

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155494	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 07/23/2012
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NAME OF PROVIDER OR SUPPLIER WATERS OF SCOTTSBURG II LLC THE	STREET ADDRESS, CITY, STATE, ZIP CODE 1350 N TODD DR SCOTTSBURG, IN 47170
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F0000	<p>This visit was for Investigation of Complaint IN00112582.</p> <p>Complaint IN00112582 - Substantiated. No deficiencies related to the allegations are cited.</p> <p>Unrelated deficiencies are cited.</p> <p>Survey dates: 7/18, 7/19, 7/20, and 7/23/12</p> <p>Facility number: 000478 Provider number: 155494 AIM number: 100290430</p> <p>Survey team: Jennie Bartelt, RN</p> <p>Census bed type: SNF/NF: 67 Total: 67</p> <p>Census payor type: Medicare: 1 Medicaid: 61 Other: 5 Total: 67</p> <p>Sample: 25</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p>	F0000	<p>Preparation and or execution of this plan of correction in general, or this corrective action in particular, does not constitute an admission or agreement by this facility of the facts alleged or conclusion set forth in this statement of deficiencies. The plan of correction and specific corrective actions are prepared and/or executed in compliance with state and Federal laws. We respectfully request that a desk review with paper compliance be completed.</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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	Quality review completed on July 27, 2012 by Bev Faulkner, RN			

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F0246 SS=E	<p>483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered.</p> <p>Based on observation and interview, the facility failed to ensure the needs of residents who smoked were accommodated during hot weather. The deficient practice affected 7 of 7 residents from a sample of 25 during 1 of 2 smoking sessions observed. (Residents J, K, L, N, O, P, and Q)</p> <p>Findings include:</p> <p>During Initial Tour conducted with the Medical Records Supervisor on 7/18/12 at 10:50 a.m. through 11:35 a.m., the residents' smoke shed was observed. The shed was a metal building with screened windows and an unscreened open double door with steep wooden ramp without hand rails leading to the door. The sun was shining in at the edge of the door, and the interior felt very warm. No fan was observed in the shed. House flies were observed buzzing around in the shed, and no insect control devices were present. A horse fly and yellow jacket were observed between the window</p>	F0246	<p>F 246 Reasonable accommodation of needs/preferences It is the intent of this facility to ensure the needs of residents who smoke are accommodated resident during hot weather. 1. Action Taken: In regards to all residents who smoke the following interventions will be implemented: a) The smoking shelter exit ramp will be inspected to validate the exit path is compliant with regulations related to slope/grade and need for handrails. Modifications will be made if needed for compliance. b) The pest company has been consulted regarding flying insects and insect control devices. c) Battery operated fans have been purchased and utilized in the smoking shelter. 2. Others identified: a) All residents who smoke are at risk. 3. Measures Taken: a) Staff in-serviced on signs and symptoms of heat induced illness on 7/18/12 by the Director of Nursing. b) All residents who smoke were interviewed and educated on risks of wearing heavy clothing and going outside</p>	08/21/2012			

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	<p>screen and raised window. A pitcher of water without ice, and Styrofoam cups, were on a table. During interview, the Medical Records Supervisor indicated the shed was new since a revised smoking policy had been implemented recently. She indicated the residents smoked in two shifts at scheduled times. She also indicated the Activities Director was on vacation, and CNA #17 was filling in for the Activities Director. No residents were present at the time of the observation.</p> <p>On 7/18/12 at 1:10 p.m., the Medical Records Director indicated she was getting fresh water for the smokers, and would be helping CNA #17 with supervision of smoking, since this was CNA #17's first time to supervise smoking.</p> <p>Observations were as follows for the smoking session on 7/18/12 from 1:15 to 1:45 p.m. smoke time: At 1:30 p.m., the first group of residents was observed coming into the building. As he entered, Resident J indicated, "It was hot." The resident was wearing a hat, sweat shirt, and sweat pants. The Medical Records Director indicated, "He always wears a hat," and proceeded to the smoke shed. When the second group of residents arrived in the smoke shed, the temperature measured 97.7 degrees</p>		<p>in extreme weather conditions c) Smoking times will be limited to 1 cigarette per residents who smoke per smoke break during times of extreme weather conditions. d) Staff assigned to monitor residents who smoke will report flying insect problems to their supervisor. 4. How Monitored: a) Director of Maintenance / Designee will inspect the smoking shelter and exit path on monthly basis and report findings to the Quality Assurance Team at the monthly meeting. Findings will be reviewed with Medical Director at the quarterly Quality Assurance meeting. 5. This Plan of Correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is August 21, 2012. Addendum a) A thermometer has been placed in the smoking shelter. b) The Director of Maintenance/Designee will check the temperature five days a week. c) This will be an on-going process.</p>				

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	<p>Fahrenheit (F). No fan was in the shed or the windows. Resident K arrived wearing a long sleeved shirt, long pants, and a woolen hat with ear flaps. Resident P was also wearing long pants and a hat. The temperature measurement rose to 98.5 degrees F. Resident L was wearing long sweat pants and short sleeves, and Resident N wore long jeans and short sleeves. The Administrator arrived to request the Medical Records Director meet with a family. The temperature measured 99.1 degrees F. CNA #3 had arrived and indicated, "I bet you're roasting." Resident O indicated, "We did have a fan - and we have no light for night." A late arrival, Resident Q was rolled out in a wheel chair and was wearing a long sleeved flannel dress. She was breathing in through her nose and out through her mouth. She was assisted to don a smoking apron. She was not offered water. Resident O indicated, "We're getting the bees back," referring to insects in the shed. Residents wiped sweat from their faces. The Medical Records Supervisor arrived back at the shed and offered Resident Q water. At 1:45 p.m., residents were assisted back into the facility.</p> <p>During the Exit Conference on 7/23/12 at 6:15 p.m., the Regional Vice President indicated the smoking policy is new to the</p>			

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	<p>facility, and the facility is just adjusting to it. At this same time, in regard to insects in the shed, the Administrator indicated, "It's an outdoor area."</p> <p>3.1-3(v)(1)</p>			

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F0312 SS=E	<p>483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS</p> <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 observation, record review, and interview, the facility failed to ensure effective incontinence care was provided as needed for 4 of 4 residents reviewed related to maintaining personal hygiene in a sample of 25. (Residents B, D, I, and H)</p> <p>Findings include:</p> <p>1. On 7/19/12 at 3:30, Resident B was in her low bed lying on her side. A strong odor of urine was in the room. The resident's bed covers were pulled to the side, and she was wearing a brief. Visible on the bed pad under the resident's hips were yellow-brown rings of stains.</p> <p>On 7/19/12 at 4:05 p.m., the Restorative Aide and CNA #21 were observed assisting Resident B to dress. LPN #16 had also entered the room and indicated Resident B had been incontinent of diarrhea stool.</p> <p>The clinical record for Resident B was reviewed on 7/23/12 at 3:40 p.m. The Care Plan, originally dated 6/6/11,</p>	F0312	<p>F 312 It is the intent of this facility to provide effective incontinence care to residents per the plan of care to maintain personal hygiene.</p> <p>1. Action Taken:</p> <p>a. In regards to residents identified and all other residents: A head to toe skin assessment has been completed to determine any skin issues that would be related to incontinence. There were no skin issues identified.</p> <p>b. All rooms have been inspected for urine odors. Any issues noted have been addressed.</p> <p>2. Others Identified:</p> <p>a. All incontinent residents would be at risk.</p> <p>3. Measures Taken:</p> <p>a. Nursing staff has been in-serviced by the Director of Nursing/Designee via a read and sign educational page utilizing a return demonstration to validate learning; covering the proper way and times to perform/provide complete incontinence care.</p> <p>b. The facility leadership team has been in-serviced by the administrator to include visual</p>	08/21/2012			

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	<p>indicated a problem of "I have a history /dx [diagnosis] of bladder incontinence...." Interventions included, but were not limited to, "...Approach me at least every two hours and check me for evidence of incontinence....Provide pericare every shift and as needed...."</p> <p>2. On 7/23/12 at 12:45 p.m., residents were seated in the Dining/Activity Room after lunch. CNA #3 and CNA #19 came from a resident's room and, during interview, indicated they were assisting residents to bed if they wished to rest after lunch. At this time, Resident D was in the dining room and indicated he wanted to lie down, stating, "This wheel chair is killing me."</p> <p>On 7/23/12 at 12:50 p.m., CNA #3 rolled Resident I into his room, and CNA #19 entered to assist CNA #3. As the resident was transferred from wheel chair to bed, the back of his sweat pants were observed to be wet at the brief line on both pant legs. The CNAs did not check to ensure the resident was clean and dry but proceeded to position the resident in bed, place the bed covers, turn on the television, wash their hands, and leave the room.</p> <p>The clinical record for Resident I was reviewed on 7/23/12 at 5:35 p.m.</p>		<p>observation of residents with a focus on resident clothing being clean and dry during daily rounds thru the facility.</p> <p>4. How Monitored:</p> <p>a. Department leaders will observe residents for clean and dry clothing during daily rounds and report any issues noted to the DON and Charge Nurse. Results of daily rounds will be reviewed/reported to the Interdisciplinary Team during the morning meeting.</p> <p>b. The DON/Designee will randomly observe three C.N.A's a day, five days a week, and observe incontinent care. This is to validate proficiency in regards to appropriate incontinent care provided and appropriate procedures followed. These proficiencies will continue for the next 8 weeks; then one CNA weekly on each shift for four weeks; then each CNA will be required to perform a proficiency quarterly. The results will be reported to the Quality Assurance Committee at the monthly meeting. The findings will be reviewed/discussed with the Medical Director at the quarterly Quality Assurance Meeting.</p> <p>5. This plan of correction is our credible allegation of compliance with all regulatory requirements. Our date of compliance is August 21, 2012.</p>				

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	<p>The quarterly Minimum Data Set assessment, dated 6/26/12, indicated the resident was always incontinent of bowel and bladder.</p> <p>The Care Plan, originally dated 4/21/12, and most recently updated 6/26/12, indicated the problem: "I have history/dx [diagnosis] of: bladder incontinence R/T [related to] dementia..." Interventions included, but were not limited to, "...Approach me at least every two hours and check me for evidence of incontinence. Provide pericare every shift and as needed...."</p> <p>2. On 7/23/12 at 12:55 p.m., Resident D was in his room, and CNA #3 and CNA #19 entered and rolled his wheel chair next to his bed. CNA #19 indicated to CNA #3 that a wet wash cloth was needed - "he told me he went [had a bowel movement] - didn't you [to the resident]." The resident was transferred from wheel chair to bed, and the pants and brief were removed. The brief contained stool, and the anal area was cleansed of light brown stool, and a fresh brief was applied. The hips, penis, and abdominal area were not cleansed.</p> <p>The clinical record for Resident D was reviewed on 7/23/12 at 5:00 p.m.</p>			

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	<p>The quarterly Minimum Data Set assessment, dated 4/27/12, indicated the resident was frequently incontinent of bowel and bladder.</p> <p>The Careplan Worksheet for Urinary Incontinence indicated, "Provide pericare every shift and as needed."</p> <p>During interview on 7/23/12 at 4:00 p.m., CNAs #3 and #19 indicated Residents D and I had finished napping but did not want to get up for supper. The CNAs were rolling the linen and trash barrels down the hall and indicated they had just now checked and changed the two residents.</p> <p>3. On 7/23/12 at 2:30 p.m., Resident H was observed from the hallway, seated in his room in his wheel chair. He did not respond to a knock on the door. The resident's head was drooped down to his chest, and his respirations were snoring. A strong urine odor was evident around the resident. The front of the resident's sweat pants between his legs had a large wet stain, and a puddle was observed under the resident's wheel chair.</p> <p>On 7/23/12 at 3:15 p.m., Resident H was observed from the hallway, seated in his room with his wheel chair moved closer</p>						

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	<p>to the bed. The puddle remained where the wheel chair was previously placed. The urine odor remained, and the resident was wearing the same sweat pants, but the wet stain on the front between his legs was less visible.</p> <p>On 7/23/12 at 4:30 p.m., Resident H was observed in the hallway wearing different clothing. During interview at this time, CNA #15 indicated she had just changed the resident.</p> <p>The clinical record for Resident H was reviewed on 7/23/12 at 5:25 p.m.</p> <p>The quarterly Minimum Data Set assessment, dated 4/27/12, indicated the resident was frequently incontinent of bladder and required the extensive assistance of two for toileting and dressing.</p> <p>A Care Plan originally dated 6/2/11, and most recently updated 4/27/12, indicated, "I require assistance for toileting." Approaches included, but were not limited to, "Assist me with adjusting my clothing...Give me verbal cues to help prompt me..." Another Care Plan, with the same dates, indicated, "I am sometimes incontinent of urine." Approaches included, but were not limited to, "Initiate scheduled toileting</p>						

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	<p>plan....Provide me incontinent pads...Assist me to the bathroom or commode as needed, and assist me with perineal cleansing as needed."</p> <p>3.1-38(a)(3)(A)</p>			

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F0315 SS=D	<p>483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER</p> <p>Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.</p> <p>Based on observation, interview, and record review, the facility failed to ensure residents received toileting as planned to restore bladder function for 2 of 2 residents reviewed related to restoration of continence in a sample of 25. (Residents H and D)</p> <p>Findings include:</p> <p>1. On 7/23/12 at 2:30 p.m., Resident H was observed from the hallway, seated in his room in his wheel chair. He did not respond to a knock on the door. The resident's head was drooped down to his chest, and his respirations were snoring. A strong urine odor was evident around the resident. The front of the resident's sweat pants between his legs had a large wet stain, and a puddle was observed under the resident's wheel chair.</p>	F0315	<p>F 315 No Catheter, Prevent UTI, Restore Bladder</p> <p>It is the intent of this facility to provide toileting as planned to restore bladder function.</p> <p>1. Action Taken a. A continence/incontinence assessment has been completed on all residents including the two residents identified to determine the appropriate toileting schedule and/or program for each resident. The CNA pocket worksheets were updated to reflect the continence/incontinence assessments.</p> <p>2. Others Identified: a. All incontinent residents would be at risk.</p> <p>3. Measures Taken: a. The nursing staff has been in-serviced by the Director of</p>	08/21/2012	

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	<p>On 7/23/12 at 3:15 p.m., Resident H was observed from the hallway, seated in his room with his wheel chair moved closer to the bed. The puddle remained where the wheel chair was previously placed. The urine odor remained, and the resident was wearing the same sweat pants, but the wet stain on the front between his legs was less visible.</p> <p>On 7/23/12 at 4:30 p.m., Resident H was observed in the hallway wearing different clothing. During interview at this time, CNA #15 indicated she had just changed the resident. CNA #15 also indicated the resident is not routinely toileted, but if he desires to use the toilet, he is assisted for toileting.</p> <p>The clinical record for Resident H was reviewed on 7/23/12 at 5:25 p.m.</p> <p>The quarterly Minimum Data Set assessment, dated 4/27/12, indicated the resident was frequently incontinent of bladder, required the extensive assistance of two for toileting, and was on a toileting program.</p> <p>The Scheduled Toileting Program, originally dated 1/23/12, and most recently updated 4/27/12, indicated, "The resident requires cues, reminders and/or assistance to use the toilet." Approaches</p>		<p>Nursing/Designee via a read and sign educational page utilizing a return demonstration to validate learning covering the proper way and times to perform complete incontinence care.</p> <p>b. The facility leadership team has been in-serviced by the administrator to include visual observation of residents with a focus on resident clothing being clean/dry during daily rounds through the facility.</p> <p>4. How Monitored:</p> <p>a. Department leaders will observe residents for clean/dry clothing during rounds and report any issues noted to the DON and Charge Nurse. Results of daily rounds will be reported to the Interdisciplinary Team during the morning meeting.</p> <p>b. The DON/Designee will randomly observe three CNA's a day to observe incontinent care validating appropriate procedures for the next 8 weeks. The results will be reported/reviewed by the Quality Assurance Committee at the monthly meeting. The findings will be reviewed/discussed with the Medical Director at the quarterly Quality Assurance Meeting.</p> <p>5. This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is August 21, 2012.</p>		

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	<p>and interventions included, but were not limited to, "Cue, remind and assist to toilet/bed pan upon rising, before and after meals, before bed, and as needed."</p> <p>The Nursing Assistant Pocket Worksheet, provided by the Administrator on 7/18/12 at the end of the Initial Tour at 11:35 a.m., indicated Resident H was on an every two hour toileting schedule.</p> <p>2. On 7/23/12 at 12:55 p.m., Resident D was in his room, and CNA #3 and CNA #19 entered and rolled his wheel chair next to his bed. CNA #19 indicated to CNA #3 that a wet wash cloth was needed - "he told me he went [had a bowel movement] - didn't you [to the resident]." The resident was transferred from wheel chair to bed, and the pants and brief were removed. The brief contained stool, and the anal area was cleansed of light brown stool, and a fresh brief was applied. The hips, penis, and abdominal area were not cleansed. Toileting was not offered to the resident.</p> <p>The clinical record for Resident D was reviewed on 7/23/12 at 5:00 p.m.</p> <p>The quarterly Minimum Data Set assessment, dated 4/27/12, indicated the resident was frequently incontinent of bowel and bladder, required total</p>			

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	<p>assistance of two for toileting, and was on a toileting program.</p> <p>The Scheduled Toileting Program, originally dated 1/23/12, and most recently updated 4/27/12, indicated, "The resident requires cues, reminders and/or assistance to use the toilet. " Approaches and interventions included, but were not limited to, "Cue, remind and assist to toilet/bed pan upon rising, before and after meals, before bed, and as needed."</p> <p>The Nursing Assistant Pocket Worksheet, provided by the Administrator on 7/18/12 at the end of the Initial Tour at 11:35 a.m., indicated Resident D was on an every two hour toileting schedule.</p> <p>During interview on 7/23/12 at 4:00 p.m., CNAs #3 and #19 indicated Resident D had finished napping but did not want to get up for supper. The CNAs were rolling the linen and trash barrels down the hall and indicated they had just now checked and changed Resident D.</p> <p>3.1-41(a)(2)</p>			

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F0323 SS=D	<p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>Based on observation, record review, and interview, the facility failed to ensure effective interventions and supervision were in place to prevent a resident at risk for falls from rising and ambulating unassisted. The deficient practice affected 1 of 1 resident reviewed related to falls in a sample of 25. (Resident A) The facility also failed to ensure use of a gait belt for safe transfer for 2 of 3 residents observed during transfer in a sample of 25. (Residents D and U)</p> <p>Findings include:</p> <p>1. On 7/23/12 at 4:35 p.m., Resident A was observed seated in his wheel chair between the central nurse's station and the door leading to the fenced yard. The resident was wearing a sling on the left arm. The resident indicated several times, "I have to wet. All I have to do is wet." The resident arose from his chair and ambulated several steps toward a near-by doorway, indicating, "I have to wet." The Maintenance Supervisor came around the corner and went to the</p>	F0323	<p>F 323 Free of Accidents Hazards/Supervision/Devices It is the intent of this facility to provide effective interventions and supervision to prevent a resident at risk for falls from rising and ambulating unassisted; and to utilize gait belts during resident transfers. 1. Action Taken: a. Resident A has been re-assessed for fall prevention and the clip alarm has been replaced with a sensor pad alarm. b. The identity of Residents D and U could not be determined 2. Others Identified: a. All residents at risk for falls or requiring a gait belt for transfer would be at risk. 3. Measures Taken: a. The nursing staff has been in-serviced by the Director of Nursing/Designee about appropriate fall prevention measures; appropriate supervision of residents to prevent falls; ensuring alarms are on at the beginning of each shift; ensuring batteries are changed twice a month; toileting per the plan of care; and utilizing gait belts for transfers. 4. How Monitored: a. C.N.A's are to validate proper alarm function with care of residents. They are</p>	08/21/2012

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	<p>resident. The resident indicated he needed help and, "All I got to do is wet, honey." The Maintenance Supervisor alerted RN #6 who was at the medication cart on the Sapphire Hall and out of view. The Maintenance Supervisor told Resident A that RN #6 was getting someone to help. RN #6 subsequently came to Resident A and assisted the resident to be seated in his wheel chair. During interview at this time, RN #6 indicated the resident had a sling on his arm due to a fall. When interviewed about the resident's alarm, RN #6 indicated, "He unclips it. He's known for taking the alarm off." She rolled the resident in the wheel chair toward his room.</p> <p>The clinical record for Resident A was reviewed on 7/23/12 at 4:50 p.m.</p> <p>Nurse's Notes for 5/24/12 at 10:35 p.m., indicated, "Called to res. [resident's] room per Laundry Aide who, upon delivering clothing, noted res. upon floor. Signer immediately responded to Laundry Aide call for help. Upon entrance to room res is noted laying [sic] on back parallel to bed [symbol for with] W/C [wheel chair] straddling BLE [bilateral lower extremities]. Res. unable to recall events leading to his placement on floor. Noted BM [bowel movement] on floor, brief, et</p>		<p>to report any issues noted to their supervisor. b. DON /Designee to include gait belts as part of routine rounds to validate compliance with protocols for transfers and toileting. c. Results will be reported by DON/Designee in the morning stand-up QA meeting; to the Quality Assurance Committee on a monthly basis; and reviewed/discussed with the Medical Director at the quarterly Quality Assurance Meeting. 5. This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our compliance date is August 21, 2012. Addendum a) An audit of 100% of the residents was conducted to determine risk potential. No other residents were identified. b) This will be on on-going process.</p>		

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	<p>[and] sheet of bed...."</p> <p>Nurse's Notes for 6/18/12 at 7:00 a.m., "Res. was found laying [sic] on left side. Res has skin tear on left elbow, left forearm and left hand on knuckles...."</p> <p>A Condition Change Form, dated 6/21/12, indicated, "Res c/o [complains of] discomfort to L) [left] shoulder. Discoloration noted. MD notified. New order received to obtain x-ray of L) shoulder."</p> <p>Radiology results for an x-ray of the left shoulder, dated 6/21/12, indicated, "Results: Views of the left shoulder demonstrate an acute fracture of end of left clavicle without displacement. The acromioclavicular joint is intact. Conclusion: Acute small avulsion fracture of distal end of left clavicle, new since 2/17/12."</p> <p>The Resident Care Plan, originally dated 3/23/10, and with the most recent update of 7/12/12, indicated a problem of "At risk for falls r/t [related to] dementia." Preprinted Nursing Interventions were followed by handwritten, "...bed alarm; w/c alarm...." Neither of the handwritten interventions were labeled with a date added to the care plan.</p>			

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	<p>The Careplan Worksheet, originally dated 1/1/11, and with the most recent update of 7/12/12, indicated, "Res has fall risk assessment score > [greater than] 10." The last intervention in the listed interventions indicated, "Scoop mattress applied to bed." The date the intervention was added was not indicated.</p> <p>During interview on 7/23/12 at 5:20 p.m., the Director of Nursing indicated the resident fell from the wheel chair on 5/24/12, and the alarms were added at that time. She indicated the resident fell from bed on 6/18/12, and the scoop mattress was added at that time.</p> <p>2. On 7/23/12 at 12:45 p.m., residents were seated in the Onyx Cove unit's Dining/Activity Room after lunch. Resident D indicated he wanted to lie down - "this wheel chair is killing me." At 1:00 p.m., Resident D was in his room, and CNA #3 and CNA #19 entered the resident's room and rolled his wheel chair next to his bed. To the resident, CNA #19 indicated, "How'd we do this Friday - me and you - we did it like..." and CNA #19 described how she had placed the wheel chair to make it easier to transfer the resident. The resident indicated he had a stroke and was paralyzed. Without applying a gait belt around the resident's waist, CNA #3 and CNA #19 reached</p>			

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	<p>under the resident's arms and assisted him to stand. As the resident was pivoted, CNA #19 held the waistband of the resident's pants. CNA #19 indicated, "See, it's easier that way for him."</p> <p>The clinical record for Resident D was reviewed on 7/23/12 at 5:00 p.m.</p> <p>The quarterly Minimum Data Set assessment, dated 4/27/12, indicated the resident was totally dependent on two staff for transfers.</p> <p>The Nursing Assistant Pocket Worksheet was provided at the end of the Initial Tour on 7/18/12 at 11:35 a.m. The assignment indicated Resident D was non-ambulatory and two assist for transfer.</p> <p>The facility's policy for "Transfer Belts/Gait Belts" was provided on the Conference Room table on 7/23/12 at 5:05 p.m. The policy indicated, "Guideline: It is the intent of the facility to promote safety in transferring and ambulating residents, a gait belt. [sic] Responsibility: All Nursing Staff, Therapy Staff...Procedure: ...2. A gait belt is used as indicated for safety by the person qualified to transfer the resident...4. The resident is transferred by grasping the secured gait belt to provide stability and balance during movement...."</p>			

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	<p>3. On 7/20/12 at 5:25 p.m., CNA #9 called from Resident U's room to LPN #2 in the hall for assistance with the resident. CNA #9 was in process of transferring Resident U from his bed to his wheel chair. A gait belt was observed rolled up on the resident's bedside table and was not applied to the resident. CNA #9 and LPN #2 leaned down to the low bed and reached under the resident's arms to lift him to his feet. The resident did not straighten his legs. He bore weight on his feet, but his knees remained bent as he slowly pivoted with the staff supporting him as he maneuvered into the wheel chair.</p> <p>The Nursing Assistant Pocket Worksheet was provided at the end of the Initial Tour on 7/18/12 at 11:35 a.m. The assignment indicated Resident U was non-ambulatory and the assist of one for transfers.</p> <p>3.1-45(a)(2)</p>			

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F0353 SS=E	<p>483.30(a) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS</p> <p>The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care.</p> <p>The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans:</p> <p>Except when waived under paragraph (c) of this section, licensed nurses and other nursing personnel.</p> <p>Except when waived under paragraph (c) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty.</p> <p>Based on observation, record review, and interview, the facility failed to ensure sufficient numbers of nursing staff were available to meet the nursing needs of residents on 4 of 4 units for 10 of the facility's 67 residents whose needs required staff assistance for hands-on care. (Residents B, V, W, X, Q, U, Y, I, D, and H)</p> <p>Findings include:</p> <p>1. During the Initial Tour on 7/18/12 from 10:50 a.m. to 11:35 a.m., the facility was</p>	F0353	F 353 Sufficient 24-HR Nursing Staff per Care Plans It is the intent of this facility to ensure sufficient numbers of nursing staff are available to meet the needs of the residents, whose needs require staff assistance for hands-on care. 1. Action Taken: a. The staffing patterns have been reviewed and adjusted providing more staffing hours to be utilized for nursing care. 2. Others Identified: a. All residents have the potential to be affected. 3. Measures Taken: a. The Nursing staff has been in-serviced on Activity programming by the DON /	08/21/2012	

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	<p>observed to have three secured units (Onyx Cove, Ruby Bay, and Emerald Brook) and one non-secured unit (Sapphire Springs). The Initial Tour was conducted with the Medical Records Director who indicated that until recently staffing had included an Activity Aide on each of the secured hallways. She indicated the staffing pattern had changed, and the Activities Director is responsible for all activities, with the help of nursing staff. The following staff and residents were on the units:</p> <p>Onyx Cove: LPN #8 and CNA #3 with 20 male residents; Ruby Bay: LPN #4 and CNA #5 with 13 female residents; Emerald Brook: RN #10 and CNA #9 with 13 male residents; and Sapphire Stream: LPN #14 and CNAs #1 and #25 with 21 male and female residents. At the time of the Initial Tour, the Restorative Aide was assisting a resident with ambulation on the Onyx Cove unit.</p> <p>2. At the end of the Initial Tour on 7/18/12 at 11:35 a.m., the Administrator provided the Daily Hall Assignment schedules. For 7/18/12, from 6:00 a.m. to 6:00 p.m., one nurse and one aide were scheduled on each of the three secured units. One nurse and two aides were scheduled on the non-secured unit. For</p>		<p>Designee. Activity Programming has been incorporated into the daily routine of providing care by the nurses and aides on each unit. b. The facility leadership team has been in-serviced on the importance of activities being consistently conducted. c. Activity programming will be discussed in the facility leadership team each morning Monday through Friday and adjustments made as needed. d. Activities for weekends will be discussed each Friday in the facility leadership team and adjustments will be made as needed. e. Staffing will be discussed in the facility leadership team each morning Monday through Friday and adjustments made as needed. f. Staffing for weekends will be discussed each Friday in the facility leadership team and adjustments will be made as needed. 4. How Monitored a. The DON or Designee will present a summary of staffing concerns to the Quality Assurance Committee at the monthly meeting and will discuss results with the Medical Director at the quarterly Quality Assurance committee meeting. b. The Activity Director will present a summary of the program to the Quality Assurance Committee on a monthly basis and will discuss with the Medical Director at the quarterly Quality Assurance meeting. 5. This plan of</p>				

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	<p>7/18/12, from 6:00 p.m. to 6:00 a.m., one nurse and one aide were scheduled on each unit. The Daily Hall Assignment schedule for 7/19, 7/20, and 7/23/12, indicated the Onyx Cove unit had two CNAs scheduled on 7/19, 7/20, and 7/23/12; otherwise all schedules were the same as for 7/18/12. A Restorative Aide was scheduled from 6:00 a.m. to 6:00 p.m. on 7/18 and 7/23/12. Activity Aide slots on the Daily Hall Assignment sheets for July 18, 19, 20, and 23, 2012, were blank.</p> <p>3. Confidential staff interviews with nurses and CNAs indicated the following:</p> <p>A. On 7/18/12: "One CNA on the Onyx Cove unit day and night isn't enough - not if one of those men goes off [with behaviors]."</p> <p>On 7/19/12:</p> <p>B. Until recently there were two CNAs and an Activity Aide on Onyx Cove - now there's just one aide and a nurse.</p> <p>C. Previously there was an Activity Aide for each of the secured units - now the CNAs and nurse are responsible for the activities. All the Activity Aides were fired.</p>		<p>correction constitutes our credible allegation of compliance with all regulatory requirements. Our compliance date is August 21, 2012. Addendum a) The facility Director of Nursing, facility Administrator, Regional Nurse Consultant and Regional Vice President met to determine a revised staffing pattern. b) This will be an on-going process</p>				

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	<p>On 7/23/12:</p> <p>D. Last week there was just one aide and a nurse on Onyx Cove - now there are two - it's too hard with just one.</p> <p>E. Just two staff (a nurse and a CNA) on the unit is hard - especially when everything happens at once.</p> <p>4. Review of the Nursing Assistant Pocket Worksheet provided by the Administrator at the conclusion of the Initial Tour on 7/18/12 at 11:35 a.m., indicated the following:</p> <p>On Onyx Cove unit: 4 were assist of 2 for transfer; 10 were on an every two hour toileting schedule; 1 was on an every hour toileting schedule; and 4 were incontinent.</p> <p>During interview on 4/23/12 at 12:55 p.m., CNAs #3 and #19 indicated there were nine residents requiring two person assistance for transfers.</p> <p>On Emerald Brook unit: 3 were 1 to 2 assist for transfer; 5 were incontinent; 3 were on an every two hour toileting schedule; 1 was every hour toileting, and 1 required total assistance with feeding.</p> <p>On Ruby Bay unit: 2 were transfer by</p>				

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	<p>Hoyer lift (requiring assist of 2); 1 was assist of 2 for transfer; 6 were every two hour toileting; and 2 were incontinent.</p> <p>On Sapphire Stream unit: 4 were transfer by Hoyer lift and 1 by stand-up lift; 4 were assist of two for transfer; 7 were every two hour toileting schedule; 5 were incontinent; 5 were total assist for feeding.</p> <p>5. The following was observed on the Ruby Bay unit on 7/19/12:15 between 3:30 and 4:15 p.m., with LPN #16 and CNA #15 on duty:</p> <p>At 3:30, Resident B was in her low bed lying on her side. A strong odor of urine was in the room. The resident's bed covers were pulled to the side, and she was wearing a brief. Visible on the bed pad under the resident's hips were yellow-brown rings of stains.</p> <p>At 3:35 p.m., the PT (Physical Therapist) was at the bedside of Resident V. During interview, he indicated he was waiting for staff to help him get Resident V up to take her for her therapy session, since she is an assist of two for transfers.</p> <p>At 3:40 p.m., Resident W began yelling loudly, "I need to pee" multiple times. The PT replaced Resident V's mat beside</p>			

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	<p>her bed and went into Resident W's room and spoke to the resident.</p> <p>LPN #16 and CNA #15 emerged from the room of Resident X. LPN #16 indicated she was assisting CNA #15 with completing Resident X's shower. CNA #15 indicated the resident is a "heavy shower," which takes her about 45 minutes to complete.</p> <p>LPN #16 indicated she needed to get the Hoyer lift to transfer Resident W to bed for changing. LPN #16 indicated when the resident yells out, she is already wet and needs to be changed.</p> <p>At 3:45 p.m., LPN #16 entered Resident V's room to assist the PT in getting the resident out of bed.</p> <p>At 4:05 p.m., Resident Q indicated she needed assistance to the toilet, and LPN #16 indicated the resident was an assist of two for transfer, as the room for Resident B was entered with LPN #16. The Restorative Aide and CNA #21 (not scheduled on the unit) were in process of providing incontinent care for Resident B. LPN #16 left the room, indicating she would assist Resident Q, while the CNA #21 and Restorative Aide completed care for Resident B.</p>			

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	<p>As the room of Resident B was exited, CNA #23 and CNA #27 entered the unit to assist Resident Q with transfer off the toilet. During interview at this time, the CNAs indicated they were working on Sapphire Stream, but the Medical Records Director and MDS Coordinator were with their residents on that unit.</p> <p>At 4:15 p.m., the PT was observed wheeling Resident V onto the unit after her therapy session.</p> <p>6. The following was observed on the Emerald Brook unit on Friday, July 20, 2012, between 5:25 p.m. and 5:35 p.m. with LPN #2 and CNA #9 on duty:</p> <p>Some residents were gathering in the two small dining rooms at the end of the hall. No beverages were served to the residents. The dinner tray cart was delivered to the door, and LPN #2 began pushing the cart down the hall. She was stopped by CNA #9 calling her from Resident U's room to come and assist her in transferring Resident U from bed to wheel chair. LPN #2 left the tray cart in the hall and assisted CNA #9, who indicated she had just changed the resident's brief. After the resident was in his wheel chair, LPN #2 began pushing the tray cart down the hall. The front of Resident U's shirt had a large wet-looking</p>			

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	<p>stain, and brown debris was observed on his lips. The resident was not assisted to change his shirt or clean his mouth. As CNA #9 was exiting Resident U's room and assisting him to roll his wheel chair to the dining room, the tray cart was standing in the hall. LPN #2 called to CNA #9 for assistance with Resident Y. Resident Y was observed on the floor of a room not his own. Resident Y indicated, "Help me up. I slipped off the bed." LPN #2 left CNA #9 to obtain equipment for assessing the resident. At this time, the MDS Coordinator entered the room and assisted also. At 5:35 p.m., five residents were seated in one of the two dining rooms, and CNA #9 was serving trays. The Director of Nursing, who had also entered the hall, and MDS Coordinator assisted Resident Y to the dining room.</p> <p>7. The following was observed on the Onxy Cove unit on 7/23/12:</p> <p>A. At 12:50 p.m., CNA #3 rolled Resident I into his room, and CNA #19 entered to assist CNA #3. As the resident was transferred from wheel chair to bed, the back of his sweat pants were observed to be wet at the brief line on both pant legs. The CNAs did not check to ensure the resident was clean and dry but proceeded to position the resident in bed, place the bed covers, turn on the</p>			

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	<p>television, wash their hands, and leave the room.</p> <p>The clinical record for Resident I was reviewed on 7/23/12 at 5:35 p.m.</p> <p>The quarterly Minimum Data Set assessment, dated 6/26/12, indicated the resident was always incontinent of bowel and bladder.</p> <p>The Care Plan, originally dated 4/21/12, and most recently updated 6/26/12, indicated the problem: "I have history/dx [diagnosis] of: bladder incontinence R/T [related to] dementia..." Interventions included, but were not limited to, "...Approach me at least every two hours and check me for evidence of incontinence. Provide pericare every shift and as needed...."</p> <p>B. At 12:55 p.m., Resident D was in his room, and CNA #3 and CNA #19 entered and rolled his wheel chair next to his bed. CNA #19 indicated to CNA #3 that a wet wash cloth was needed - "he told me he went [had a bowel movement] - didn't you [to the resident]." The resident was transferred from wheel chair to bed, and the pants and brief were removed. The brief contained stool, and the anal area was cleansed of light brown stool, and a fresh brief was applied. The hips, penis,</p>						

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	<p>and abdominal area were not cleansed.</p> <p>The clinical record for Resident D was reviewed on 7/23/12 at 5:00 p.m.</p> <p>The quarterly Minimum Data Set assessment, dated 4/27/12, indicated the resident was frequently incontinent of bowel and bladder, required total assistance of two for toileting, and was on a toileting program.</p> <p>The Careplan Worksheet for Urinary Incontinence indicated, "Provide pericare every shift and as needed."</p> <p>The Scheduled Toileting Program, originally dated 1/23/12, and most recently updated 4/27/12, indicated, "The resident requires cues, reminders and/or assistance to use the toilet. " Approaches and interventions included, but were not limited to, "Cue, remind and assist to toilet/bed pan upon rising, before and after meals, before bed, and as needed."</p> <p>The Nursing Assistant Pocket Worksheet, provided by the Administrator on 7/18/12 at the end of the Initial Tour at 11:35 indicated Resident D was on an every two hour toileting schedule.</p> <p>During interview on 7/23/12 at 4:00 p.m., CNAs #3 and #19 indicated Residents D</p>			

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	<p>had finished napping but did not want to get up for supper. The CNAs were rolling the linen and trash barrels down the hall and indicated they had just now checked and changed Resident D.</p> <p>8. On the Sapphire Stream unit, on 7/23/12 at 2:30 p.m., Resident H was observed from the hallway, seated in his room in his wheel chair. He did not respond to a knock on the door. The resident's head was drooped down to his chest, and his respirations were snoring. A strong urine odor was evident around the resident. The front of the resident's sweat pants between his legs had a large wet stain, and a puddle was observed under the resident's wheel chair.</p> <p>On 7/23/12 at 3:15 p.m., Resident H was observed from the hallway, seated in his room with his wheel chair moved closer to the bed. The puddle remained where the wheel chair was previously placed. The urine odor remained, and the resident was wearing the same sweat pants, but the wet stain on the front between his legs was less visible.</p> <p>On 7/23/12 at 4:30 p.m., Resident H was observed in the hallway wearing different clothing. During interview at this time, CNA #15 indicated she had just changed the resident.</p>						

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	<p>The clinical record for Resident H was reviewed on 7/23/12 at 5:25 p.m.</p> <p>The quarterly Minimum Data Set assessment, dated 4/27/12, indicated the resident was frequently incontinent of bladder and required the extensive assistance of two for dressing and toileting.</p> <p>A Care Plan originally dated 6/2/11, and most recently updated 4/27/12, indicated, "I require assistance for toileting." Approaches included, but were not limited to, "Assist me with adjusting my clothing...Give me verbal cues to help prompt me..." Another Care Plan, with the same dates, indicated, "I am sometimes incontinent of urine." Approaches included, but were not limited to, "Initiate scheduled toileting plan....Provide me incontinent pads...Assist me to the bathroom or commode as needed, and assist me with perineal cleansing as needed."</p> <p>3.1-17(a)</p>			

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F0363 SS=E	<p>483.35(c) MENUS MEET RES NEEDS/PREP IN ADVANCE/FOLLOWED 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.</p> <p>Based on observation, record review, and interview, the facility failed to ensure the menu was followed for 1 of 2 observations of meal service. The deficient practice affected 11 of 11 residents observed with a regular diet in the dining room on Onyx Cove unit where 20 residents resided; 3 of 3 residents observed with regular diet on the Emerald Brook unit (Residents M, R, and S) where 13 residents resided, and 9 of 9 residents observed with a regular diet in the Main Dining Room used by the 21 residents residing on Sapphire Cove unit.</p> <p>Findings include:</p> <p>On 7/20/12 at 5:15 p.m., the supper tray cart was observed to arrive on the Onxy Cove unit. Eleven residents were seated at tables awaiting the meal service. Eleven residents receiving the regular diet were served a plate with sandwich consisting of one thin slice of baloney between two slices of plain white sandwich bread, tomato/onion salad, and</p>	F0363	<p>F 363 Menus Meet Res Needs/Prep In Advance/Followed It is the intent of this facility to follow the menus as written. 1. Actions Taken a. In regards to the residents identified: The cook was educated/counseled on the necessity of following the menu as written to ensure appropriate dietary needs are met. b. In regards to the residents identified: The dietary staff was in-serviced on the necessity of following the menu as written by the Dietary Director on August 3, 2012. 2. Others Identified: a. All residents have the potential to be affected. 3. Measures Taken: a. Each Monday, the Dietary Manager/Designee will review the upcoming menus for the week with the cooks to validate their understanding of the menus, items needed, and the preparation necessary. b. The cooks were educated/in-serviced to review the menu the prior day to ensure they understand the necessary items needed for the meal enabling them to ask questions while having sufficient time to make changes if needed. 4. How Monitored: a. The</p>	08/21/2012

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	<p>chocolate cake.</p> <p>On 7/20/12 at 5:40 p.m., residents on the Emerald Brook unit were observed being served the supper meal. Residents M, R, and S were served a regular diet. On each of the residents' plates was a sandwich, consisting of two slices of plain white sandwich bread and a thin slice of baloney, tomato/onion salad, and chocolate cake. Resident M lifted the top piece of white bread on his sandwich and indicated, "It doesn't even have cheese on it." Resident S looked at his sandwich, and indicated, "I don't want to touch it," and refused the baloney sandwich.</p> <p>On 7/20/12 at 5:50 p.m., nine residents were observed eating the regular diet in the main dining room. On their plates, the residents had a sandwich consisting of two slices of plain white sandwich bread and a thin slice of baloney, a tomato/onion salad, and chocolate cake.</p> <p>On 7/23/12 at 4:15 p.m., the Dietary Manager provided the menu including the supper on 7/20/12. Review of the menu indicated, "Deli Meat & Cheese Sandwich, Tomato & Onion Salad, Chocolate Chip Cookie Bar, 2% Milk, Choice of Beverage."</p> <p>On 7/23/12 at 4:20 p.m., the Dietary</p>		<p>Dietary Director/Designee will audit two of three meals daily to validate the menu is followed. b. The Manager on Duty will review two of three meals each week-end to ensure the menu is being followed. This will be included on the Manager on Duty that is completed each week-end. c. The Dietary Director/Designee will report daily to the Quality Assurance Committee during the daily stand-up meeting; and will review the information monthly meeting; and review/discuss findings with the Medical Director at the quarterly Quality Assurance Meeting. 5. This plan of correction is our credible allegation of compliance with all regulatory requirements. Our completion date is August 21, 2012. Addendum a) All residents that had that specific meal were affected. b) The Quality Assurance Committee will determine the need for continued monitoring based on results reported to the committee and comments from the Resident Council Meetings. The Quality Assurance Committee will make recommendations to increase or decrease monitoring based on the reported outcomes.</p>				

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	<p>Manager provided the "Therapeutic Spreadsheets" including the supper meal on 7/20/12. The entry for the Deli Meat and Cheese Sandwich indicated two ounces of "edible protein" (three ounces for high protein diets) and two slices of bread.</p> <p>During observation in the kitchen on 7/23/12 at 4:40 p.m., the Dietary Manager measured out thin baloney slices from a bag of baloney she indicated was sliced for sandwiches from a chunk of baloney. She placed five slices of baloney on the scale to register two ounces. The Dietary Manager indicated, "Maybe we need a new scale." She indicated she was in the building at the time of the supper meal on 7/20/12 but "had an issue going on" and did not see the sandwiches that were prepared. She indicated she did not see if cheese was used on the sandwiches and was not sure if cheese was in stock at that time.</p> <p>3.1-20(i)(4)</p>			