STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355100	A. BUILDING _____ B. WING _____	C 10/08/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - DEVILS LAKE	302 7TH AVE NE DEVILS LAKE, ND 58301

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS For the unannounced complaint survey started on 10/07/09 and completed on 10/08/09, the sample included 8 sampled residents and 2 closed records for review.	F 000	**General Disclaimer** Preparation and Execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of Federal and State law. For the purposes of any allegations that the facility is not in substantial compliance with Federal requirements of participation, this response and plan of correction constitutes the facility's allegation of compliance in accordance with section 7305 of the State Operations Manual.	
F 244 SS=E	483.15(c)(6) PARTICIPATION IN RESIDENT & FAMILY GROUPS When a resident or family group exists, the facility must listen to the views and act upon the grievances and recommendations of residents and families concerning proposed policy and operational decisions affecting resident care and life in the facility. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, family interview, review of Resident Council meeting minutes, and staff interview, the facility staff failed to act upon grievances in a timely manner regarding menus, voiced by the facility's organized Resident Council, for 4 of 4 Resident Council meetings prior to the survey. Failure to act upon the grievances did not recognize the residents' individuality, their right to make choices, or their right to timely resolution of grievances. Findings include: - On 10/07/09 at approximately 4:00 p.m., the facility's Resident Council president gave permission for review of the minutes of the Resident Council meetings. Review of these minutes on October 07-08, 2009 identified the following: Eight different staff members attended the	F 244		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Mindi D Hodges	Administrator	10/30/2009

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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F 244	Continued From page 1 following four meetings. One staff member attended all four meetings. *07/01/09 - "[Resident's name] stated that she received Tuna Salad and doesn't like tuna. [Staff member (#12)] said he had cold Salmon [sic] on menu and had put Tuna [sic] on instead. . . ." *08/05/09 - "[Resident's name] said that the supper meals were "terrible" and that she did not like what was served for suppers and other residents agreed. . . ." *09/02/09 - "Residents said that it's the same menu and that they don't always serve what is on menu. [Staff member (#13)] said that we had hired a new Dietary Manager and hopefully things would improve. . . ." *10/07/09 - [Resident's name] said that she still was not getting a menu. [Staff member (#14)] explained that [Staff member (#15)], in dietary, said that there will be a new menu next week for the Fall/Winter. . . ." - During interview, on 10/07/09 at 6:05 p.m., Family Member #A reported over the past two months: *The facility did not post a menu. *Two or three weeks ago the evening meal was "undefinable" and a menu was not available. *The facility did not make a menu available for any meal. *Carrots are served several consecutive days. - Observation on 10/08/09 at 11:30 a.m., identified the facility staff serving the noon meal from a buffet line. The entrees for the meal were meat loaf or pork chops. Residents selected their meal items from the buffet or facility staff served them at their tables. Observation, on 10/08/09 at 11:45 a.m., identified	F 244	**F244 Participation in Resident & Family Groups** **This is what the facility will do to correct the specific problems, found related to the specific resident identified.** Resident #5's individual needs have been addressed by completing a nutritional assessment and the care plan was reviewed and revised as needed. Resident #5 was given a copy of the updated menu for review. This was completed on 11-06-09 Resident #4's individual needs have been address by completing a nutritional assessment and the care plan was reviewed and revised as needed. The DDS completed a meal preference assessment and a new diet/tray card was produced based on a current meal preference. This was completed on 11-06-09. Resident #7's individual needs have been addressed by completing a nutritional assessment and the care plan was reviewed and revised as needed.	11-22-09

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F 244	Continued From page 2 Resident #5 seated in a wheelchair at a dining room table. A facility staff member served the resident her noon meal, which included meat loaf. During interview at this time, Resident #5 stated the facility staff did not make a menu available for the meal. Review of Resident #5's medical record, on October 07-08, 2009, identified the facility admitted the resident in May 2009. The resident's physician orders included a regular mechanical soft diet. The current Minimum Data Set (MDS), dated 08/03/09, identified short term memory problems and no long term memory problems. The facility identified the resident was interviewable. - When interviewed on 10/08/09 at 9:00 a.m., Resident #4, identified as interviewable by the facility, stated facility staff "used to send me a menu." Resident #4 stated the previous dietary manager would visit with her regarding her meal preferences. She stated facility staff lost her original diet card. She had written the foods she disliked on her new diet card, sent on her meal tray, but questioned if staff could read her handwriting. Resident #4 stated she liked chicken drummies and disliked chicken wild rice soup, squash, and rutabagas and when she received these foods she pushed them off her plate onto a napkin. Review of Resident #4's medical record on 10/08/09, identified the resident received a regular diet. The current quarterly MDS, dated 09/04/09, identified the resident as having short-term memory problems and no long-term memory problems.	F 244	Resident #7 was given a copy of the updated menu for review. This was completed on 11-06-09. **This is what the facility will do to identify and correct any problems found with other residents who also could be affected by the facility practice.** Any resident council member who complained about the food will have the potential to be effected. Each complaint noted at the Resident Council will be follow up by the appropriate department. The Social Worker/Designee will be responsible to track any concerns to make sure they are resolved timely. Resident Council Meetings for the past 6 months (May-Oct 2009) were reviewed by the Social Worker and all grievances noted in the meetings were re-investigated and resolved. This was accomplished by 11-13-09. **This is what the facility will do or changes it will make to the systems that will prevent this problem from reoccurring in the future.** On 11-6-09 the Social Worker, Activities Director and Administrator were re-educated on the procedure for Resident Council.	

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F 244	Continued From page 3 During an interview on 10/08/09 at 11:30 a.m., a dietary staff member (#1) stated the cook sent a staff member to obtain Resident #4's meal preferences because no menu had been provided by the dietitian for two weeks or more. When requested on the afternoon of 10/08/09, facility staff could not provide Resident #4's diet card and administrative staff member (#2) identified it had been lost at the noon meal on 10/08/09. - When interviewed on 10/08/09 at 11:45 a.m., Resident #7, identified as interviewable by the facility, stated the facility staff did not provide a menu since June. Review of Resident #7's medical record on 10/08/09, identified the resident received a low sodium diet. The current significant change MDS, dated 07/10/09, identified the resident as having short-term memory problems and no long-term memory problems. - On request, on 10/08/09 at 1:30 p.m., facility staff provided menus for the past week. The menu for the noon meal on 10/08/09 included the entrees of pork chops and meat loaf. At this time, surveyors attempted to contact the facility's consultant dietitian by telephone, without success. - During interview, on 10/08/09 at 2:30 p.m., two administrative staff members (#2 and #6) reported the facility's Dietary Department had staffing changes and they were not aware of the residents' grievances during the Resident Council meetings. These staff members agreed the facility staff failed to resolve the residents' grievances in a timely manner; the facility should	F 244	The Social Worker will be responsible to track and follow up on any grievances using the Grievance Tracking Log. The Activity Director is responsible in the absence of the Social Worker. The current menu system was reviewed, updated as needed and approved by the facility's Registered Dietician. The revised menu was presented to the Resident Council for their review by the Social Worker. This was completed by 11-13-09. A copy of the updated menu for the whole week was posted for all residents. The Dietary Manager/Designee will make sure this process is completed on a weekly basis starting on 11-13-09. The Social Worker will be responsible to post minutes of the Resident Council next to the Survey book near the front entrance. Minutes will not have any resident names included.	

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F 244	Continued From page 4 provide menus to the residents; menus should be followed; and, menus should be posted. - During interview, on 10/08/09 at 3:15 p.m., a supervisory dietary staff member (#15) reported she accepted her supervisory position within the past month. This staff member reported she was not aware of the residents' grievances. This staff member reported she will begin the dietary manager training program soon. The residents voiced their grievances at Resident Council meetings for the months July through October 2009. Facility staff members attended those meetings on more than one occasion. The facility staff failed to respond to the grievances and failed to resolve the grievances in a timely manner.	F 244	**This is how the facility will monitor to make sure the changes continue and the problem is prevented.** An audit tool will be developed for the documentation and follow up on all grievances. A monthly audit of the Grievance Tracking Log will be completed by the Social Worker/Designee. The social worker, or her designee, will be responsible for the completion of the audit. She will provide a monthly summary of the audits to provide the audit to the QA/CQI Committee for further recommendations. This will continue on an ongoing basis	
F 309 SS=D	483.25 QUALITY OF CARE 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. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, the facility staff failed to provide the necessary care and services to maintain the highest practicable physical, mental, and psychosocial well-being regarding assistance with personal hygiene for 1 of 5 sampled residents (Resident #2) requiring total assistance with toileting. Failure to provide Resident #2 with	F 309	F309 Quality of Care **This is what the facility will do to correct the specific problems, found related to the specific resident identified.** Resident #2's individual needs have been addressed by performing and documenting a though skin assessment, bowel assessment, and is a currently asymptomatic for any signs or systems of a UTI. Her care plan was updated as needed. Resident # 2 was evaluated using a Geriatric Depression Scale. The	11-22-09

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F 309	Continued From page 5 assistance in a timely manner after an episode of bowel incontinence placed the resident at risk of skin breakdown, urinary tract infection, and did not recognize the resident's psychosocial well-being. Findings include: Review of Resident #2's medical record, on October 07-08, 2009, identified the facility admitted the resident in November 2002. The resident's current diagnoses included hypertension, depression, and history of stroke with right extremities paralysis. The resident's current Minimum Data Set (MDS), dated 07/24/09, identified short and long term memory problems, total dependence on two persons for toileting, extensive assistance of one person for personal hygiene, transfer with a mechanical lift, and occasionally incontinent of bowel during the 14 days prior to the MDS. Resident #2's current care plan, dated 08/05/09, stated "Problems . . . Self care deficit r/t [related to] hx [history] CVA [cerebral vascular accident] [stroke] with R) [right] sided weakness, depressive illness . . . m/b [manifested by] needs assistance with bathing and ADL's [Activities of Daily Living] . . . Problems . . . Impaired mobility r/t hx CVA with R) sided weakness, hx DJD [degenerative joint disease] m/b unsteady sitting balance with w/c [wheelchair], bed mobility & [and] transfers. . . . Plans . . . Total lift XL [extra large] sling for transfer . . . Problems . . . Alteration in elimination r/t hx CVA with R) sided weakness, decreased mobility m/b urinary incontinence and hx constipation . . . Plans . . . Wears incontinent pad . . . Problems . . . Potential for alteration in skin integrity r/t hx CVA with R)	F 309	results of the assessment have been reported to the primary care physician. Any new physician orders will be noted and had her care plan will be updated as needed. All of these were completed by the Nurse Manager/Designee by 10-30-09. **This is what the facility will do to identify and correct any problems found with other residents who also could be affected by the facility practice.** Residents who are incontinent of bowels could have the potentially to be affected in this area. The listed residents will have a documented Skin inspection, reviewed and updated as needed Bowel Assessment, and will be evaluated for a possible UTI. Any abnormal findings will be reported to the primary care physician and their care plans will be updated This process will be completed by 11-22-09 **This is what the facility will do or changes it will make to the systems that will prevent this problem from reoccurring in the future.** A mandatory nurses meeting was held on October 15, 2009 to re-educated the nursing staff on the	

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F 309	Continued From page 6 sided weakness, impaired mobility, itchy, dry skin. . . ." Observation, on 10/08/09 at 9:05 a.m., identified Resident #2 seated in her wheelchair in her room, asleep with her call light attached to her lap blanket. The resident's roommate was lying on her bed, asleep. A very strong fecal odor was present in the room. Observation, on 10/08/09 at 9:23 a.m., identified a certified nursing assistant (CNA) (#10) entered Resident #2's room with a full body lift and then left the room. At 9:45 a.m., CNA (#10) returned to Resident #2's room accompanied by CNA (#11). At this time, CNA (#10) reported Resident #2 was incontinent of bowel with fecal material on the floor and would need to "wash up" the resident. CNA (#11) began removing Resident #2's sweater and stated, regarding the sweater and extent of bowel incontinence, "Got to go [the sweater] if that tells you anything. Have to undress you [Resident #2] completely." During interview, on 10/08/09 at 10:15 a.m., CNA (#10) reported Resident #2 usually activates her call light to summon assistance for bowel movements but did not do so this morning. The CNA (#10) reported transferring the resident to the toilet with the full body lift, washed the resident's back and perineal area which were soiled with fecal matter and dressed the resident in a new brief and a change of clothes. This staff member reported fecal matter soiled the wheelchair and the room carpet, requiring cleaning by the facility Housekeeping Department. After cleaning the wheelchair, the CNAs (#10 and #11) transferred Resident #2 back to the wheelchair. This staff member (#10)	F 309	Procedure for performing pericare. Staff were also reminded to address any instances of bowel incontinence quickly. Staff that did not attending the education were followed up by Staff Development/Designee by 11-22-09. **This is how the facility will monitor to make sure the changes continue and the problem is prevented.** The SDC will complete 5 peri care observations each month for 3 months and monitoring the response time to call light times 2 X's per week for three months. A summary of the audits will be completed by the SDC and reported to the QA/CQI Committee for further recommendations.	

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F 309	Continued From page 7 reported she was aware of Resident #2's bowel incontinence onto the wheelchair and floor at 9:23 a.m. and did not begin the toileting and cleaning process because she knew she would need help. CNA (#10) reported CNA (#11) was "busy" and not able to assist her until 9:45 a.m., 22 minutes later. The facility staff identified Resident #2 was dependent for toileting, occasionally incontinent of bowel and at risk for skin breakdown. The facility staff identified the resident had an incontinent bowel movement with fecal material on the wheelchair and floor. The facility staff waited 22 minutes after identifying the extensive bowel incontinence before initiating the toileting and cleaning process during which time Resident #2 remained seated in the fecal material and the roommate remained in the room with the very strong odor. During interview, on 10/08/09 at 2:30 p.m., two administrative staff members (#2 and #6) agreed the facility staff should not have waited to begin toileting and cleaning Resident #2, this episode of Resident #2's care was a high priority, and other staff were available to assist with Resident #2's care. Failure to provide toileting and incontinence cares in a timely manner for Resident #2 resulted in Resident #2 and her roommate being exposed to a very strong fecal odor for an extended period of time and Resident #2 remained in soiled undergarments and clothing for an extended period of time. This failure placed Resident #2 at risk of skin breakdown and urinary tract infection and failed to recognize the psychosocial well-being of Resident #2 and her roommate.	F 309		
F 314 SS=D	483.25(c) PRESSURE SORES	F 314		

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F 314	Continued From page 8 Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policy and procedure, and staff interview, the facility staff failed to ensure 2 of 2 sampled residents with skin breakdown (Resident #1 and #6) received adequate perineal care and preventive measures to promote skin healing and minimize the risk of skin breakdown. Failure to provide adequate perineal care placed Resident #1 at risk of delayed healing of existing skin breakdown on the coccyx; and, failure to provide preventive measures resulted in skin breakdown of Resident #6's heel and increased the risk of skin breakdown for Resident #1's heels. Findings include: Review of the facility's policy and procedure, Perineal Care, occurred on 10/08/09. This policy and procedure, dated 01/09, stated "PURPOSE * To keep the perineal area clean * To prevent infection and odors in the perineal area * To promote good perineal hygiene * To observe perineal area . . . PROCEDURE . . . 7. Turn resident on side to	F 314	F314 Pressure Sores **This is what the facility will do to correct the specific problems, found related to the specific resident identified.** Resident #1's individualized needs have been addressed by conducting a skin assessment with a focus on the coccyx and heels, bowel assessment, and was evaluated for a UTI on 10-30-09. His care plan was reviewed and revised as needed. Resident #6's individualized needs have been addressed by assessing and removing the Croc style shoe strap and both heels. Her care plan will be reviewed and revised as needed. This was completed on 10-22-09. **This is what the facility will do to identify and correct any problems found with other residents who also could be affected by the facility practice.** All residents who have identified skin breakdown ~~pressure sore~~ areas are potentially affected by this area. A list of all residents who have a skin breakdown ~~pressure sore~~ area has been identified and a skin assessment was completed. Care plans will be reviewed and revised as needed. The Nurse	11-22-09 plan call G. Hodges admin 11/3/09, KH

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F 314	Continued From page 9 wash, rinse and dry anal area. . . ." Review of Resident #1's medical record on October 07-08, 2009, identified the facility admitted the resident in October 2001. The resident's current diagnoses included cerebral vascular accident (CVA) and positive Methicillin Resistant Staphylococcus Aureus (MRSA). The resident's current Minimum Data Set (MDS), dated 08/14/09, identified short and long term memory problems, total dependence on one person for toileting and personal hygiene needs and incontinence of bowel and bladder. Resident #1's current care plan, dated 08/14/09, stated "Problems . . . Self care deficit r/t [related to] past CVA with quadriplegia, decreased mobility . . . Needs assist with ADLs [Activities of Daily Living] . . . Plans . . . Total assist with ADLs . . . Problems . . . Alteration in elimination r/t CVA . . . m/b [manifested by] incontinent of bowel & [and] bladder. . . . Goals . . . Will be kept clean and dry . . . Plans . . . Monitor BM [bowel movement] Q [every] shift. . . . Problems . . . Alteration in skin integrity r/t CVA, decreased mobility, dry skin, low Braden score . . . skin MRSA m/b scratches to different areas and lesions over body. Open lesions to various areas of body. . . . Plans . . . Heels off of bed @ [at] all times. . . ." Resident #1's Braden Scale For Predicting Pressure Sore Risk, dated 08/14/09 and 05/19/09, showed "16," identified as "Mild Risk" for development of pressure sores. Resident #1's Interdisciplinary Progress Notes (IDP), dated 09/25/09, identified three openings "too small to measure" on the coccyx; dated	F 314	Manager/Designee completed this task by 11-22-09. **This is what the facility will do or changes it will make to the systems that will prevent this problem from reoccurring in the future.** A Mandatory Nursing meeting was held on 10-15-09 to re-educate the staff on proper positioning, the use of pressure reducing devices, performing proper peri care, and the prevention of ~~pressure ulcers.~~ skin breakdown Staff were also reminded to address any instances of bowel incontinence quickly. Staff not attending the education were followed up by Staff Development/Designee by 11-22-09. **This is how the facility will monitor to make sure the changes continue and the problem is prevented.** An audit tool will be developed to check for positioning devices and proper use of the assistive device according to the resident's care plan, pericare according to procedure, and that skin assessments are completed on all at High risk residents weekly, and daily documentation is being done on residents who have an open	

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F 314	Continued From page 10 09/26/09, identified an opening at the "crack of coccyx, ½ centimeter [cm] x [by] 1 cm" and use of a "hydrocolloid" dressing; and, dated 10/06/09, identified a change in dressings to use of an ointment only, two times each day and as needed. Observation, on 10/08/09 at 8:45 a.m., identified two certified nursing assistants (#8 and #9) providing cares for Resident #1. The CNAs removed foam foot protectors from both feet, washed the resident's trunk and provided frontal perineal care. The CNAs turned the resident to his right side and removed his brief. The resident had been incontinent of bowel and CNA (#8) began removing fecal material from the resident's rectal area. After using several wipes and removing fecal material, the CNA (#8) removed her gloves and began to dispose of the protective underpad. The last wipe used by the CNA (#8) contained fecal material. On request of the surveyor, the CNA (#8) wiped Resident #1's rectal area again with more fecal material on the wipe. The CNA repeated this process approximately ten times, finding additional fecal material at Resident #1's rectal area with each wipe, until no additional fecal material was found with the wipe. The CNA (#8) then washed and dried Resident #1's rectal area, placed a new brief on the resident, and completed the morning's cares. During the cares on 10/08/09 at 8:45 a.m., observation also identified a slit like area in the skin fold of the buttocks at the coccyx. Observation, on 10/08/09 at 10:10 a.m., identified Resident #1 supine in bed and a CNA (#8) at his bedside. A licensed nurse (#7) entered the room to provide the treatment and dressing to Resident	F 314	area. The audit will be complete 2X's per week for the next three months. The Nurse Manager or designee is responsible for completing the audit and provide immediate follow up if any problems are noted during the audits. The results of the audits will be reported to the QA/CQI Committee for further recommendations.	

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	355100	A. BUILDING _____ B. WING _____	C 10/08/2009

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F 314	Continued From page 11 #1's coccyx area. The CNA re-positioned the resident on his right side and lowered his brief and clothing. The licensed nurse (#7) wiped the area with a gauze pad identified to be soaked with sterile water, wiped the area dry with a gauze pad, and then applied the ointment as ordered. Following the treatment, the CNA re-positioned the resident's brief and clothing and re-positioned the resident on his back with his heels in contact with the bed linens. During interview following this episode of care, the licensed nurse (#7) reported the initial hydrocolloid dressing did not work well as it "rolled down" and frequently would have "BM" in it. This nurse reported since changing to the ointment only, Resident #1's coccyx area had steadily healed to now the slit like opening. Observation on 10/08/09 at 10:45 a.m. and at 1:15 p.m., identified Resident #1 in bed with his feet and heels on the bed and in contact with the bed linens. The facility staff failed to ensure complete wiping during perineal cares to ensure fecal material did not come in contact with the coccyx area. The facility staff also failed to implement preventive skin breakdown techniques by ensuring Resident #1's heels remained off the bed and bed linen. During interview, on 10/09/09 at 2:30 p.m., two administrative staff members (#2 and #6) confirmed the staff should have ensured complete removal of fecal material and should have positioned Resident #1's heels off the bed and bed linens with a pillow or the foot protectors observed to be removed with morning cares. Failure to remove the fecal material placed	F 314		

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F 314	Continued From page 12	F 314		

Resident #1 at risk of delayed healing and additional skin breakdown at the coccyx. Failure to position his heels off the bed and bed linens placed him at risk of developing avoidable skin breakdown on his feet and heels.

- Review of Resident #6's medical record, occurred on 10/08/09. Record review identified the resident's diagnoses included diabetes mellitus, right heel ulcer, cellulitis L (left) shin, and hypertension.

Review of the "Braden Scale for Predicting Pressure Sore Risk," completed for Resident #6 on 07/09/09 showed "18," identified as "Mild Risk" for development of pressure sores.

Review of a "Fax Communication to Physician," dated 09/30/09, stated, "Resident had a 3 cm by 1.8 cm blister-like area, fleshy-like broken blister [with] a red rim of .6 cm . . . adjusted strap on crock [Croc] shoe so not rubbing on area. . . . " (A Croc shoe is a brand name slip-on shoe with a strap that may be worn behind the heel.)

Review of Resident #6's care plan, dated 07/22/09, included the problem of "heel wound," dated 09/30/09, with the approach of "keep shoe strap off back of foot heel."

Review of Resident #6's "Wound Flow Sheet," on 10/07/09 showed the resident had a blister on her right heel identified as 3 cm by 1 cm in size.

Observation of cares on 10/08/09 at 10:10 a.m. by CNA (certified nursing assistant) (#3) and administrative nursing staff member (#4) showed the strap of the resident's Croc shoe positioned behind the heel of her left foot.

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F 314	Continued From page 13 Observation on 10/08/09 at 1:30 p.m. with two administrative nursing staff members (#4 and #5) showed the resident's strap of her Croc shoe remained positioned behind the heel of her left foot. Facility staff identified positioning of the strap on the resident's Croc shoe as a contributing factor in the development of Resident #6's pressure ulcer on her right heel. Positioning the strap of the Croc shoe behind the heel of her left foot has the potential to cause a reddened area that could develop into a second pressure ulcer. When interviewed on 10/08/09 at 1:30 p.m., an administrative nursing staff member (#4) agreed there is potential for a pressure ulcer to develop with the shoe strap positioned behind the heel. This staff member removed Resident #6's left Croc shoe and adjusted the strap so it rested on the top of the shoe, away from the back of the resident's heel. An administrative nursing staff member (#5) confirmed the strap of the left shoe "should be forward" not behind the heel.	F 314		
F 366 SS=B	483.35(d)(4) FOOD Each resident receives and the facility provides substitutes offered of similar nutritive value to residents who refuse food served. This REQUIREMENT is not met as evidenced by: Based on observation, record review, family and staff interview, complainant information, and review of facility policy and procedure, the facility failed to ensure each resident received meals which honored each resident's individual food	F 366	F366 Food **This is what the facility will do to correct the specific problems, found related to the specific resident identified.** Resident #6's individualized needs have been addressed by completing a nutritional assessment and updating her care plan. The Dietary Manager/Designee completed a meal preference assessment and a new diet/tray card was produced based on a current	11-22-09

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F 366	Continued From page 14 preferences for 2 of 8 sampled residents (Resident #6 and #8) and 2 of 2 closed (Resident #9 and #10) sampled records. Failure to honor individual preferences did not recognize each resident's individuality, their right to make choices, and placed residents at nutrition risk by not consuming nutritionally balanced meals and snacks. Findings include: Review of State Agency files revealed complainant information that the facility failed to honor the resident's food preferences. Review of the policy and procedure, "Dietary Documentation," occurred on the afternoon of 10/08/09. The procedure stated, ". . . c. Complete the nutrition data portion of the Initial Interdisciplinary Data Collection Tool within 72 hours. d. Obtain food preferences and dislikes. . . ." - During interview, on 10/07/09 at 6:05 p.m., Resident #8's family member reported over the past two months: *The facility staff have not questioned the resident or family members regarding the resident's food preferences. *The resident dislikes eggs and facility staff continued to serve the resident eggs at meals until recently. Review of Resident #8's medical record identified the facility admitted the resident in August 2009. The resident's Minimum Data Set (MDS), dated 08/11/09, identified short and long term memory problems and moderately impaired daily decision making abilities. The record identified the family	F 366	meal preference was completed by 11-06-09. She was also provided with a copy of the updated menu for review. Resident #8's individualized needs have been addressed by completing a nutritional assessment and updating her care plan. The Dietary Manager/Designee completed a meal preference assessment and a new diet/tray card was produced based on a current meal preference was completed by 11-06-09. She was also provided with a copy of the updated menu for review. Residents #9 and #10 have been discharged. **This is what the facility will do to identify and correct any problems found with other residents who also could be affected by the facility practice.** All Residents that eat oral food could have the potential to be affected in this area. The Dietary Manager/Designee will ensure documentation of meal preferences, a completed nutritional assessment, and create an new accurate tray cards for all residents. Care plans	

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F 366	Continued From page 15 member as the responsible party. The resident's Nutrition Assessment, dated 08/17/09, failed to include food preferences or likes/dislikes. The facility staff failed to complete the resident's Initial Interdisciplinary Data Collection Tool. The resident's Diet Card, undated, reviewed on 10/08/09, identified "DISLIKES: EGGS." - Review of Resident #6's medical record, occurred on 10/08/09. The resident's care plan, dated 07/22/09, identified the resident "Does not like milk." Review of Resident #6's diet card on the afternoon of 10/08/09, showed "No Milk" for the breakfast, dinner, and supper meals. When interviewed on 10/08/09 at 9:25 a.m., a dietary staff member (#1) stated Resident #6 consumed 60 cc or 1/2 a glass of milk at the breakfast meal on 10/08/09. - Review of Resident #9's closed medical record, on 10/08/09, identified the facility admitted the resident in June 2009 and the resident expired on 09/08/09. The resident's Nutrition Assessment, dated 06/22/09, failed to include food preferences or likes/dislikes. The facility staff failed to complete the resident's Initial Interdisciplinary Data Collection Tool. - Review of Resident #10's closed medical record, on 10/08/09, identified the facility admitted the resident in July 2009 and the resident expired on 10/01/09. The resident's Nutrition Assessment failed to include food preferences or likes/dislikes. The medical record failed to include the Initial	F 366	will be reviewed and updated as needed. This will be accomplished by the Dietary Manager/Designee by 11-22-09. **This is what the facility will do or changes it will make to the systems that will prevent this problem from reoccurring in the future.** The menu system was reviewed, updated and approved by the facility's Registered Dietician. The revised menu was present to the Resident Council for their review by the Social Worker. This was completed by 11-13-09 **This is how the facility will monitor to make sure the changes continue and the problem is prevented.** An audit tool will be developed to monitor meal serves, including making sure the cook is observed following the menu, reading the diet/tray card, and addressing preferences to ensure the residents choice is being addressed. The audit will be completed 2X's per week for the next three months. The DDS or her designee is	

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F 366	Continued From page 16 Interdisciplinary Data Collection Tool form. - During interview, on 10/08/09 at 2:30 p.m., two administrative staff members (#2 and #6) reported the facility's Dietary Department had staffing changes and completion of the Initial Interdisciplinary Data Collection Tool form, including food preferences and likes/dislikes may have been overlooked for residents admitted to the facility since the change in staff. Facility staff had completed some Diet Cards despite failure to complete the Initial Interdisciplinary Data Collection Tool form. The lack of completed Initial Interdisciplinary Data Collection Tool forms in the closed medical records of Resident #9 and #10 limits the facility's ability to ensure these residents' food preferences and likes/dislikes were honored. Failure to complete the Initial Interdisciplinary Data Collection Tool form resulted in inconsistent identification of residents' food preferences, likes/dislikes, and resulted in residents receiving meal and snack items they did not like and did not consume.	F 366	responsible for completing the audit and to provide immediate follow up if any problems are noted during the audits. The results of the audits will be reported to the QA/CQI Committee for further recommendations.	