

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G458	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 11/09/2011
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NAME OF PROVIDER OR SUPPLIER ST VINCENT NEW HOPE INC	STREET ADDRESS, CITY, STATE, ZIP CODE 6068 MUNSEE LN INDIANAPOLIS, IN46208
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W0000	<p>This visit was for a predetermined full recertification and state licensure survey.</p> <p>Dates of Survey: November 1, 2, 3, 4, 7, and 9, 2011.</p> <p>Facility number: 000972 Provider number: 15G458 AIM number: 100244840</p> <p>Surveyor: Brenda Nunan, RN, Public Health Nurse Surveyor III</p> <p>The following federal deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 11/28/11 by Ruth Shackelford, Medical Surveyor III.</p>	W0000		
W0153	<p>The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures.</p> <p>Based on interview and record review, the facility failed to ensure all allegations of neglect or abuse were immediately</p>	W0153	<i>What corrective action(s) will be accomplished for those residents found to have been</i>	12/09/2011

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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	<p>reported to the administrator or to other officials in accordance with State law for 2 of 11 incidents reviewed for abuse, neglect or mistreatment (clients #2 and #3).</p> <p>Findings include:</p> <p>1. The facility's reportable incidents and/or investigations were reviewed on 11/01/2011 at 10:40 a.m. The record did not include documentation to indicate client #3 eloped from the facility.</p> <p>Client #3's record was reviewed on 11/02/2011 at 12:34 p.m.</p> <p>An "Individual Progress Note," dated 09/18/2011 at 9 p.m. indicated, "[Client #3] was in the restroom...Staff came back w/ (with) clean clothes and saw [client #3] was gone. Staff looked through the house. Staff saw housemates door open and side door. Staff found [client #3] outside and inside (SIC) the neighbor's truck...."</p> <p>Client #3's Behavioral Support Plan (BSP), dated 03/31/2011, indicated target behaviors included but were not limited to elopement.</p> <p>A "Functional Behavioral Assessment," dated 08/17/2011, indicated, "...Eloping:</p>		<p>affected by the deficient practice? All staff responsible for working with individuals at this facility will be retrained on the requirements for reporting incidents and the appropriate action to do so. In addition to a review of those requirements, the Director and/or QDDP will conduct a competency quiz with each of those staff to ensure the process is understood. How will the facility identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? All residents have the potential to be affected by the deficient practice. The program data and documented notes for all individuals in the home was reviewed to ensure that no additional reportable incidents had gone without reporting. What measures will be put into place or what systemic changes will the facility make to ensure the deficient practice does not recur? The Team Leader and/or QMRP will review the notes for each individual in the facility routinely, not to occur less than weekly to ensure that future incidents are documented, reported and investigated if and when they occur. How will the corrective action be monitored to ensure the deficient practice will not recur and what quality assurance program will be put into place? The QMRP will</p>		

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	<p>Leaving the house without staff, wandering into the neighborhood. Average Frequency = 3.22 incidents per month...."</p> <p>During an interview on 11/04/2011 at 2:10 p.m., the Residential Director indicated the elopement incident had not been reported to administrative staff and State officials.</p> <p>2. The facility's reportable incidents and/or investigations were reviewed on 11/01/2011 at 10:40 a.m. The record did not include documentation to indicate client #2's hair was pulled by a peer.</p> <p>Client #2's record was reviewed on 11/03/2011 at 10:21 a.m.</p> <p>An "Individual Progress Note," dated 08/26/2011 at 8:55 a.m., indicated, "... [Client #2] tried to spit at peer and spit went on floor. Peer (not identified) pulled her hair...."</p> <p>During an interview on 11/04/2011 at 1:50 p.m., the Residential Director stated she "was not sure" if the client to client aggression had been reported. The Residential Director sent an email on 11/04/2011 at 4:38 p.m. The email indicated, "...8/26/11 a.m. - there is no BDDS report or investigation for this</p>		<p>review the casemanagement summaries on a routine basis, at minimum monthly to ensure that reportable incidents and occurances are reported and investigated according to St. Vincent New Hope policy and procedure. The competency quiz for reporting incidents appropriately will be completed monthly for staff for the next 3 months. At that time the need for competency reviews will be reviewed by the team and resume at a schedule that would occur no less than the annual mandatory training. The schedule will be determined by the quiz answers and competency shown during staff review.</p>		

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W0154	<p>incident..."</p> <p>9-3-2(a)</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated. Based on interview and record review for 3 of 11 allegations of abuse, neglect and/or mistreatment, the facility failed to thoroughly investigate elopement from the property for clients #3 and #4 and failed to thoroughly investigate client #2's hair being pulled by a peer.</p> <p>Findings include:</p> <p>1. Client #3's record was reviewed on 11/02/2011 at 12:34 p.m.</p> <p>An "Individual Progress Note," dated 09/18/2011 at 9 p.m. indicated, "[Client #3] was in the restroom...Staff came back w/ (with) clean clothes and saw [client #3] was gone. Staff looked through the house. Staff saw housemates door open</p>	W0154	<p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? The lack of a thorough investigation for noted events was secondary to improper reporting of the events. The staff were retrained and a competency quiz will be conducted monthly to monitor staff understanding of reporting procedures. In addition, the Team Leader and/or QDDP will review the daily notes for each person weekly in order to ensure no other events go unreported. How will the facility identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? All residents have the potential to be affected by the deficient practice.</p>	12/09/2011	

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	<p>and side door. Staff found [client #3] outside and inside (SIC) the neighbor's truck...."</p> <p>Client #3's Behavioral Support Plan (BSP), dated 03/31/2011, indicated target behaviors included but were not limited to elopement.</p> <p>A "Functional Behavioral Assessment," dated 08/17/2011, indicated, "...Eloping: Leaving the house without staff, wandering into the neighborhood. Average Frequency = 3.22 incidents per month...."</p> <p>During an interview on 11/04/2011 at 2:10 p.m., the Residential Director indicated the elopement had not been reported or investigated by administrative staff.</p> <p>2. Client #4's record was reviewed on 11/02/11 at 12:24 p.m.</p> <p>An "Individual Progress Note," dated 10/28/2011 at 7:30 p.m., indicated, "... [Client #4] eloped and writer drove around trying to find her...."</p> <p>Client #4's BSP, dated 03/31/2011, indicated target behaviors included, but were not limited to, elopement. The BSP indicated, "...Elopement: Leaving the</p>		<p>The program data and documented notes for all individuals in the home was reviewed to ensure that no additional reportable incidents had gone without reporting or investigating What measures will be put into place or what systemic changes will the facility make to ensure the deficient practice does not recur? The Team Leader and/or QMRP will review the notes for each individual in the facility routinely, not to occur less than weekly to ensure that future incidents are documented, reported and investigated if and when they occur. Staff will be reviewed monthly for competency in understanding reportable events and the appropriate means to do so. The SVNH Investigation format was revised to model DDRS investigation template. This template will provide greater guidance and elicit more thorough investigation of events through the process of the investigation. How will the corrective action be monitored to ensure the deficient practice will not recur and what quality assurance program will be put into place? The QMRP will review the casemanagement summaries on a routine basis, at minimum monthly to ensure that reportable incidents and occurrences are reported and investigated according to St. Vincent New Hope policy and</p>		

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	<p>house or yard or walking/running away from staff in community, usually when angry...."</p> <p>The record did not include documentation to indicate the facility investigated why Direct Support Professional (DSP) #6 did not consult/inform her co-worker that she was unaware of client #4's location prior to driving around looking for client #4.</p> <p>During an interview on 11/04/2011 at 2:40 p.m., the House Manager stated the elopement was not reported or investigated "because one staff knew where [client #4] was and the other did not...." The House Manager indicated she did not investigate why DSP #6 did not inform her co-worker she was unaware of client #4's location prior to driving around looking for her.</p> <p>3. Client #2's record was reviewed on 11/03/2011 at 10:21 a.m.</p> <p>An "Individual Progress Note," dated 08/26/2011 at 8:55 a.m., indicated, "... [Client #2] tried to spit at peer and spit went on floor. Peer pulled her hair...."</p> <p>During an interview on 11/04/2011 at 1:50 p.m., the Residential Director stated she "was not sure" if the client to client aggression had been investigated. The</p>		<p>procedure. The investigation format will be implemented to guide a more thorough investigation than presently exists. The team members will be monitored monthly to ensure the are clear on the reporting process.</p>	

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W0252	<p>Residential Director sent an email on 11/04/2011 at 4:38 p.m. The email indicated, "...8/26/11 a.m. - there is no BDDS report or investigation for this incident...."</p> <p>9-3-2(a)</p> <p>Data relative to accomplishment of the criteria specified in client individual program plan objectives must be documented in measurable terms.</p> <p>Based on interview and record review, the facility failed to document staff awareness of a client's location for 1 of 1 client with 15 minute checks (client # 3).</p> <p>Findings include:</p> <p>Client #3's record was reviewed on 11/02/2011 at 12:34 p.m.</p>	W0252	<p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? All staff were retrained on behavior management plan, including elopement plan, for clients affected. Staff were also retrained on documentation requirements. In addition to the competency review in W153 and W154, the staff working with</p>	12/09/2011	

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	<p>An "Individual Progress Note," dated 09/18/2011 at 9 p.m. indicated, "[Client #3] was in the restroom...Staff came back w/ (with) clean clothes and saw [client #3] was gone. Staff looked through the house. Staff saw housemates door open and side door. Staff found [client#3] outside and inside (SIC) the neighbor's truck...."</p> <p>Client #3's Behavioral Support Plan (BSP), dated 03/31/2011, indicated target behaviors included but were not limited to elopement. The BSP indicated, "...Make sure you are aware of [client #3's] whereabouts at all times...15-minute checks will be done to make sure we know where she is...."</p> <p>A "Functional Behavioral Assessment," dated 08/17/2011, indicated, "...Eloping: Leaving the house without staff, wandering into the neighborhood. Average Frequency = 3.22 incidents per month...."</p> <p>Client #3's record did not indicate a "Visual Check" form was completed on the day client #3 eloped from the facility. The record did not include documentation of 15 minute checks between 9:15 a.m. and 10:45 p.m. on 09/15/2011, between 7:00 a.m. and 8:00 a.m. and between 11:45 a.m. and 11:45; p.m. on</p>		<p>individuals in this facility will sign statement of understanding that they are responsible to complete daily documentation requirements and failure to do so will result in disciplinary action. How will the facility identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? Staff were reeducated on behavior plans and documentation for all individuals. What measures will be put into place or what systemic changes will the facility make to ensure the deficient practice does not recur? Staff were reeducated on the needs and requirements, as well as reminded that documentation is a prime function of their duties and must be completed as indicated in the program plan. Failure to do so may result in further disciplinary aciton. How will the corrective action be monitored to ensure the deficient practice will not recur and what quality assurance program will be put into place? The facility Team Leader and/or QMRP will routinely review the program data and information for each individual in the home, at minimum weekly.</p>		

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W0331	<p>09/16/2011. There was no documentation to indicate any checks were completed on 09/17/2011, 09/18/2011, and 09/19/2011.</p> <p>During an interview on 11/04/2011 at 2:10 p.m., the House Manager indicated staff were supposed to complete 15 minute checks to ensure client #3's whereabouts.</p> <p>9-3-4(a)</p> <p>The facility must provide clients with nursing services in accordance with their needs. Based on observation, interview and record review, the facility failed to ensure nursing services followed up on physician recommendations or referred for medical evaluation of health conditions. The facility failed to revise health risk plans when needed and failed to ensure staff followed physician's orders for 4 of 4 sampled clients (clients #1, #2, #3, and #4).</p> <p>Findings include:</p> <p>1. Client #1's record was reviewed on 11/03/2011 at 11:11 a.m.</p> <p>Diagnoses included, but were not limited to, pneumonia, asthma, and hypertension (high blood pressure).</p>	W0331	<p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? All nurses reviewed and approved an admission checklist to utilize when an individual is admitted or readmitted to the facility. The checklist will be used in conjunction with the BDDS Transition Plan if BDDS is responsible for coordinating the return. PT/OT orders were received. Client recieved in home PT from 11/9/11 --12/2/11 After in home PT discontinues, in home exercise program will be implemented as indicated by PT. Oxygen orders were clarified and implemented. Medical supplier provided and trained on oxygen on 12/7/11. Nurse consultant completed training on 12/9/11. High Risk Plan</p>	12/09/2011	

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	<p>The record indicated client #1 was hospitalized 06/18/2011-07/15/2011 with right lower lobe necrotizing pneumonia (pneumonia that causes death of lung tissue) that required surgical removal of the abscessed area on 06/24/2011.</p> <p>The record indicated client #1 was a patient at a nursing facility following discharge from the hospital on 07/15/2011 through 10/13/2011.</p> <p>A physician's order, dated 10/06/2011, indicated, "PT/OT (Physical Therapy/Occupational Therapy) @ (at) home. D/C (Discharge) home 10-13-11...."</p> <p>"Post Discharge Instructions," dated 10/13/2011, indicated, "...O2 (oxygen) @ 2 L (liters) via NC (nasal canula) PRN (as needed) (for) O2 Sat (Saturation) < (less than) 88%...."</p> <p>A Respiratory Plan, dated 10/31/2011, did not include monitoring O2 saturation or use of oxygen when O2 saturation was less than 88%.</p> <p>During an interview on 11/04/2011 at 1:10 p.m., the facility nurse indicated she was not aware of the orders for monitoring O2 saturation. She indicated the O2 saturation had not been monitored</p>		<p>updated. Incontinence reviewed by urology. Dr reviewed urinalysis and requested ultrasound. TSH level repeated and faxed to physician/VFSS to reevaluate swallowing reflexes ordered and scheduled. Staff were retrained on appropriate response to gagging, coughing while eating according to AHA First Aid and CPR guidelines. How will the facility identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? All individuals who are admitted to the facility will be guided with the same admission checklist and procedure. Team Leader routine check of MAR, at least weekly. Nurse Consultant routine check of MAR, at least monthly. Nursing weekly oxygen sat monitoring. Weekly weight monitoring in addition to program to monitor % of meal consumed. Program for dining safety implemented and Dining Plan revised. What measures will be put into place or what systemic changes will the facility make to ensure the deficient practice does not recur? Personal Care Sheets indicating specific monitoring for individual need are completed and faxed to the nurse weekly. Specific care needs are indicated on the MAR with instruction of when to call the nurse related to symptoms</p>		

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	<p>and there was no oxygen in the home. The facility nurse indicated OT/PT home services had not been arranged for client #1.</p> <p>2. Client #2's record was reviewed on 11/03/2011 at 10:21 a.m.</p> <p>The "Individual Progress Notes" indicated client #2 was incontinent of urine during the night on September 29, 30, 2011, and October 2, 4, 7, 10, 12, 13, 12, 26, and 28, 2011. The record did not indicate client #2 was incontinent prior to September 29, 2011.</p> <p>During an interview on 11/04/2011 at 1:50 p.m., the facility nurse indicated client #2 had not been evaluated to determine if a medical condition attributed to the incontinence.</p> <p>3. During meal observations on 11/04/2011 at 5:50 p.m., DSP #4 did not encourage alternating liquids with bites and did not redirect client #3 to take smaller bites.</p> <p>During observations on 11/01/2011 at 5:50 p.m., Direct Support Professional (DSP) #9 served client #3 one blue handled spoodle (a kitchen serving utensil used for portion control) of chili with 3 crackers crumbled into the chili, 2</p>		<p>outside expected range. The Program Director and/or QDDP will conduct a nursing chart audit within 2 working days of an admission. How will the corrective action be monitored to ensure the deficient practice will not recur and what quality assurance program will be put into place? The facility Team Leader, QMRP, Nursing and/or Director will do routine chart audit and review. The Program Director and/or QDDP will conduct a nursing chart audit within 2 working days of an admission.</p>		

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	<p>large serving spoons of applesauce, 1 silver handled spoodle of low fat cole slaw, and 8 ounces of water in a cup with a "flip top" hard plastic straw. DSP #9 used a rocker knife to cut client #3's food into small bites. Client #3 used a toddler sized spoon to feed herself but took large bites and ate quickly. Client #3 grabbed a whole saltine cracker from the sleeve and shoved it into her mouth. DSP #9 moved the sleeve of crackers away from client #3. Client #3 coughed during the meal three times. DSP #4 patted client #3 on the back and encouraged her to drink water while she was coughing. Bite sizes and dry swallow techniques were not followed during the meal observation on 11/04/2011 at 5:50 p.m.</p> <p>Client #3's record was reviewed on 11/02/2011 at 12:34 p.m.</p> <p>A "Quarterly Nutrition Review," dated 06/21/2011, indicated, "...Weight down 15# (pounds) this quarter. Weight down 20# x (times) 90 day (SIC) which is significant...Unsure why weight decreased?.../question accuracy of weights?...Current Diet Order: Mechanical soft diet with single servings and thin liquids, single sips, cut up food, no chips/pretzels...Staff to monitor closely at meals and prevent from grabbing at dishes...."</p>				

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	<p>A "Dining Plan," dated 08/25/2011, indicated, "...Limit to < (less than) 1 tsp (teaspoon) of food per swallow. Avoid non-cohesive dry solids like nuts, rice. Chop food into 1/4-1/2 inch pieces. Dry swallow 1-2 times between bites...TRIGGERS TO VOICEMAIL NURSE ABOUT: ...Coughing with signs of struggle (watery eyes, drooling facial redness)...."</p> <p>An "Interdisciplinary Team (IDT)" note, dated 09/21/2011, indicated, "...Continue mechanical soft w/ (with) "ground meat" (SIC) thin liquids and single servings....Avoid non-cohesive dry solids like nuts, rice. Dry swallow 1-2 times after each intake. Alternate liquids and solids. Prompt to slow down when eating and chew food thoroughly...."</p> <p>The Medication Administration Record (MAR) dated March 2011 indicated client #3 weighed 200 pounds. The April 2011 MAR indicated client #3 weighed 195 pounds. The May and June 2011 MARs indicated client #3 weighed 180 pounds. Additional weight records were requested on 11/04/2011 at 2:10 p.m. , but not provided.</p> <p>A "Preliminary Videofluoroscopic Swallow Study," dated 2/11/2011 at 12:10</p>			

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	<p>(p.m.), indicated, "...Cue patient for...liquids by cup...Limit intake to single small bites of food...Upright positioning for eating...."</p> <p>During an interview on 11/04/2011 at 2:10 p.m., the facility nurse indicated staff should have followed the dining plan strategies for feeding including portion sizes. She indicated staff should not have given water while client #3 was coughing. The facility nurse indicated client #3 had not been referred to the physician to evaluate the client's weight loss. The nurse stated client #3 "did not appear to have lost weight."</p> <p>4. Client #4's record was reviewed on 11/04/2011 at 12:20 p.m.</p> <p>A "Quarterly Nutrition Review," dated 06/21/2011, indicated, "...Weight down 27# this quarter...."</p> <p>A Dining Plan, dated 10/06/2011, indicated, "...Regular Low Fat Low Chol (cholesterol) NCS (no concentrated sweets)...."</p> <p>A "Progress Note," dated 10/11/2011, indicated, "D/C (Discontinue) Diabetic Diet. (Symbol for change) to regular diet. D/C tid (three times a day) snacks...."</p>			

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9-3-6(a)	<p>A laboratory report, dated 10/18/2011, indicated, "...TSH (Thyroid Stimulating Hormone) 5.78 (normal range 0.40-4.50)...."</p> <p>The physician's orders, dated 10/10/2011, indicated, "...PROPRANOLOL (a medication used to treat hypertension and other heart conditions, anxiety, tremors, and other health conditions) ER (Extended Release) 80 MG (milligram) CAPSULE-GIVE 1 CAPSULE ORALLY 2 TIMES A DAY...." The order did not include instructions for monitoring vital signs (due to side effects of low blood pressure or slow pulse) and when to hold the Propranolol.</p> <p>During an interview on 11/04/2011 at 2:40 p.m., the facility nurse indicated client #4 had not been referred for medical evaluation of weight loss. The nurse stated she notified the physician of the abnormal labs and there were "no new orders." She stated, she was "not sure" if the physician considered the abnormal thyroid function as a cause of weight loss. The nurse indicated she was not aware the MAR did not include orders for monitoring vital signs or vital sign parameters for when to hold the Propranolol.</p>						

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W0362	<p>A pharmacist with input from the interdisciplinary team must review the drug regimen of each client at least quarterly. Based on record review and interview, the facility failed to ensure a pharmacist reviewed 1 of 4 sampled client's drug regimen at least quarterly (client #4).</p> <p>Findings include:</p> <p>Client #4's pharmacy recommendations were reviewed on 11/04/2011 at 12:20 p.m.</p> <p>The pharmacist reviewed drug regimens on 09/21/2010, 03/04/2011, 06/10/2011, and 09/02/11. There was no documentation to indicate a review was completed in December 2010.</p> <p>During an interview on 11/04/2011 at 2:40 p.m., the QDDP (Qualified Developmental Disabilities Professional) indicated a review was not completed in December 2010.</p> <p>9-3-6(a)</p>	W0362	<p>This quarterly review had been completed at the appropriate time -- attached. All other individuals were reviewed to be compliant with pharmacy reviews. Group Home Director schedules with pharmacy for timely pharmacy reviews. Consulting pharmacy contract was changed to an improved provider. Group Home Director will meet with new pharmacy after contract change 12/1/11 in respect to consultant pharmacy reviews and processes.</p>	12/09/2011

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W0460	<p>Each client must receive a nourishing, well-balanced diet including modified and specially-prescribed diets.</p> <p>Based on observation, interview and record review, the facility failed to provide the appropriate quantity of food for 2 of 4 sampled clients (clients #1 and #3).</p> <p>Findings include:</p> <p>1. During observations on 11/01/2011 at 5:50 p.m. client #1 served herself 2 blue handled spoodles (kitchen utensil used for food portions) of chili, 2 large serving spoons of apple slices, 1 eight ounce glass of skim milk, and an eight ounce glass of water. Client #1 did not serve herself any cheese, crackers or cole slaw and refused substitutions of lettuce salad, green beans or celery offered by Direct Support Professional (DSP) #4.</p> <p>Client #1's record was reviewed on 11/03/2011 at 11:11 a.m.</p> <p>A "Quarterly Nutrition Review," dated 06/21/2011, indicated, "...Current Diet Order: ...No second helpings except non-starchy vegetables...."</p> <p>An undated, week 1 "Fall/Winter Menu" for low fat, low cholesterol, no</p>	W0460	<p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? All staff have been retrained on Dining Plans and procedures. Menu measurements and serving sizes were reviewed. <i>How will the facility identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</i> All residents diets and plans are reviewed. They routinely are reviewed after each dietician review, at minimum quarterly. Specific size measuring spoons (color coded) were purchased for the facility to facilitate more consistent portioning. Color coded reference indicated on serving utensil and posted on refridgerator. <i>What measures will be put into place or what systemic changes will the facility make to ensure the deficient practice does not recur? How will the corrective action be monitored to ensure the deficient practice will not recur and what quality assurance program will be put into place?</i> Team Leader and/or QMRP to observe meals routinely, at least weekly for 2 months. Meal observations to</p>	12/09/2011			

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	<p>concentrated sweets, was provided by the House Manager on 11/02/2011 at 2:19 p.m. and identified as current. The menu indicated, "...1c (cup) Chili, 1/4 c Ched (Cheddar) Cheese, 1 c LF (low fat) Cole Slaw, 6 Saltines, 1 tsp (teaspoon) Margarine, 1 Apple, 1 c Water, 1 c SK (skim) or 1/2 % milk..."</p> <p>During an interview on 11/04/2011 at 1:10 p.m., the House Manager stated she thought "the spoodle was 1 cup, but was not sure."</p> <p>An email message from the Residential Director, dated 11/07/2011 at 10:49 a.m., indicated the dietitian verified the blue handled spoodle was 8 ounces or 1 cup.</p> <p>2. During observations on 11/01/2011 at 5:50 p.m., DSP #9 served client #3 one blue handled spoodle of chili with cheese and 3 crackers crumbled into the chili, 2 large serving spoons of applesauce, 1 silver handled spoodle of low fat cole slaw, and 8 ounces of water in a cup with a "flip top" hard plastic straw. DSP #9 used a rocker knife to cut client #3's food into small bites. Client #3 used a toddler sized spoon to feed herself but took large bites and ate quickly. Client #3 grabbed a whole saltine cracker from the sleeve and shoved it into her mouth. DSP #9 moved the sleeve of crackers away from client</p>		include compliance with diet orders, consistency and portioning.		

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#3.	<p>Client #3's record was reviewed on 11/02/2011 at 12:34 p.m.</p> <p>A "Quarterly Nutrition Review," dated 06/21/2011, indicated, "...Current Diet Order: Mechanical soft diet with single servings...."</p> <p>An Interdisciplinary Team (IDT) note, dated 09/21/2011, indicated, "...Continue mechanical soft w/ (with) "ground meat" (SIC) thin liquids and single servings...."</p> <p>An undated, week 1 "Fall/Winter Menu" for mechanical soft diet, was provided by the House Manager on 11/02/2011 at 2:19 p.m. and identified as current. The menu indicated, "...1 c (cup) Chili, 1/4 c LF (low fat) Ched (Cheddar) Cheese, 1 c LF (low fat) Finely Shred (SIC) Cole Slaw, 6 Saltines-crushed in chili, 1 tsp (teaspoon) Margarine, 1 Apple, 1 c Water, 1 c SK (skim) or 1/2 % milk...."</p> <p>During an interview on 11/04/2011 at 1:10 p.m., the House Manager stated she thought "the spoodle was 1 cup, but was not sure."</p> <p>An email message from the Residential Director, dated 11/07/2011 at 10:49 a.m., indicated the dietitian verified the blue</p>			

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	<p>handled spoodle was 8 ounces or 1 cup.</p> <p>9-3-8(a)</p>				