

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155720	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 01/04/2012
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NAME OF PROVIDER OR SUPPLIER PROVIDENCE HOME HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 520 W 9TH ST JASPER, IN47546
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F0000	<p>This visit was for the Investigation of Complaints IN00101251 and IN00101744.</p> <p>This visit was in conjunction with the PSR (Post Survey Revisit) to the Recertification and State Licensure survey, completed on November 16, 2011.</p> <p>This visit was in conjunction with the PSR to Complaint IN00099205, completed on November 9, 2011.</p> <p>Complaint IN00101251-Substantiated, Federal/State deficiencies related to the allegations are cited at F282 and F363.</p> <p>Complaint IN00101744--Substantiated, Federal/State deficiencies related to the allegations are cited at F282, F312 and F363.</p> <p>Unrelated deficiencies cited at F 250.</p> <p>Survey dates: January 3 and 4, 2012</p> <p>Facility number: 000315 Provider number: 155720 AIM number: 100289030</p> <p>Survey team: Marla Potts, RN, TC</p>	F0000	<p>By submitting the enclosed material we are not admitting the truth or accuracy of any specific findings or allegations. We reserve the right to contest the findings or allegations as part of any proceedings and submit these responses pursuant to our regulatory obligations. The facility requests the plan of correction be considered our allegation of compliance effective January 30, 2012 to the state findings of the complaint survey conducted on January 3 and 4, 2012. The facility respectfully requests a desk review of the plan of correction.</p>	

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>Melinda Lewis, RN Sharon Whiteman, RN</p> <p>Census bed type: SNF/NF: 54 Total: 54</p> <p>Census payor type: Medicare: 1 Medicaid: 43 Other: 10 Total: 54</p> <p>Sample: 12</p> <p>These deficiencies also reflect state findings in accordance with 410 IAC 16.2.</p> <p>Quality review completed on January 6, 2012 by Bev Faulkner, RN</p>				
F0250 SS=D	The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.	F0250	The corrective action taken for	01/30/2012	

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	<p>Based on interview and record review, the facility failed to ensure interventions were implemented to manage behaviors rather using drugs or transporting to behavior units, for 1 of 2 residents reviewed for behaviors. Resident I</p> <p>Findings include:</p> <p>The clinical record for Resident I was reviewed on 1/4/12 at 10:00 A.M. The record indicated Resident I had a diagnoses that included but were not limited to diabetes, legally blind, and agitation/anxiety. The MDS [Minimum Data Set] assessment, dated 10/21/11, indicated Resident I had severely impaired cognition. Resident I had no behaviors. Resident I required limited assistance of one with bed mobility, transfers, ambulation, eating and toilet use.</p> <p>A Care plan, dated 10/26/11, indicated a problem of "Potential for confusion related to UTI's [urinary tract infections] has behaviors at risk for injury." The approaches were "1. offer snack. 2. Redirect to calm quiet area. 3. Offer activity read to him. 4. Offer shower. 5. Offer radio. 6. Walk with resident. 7. Offer radio. 6. Walk with resident. 7. Keep family MD notified. 8. Notify Dr (name). 9. Offer resident to walk if agitated. 10. If combative with CNA allow to calm."</p>		<p>those residents found to be affected by the deficient practice is that the resident identified as resident I has had a behavior plan developed and implemented to address the resident's behavior. The nursing staff has been inserviced on the behavior plan and understands that three or four interventions must be attempted. If the interventions are unsuccessful the facility will add additional interventions in an attempt to manage the resident's behaviors without the use of drugs or transfer to a behavior unit. The resident's physician will be notified for further direction/instruction after three or four interventions have been attempted and unsuccessful. The corrective action taken for the other residents having the potential to be affected by the same deficient practice is that all residents with behaviors have had their behavior plans reviewed and revised as needed. The measures or systemic changes that have been put in place to ensure that the deficient practice does not recur is that a mandatory inservice has been provided for all staff on the facility's behavior management care plans and the logs for behavior documentation. The staff was directed that three or four interventions on the individualized behavior plans must be attempted in an effort to manage the resident's behaviors.</p>				

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	<p>The Social Service Notes, dated 12/22/11, no time, indicated "Returned to facility (from behavior unit). I observed at 4:00 PM- calm. Agreed to a shower. Told me he needed to go to Louisville. explained it was a holiday. he said call mother that don't matter. Some confusion but calm."</p> <p>The Nurses Notes, dated 12/22/11 at 1600 (4:00 P.M.), indicated "CNAs toileting res [resident]. Unable to ambulate > (less than) 20 ft [feet] gait unsteady. Res became physically et [and] verbally abusive towards staff, swinging arms, punching, stating I will box you. Explained to res we were only trying to help states I don't care. Res assisted to w/c unable to stand with ii [two] assist. Leans forward in w/c not wanting to sit up straight. Remains disoriented, becoming more agitated et wanting to get up out of chair, attempts to ambulate gait very unsteady et res holding hand et talking to res. Unable to carry on meaningful conversation."</p> <p>The Social Service Notes, dated 12/22/11, no time, indicated "Back to facility. Received a call at 4:30. Resident very upset. Came to facility around 5:00 p.m. Had a shower. CNA was sitting with him. He would not go to the dining room but wanted to eat. She assisted ate 100% of</p>		<p>The staff was directed that if interventions fail that new interventions are to be added to the behavior plan in an effort to manage the residents' behavior without the use of drugs or transfer to a behavior unit. The resident's physician will be notified for further direction/instruction after all possible interventions have been attempted and unsuccessful. In addition the behavior logs will be reviewed daily by social service director and/or designee. The corrective action taken to monitor to assure performance to assure compliance through quality assurance is a Quality Assurance tool has been developed and implemented to ensure that all residents with behaviors have an appropriate behavior plan. The tool will monitor the effectiveness of behavior plans. The tool will review the documentation to ensure that all appropriate interventions have been attempted when behaviors occur. The tool will monitor the behavior plan to ensure that additional interventions have been added when existing interventions have been found to be unsuccessful. The tool will also monitor the documentation to ensure that the physician has been notified if additional direction/instruction is needed. This tool will be completed by Social Service Director and/or designee weekly</p>		

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	<p>his meal. When I left facility at 6:00 calm."</p> <p>The Nurses Notes, dated 12/22/11 at 1730 (5:30 P.M.), indicated "Rec'd [received] call from from (sic) (name) RN coordinator of behavioral health unit at (name). She states Dr (name) thinks behaviors are d/t [due to] transition of return et [and] does not want to give any more meds to res. Nurse stated she had taken care of res in hosp [hospital] et she would be in facility to assess res et educate staff. Dr (name) to review res in 2 days. Res remains restless et anxious sitting in chair in lounge at nurses station."</p> <p>The Nurses Notes, dated 12/22/11 at 2100 (9:00 P.M.), indicated "...Res resting quietly in bed at this x [time]..."</p> <p>The Nurses Notes, dated 12/23/11 at 0545 (5:45 A.M.), indicated "...Resident rested well thru night..."</p> <p>The Social Service Notes, dated 12/23/11, no time, indicated "Resident remained calm through the night. Did report to Behavior unit on 12-22-11 concerns (name) here to assess today. Resident resting quietly in chair in the lobby. She informed nursing to call if there were any change."</p>		<p>for four weeks, then monthly for three months and then quarterly for three quarters. The outcome of the tool will be reviewed at the Quality Assurance meeting to determine if additional action is warranted.</p>		

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	<p>The Nurses Notes, dated 12/23/11 at 2100 (9:00 P.M.), indicated "No behaviors this shift."</p> <p>The Nurses Notes, dated 12/24/11 at 1200 (12:00 P.M.), indicated "...Res has been cooperative with care this day so far. Had one episode of agitation while at breakfast but easily redirected...No behavior problems."</p> <p>The Nurses Notes, dated 12/25/11 at 1910 (7:10 P.M.), indicated "Assisted to shower with ii [two] assist et w/c. Resistive while transferring to shower. Threatening to "p--" on CNAs. Also threatening to et attempting to throw self into floor. Cursing at staff. Once transferred to shower chair res with only verbal comments to CNAs. HS [hour of sleep] meds [medications] given at 1900 (7:00 P.M.) threatened to "spit them out" but did take meds et drink water."</p> <p>The Nurses Notes, dated 12/26/11 at 1030 (10:30 A.M.), indicated "...He is anxious at times he keeps trying to get up from chair..."</p> <p>The Social Service Notes, dated 12/26/11, no time, indicated "Phoned (behavior unit name) to speak to (name). Will return call. Noted resident had threatening comments</p>				

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	<p>"Will urinate on them while in the shower and required redirection. Continue to monitor."</p> <p>The Nurses Notes, dated 12/26/11 at 1735 (5:35 P.M.), indicated "Resident in d/r [dining room]. CNAs tried to get resident up to take to lobby. Res pushed back et became agitated. Rs started yelling at CNA them when CNA stated res's name (Name) res stated he was not (name). CNA asked res who he was et res stated she did not want to find out then told CNA he was going to stab her."</p> <p>The Nurses Notes, dated 12/26/11 at 1820 (6:20 P.M.), indicated "Res in lobby in recliner. Res leaning forward et trying to get up several times CNA sat 1 on 1 with resident to provide safety. Res told CNA he was going to shoot her. Res then taken to shower room et given a shower. During shower res very agitated et combative. Res offered to go to bed et he agreed that would be good."</p> <p>The Nurses Notes, dated 12/27/11 at 1821 (6:21 P.M.), indicated "Res in shower room with CNA and got agitated and aggressive and punched CNA x [times] 2 in face. CNA called for assist. ii CNA moved res to his room and was attempting to hit and kick CNAs. Got res in bed. Will monitor."</p>				

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	<p>The Nurses Notes, dated 12/27/11 at 1842 (6:42 P.M.), indicated "Called DON [Director of Nursing] (name) about above incidents and was directed to call (Social Services Director name) for further instructions."</p> <p>The Nurses Notes, dated 12/27/11 at 1901 (7:01 P.M.), indicated "Placed call to (behavior unit) line who stated they would call back with info for possible transfer if bed available. Res very combative/agitated at this time. Very difficult to redirect. Offered snack/drink res refused. Restroom/urinal offered."</p> <p>The Nurses Notes, dated 12/27/11 at 2045 (8:45 P.M.), indicated "(Behavior unit) called back spoke with (name) who informed this nurse no beds were available at this time and she would notify. Dr (name) in the morning about possible bed. Instructed to call Dr (name) to obtain PRN [as needed] dose of med."</p> <p>The Nurses Notes, dated 12/27/11 at 2108 (9:08 P.M.), indicated "Called Dr (name) who gave a one time order for Klonopin 1 mg PO [by mouth] to be given now."</p> <p>The Nurses Notes, dated 12/27/11 at 2110 (9:10 P.M.), indicated "Res combative with staff trying to change linen from</p>			

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	<p>incontinent episode. Klonopin 1 mg po dose given. Roommate very upset at this time and res said shut up. Able to get res calmed down and in bed covers."</p> <p>The Nurses Notes, dated 12/27/11 at 2143 (9:43 P.M.), indicated "Res still attempting to get up and verbal cussing at staff. Able to redirect."</p> <p>The Nurses Notes, dated 12/28/11 at 1600 (4:00 P.M.), indicated "Resident getting very agitated, setting off alarms. Attempted to redirect with snack or drink, until or depends changed. Attempted to get up more times. CNA was kicked x [times] 3 and swinging at staff."</p> <p>The Nurses Notes, dated 12/28/11 at 1636 (4:36 P.M.), indicated "paged Dr (name) who returned call immediately. Explained behaviors and ordered increase Risperdal to 2 mg. BID [two times daily] and give extra dose of Klonopin with dose of 2 mg now."</p> <p>The Nurses Notes, dated 12/28/11 at 1640 (4:40 P.M.), Meds given Res spit meds out..."</p> <p>The Nurses Notes, dated 12/28/11 at 1651 (4:51 P.M.), indicated "Paged Dr (name) again with return called back. Requested another order. Order given for 5 mg IM</p>				

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	<p>Haldol now."</p> <p>The Nurses Notes, dated 12/28/11 at 1700 (5:00 P.M.), indicated "Gave IM Haldol at this time. Required 3 CNAs to assist. CNA sitting with resident talking."</p> <p>The Nurses Notes, dated 12/28/11 at 1900 (7:00 P.M.), indicated "Res starting to be calmer. No yelling or aggressive behavior noted."</p> <p>The Nurses Notes, dated 12/29/11 at 0530 (5:30 A.M.), indicated "...Cooperative with care..."</p> <p>The Nurses Notes, dated 12/29/11 at 0700 (7:00 A.M.), indicated "Spoke to Dr (name) regarding rsd [resident] agitation et restlessness. Order received to send to (behavior unit name) r/t [related to] behaviors..."</p> <p>The Social Service Notes, dated 12/29/11, no time, indicated "Resident has continued to have behaviors. (Behavior unit name) has no beds available. Waiting to see if Dr (name) will accept."</p> <p>The Social Service Notes, dated 12/29/11, no time, indicated "(Nurse name) has sought other units per mother's permission. Dr (name) here said he would assist as needed. At noon (Behavior unit</p>				

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	<p>name) phoned with available bed spoke with mother. She said (hospital name) was very kind on the phone but (behavior unit name) was familiar with him. Permission given for a direct admit. Was admitted to (behavior unit name)."</p> <p>On 1/04/12 at 10:00 A.M., in an interview with the Social Services Director she indicated she was off when resident was sent to behavior unit on 12/29/11. She stated Resident I had a behavior plan but when she got the behavior book out there was no plan for Resident I. She did provide a care plan with interventions. She further indicated she was not sure who was reviewing the behaviors while she was off.</p> <p>3.1-34(a)</p>				

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F0282 SS=D	<p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>Based on observation, interview and record review, the facility failed to follow the physician orders regarding diet orders for 1 of 12 residents reviewed for following the plan of care, in the sample of 12. Resident A</p> <p>Findings include:</p> <p>1. Resident A was observed on 1/03/12 at 12:15 P.M., in the upstairs dining room with his lunch tray. The resident was</p>	F0282	<p>The corrective action taken for those residents found to be affected by the deficient practice is that the resident identified as resident A is now receiving his meals in accordance with the established menu and physician ordered diet. The corrective action taken for those residents having the potential to be affected by the same deficient practice is that all residents have the potential to be affected by the deficient practice. All residents' diets have been reviewed with a special focus on individualized</p>	01/30/2012

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	<p>served vegetable lasagna, fruit, lima beans, and 3 drinks. None of which were milk. His tray card indicated no milk products. The menu indicated fruit with cottage cheese, sherbet and 1 cup milk. During interview with Cook #1, on 1/3/12 at 12:30 P.M. she indicated the protein needs were met by the milk and cottage cheese.</p> <p>On 1/04/12 at 12:00 P.M., the resident was observed to receive spaghetti and 3 meat balls on his tray, pears, and 3 drinks-water, applesauce, bread, and salad. The menu indicated the resident should have received 3 ounces of meatballs. The cook weighed out the meatballs and indicated 5 meatballs would equal 3 ounces.</p> <p>Resident A's clinical record was reviewed on 1/04/12 at 10:00 A.M. Diagnoses included, but were not limited to Cerebral palsy and Mental Retardation. A Telephone Physician order, dated 12/12/11 indicated an order for " Change diet to Regular, Double meats, no milk products, chicken must be deboned."</p> <p>This federal tag is related to Complaints IN00101251 and IN00101744.</p> <p>3.1-35(g)(2)</p>		<p>dietary orders. All residents are now receiving their meals in accordance with established menu and their individualized diet orders. The measures or systematic changes put in place to ensure the deficient practice does not recur is that the facility has conducted a mandatory inservice for all dietary staff to ensure that established menus are followed in accordance with each residents's dietary orders. The staff has been instructed to follow each menu in accordance with the spreadsheet and the resident's individualized diet order. The corrective action taken to monitor to assure performance to assure compliance through quality assurance is that a Quality Assurance tool has been developed and implemented to monitor the resident's meal service to ensure that the spreadsheets are being followed and in accordance with each resident's individualized diet order. This tool will be completed by the Dietary Manager and/or his designee weekly for four weeks, then monthly for three months and then quarterly for three quarters. The outcome of this tool will be reviewed at the Quarterly Assurance meeting to determine if additional action is warranted.</p>		

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F0312 SS=D	<p>A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.</p> <p>Based on interview, record review and observation, the facility failed to ensure a dependant for care resident's teeth were brushed daily for 1 of 5 residents reviewed for oral care in the sample of 12. Resident A</p> <p>Finding include:</p> <p>Resident A was observed on 1/03/12 at 12:00 noon in the upstairs dining room. His teeth were observed to have a build up of yellow scum all over them. On 1/04/11 at 8:55 A.M. Resident A was observed in the hallway. His teeth were observed to have a yellow scum type substance over them and appeared as not having been brushed.</p> <p>Resident A's clinical record was reviewed on 1/04/12 at 10:00 A.M. Diagnoses included, but were not limited to Cerebral Palsy and Mental Retardation. A dental assessment, dated 6/17/11, indicated the</p>	F0312	<p>The corrective action taken for those residents found to be affected by the deficient practice is that the resident identified as resident A has been reassessed related to his oral care needs and is now receiving oral care daily in accordance with the plan of care. The corrective action taken for the other residents having the potential to be affected by the same deficient practice is that all dependent for care residents were reviewed related to their oral care needs. Each dependent for care resident is now receiving oral care in accordance with their plan of care. The measures or systematic changes that have been put in place to ensure that the deficient practice does not recur is that the facility conducted a mandatory inservice for all nursing staff on the importance of good oral care. The staff was directed that all residents are to receive oral care in accordance with their plan of care. In addition the staff was instructed that any problems identified in providing</p>	01/30/2012	

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	<p>resident had no bleeding when his teeth were brushed, no pain while brushing teeth and no complaints of mouth pain. The most recent Minimum Data Set, dated 12/7/11, indicated the resident was dependant for personal hygiene on one staff member.</p> <p>The care plan included a problem, dated 3/17/11, for "at risk for tooth loss related to needing supervision and assist to maintain adequate oral hygiene" interventions included: supervise and assist as needed to provide adequate oral care.</p> <p>The care plan meeting notes, dated 12/9/11, included" (responsible family member) wants teeth brushed twice daily..."</p> <p>The Activities of Daily Living sheets, dated January 1st through the 3rd, and for December 2011 indicated oral care had been completed with assist, two times daily.</p> <p>During interview with CNA#1 on 1/4/12 at 9:20 A.M., she indicated she had not provided oral care to the resident as her and CNA #2 had gotten him up that a.m. She showed a bag with a dry toothbrush inside. The bag was dated 11/11. There was a new tube of toothpaste inside the</p>		<p>oral care in accordance with the resident's plan of care is to be reported to their charge nurse for further direction/instruction. The corrective action taken to monitor to assure performance to assure compliance through quality assurance is that a Quality Assurance tool has been developed and implemented to monitor dependent residents' oral care. The tool will make random observations of the residents' teeth to validate that oral care has been provided. This tool will be completed by the Director of Nursing and/or designee weekly for four weeks, then monthly for three months and then quarterly for three quarters. The outcome of this tool will be reviewed at the Quality Assurance meeting to determine if additional action is warranted.</p>				

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F0363 SS=F	<p>resident's drawer. CNA #2 during interview on 1/04/12 at 9:40 A.M., indicated she had only used a toothette, and had never brushed his teeth while providing care. She indicated she was afraid this would set the resident off and cause behavior issues. She indicated she had not reported this to a nurse.</p> <p>This federal tag is related to Complaint IN00101744.</p> <p>3.1-38(a)(3)(C)</p> <p>Menus must meet the nutritional needs of residents in accordance with the recommended dietary allowances of the Food and Nutrition Board of the National Research Council, National Academy of Sciences; be prepared in advance; and be followed. Based on interview, observation and record review, the facility failed to ensure the menu was followed regarding serving of sherbet for 52 of 54 facility residents with menued sherbet and failed to ensure the protein needs were met 1 of 5 residents reviewed for meals served, in the sample of 12. Resident A.</p> <p>Findings include:</p>	F0363	The corrective action taken for those residents found to be affected by the deficient practice is that the resident identified as resident A is now receiving his meals in accordance with the established menu and his physician ordered diet. The corrective action taken for the other residents having the potential to be affected by the same deficient practice is that all residents have the potential to be affected by the deficient practice.	01/30/2012	

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	<p>1. Resident A was observed on 1/03/12 at 12:15 P.M., in the upstairs dining room with his lunch tray. The resident was served vegetable lasagna, fruit, lima beans, and 3 drinks-tea, kool-aid and fruit juice. His tray card indicated no milk products. The menu indicated the resident should have received lasagna, fruit with cottage cheese, sherbet and 1 cup milk. During interview with Cook #1, on 1/03/12 at 12:45 P.M., she indicated the protein needs were met by the milk and cottage cheese. No resident was observed at lunch time on 1/03/12 to have received the menued sherbet.</p> <p>On 1/04/12 at 12:00 P.M., the resident was observed to receive spaghetti and meat balls (3) on his tray, pears, and 3 drinks-water, applesauce and koolaid, bread, and salad. The menu indicated the resident should have received 3 ounces of meatballs, and 1 cup of milk. The cook weighed out the meatballs and indicated 5 meatballs would equal 3 ounces.</p> <p>Resident A's clinical record was reviewed on 1/04/12 at 10:00 A.M. Diagnoses included, but were not limited to Cerebral palsy and Mental Retardation. A Telephone Physician order, dated 12/12/11, indicated an order for " Change diet to Regular, Double meats, no milk</p>		<p>All residents' diets have been reviewed with a special focus on individualized dietary orders. All residents are now receiving their meals in accordance with the established menu with a special focus on protein needs and their individualized diet orders. The measures or systematic changes that have been put in place to ensure the deficient practice does not recur is that the facility has conducted a mandatory inservice for all dietary staff to ensure that the established menus are followed in accordance with each residents' dietary orders. The staff has been directed to follow each menu in accordance with the spreadsheet and the resident's individual diet order to ensure that the resident's dietary needs are being met. The corrective action taken to monitor to assure performance to assure compliance through quality assurance is that a Quality Assurance tool has been developed and implemented to monitor the resident's meal service to ensure that the spreadsheets are being followed and in accordance with each resident's individualized diet order. The tool will also monitor to ensure that all items and portions listed on the spreadsheet are served to the resident. This tool will be completed by the Dietary Manager and/or his designee weekly for four weeks, then monthly for three months</p>	

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	<p>products, chicken must be deboned."</p> <p>During interview with the Cook #2, on 1/04/12 at 12:45 A.M., she indicated the residents were not served sherbet on 1/03/12 because the cooks must have thought the cottage cheese and fruit was the dessert. She indicated it was just missed. She further indicated milk was served at breakfast and supper at the facility. She indicated she did not realize it was menued for lunch. Cook #2 indicated Resident A should have received 10 meatballs for the double portion of meat.</p> <p>During interview on 1/04/12 at 1:00 P.M., with the Dietary Manager, he indicated Resident A should have received peanut butter on 1/03/12 to replace the protein he was not provided with the cottage cheese. He further indicated the cooks had just not followed the menu.</p> <p>This federal tag is related to Complaint IN00101251 and IN00101744.</p> <p>3.1-20(i)(4)</p>		and then quarterly for three quarters. The outcome of the tool will be reviewed at the Quality Assurance meeting to determine if further action is warranted.		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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