

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155473	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 07/12/2013
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NAME OF PROVIDER OR SUPPLIER CHALET VILLAGE HEALTH AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1065 PARKWAY ST BERNE, IN 46711
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F000000	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: July 8, 9, 10, 11, 12, 2013</p> <p>Facility number: 000546 Provider number: 155473 AIM number: 100267370</p> <p>Survey team: Angela Strass, RN Sue Brooker, RD Julie Call, RN Virginia Terveer, RN</p> <p>Census bed type: SNF/NF: 33 Total: 33</p> <p>Census payor type: Medicare: 4 Medicaid: 22 Other: 7 Total: 33</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2</p> <p>Quality review completed on July 16, 2013 by Randy Fry RN.</p>	F000000	<p>Submission of this plan of correction does not constitute admission or agreement by the provider of the truth of facts alleged or correction set forth on the statement of deficiencies. This plan of correction is prepared and submitted because of requirement under state and federal law. Please accept this plan of correction as our credible allegation of complianace.</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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F000282 SS=D	<p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</p> <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 interview and record review, the facility failed to follow a physician order for fluid restriction for 1 resident (Resident #26) of 24 residents reviewed for physician orders and failed to ensure the Dietician ' s recommendation for Magic Cup (fortified nutrition) was followed for 1 of 5 residents who met the criteria for nutrition. (Resident #34)</p> <p>Findings include:</p> <p>Review of the clinical record for Resident #26 on 7/11/13 at 9:01 a.m., indicated the following: diagnoses included, but were not limited to, diabetes mellitus, hypertension, end stage renal disease, hyperkalemia, coronary artery disease, atrial fibrillation, and pulmonary hypertension.</p> <p>A physician's order for Resident #26, dated for the month of July, 2013, indicated a liberal renal diet, low</p>	F000282	<p>F282-</p> <p>1. A. Resident 26 fluid distribution plan was changed to include liquids given with supplements and medications on 7-11-13. (Nursing 780cc of fluids, 300cc on the 6-2 shift, 240 on the 2-10 shift, and 240cc on the 10-6 shift. Dietary 720cc of fluids with 240cc of fluids at each meal) B. Resident 34 magic cup order was received on 7-10-13.</p> <p>2. In an effort to identify all applicable residents, the RD will be requested to provide a copy of all recommendations being made as well as any fluid distribution records to the DON or designee. The DON or designee shall then be responsible to contact the applicable physician (via fax or email on the same day of receipt of the recommendation) regarding the recommendation and hold the recommendation as "awaiting an order" until response is received. The same will apply with any other resident with a fluid restriction The Nursing staff were immediately re-educated on the policies for Fluid Restrictions and Dietary recommendations. The fluid distribution record placed in the MAR to assure Nursing is aware of</p>	07/26/2013

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	<p>concentrated sweets, and no added salt. The order also indicated a 1500 ml (milliliter) fluid restriction.</p> <p>A Fluid Distribution Sheet for Resident #26, dated 5/13/13, indicated dietary was to provide a total of 1020 ml of fluid daily, 420 ml at breakfast, 360 ml at lunch, and 240 ml at dinner, and nursing was to provide 480 ml of fluid daily.</p> <p>A dietary tray card for Resident #26 indicated she received the following fluids at mealtime: 420 ml at breakfast, or 8 ounces of skim milk and 6 ounces of juice; 360 ml at lunch, or 8 ounces of water and 4 ounces of juice; and water for dinner, although the amount was not specified.</p> <p>A Nutritional Assessment Form for Resident #26, dated 5/3/13, indicated she received dialysis. The assessment recommended a 4 ounce sugar free shake at HS (hour of sleep) and 1 scoop Beneprotein (high protein supplement) BID (twice a day). No recommendation was made to change the fluid distribution plan between nursing and dietary for Resident #26.</p> <p>The manufacturer's instructions for</p>		<p>what fluids are allowable on each shift, and as a reminder that any added fluids, per medication supplement etc., must be communicated to dietary immediately.</p> <p>3. As a means to ensure ongoing compliance with timely response to RD recommendations and Fluid restrictions, The DON or designee will monitor dietary recommendations as well as any new orders for residents on fluid restrictions daily on scheduled work days. The Nurse Consultant shall be responsible to review the dietician report/recommendation as well as any resident with fluid restriction at least every two weeks to verify compliance. Should non-compliance be noted, corrective action shall be taken.</p> <p>4. As a means of quality assurance, the DON and Nurse Consultant observations and any corrective actions taken will be reported to the Quality Assurance Committee monthly x 3 months, then quarterly thereafter. Revisions will be made to the plan, if warranted.</p> <p>5. 7-26-13</p>				

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	<p>the Beneprotein indicated to stir one scoop of powder into at least 4 fluid ounces.</p> <p>A physician's order based on a dietary recommendation for Resident #26, dated 5/6/13, indicated a 4 ounce sugar free shake at HS, providing 120 ml fluid, and 1 scoop of Beneprotein Powder BID, providing 240 ml. Nursing would be providing 360 ml fluid per day.</p> <p>A Nutritional Progress Notes for Resident #26, dated 5/31/13, indicated she remained on a renal diet with a 1500 ml fluid restriction. The note also indicated she was started on Questran (cholesterol lowering medication). No recommendation was made to change the fluid distribution plan between nursing and dietary for Resident #26.</p> <p>A physician's order for Resident #26, dated 6/12/13, indicated Questran Lite 1 packet in water BID.</p> <p>The manufacturer's instructions for the Questran indicated to add the packet to at least 2 to 6 ounces of fluid. Nursing would now be providing 520 to 720 ml fluid per day, depending on how much fluid nursing</p>						

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	<p>was using for the Questran.</p> <p>A physician's order for Resident #26, dated 6/25/13, indicated to discontinue the Beneprotein Powder 1 scoop in liquid BID and to start Beneprotein powder 1 scoop in liquid TID (three times a day), now providing 360 ml. With the sugar free shake and the Questran, nursing would now be providing 640 to 1020 fluid per day, depending on how much fluid nursing was using for the Questran.</p> <p>Physician order for Resident #26, dated for the month of July, 2013, indicated she received medication twice a day, including Questran Light packet (mix in liquid) BID, Beneprotein Powder 1 scoop in liquid TID, and a 4 ounce sugar free shake at HS.</p> <p>Review of the Medication Administration Records for Resident #26, for the months of May, 2013, June, 2013, and July, 2013, indicated the sugar free shake and medications, including the Questran and Beneprotein, were given as ordered.</p> <p>RN #1 was interviewed on 7/11/13 at 9:32 a.m. During the interview she</p>				

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	<p>indicated she used between 2 ounces to 6 ounces of water to mix the Questran and 4 ounces of water to mix the Beneprotein for Resident #26. She also indicated she also gave Resident #26 a small amount of water to drink with her medication.</p> <p>Calculations for the fluids provided by nursing services for Resident #26, indicated she received 640 ml to 1020 ml in a 24 hour period from nursing staff. The resident also received 1020 ml fluid from dietary, providing a total of 1660 to 2041 ml in 24 hours, Any water provided to the resident during medication pass would be in addition to the totals.</p> <p>A facility care plan for Resident #26, dated 5/3/13, indicated the problem area of alteration in nutrition/hydration status due to end stage renal disease and dialysis. The care plan also indicated she was on a 1500 ml fluid restriction daily and receive a 4 ounce shake 1 time a day.</p> <p>A facility care plan for Resident #26, dated 5/9/13, indicated the problem area of renal failure. Interventions to the problem included, but were not limited to, provide diet and liquids as ordered.</p>			

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	<p>The Consultant Nurse was interviewed on 7/11/13 at 3:38 p.m. During the interview she indicated dietary did the initial breakdown of fluid between dietary and nursing for a resident on a fluid restricted diet. She also indicated dietary and nursing were to communicate with each other concerning changes in fluids provided by each department.</p> <p>A current facility policy "Fluid Restriction Policy", dated 11/12/08 and provided by the Consultant Nurse on 7/11/13 at 2:50 p.m., indicated "...It is the policy of the Dietary Department to follow guidelines for a Physician-ordered fluid restriction...Nursing will provide the Dietary department with an order for the exact amount of fluids allowable within a 24 hours period...The Dietary Supervisor will work with the Nursing staff to assess how much fluid is required for medication passes throughout all shifts...After the amount necessary for Nursing needs is determined, Dietary will provide ALL remaining needs...A fluid distribution sheet should be completed for each resident by the Dietary Supervisor...Fluid restriction will be care planned and adjusted accordingly...."</p>			

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2. An observation of Resident #34's meal tray on 7-10-2013 at 11:48 a.m., indicated there was cut up meat, small round potatoes, green bean casserole and a piece of chocolate pie with whipped cream, water, and red punch on the tray. There was not a Magic Cup on the meal tray.

An interview with the Dietician on 7-10-2013 at 3:30 p.m., indicated the dietary staff stopped placing the Magic Cup on Resident #34's meal tray because Resident #34 liked the Breeze (liquid nutritional supplement) better. The Dietician indicated the intention was to provide the Magic Cup in addition to the Breeze.

Further interview with the Dietician on

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	<p>7-10-2013 at 3:45 p.m., indicated when the Magic Cup recommendation was made on 5-31-2013, a copy of the recommendation was given to the Dietary Manager, Administrator and the DON (Director of Nursing).</p> <p>An interview with the Dietary Manager on 7-11-2013 at 10:15 a.m., indicated when the resident returned from the hospital on 6-28-2013, the Magic Cup was not ordered so it was not provided. The Dietary Manager indicated she was unsure if the Magic Cups were being provided after the Dietician recommendation on 5-31-2013.</p> <p>An interview with the Dietician on 7-11-2013 at 10:20 a.m., indicated dietary stopped the Magic Cup because they did not have a physician order. The Dietician indicated a physician order was not needed for the Magic Cup but the facility required a physician order and Nursing obtained an order late yesterday.</p> <p>The record review began 7-9-2013 at 1:30 p.m. Diagnoses included but were not limited to, Clostridium difficile with diarrhea, left hip fracture, severe coronary artery disease, severe ischemic cardiomyopathy,</p>				

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	<p>systolic heart failure, hyperlipidemia, atrial fibrillation, hypertension, chronic normocytic anemia, chronic bilateral lower extremity ulcerations secondary to peripheral artery disease.</p> <p>A review of the Nutritional Progress Notes dated 5-31-2013 and signed by the Registered Dietician indicated but was not limited to, "...Rec: (Recommendation) Magic Cup at lunch, supper...."</p> <p>A Magnolia Registered Dietitian (RD) Recommendations to the Facility form dated 5-31-2013 was provided by the Administrator on 7-10-2013 and indicated Resident #34 had a concern of weight loss and a recommendation of Magic Cup BID (2 times daily) with lunch and supper was written on the form. SWAT (Skin, Weight, Assessment, Treatment) record was also provided and indicated on 5-31-2013 meeting, the RD (Registered Dietician) was to evaluate, Magic Cups and preferences updated.</p> <p>A review of Resident #34's physician orders indicated a physician order was not present after the 5-31-2013 Magic Cup recommendation until 7-10-2013.</p>				

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	<p>A meal tray card provided by the Dietician on 7-10-2013 indicated Magic Cup was not recorded on the card in the lunch and dinner sections.</p> <p>A review of the Nutrition Care Plan initiated on 4-19-2013, and updated on 5-31-2013 and 7-2-2013, did not indicate Magic Cup as an approach for Resident 34's nutritional status.</p> <p>A policy "Nutrition and Weight Loss Management Program" provided by the Consultant Nurse on 7-11-2013 at 2:52 p.m., indicated "...13. Recommendations made by the RD will be forwarded by nursing to the attending physician for action...16. Commercially prepared supplements...require a physician's order...."</p> <p>3.1-35(g)(2)</p>			

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F000309 SS=G	<p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>Based on interview and record review, the facility failed to protect 2 of 5 residents (Resident #8 and Resident #22) who attended an outdoor facility activity from receiving a sunburn. This action resulted in resident #22 experiencing a severe sun burn with blisters to his forehead which caused him pain.</p> <p>Findings include:</p> <p>1. Review of the clinical record for Resident #8 on 7/10/13 at 8:37 a.m., indicated the following: diagnoses included, but were not limited to, malignant neoplasm of pancreas, secondary malignant neoplasm of respiratory and malignant neoplasm of liver, pain, diabetes mellitus, and anemia.</p> <p>A Nursing Progress Notes for Resident #8, dated 5/22/13 at 6:30 p.m., indicated a new order was received for Aloe Vera topically to</p>	F000309	F3091. Resident 8 and 22 immediately received orders to treat the sunburn. One should note that residents were provided caps and utilized umbrellas as sunshade on the outing, however, still yet incurred sunburn.2. An order for sunscreen to be applied was received immediately for all residents who may be affected by the sun during outside activities of any kind. Staff was re-educated to assure they are aware of the need for sunscreen for residents going outside for activities, events, or for pleasure.3. All staff were re-educated on the need to assure residents going outside for activities, events or for pleasure have sunscreen applied to ensure no injury occurs. Activity staff will alert Nursing staff to any outdoor activities. Nursing staff will document the PRN use of sunscreen. The DON and/or designee will monitor to confirm resident use of sunscreen and subsequently assess residents' skin condition following an outdoor outing daily on scheduled work days to assure compliance with this practice.4. The DON will	07/26/2013			

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	<p>sunburn q (every) shift et (and) PRN (as needed) x (times) 3 days. The note also indicated Benadryl (anti-histamine) 25 mg(milligrams) orally q 4 hours PRN for itching and discomfort.</p> <p>Resident #8 was interviewed on 7/11/13 at 9:00 a.m. During the interview he indicated he went with other residents from the facility to a baseball game on 5/22/13. He also indicated he received a sunburn to his arms which eventually peeled. Resident #8 observed to have very fair skin.</p> <p>2. Review of the clinical record for Resident #22 on 7/9/13 at 1:32 p.m., indicated the following: diagnoses included, but were not limited to, diabetes mellitus, Parkinson's disease, seizure disorder, coronary artery disease, asthma, debility, and hypertension.</p> <p>A Nursing Progress Notes for Resident #22, dated 5/22/13 at 5:30 p.m., indicated he had returned from an activity to a baseball game. The note also indicated the skin on his face, arms, head and neck were red from the sun. At 5:45 p.m., the note indicted a new order was received for Benedryl 25 mg orally q 4 hours PRN</p>		<p>report the findings of the resident sunscreen use and skin assessments to the Quality Assurance Committee monthly x 3 months, then quarterly thereafter. Revisions will be made to the plan, if warranted.5. 7-26-13</p>				

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	<p>x 3 days. The order also indicated Aloe Vera topically to sunburn q shift PRN.</p> <p>A Nursing Progress Notes for Resident #22, dated 5/26/13 at 4:00 p.m., indicated the skin on his face, arms, hands, and forehead remained very red from the sunburn.</p> <p>Resident #22 was admitted to the local hospital on 5/26/13. A History and Physical Report from the hospital, dated 5/26/13, indicated..."It should be noted that the patient has relatively impressive sunburn on his face and arms....the patient has profound sunburn...Diffuse peeling sunburn on much of his face...Small area in the central part of his forehead that appeats to have likely blistered recently...."</p> <p>Resident #22 was interviewed on 7/10/13 at 1:45 p.m. During the interview he indicated he had attended a baseball game with other residents from the facility on 5/22/13. He also indicated he received a bad sunburn which caused him great discomfort. Resident #22 was observed to have very fair skin.</p> <p>The Director of Nursing was interviewed on 7/10/13 at 9:20 a.m.</p>						

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	<p>During the interview she indicated five residents went to the baseball game on 5/22/13 and 2 of the residents came back with sunburns. She also indicated sun screen had not been applied to the residents who attended the baseball game. She further indicated the residents were to be seated under an awning and the day was cloudy.</p> <p>The Director of Nursing was interviewed on 7/10/13 at 10:30 a.m. During the interview she indicated Activity staff #2 did not take sunscreen with her to the ball game for the residents since she thought they would be seated under an awning. She also indicated she thought the actual time of the game was 2 1/2 hours.</p> <p>Activity staff #2 was interviewed on 7/10/13 at 10:35 a.m. During the interview she indicated she was not given any sunscreen to take the baseball game. She also indicated the game lasted 3 hours.</p> <p>The Administrator was interviewed on 7/10/13 at 2:05 p.m. During the interview she provided a copy of the weather forecast for the day on the baseball game on 5/11/13. The forecast listed an actual temperature</p>						

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	<p>on 80 degrees on that day. She also indicated the severe weather policy was not implemented due to actual temperature being only 80 degrees. When queried, the Administrator indicated the use of sunscreen was not included in the severe weather policy.</p> <p>3.1-37(a)</p>			

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F000323 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. Based on observation, interview and record review, the facility failed to follow their policy and procedure for ambulating residents for 1 of 4 residents who met the criteria for accidents; this deficient practice resulted in a fall with a skin tear. (Resident # 32)</p> <p>Findings include:</p> <p>During an observation on 07/8/13 at 4:10 p.m., Resident #32 had geri sleeves on both of his arms, covering top of his hands and forearms. Resident #32 lifted his geri sleeves that covered the top of his hands. Steri strips were observed intact and covered the skin tear on top of his right hand. The left hand's skin tear had a pink scar line with dry flaky skin that surrounded the healed skin tear.</p> <p>During an observation of wound and skin care for Resident #32 on 7/10/13 at 9:20 a.m. with RN #3, the geri sleeves were off after morning care. The skin tear on left top of Resident</p>	F000323	F3231. Resident 32 was immediately assessed, and orders were received from physician at time of fall. The C.N.A. was immediately re-educated concerning use of gait belt.2. Records and care plans for all residents with the potential for falls were reviewed and any identified concerns were addressed. All staff were re-educated on the proper transfer procedure and use of gait belts, as well as any other assistive devices. The C.N.A. assignment sheets were updated accordingly.3. Nursing staff were re-educated on proper transfers and use of gait belt, as well as any other assistive devices. C.N.A. Assignment sheets were updated. The DON and/or designee will observe all C.N.A.s and nurses for proper transfer techniques. The DON and/or designee will observe transfer techniques daily on scheduled work days x 4 weeks, then 3 x / week x 4 weeks, then 1 x / week x 4 weeks. Random observations 1 x per month ongoing. Should concerns be observed, corrective action shall be taken.4. The DON and/or designee will report	07/26/2013			

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	<p>#32's hand remained covered completely with steri strips and there was dried blood spots along line of skin tear. The skin tear on top of his right hand had a pink scar surrounded by dry skin. RN #3 applied clean geri sleeves to both arms and indicated the skin tears were to be left open to air.</p> <p>During an interview with LPN #4 on 07/08/13 at 1:55 p.m., LPN #4 indicated Resident #32 had fallen on 07/02/13. LPN #4 indicated the resident was lowered to the floor by CNA #5 after Resident #32 lost his balance when he was ambulated by CNA #5. LPN #4 indicated Resident #32 hit his hand on the wall when he fell and sustained a skin tear.</p> <p>During an interview with CNA #5 on 07/09/13 at 5:05 p.m., indicated she was with Resident #32 when he fell in his bathroom. CNA #5 indicated Resident #32 was ambulated from his bathroom with his walker and she stood on resident's left side and slightly behind him when he lost his balance and he fell straight back. She indicated she was only able to grab him and eased him to the floor. CNA #5 indicated Resident #32's right hand scraped down the wall and he got a skin tear. CNA #5 stated, " I did</p>		<p>findings of transfer monitoring and any corrective actions taken to the Quality Assurance Committee monthly x 3 months then quarterly thereafter. Revisions will be made to the plan, if warranted.5. 7-26-13</p>				

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	<p>not use the gait belt during the transfer." CNA #5 indicated she should have used the gait belt during the transfer and ambulation. CNA #5 also indicated she had a gait belt she could have used for the Resident #32.</p> <p>During an interview with the Manager of Therapy Services on 7/10/13 at 11:15 a.m., indicated during the weekly Falls Meeting, the committee concluded the staff needed re-education on the use of walkers and use of gait belts for all residents dependent for assistance with transfers and ambulation.</p> <p>During an interview with DON (Director of Nursing) on 07/12/13 at 9:50 a.m., indicated all CNA's were instructed on use of gait belt during their orientation and the CNA's were checked off on their skills. Each CNA was also given their own gait belt to be used for resident's transfers and ambulation. DON indicated CNA's are educated to the facility's policies and procedures on use of gait belts.</p> <p>Resident # 32's clinical records was reviewed on 07/9/13 at 1:20 p.m.. Resident #32's diagnoses included, but not limited to: CVA(Cerebral Vascular Accident or "a stroke") with right hemiparesis (right side</p>				

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	<p>weakness), multiple TIA (Transient Ischemic Attack or "a mini stroke"), generalized weakness, HTN (hypertension or "high blood pressure"), asthma, gout, history of MI (myocardial infarction or "a heart attack"), prostate cancer.</p> <p>On 07/09/13 at 4:00 p.m., the Incident and Accident Report and Investigation from fall on 07/02/13 at 10:00 p.m., was reviewed. The report stated, "...the CNA helped the resident ambulate out of the bathroom. The CNA stepped around him and the resident lost his balance. The CNA lowered the resident to floor. The Resident hit the top of his right hand on the wall and caused a C-shaped skin tear with a small amount of bloody skin intact....The Resident did not hit his head; no changes in cognition, resident denied pain. Skin tear: area cleansed and Steri-Strips applied. ACTION: CNA to use gait belt for transfers; CNA in-serviced for education." Review of CNA # 5's written statement stated, "Resident #32 was in the bathroom with me. I was on the side of him trying to get around him so he could get through the door, he lost his balance and I did not get a grip on him so I lost grip and he tore skin open on his hand against a wall. I</p>			

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	<p>took him to the floor with as much control as I could; his only injury is his hand. He did not hit his head... " signed by CNA#5, on 7/2/13.</p> <p>Review of the Post Fall Investigation Worksheet completed by DON on 07/03/13 indicated, "...fall occurred on 7/2/12... Were staff performing the skill per policy?: No/No gait belt.... What does the interdisciplinary team determine the cause of the fall to be?: CNA not using gait belt.... Assistive device modifications: Gait belt...."</p> <p>A review of the facility policies, provided by Consulting Nurse on 7/10/13 at 1:40 p.m., included but were not limited to:</p> <p>The facility policy indicated, titled: Ambulation Procedure, dated 9/05, indicated, "...To assist the resident with maintaining or improving the ability to ambulate. Equipment: 1. Walker; 2. Cane; 3. Gait belt; Procedure: ...2. Put the gait belt on the resident...."</p> <p>The facility policy titled, Gait Belt Procedure, dated 9/05, indicated, "...Purpose: To insure safety in transfer and ambulation. To provide a point of contact and increased support from the staff and prevent</p>						

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	<p>injuries to staff and residents who are unable to transfer or ambulate independently. Procedure: ...Ambulating: 6. Apply belt.... Walk closely beside resident...7. Maintain firm grasp on belt at mid back...."</p> <p>The facility policy, titled, Transferring a Resident from Bed to Chair, dated 9/05, indicated, "...8. Apply gait belt to waist if resident requires weight bearing assist. (See gait belt procedure) 9. Using gait belt-grasp sides of belt with both hands and assist resident to standing...."</p> <p>3.1-45(a)(2)</p>			

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F000327 SS=G	<p>483.25(j) SUFFICIENT FLUID TO MAINTAIN HYDRATION</p> <p>The facility must provide each resident with sufficient fluid intake to maintain proper hydration and health.</p> <p>Based on interview and record review, the facility failed to provide 1 resident (Resident #22) with the calculated fluid needs required to keep him hydrated. This resulted in resident #22 being hospitalized with an acute kidney injury secondary to dehydration.</p> <p>Findings include:</p> <p>Review of the clinical record for Resident #22 on 7/9/13 at 1:32 p.m., indicated the following: diagnoses included, but were not limited to, diabetes mellitus, Parkinson's disease, seizure disorder, insomnia, anxiety, coronary artery disease, dementia, asthma, debility, depressive disorder, esophageal reflux, obstructive uropathy, and hypertension.</p> <p>A Minimum Data Set (MDS) Assessment for Resident #22 indicated a score of 9 out of 15 on the Brief Interview for Mental Status, or moderate cognitive impairment. The MDS also indicated he required supervision with eating.</p>	F000327	F 3271. Resident 22's records were reviewed. Resident will be offered 120 cc of fluids an additional 7x per day during waking hours, (940cc) in addition to the fluids received at meals to assure proper hydration needs are addressed.2. The food and fluid consumption records for all residents have been reviewed to determine if any other residents require further intervention. The RD will review all residents' records. The fluid needs of all residents will be documented on individual food and fluid consumption records and monitored by the night shift nurse to assure all residents are receiving adequate hydration. Any residents noted at risk for not meeting fluid needs will also be offered 120 cc of fluids an additional 7x per day during waking hours, by nursing staff and recorded accordingly on the MAR.3. Nursing staff were re-educated on the facility policy and procedure related to hydration. The DON and/or designee will monitor food and fluid consumption records for all residents on scheduled work days x 4 weeks, 3x/week x 4 weeks, and weekly thereafter, to assure proper hydration is provided for all	07/26/2013			

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	<p>A Nutritional Assessment Form for Resident #22, dated 9/2 8/13, indicated his fluid needs were calculated at 3400 cc's (cubic centimeters) per day. The assessment also indicated his diet provided 1860 cc's of fluid at mealtime and along with his fluids at bedside, his fluid needs would be met. The assessment further indicated he had a decline in self-feeding and shaking was noted with fluids. A history of increased BUN (blood urea nitrogen) and Creatinine was noted.</p> <p>A laboratory report for Resident #22, dated 11/25/12, indicated a BUN of 35 mg/dL (milligrams per deciliter), with a reference range of 8-23 mg/dL, and a Creatinine of 1.80 mg/dL, with a reference range of 0.7 - 1.20 mg/dL.</p> <p>A laboratory report for Resident #22, dated 2/4/13, indicated a BUN of 25 mg/dL, with a reference range of 8-23 mg/dL, and a Creatinine of 1.60 mg/dL, with a reference range of 0.7 - 1.20 mg/dL.</p> <p>A Nutritional Assessment Form for Resident #22, dated 2/19/13, indicated his fluid needs were calculated at 3100 cc's per day. The</p>		<p>residents. Should concerns be noted, corrective actions shall be taken. The RD will alert the DON and/or designee as to any changes made in resident needs per Nutritional Assessments. 4. The DON and/or designee will report the findings of these audits and any corrective actions taken to the Quality Assurance Committee monthly x 3 months then quarterly thereafter. Revisions will be made to the plan, if warranted.5. 7-26-13</p>				

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	<p>assessment also indicated his diet provided 1860 cc's of fluid at mealtime and along with his fluids at bedside, his fluid needs would be met. The assessment further indicated he ate his meals at the assist table and at times he needed to be fed by staff. The assessment did not address the elevated BUN and Creatinine on 2/4/13. No recommendation was made to increase the fluids provided by dietary at mealtime.</p> <p>A laboratory report for Resident #22, dated 5/6/13, indicated a BUN of 27 mg/dL, with a reference range of 8-23 mg/dL, and a Creatinine of 1.60 mg/dL, with a reference range of 0.70-1.20 mg/dL.</p> <p>A Nutritional Assessment Form for Resident #22, dated 5/31/13, indicated his fluid needs were calculated at 3600 cc's per day. The assessment also indicated his diet provided 1860 cc's of fluid at mealtime and along with his fluids at bedside, his fluid needs would be met. The assessment further indicated he ate his meals in the main dining room and required supervision and cueing. The assessment also indicated Resident #22 was recently hospitalized for dehydration and his</p>						

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	<p>labs showed increased BUN and Creatinine levels. No recommendation was made to increase the fluids provided by dietary at mealtime.</p> <p>A meal tray card for Resident #22, indicated he was to receive 360 cc's fluid at breakfast, 120 cc's fluid at lunch, and 240 cc's at dinner, or a total of 720 cc fluid per dietary service in a 24 hour period.</p> <p>Review of the physician orders for Resident #22, dated for the month of May 2013, indicated he received oral medication TID (three times a day).</p> <p>RN #3, was interviewed on 7/11/13 at 11:40 a.m. During the interview she indicated Resident #22 took his medications orally and during each medication pass an 8 ounce glass of water was provided, or a total of 720 cc fluid per nursing service in a 24 hour period.</p> <p>Calculations for the fluids provided by nursing services and dietary service for Resident #22, indicated he received a total of 1440 cc's in a 24 hour period. His consumption of bedside fluids would need to be 2000 cc's or more to meet his calculated fluid needs.</p>						

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	<p>A Nursing Progress Notes for Resident #22, dated 5/22/13 at 5:30 p.m., indicated he had returned from an activity at a baseball game with red face, arms, head, and neck from a sunburn. The note did not indicate staff provided extra fluids for re-hydration due to the sunburn.</p> <p>A Nursing Progress Notes for Resident #22, dated 5/26/13 at 1:30 a.m., indicated he had emesis x (times) 1 et (and) loose stools x 1.</p> <p>A Nursing Progress Notes for Resident #22, dated 5/26/13 at 2:00 a.m., indicated emesis continued. The note did not indicate how much or how many times.</p> <p>A Nursing Progress Notes for Resident #22, dated 5/26/14 at 3:10 a.m., indicated small amount of emesis.</p> <p>A Nursing Progress Notes for Resident #22, dated 5/26/13 at 5:00 a.m., indicated no further emesis or loose stools noted. The note did not indicate if any fluids were offered or consumed.</p> <p>A Nursing Progress Notes for Resident #22, dated 5/26/13,</p>			

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NAME OF PROVIDER OR SUPPLIER CHALET VILLAGE HEALTH AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1065 PARKWAY ST BERNE, IN 46711
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	<p>indicated his 8:00 a.m. medications were held. The note also indicated his nausea was improving. The note did not indicate if any fluids were offered or consumed.</p> <p>A Nursing Progress Notes for Resident #22, dated 5/26/13 at 12:00 p.m., indicated no further emesis or loose stools noted. The note did not indicate if any fluids were offered or consumed.</p> <p>A Nursing Progress Notes for Resident #22, dated 5/26/13 at 4:00 p.m., indicated he continued to have very red skin on his face, arms, hands, and forehead from the sunburn and was lethargic. The note also indicated he consumed 120 cc's fluid.</p> <p>A Nursing Progress Notes for Resident #22, dated 5/26/13 at 4:05 p.m., indicated a large loose liquid stool.</p> <p>A physician's order for Resident #22, date 5/26/13, indicated to send to the emergency room for evaluation and treatment.</p> <p>A Nursing Progress Notes for Resident #22, dated 5/26/13 at 9:30 p.m., indicated the hospital called and</p>			

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	<p>he was admitted with dehydration and elevated Creatinine.</p> <p>A History and Physical Report from the hospital, dated 5/26/13, indicated he was sent to the emergency room due to a concern with progressive lethargy. The note also indicated ..." When the patient arrived in the emergency room, his only complaint was that of thirst...The patient is continuing to complain of profound thirst and has been drinking vigorously throughout the morning...Evaluation there revealed what appeared to be acute onset renal failure and dehydration....It should be noted that the patient has relatively impressive sunburn on his face and arms....the patient has profound sunburn...The clinical picture at this time seems to be most consistent with acute kidney injury related to dehydration..." The note further indicated he was given IV fluids and felt a bit better.</p> <p>A laboratory report for Resident #22, dated 5/26/13, indicated a BUN of 71 mg/dL, with a reference range of 8-23 mg/dL, and a high critical Creatinine of 4.40 mg/dL, with a reference range of 0.70-1.20 mg/dL.</p> <p>A laboratory report for Resident #22,</p>						

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	<p>dated 5/27/13, indicated a BUN of 74 mg/dL, with a reference range of 8-23 mg/dL, and a high critical Creatinine of 4.40 mg/dL, with a reference range of 0.70-1.20 mg/dL.</p> <p>Re-admission orders for Resident #22, dated 5/30/13, indicated the diagnosis of acute kidney injury. There was no indicated the fluids provided through dietary services and nursing services had been increased upon his return to the facility.</p> <p>The Consultant Nurse was interviewed on 7/10/13 at 10:25 a.m. During the interview she indicated the facility only kept track of all fluid intake if a resident was on I & O (intake and output).</p> <p>The Dietary Manager was interviewed on 7/12/13 at 11:45 a.m. During the interview she indicated she had only been working in the facility a short time. She also indicated she continued to provide those fluids to the residents which were already identified on their meal cards at mealtime.</p> <p>A facility care plan for Resident #22, with a start date of 2/4/13, indicated the problem area of resident is at risk for exhibiting signs and symptoms of</p>						

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	<p>dehydration due to increased BUN. Interventions to the problem area included, but were not limited to, encourage resident to drink all fluids offered, offer a variety of fluids at frequent intervals as residents orders allow, and monitor consumption for adequate intake.</p> <p>A facility care plan for Resident #22, dated 5/31/13, indicated the problem area of alteration in nutritional/hydration status and a history of dehydration. A goal to the problem area was for the resident to maintain adequate hydration status...At the time of admission, dietary will determine each resident's daily fluid needs...A fluid plan to increase fluid intake will be put into place to reach the resident's daily fluid need...Dietary will provide 1800 cc of fluid per day with meals, unless otherwise contraindicated...."</p> <p>3.1-46(b)</p>				

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F000371 SS=F	<p>483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions Based on observation, interview and record review, the facility failed to ensure food/drinks in the nourishment refrigerator were labeled/dated when opened which had the potential to affect 33 of 33 residents who resided in the facility. Findings include: During an observation on 7-11-2013 at 9:55 a.m., the nourishment refrigerator next to nurse's station contained a pitcher of yellow/orange liquid which was not labeled or dated and a styrofoam cup was not labeled with contents or dated. A jar of sweet pickles and hot cauliflower, a container of limburger cheese and french onion dip were not dated when opened. A jar of salsa was not labeled with a resident name or date opened. An interview with CNA #6 on 7-11-2013 at 10:28 a.m., indicated the yellow/orange liquid in the pitcher was orange juice and CNA #6</p>	F000371	F3711. All food in nourishment pantry items which was not dated and/or labeled was removed immediately from nourishment pantry refrigerator and discarded.2. Staff were re-educated on the policy for nourishment pantry. All food or drinks will be marked with contents, name and date opened. The policy was updated to include information on labeling and dating residents' food/drinks in the nourishment refrigerator.3. Staff were re-educated on the policy for nourishment pantry. All food/drinks will be marked with contents, name of resident and date opened. The policy was updated to include information on labeling and dating residents' food/drinks in the nourishment refrigerator. The Administrator and/or designee will monitor the nourishment refrigerator daily on scheduled work days x 4 weeks, then weekly thereafter. Should concerns be noted, corrective action shall be taken.4. The Administrator and/or designee will report the findings of monitoring and any corrective actions taken to the Quality Assurance	07/26/2013			

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	<p>indicated the juice should have been labeled with the contents and dated. CNA #6 indicated the sweet pickles, hot cauliflower, limburger cheese and French onion dip should have been dated when opened. The jar of salsa should have had a resident name and date opened on it. The styrofoam cup should have had the contents labeled and dated.</p> <p>A policy "Nourishment Pantries" dated 11-12-2018 provided by the Consultant Nurse on 7-11-2012 at 2:52 p.m., lacked information on labeling and dating of residents food/drinks in the nourishment refrigerator.</p> <p>An interview with the Consultant Nurse and DON (Director of Nursing) on 7-12-2013 at 11:05 a.m., indicated the facility does not have a policy regarding labeling and dating food items stored in the nourishment refrigerator. The DON indicated it was just expected to have all food/drink items labeled and dated when opened.</p> <p>3.1-21(i)(2)</p>		Committee monthly 3 then quarterly thereafter. Revisions will be made to the plan, if warranted. 5. 7-26-13		

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F000441 SS=D	<p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. Based on observation, interview and</p>	F000441	F441 1. Resident 34 was not	07/26/2013			

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	<p>record review, the facility failed to ensure isolation precautions were followed for 1 of 3 residents who were identified with isolation precautions of the 33 residents who resided in the facility. (Resident #34)</p> <p>Findings include:</p> <p>During an observation on 7-11-2013 at 11:45 a.m., CNA #6 and CNA #7 entered Resident #34's room who had been identified as positive for Clostridium difficile (bacteria that caused diarrhea and can be transmitted via touching contaminated surfaces). A sign outside the room indicated persons prior to entering the room to see the nurse. A cart with protective equipment was located outside the room and contained yellow gowns. CNA #7 indicated she was going to take Resident #34 off the bedpan. CNA #6 and CNA #7 were observed not to don the personal protective equipment (gown) located in the cart next to the door prior to entering Resident #34's room for personal care.</p> <p>An interview with RN #3 on 7-11-2013 at 11:46 a.m., indicated staff assisting with the bedpan should wear a gown</p>		<p>negatively affected. C.N.A.s # 6 and 7 immediately changed clothing following failure to don a gown when providing care to resident.</p> <p>2. C.N.A.s #6 and 7 changed clothing immediately to prevent spread of infection. Staff was re-educated immediately on isolation procedures and proper use of PPE.</p> <p>3. All staff were re-educated on Infection control and PPE to be worn when caring for residents in isolation. The DON and/ or designee will conduct observation of care to residents in isolation 2 x per shift x 7 days, 1 x per shift x 3 weeks, weekly x 2 months and monthly thereafter in an effort to confirm staff compliance with use/wearing of applicable PPE. Should non-compliance be observed, corrective action shall be taken.</p> <p>4. The DON and/or designee and/or designee will report findings of monitoring and any corrective actions taken to the Quality Assurance Committee monthly x 3 months then quarterly thereafter.</p> <p>5. 7-26-13</p>		

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	<p>as Resident #34 was positive for Clostridium difficile. An observation of CNA #6 and CNA #7 in Resident #34's room made by RN #3 indicated neither CNA #6 or CNA #7 wore a gown.</p> <p>An interview with CNA #6 on 7-11-2013 at 12:00 p.m., indicated she assisted CNA #7 with Resident #34 who was on the bedpan. CNA #7 indicated she held Resident #34 while CNA #7 was cleaning the resident after a bowel movement. CNA #6 indicated she was aware Resident #34 had Clostridium difficile and indicated she should have worn a gown along with the gloves.</p> <p>An interview with CNA #7 on 7-11-2013 at 12:06 p.m., indicated she assisted Resident #34 off the bedpan and cleaned the resident of the bowel movement. CNA #7 indicated she was aware Resident #34 had Clostridium difficile but didn't realize when she delivered the resident her meal tray that she had to take her off the bed pan. CNA #7 indicated she did not take the time to put on a gown prior to assisting the resident off of the bedpan.</p> <p>An interview with the DON (Director of Nursing)/Infection Control Nurse on</p>				

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	<p>7-12-2013 at 11:46 a.m., indicated she was not aware that the CNA staff did not follow the isolation procedures for Clostridium difficile and indicated staff assisting with peri care for a resident with Clostridium difficile should wear a gown and gloves.</p> <p>A policy "Clostridium Difficile" dated July 22, 2005 was provided on 7-11-2013 at 2:52 p.m. by the Consultant Nurse. The policy indicated "...Use Contact Transmission-Based Precautions: for patients with known or suspected C. difficile-associated disease:...use gloves when entering patients' rooms and during patient care; use gowns if soiling is likely...."</p> <p>3.1-18(j)</p>				

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F000520 SS=G	<p>483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS</p> <p>A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff.</p> <p>The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies.</p> <p>A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section.</p> <p>Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.</p> <p>Based on interview and record review, the facility failed to identify and implement a plan of action for the identified concerns of dehydration, fluid restrictions, protecting residents against sunburn, for labeling/dating food and drinks in the nourishment refrigerator, use of personal protective equipment for a resident in isolation and not following the Registered Dietician's recommendation. These deficient</p>	F000520	F5201. Corrective actions as described in the Plan of Correction were taken for all residents relative to concerns of dehydration, Fluid Restrictions, protecting residents against sunburn, for labeling/dating food and drinks in the nourishment refrigerator, use of PPE for a resident in isolation, and not following the Registered Dieticians' recommendation.2. As all residents could be affected, the following corrective actions have been taken. Administrative	07/26/2013			

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	<p>practices had the potential to affect 33 out of 33 residents residing in the facility.</p> <p>Findings include:</p> <p>An interview with the Administrator on 7-12-2013 at 11:05 a.m., indicated the facility has a QAA (Quality Assessment and Assurance) committee and an IDT (interdisciplinary team) committee that works on identified quality issues. The Administrator indicated some of the current issues being addressed by the QAA were staff turnover, staffing consistency with resident care and activities. The Administrator indicated the resident on a fluid restriction was non-compliant, umbrellas were provided for residents on an outing to prevent sunburn and the facility was not aware of the unlabeled/undated food stored in the nourishment refrigerator.</p> <p>An interview with the DON (Director of Nursing) on 7-12-2013 at 11:45 a.m., indicated she was not aware of the following: documentation of fluid intake was lacking for a resident with dehydration; residents participating in outdoor activities should be protected from sunburn; food/drink items were not labeled with contents, resident's</p>		<p>staff has reviewed the current Quality Assurance Committee procedures, adding to the monthly meeting, audits to include but not be limited to Concerns of dehydration, Fluid Restriction, protecting residents from sunburn, for labeling/dating food and drinks in the nourishment refrigerator, use of personal protective equipment for a resident in isolation and not following the Registered Dietician's recommendation.3. Administrative staff has reviewed the current Quality Assurance Committee procedures, adding to the monthly meeting, audits to include but not be limited to Concerns of dehydration, Fluid Restriction, protecting residents from sunburn, for labeling/dating food and drinks in the nourishment refrigerator, use of personal protective equipment for a resident in isolation and not following the Registered Dieticians' recommendation. Administrative nursing shall be responsible to conduct and/or delegate said audits in an effort to identify quality of care areas on concern and address with the Quality Assurance Committee in an effort to formulate an action plan, should deficient practice be identified.4. As a means of Quality Assurance, the DON and/or designee, the Administrator and/or designee shall report findings of aforementioned audits and</p>		

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	<p>name or a date when opened in the nourishment refrigerator; staff not following isolation procedures for residents identified with Clostridium difficile; and didn't realize the Registered Dietician's recommendations were not followed.</p> <p>There was no evidence the QAA Committee had a system in place to identify concerns or a plan in place to address the concerns regarding dehydration, fluid restrictions, protecting residents against sunburn, for labeling/dating food and drinks in the nourishment refrigerator, use of personal protective equipment for a resident in isolation and not following the Registered Dietician's recommendation.</p> <p>3.1-52(a)(2)</p>		<p>immediate corrective actions taken to the Quality Assurance Committee during monthly meetings. Further, corrective action shall be planned/executed by the committee as warranted with follow up reporting provided/reviewed at the next Quality Assurance meeting in an effort to continually identify issues with respect to which quality assessment and assurance activities are necessary and develop and implement appropriate plans of action to correct identified quality deficiencies.5. 7-26-13</p>		