on 9/19/23 of client #6's ABI dated 11/1/22 revealed she is independent with washing her hands prior to meals. During an interview on 9/19/23, Staff E revealed clients #2 and #6 are totally independent with washing their hands. Further interview revealed client #4 needs assistance with washing his hands.	W 249		

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D. During meal observations in the home on 9/18 - 19/23, clients #2, #4 and #6 did not have any napkins at their place settings during their meals. Further observations revealed there was a paper towel holder located in the kitchen. Additional observations revealed client #4 using his forearm to wipe his mouth after breakfast.

Review on 9/19/23 of client #2's ABI dated 11/1/22 revealed he is independent with using a napkin to wipe his mouth during/after meals.

Review on 9/19/23 of client #4's ABI dated 1/10/22 revealed he has partial independence with using a napkin to wipe his mouth during/after meals.

Review on 9/19/23 of client #6's ABI dated 11/1/22 revealed she is independent with using a napkin to wipe her mouth during/after meals.

E. During evening observations in the home on 9/18/23 at 6:37pm, client #3 was observed sitting on the toilet. At 6:39pm, client #3 stood up from the toilet, pulling up her underwear and then her pants. Client #3 exited the bathroom without wiping herself, flushing the toilet or washing her hands. Further observations revealed Staff B standing in front of client #3 and straightening her clothes. At no time was client #3 prompted to wipe herself, flush the toilet or wash her hands.

Review on 9/19/23 of client #3's ABI dated 11/1/22 revealed she is totally independent with wiping herself, flushing the toilet and washing her hands with soap.

During an interview on 9/19/23, management

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W 249	Continued From page 13 staff stated client #3 should have wiped herself, flushed the toilet and washed her hands prior to leaving the bathroom.	W 249		
W 262	PROGRAM MONITORING & CHANGE CFR(s): 483.440(f)(3)(i) The committee should review, approve, and monitor individual programs designed to manage inappropriate behavior and other programs that, in the opinion of the committee, involve risks to client protection and rights. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure the restrictive behavior techniques for 1 of 5 audit clients (#2) was reviewed and monitored by the human rights committee (HRC). The finding is: Review on 9/18/23 of client #2's Behavior Support Plan (BSP) dated 2/2/23 revealed target behaviors consisting of aggressive behavior, severe disruptive behavior, taking things that do not belong to him, failure to make responsible choices and attempted AWOL/actual AWOL. Further review on 9/18/23 of client #2's BSP revealed no written consent by the HRC. Interview on 9/19/23 with the Regional Director revealed that no written consent has been obtained by HRC.	W 262		
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:	W 263		

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W 263	Continued From page 14 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 1 of 5 audit clients (#2). The finding is: Review on 9/18/23 of client #2's Behavior Support Plan (BSP) dated 2/2/23 revealed restrictions for searches of client #2's room and person, restricting access to knives, not having a lock on his bedroom door and installing outside gates that would be secured. Further record review on 9/19/23 of client #2's BSP revealed no written informed consent of a legal guardian. Interview on 9/19/23 with the Regional Director confirmed written informed consent by the guardian should have but has not been obtained for client #2's BSP.	W 263		
W 352	COMPREHENSIVE DENTAL DIAGNOSTIC SERVICE CFR(s): 483.460(f)(2) Comprehensive dental diagnostic services include periodic examination and diagnosis performed at least annually. This STANDARD is not met as evidenced by: Based on record reviews and interview, the facility failed to ensure each client received comprehensive dental services including periodic examinations at least annually. This affected 1 of 5 audit clients (#2). The finding is: Review on 9/18/23 of client #2's record revealed his last dental examination and cleaning occurred on 7/22/21. No current dental examinations could	W 352		

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W 352	Continued From page 15 be located. Interview on 9/19/23 with the facility nurse revealed she did not think edentulous clients had to be seen by dental annually. However, the facility nurse confirmed client #2 has not been for a dental/gum exam since 7/22/21.	W 352		
W 369	DRUG ADMINISTRATION CFR(s): 483.460(k)(2) The system for drug administration must assure that all drugs, including those that are self-administered, are administered without error. This STANDARD is not met as evidenced by: Based on observations, record review and interview, the facility failed to ensure all medications were administered without error. This affected 2 of 5 clients (#3 and #6) observed receiving medications. The findings are: A. During observations in the home on 9/18//23 at 6:46pm, the medication technician was observed assisting client #3 with administering her medications, which included Metformin ER 500mg. Review on 9/19/23 of client #3's physician's orders dated 11/19/22 reveled an order for Metformin ER 500mg take 1 tablet by mouth, once daily after evening meal and was ordered for 5:00pm. B. During observations in the home on 9/18/23 at 6:57pm, the medication technician was observed assisting client #6 with administering her medications, which included Latuda 120mg. Client #6 refused the medication.	W 369		

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W 369	Continued From page 16 Immediate interview with the medication technician revealed the electronic MAR had an order for Latuda 120mg take 1 tablet by mouth at 5:00pm. The medication technician revealed when a client refuses a medication staff has to document it in the electronic MAR, comunication book and behavior log but does not have to notify nursing. Review on 9/19/23 of client #6's physician's orders dated 11/19/22 revealed an order for Latuda 120mg take 1.5 tablets by mouth at 8:00am. Interview on 9/19/23 with the facility nurse revealed the facility's medication policy states medications can be given one hour before or one hour after scheduled medication time. The facility nurse also confirmed that client #3 received medication outside the approved time frame. The nurse also revealed that client #6 had an order change for Latuda to be administered at 5:00pm but could not provide a physician's order to show the change. The nurse stated anytime a client refuses a medication staff should notify nursing.	W 369		
W 440	EVACUATION DRILLS CFR(s): 483.470(i)(1) at least quarterly for each shift of personnel. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure fire drills were conducted at least quarterly for each shift. The finding is: Review on 9/18/23 of the facility's fire drills for October 2022 - August 2023 revealed no recorded fire drills for June 2023, July 2023, August 2023 or September 2023.	W 440		

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W 440	Continued From page 17 Interview on 9/18/23 with the Residential Director confirmed no fire drill reports could be located for the missing months.	W 440		
W 441	EVACUATION DRILLS CFR(s): 483.470(i)(1) and under varied conditions to- This STANDARD is not met as evidenced by: Based on review of fire drill evacuation reports and interviews, the facility failed to ensure fire evacuation drills were conducted at varied times/conditions. The finding is: Review on 9/18/23 of the facility's fire drill evacuation report for the time period of October 2022 through September 2023 revealed no fire drills were conducted in the home on 1st shift; 2nd shift at 7:10pm, 7:00pm, 5:45pm, 4:15pm and 5:46pm; and 3rd shift at 5:00am and 4:30am. Interview on 9/19/23 with the Regional Director confirmed the fire drills were not conducted at varied times.	W 441		
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 1 of 5 audit clients (#3).	W 460		

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W 460	Continued From page 18 The finding is: During observations in the home on 9/18/23 at 4:29pm, client #3 was discovered eating out of a bag of potato chips while standing in the pantry. Further observations revealed client #3 consuming a potato chip which was three inches round. During dinner observations in the home on 9/18/23 at 6:18pm, client #3 was observed consuming two fish fillets with two bites each. Further observations revealed client #3 also consumed one slice of bread in two bites. At no time was client #3's meal modified modified pertaining to her diet. During breakfast observations in the home on 9/19/23 at 7:05am, client #3 was observed consuming two round sausage patties. Further observations revealed client #3 consumed both sausage patties with two bites each. At no time was client #3's two sausage patties modified pertaining to her diet. Review on 9/18/23 of the facility's diet order dated 10/19/20 stated, "[Client #3]...All food bite size pieces". During an interview on 9/19/23, management staff confirmed client #3's food should be bite sized.	W 460		
W 478	MENUS CFR(s): 483.480(c)(1)(ii) Menus must provide a variety of foods at each meal. This STANDARD is not met as evidenced by:	W 478		

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W 478	Continued From page 19 Based on observations, document review and interviews, the facility failed to assure clients residing in the home were offered the variety of foods listed on the menu. This affected 5 of 5 audit clients (#2, #3, #4, #5 and #6). The finding is: During observations in the home on 9/18/23 Staff A was observed cooking fish fillets and egg noodles for dinner. Further observations indicated fruit cups where for the clients dessert. At no time were the clients offered a vegetable with their meal. Additional observations revealed there were a variety of canned vegetables in the pantry. Review on 9/18/23 of the facility's menu book for 9/18/23 revealed stir fry shrimp over egg noodles, mandarin oranges, whole wheat bread, margarine and choice of drink for dinner. During an interview on 9/19/23, management staff confirmed the clients should have been offered a variety of food during dinner.	W 478		
W 481	MENUS CFR(s): 483.480(c)(2) Menus for food actually served must be kept on file for 30 days. This STANDARD is not met as evidenced by: Based on observations and interviews, the facility failed to ensure food substitutions were documented. The finding is: During observations in the home on 9/18/23 Staff A was observed cooking fish fillets and egg noodles for dinner. Further observations indicated fruit cups where for the clients dessert.	W 481		

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W 481	Continued From page 20 Review on 9/18/23 of the facility's menu book for 9/18/23 revealed stir fry shrimp over egg noodles, mandarin oranges, whole wheat bread, margarine and choice of drink for dinner. During a interview on 9/18/23, Staff A stated there was no stir fry shrimp in the home. Further interview revealed she was substituting the stir fry shrimp with fish fillets. Review on 9/18/23 of the menu substitution book revealed the last entry was on 6/21/23. During an interview on 9/19/23, management revealed the meal substitution form should have been filled out for the dinner meal, which occurred on 9/18/23.	W 481		