STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355046	A. BUILDING _____ B. WING _____	01/30/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN ACRES MANOR	1 E MAIN ST CARRINGTON, ND 58421

(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 standard Medicare/Medicaid recertification survey, started on 01/28/13 and completed on 01/30/13, the sample included 4 residents for complete review, 9 residents for focused review, and 2 closed records for review.	F 000		
F 164 SS=D	483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility. The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law. The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident.	F 164	F 164 1. Residents #7,#8, and #13 will have the blinds closed and the doors shut to ensure privacy during personal cares. 2. All residents of Golden Acres Manor have the potential to be affected by this practice. 3. All staff will be reeducated on the Privacy and Dignity of residents to include an in service and signs (appendix 1) for visual cuing to be posted in the staff lounge and report room as a daily reminder of Privacy and Dignity. 4. QA study on dignity and privacy monitoring for door and curtain closure will be done weekly times one month, monthly times one quarter and quarterly times one year with results reported to the QA coordinator. 5. February 19, 2012	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	Administrator	2-18-13

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 164	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on observation, review of facility policy, and staff interview, the facility failed to provide privacy for 3 of 13 sampled residents (Resident #7, #8, and #13) observed during personal cares. Failure to provide care in a manner that promotes privacy is an infringement on the residents' rights and may lead to a loss of dignity. Findings include: Review of the facility policy titled "Quality of Life-Dignity" occurred on 01/30/13. This policy, revised October 2009, stated, ". . . 10. Staff shall promote, maintain and protect resident privacy, including bodily privacy during assistance with personal care and during treatment procedures. . . ." - Observation on 01/28/13 at 5:40 p.m. showed a certified nursing assistant (CNA #2) assisting Resident #13. The CNA pulled back the resident's blanket and exposed the resident's incontinent product. The CNA obtained a pair of pants as the resident reached for the blanket to cover herself. The CNA noticed the open window blinds which faced the outside courtyard area and stated, "Oops, I should have closed that first," as she shut the window blinds. - Observation on 01/29/13 at 9:30 a.m. showed a CNA (#13) assisted Resident #7 with a sponge bath. The resident sat in a recliner in her underwear with no shirt or bra. The CNA noticed the blinds were opened, went to the window and shut the blinds, and then continued to assist the resident. This ground floor window faced the front	F 164		

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F 164	Continued From page 2 parking lot. - Observation on 01/29/13 at 9:50 a.m. showed a CNA (#4) assisted guided Resident #8 into his room leaving the bedroom door open. The resident went into the bathroom, and the CNA assisted the resident to pull down his pants and sit on toilet, without closing the bathroom door. The CNA then stepped out of the bathroom into the resident's room while the resident sat on the toilet with both the bathroom door and bedroom door open. The CNA stood in the resident's room until 9:55 a.m. when she then assisted the resident to pull up his pants and leave the bathroom. During an interview on 01/30/13 at 9:30 a.m., an administrative nurse (#6) stated facility staff are trained to provide privacy during personal cares.	F 164		
F 309 SS=D	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. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policy and procedure, resident interview, and staff interview, the facility failed to ensure 1 of 1 sampled resident (Resident #3) with physician orders for non-weight bearing (NWB) received	F 309		

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F 309	Continued From page 3 the necessary care and services to attain or maintain his highest practicable physical well-being. Failure to ensure Resident #3 maintained NWB during transfers placed the resident at risk of pain, delayed healing of his fractured pelvis, and for additional injury to his right hip. Findings include: Review of the facility policy and procedure, "Ambulation of Resident," occurred on 01/30/13. This document, dated 10/25/00, stated "Policy: Residents will be ambulated per physician orders . . . Procedure: 1. Gather equipment . . . 4. Ambulate per orders using appropriate equipment and staff . . ." Review of Resident #3's medical record occurred on January 28-30, 2013. The facility admitted the resident in October 2012. Admission diagnoses included post right hip fracture, pelvic fracture, and osteopenia. During the initial facility tour, on 01/28/13 at 10:50 a.m., a supervisory nursing staff member (#9) reported the repair of the resident's hip fracture could not be completed at the time of surgery. The staff member (#9) reported Resident #3 does not have a hip joint at this time and a surgical repair is anticipated in the future. The staff member (#9) reported the resident is non-weight bearing in transfers. The resident's quarterly Minimum Data Set (MDS), dated 01/03/13, identified the resident was cognitively intact, received scheduled and as needed (prn) pain medications, and experienced occasional pain rated as "severe."	F 309	See tag From DON 2/13/13 for correct POC F 164 1. Residents #7,#8, and #13 will have the blinds closed and the doors shut to ensure privacy during personal cares. 2. All residents of Golden Acres Manor have the potential to be affected by this practice. 3. All staff will be reeducated on the Privacy and Dignity of residents to include an in service and signs (appendix 1) for visual cuing to be posted in the staff lounge and report room as a daily reminder of Privacy and Dignity. 4. QA study on dignity and privacy monitoring for door and curtain closure will be done weekly times one month, monthly times one quarter and quarterly times one year with results reported to the QA coordinator. 5. February 19, 2012	

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1. CNA a staff caring for resident #3 will be reeducated on the need to remind the resident of the non weight bearing status to one extremity with each transfer.

2. Any resident with a non weight bearing status to one extremity has the potential to be affected by this practice.

3. Nursing and CNA in service on transferring of a resident who is non weight bearing to one extremity will be completed by restorative therapy, with emphasis on the verbal cuing necessary for all transfers that are non weight bearing to one extremity.

4. QA study on transfer of resident who is non weight bearing will be completed weekly times one month, monthly times one quarter, and quarterly times one year with results reported to the QA coordinator.

5. February 27, 2013

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Resident #3's facility admission orders, dated 10/04/12, stated "Weight Bearing Ability: . . . No wt. [weight] on (R) [right] . . ." Resident #3's physician orders on a follow-up visit regarding his right hip status, dated 01/21/13, stated "Cont. [Continue] NWB on (R). . . ."

Resident #3's current care plan, dated 01/08/13, stated "Problem, Impaired mobility, resident is wheelchair dependent . . . right hip fracture . . . Approaches . . . Extensive assist with E-Z stand for transfers assist x [times] 1. . . . Non-weight bearing right lower extremity . . ." E-Z stand is a mechanical sit to stand lift device which may be used for resident transfers.

Observation of certified nursing assistants (CNAs) transferring Resident #3 showed full weight bearing on the right lower extremity as follows:
*01/28/12, 2:50 p.m. - CNA (#2) used the E-Z stand to assist the resident from sitting in his arm chair to a standing position on the E-Z stand platform, moved him to his bathroom, and he on to the toilet. The CNA (#2) used the E-Z stand to assist the resident to a standing position on the E-Z stand platform, provided perineal cares, and returned the resident to his arm chair.
*01/28/13, 5:10 p.m. - CNA (#2) used the E-Z stand to assist the resident from sitting in his arm chair to a standing position on the E-Z stand platform, moved him to his bathroom, and he on to the toilet. The CNA (#2) used the E-Z stand to assist the resident to a standing position on the E-Z stand platform, provided perineal cares, and assisted the resident to a wheelchair.
*01/29/13, 7:35 a.m. - CNA (#5) used the E-Z stand to assist the resident from a tub chair to a

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F 309	Continued From page 5 standing position on the E-Z stand platform, and to the toilet in his bathroom. CNA (#4) used the E-Z stand to assist the resident to a standing position on the E-Z stand platform, provided perineal cares, and assisted the resident to his arm chair. *During these observations of care, the facility staff failed to provide Resident #3 with instructions to limit weight bearing on his right leg. Resident #3 did not express leg pain during these observations. During interview, on 01/29/13 at 10:45 a.m., Resident #3 reported he has pain at times, usually below the knee. The resident reported he did not have pain during the transfers with the E-Z stand. During interview, on 01/30/13 at 10:15 a.m., an administrative nursing staff member (#6) and supervisory nursing staff members (#8, #9, and #10) confirmed facility staff should have limited Resident #3 to non-weight bearing on the right leg.	F 309		
F 323 SS=D	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. This REQUIREMENT is not met as evidenced by:	F 323		

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F 323	Continued From page 6 Based on observation, record review, review of facility policy, and staff interview, the facility failed to appropriately utilize an assistance device for 1 of 10 sampled residents (Resident #1) observed transferred with a gait belt. Failure to appropriately utilize the gait belt resulted in Resident #4 experiencing discomfort during transfers and placed her at risk for a fall or injury. Findings include: Review of the facility policy "Policy and Procedure for Ambulation of Resident" occurred 01/30/13. The policy, dated 10/25/00, stated, "Procedure: . . . Apply gait belt . . . Grasp gait belt firmly with one hand and forearm with other hand. Standing on resident's weak side [sic]. . . . If resident requires two persons to ambulate: a. Apply gait belt and assist resident to standing position. b. Stand on either side of resident each grasping gait belt and forearm. . . ." Review of Resident #1's medical record occurred on all days of survey, and identified diagnoses including dementia, osteoporosis, osteoarthritis, and vertebral compression fractures. A quarterly Minimum Data Set (MDS), dated 11/12/12, identified Resident #1 required extensive assistance of one person for transfers, ambulation in the room, toileting, and personal hygiene. The MDS also identified Resident #1 had range of motion limitation of both upper extremities. On 01/28/13 at 3:35 p.m., observation identified two Certified Nursing Assistants (#1 and #2) assisted Resident #1 from her recliner to the wheelchair utilizing a gait belt. During the transfer,	F 323	F323 1. Resident #1 will have gait belt applied properly with all transfer to prevent discomfort. 2. Any resident requiring the use of a gait belt for transfers has the potential to be affected by this practice. 3. All nursing and CNA staff will be reeducated on the proper application and use of a gait belt during transfers by the restorative aide. 4. QA study on proper application and use of gait belt will be completed weekly times one month, monthly times one quarter, and quarterly times one year. 5. February 27, 2013	

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the gait belt slid up to Resident #1's underarm area. This position caused the CNAs' hands to be positioned in the resident's underarm area. The resident stated "Oh, oh, oh, oh, that hurts," and pointed to her left underarm. The CNAs (#1 and #2) then transferred Resident #1 to the toilet. As the CNAs assisted the resident to stand from the toilet, the gait belt again slid up and the resident stated, "Ow, ow, ow, set me down." Observation showed Resident #1's knees buckled as the CNAs (#1 and #2) transferred her from the toilet to the wheelchair.

On 01/29/13 at 8:55 a.m., observation showed two CNAs (#3 and #4) assisted Resident #1 to the toilet utilizing a gait belt and one CNA (#4) also holding the resident's left arm. During the transfer, Resident #1 stated, "Ow, ow, ow, oooh." At 9:00 a.m. two CNAs (#3 and #5) assisted Resident #1 to stand. The CNA (#5) applied the gait belt securely and held the belt with both hands. The gait belt did not slide up and Resident #1 had no complaints of pain while standing. At 9:15 a.m. two CNAs (#3 and #4) assisted the resident from the toilet to her wheelchair. During the transfer, the gait belt slid up to the underarm area, again causing the CNAs hands to be positioned under Resident #1's arms. The resident stated, "Ooh, ooh, ooh."

An interview occurred on 01/30/13 at 11:00 a.m. with four administrative nurses (#6, #8, #9, and #10). The nurses stated staff may be reluctant to tighten the gait belt due to Resident #1's history of compression fractures. When asked, one nurse (#6) stated staff have not completed a transfer assessment for Resident #1 to determine the appropriate mode of transfer for this resident.

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F 325 SS=E	483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem. This REQUIREMENT is not met as evidenced by: Based on observation, review of facility policy, review of professional reference, record review, and staff interview, the facility failed to adequately assess the nutritional status, needs, and risk factors, and implement appropriate interventions to restore/maintain adequate nutritional status for 4 of 4 sampled residents (Resident #4, #5, #8, and #10) who experienced severe/significant weight loss. Failure to meet residents' nutritional needs through diet, supplements, assistance, or other interventions contributed to the residents' severe weight loss. Findings include: The Centers for Medicare and Medicaid Services (CMS) has outlined the parameters for evaluating significance of unplanned & undesired weight loss: Interval Significant Loss Severe Loss 1 month 5% Greater than 5%	F 325	F325 1. Resident #8 was started on a protein energy supplement every morning on his breakfast cereal and as a drink. He also receives 2oz of Protein Energy Drink @ 9:30 am. The percent of the supplement taken is recorded in the resident MAR by the nurse for monitoring. Resident #5 was started on a Mighty Shake 6 oz mid afternoon with percent taken recorded in the resident MAR by the nurse for monitoring. Resident #10 was started on a Mighty Shake 6 oz mid morning and ice cream every afternoon with percent of mighty shake taken recorded in the resident MAR by the nurse for monitoring. Resident #4 was started on protein energy drink 2 oz TID with percent taken recorded in the resident MAR by the nurse for monitoring.	

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F 325	Continued From page 9 3 months 7.5% Greater than 7.5% 6 months 10% Greater than 10% Review of the facility policy "Policy on Meal Replacements" occurred on 01/30/13. The undated policy stated, "Goal: To make additional attempt to achieve adequate nutritional status of residents who consume less than 25% of meal. 1. A review of meal intake record is completed following each meal, and any resident who has eaten less than 25% of that meal is listed on provided form to be provided to nurses. 2. The nurse may than [sic] herself, or designate a CNA [certified nursing assistant] to provide that resident with a meal replacement. 3. Acceptable meal replacements may be any foods or fluids, or combinations of such to provide nutrition and hydration, preferably containing a protein and/or high calorie food of beverage. 4. A resident who experiences weight loss is evaluated for possible cause, which may include a diuretic change, medical status change, method of obtaining weight change, etc [etcetera]. 5. If unexplained and/or undesirable weight loss has occurred, the resident may be referred to WIPP [the facility committee monitoring weight loss and pressure ulcers] Committee for determination of need to monitor weekly. . . . 8. Care plan changes would be addressed as needed, with family involvement as necessary." Review of the facility policy "Tracking Significant Weight Change" occurred on 01/30/13. The policy, dated 2008, stated, ". . . 1. A copy of monthly weights should be forwarded to the registered dietitian (RD) or diet technician (DTR) each month to review and calculate significant change over 1 (5%), 3 (7.5%), and 6 (10%)	F 325	2. Any resident who can be identified with anorexia, recent weight loss, and significant risk for impaired nutrition has the risk of being affected by this. 3. New policies: Nutrition (impaired)/Unplanned Weight Loss – Clinical Protocol (appendix 2) Weight Assessment and Intervention - Weight percentage chart (appendix 3) Interdepartmental Notification of Diet (Including Changes and Reports) (appendix 4) Nutrition Hydration to Maintain Skin Integrity (appendix 5) Assistance with Meals (appendix 6) Therapeutic Diets (appendix 7) Mechanically Altered Diets (appendix 8) Dietary exception Log (appendix 9)	

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F 325	Continued From page 10 months. A copy of all significant weight losses and gains should be given to the POC [plan of care] team for appropriate review and documentation. . . 2. The RD/DTR reviews and documents all significant weight changes, with appropriate referrals to the RD. The RD reviews all significant weight changes and referrals and takes actions as necessary . . . 3. The physician and family (or significant other) are notified of any individual with an unplanned significant weight changes of 5% in 1 month, 7.5% in 3 months, or 10% in 6 months. 4. All individuals with significant weight variances will be re-weighed prior to reporting this to the physician. . . ." Review of the facility policy titled "High Calorie/High Protein Diet" occurred on 01/30/13. This policy from the facility diet manual, dated 2008, stated, ". . . Calorie boosters: The following suggestions are intended for people who need to increase their calories in order to maintain or gain weight . . . " and the policy identified foods which can be added at meals to increase calories. Review of weight logs for sampled residents identified staff weigh residents weekly, and do not record the actual date, but record the one week period in which the weight was taken (such as 01-06 to 01-12). - Review of Resident #8's medical record occurred on all days of survey. The record identified Resident #8 admitted in August of 2012. Diagnoses included dementia, anxiety, diabetes, and esophageal reflux. A quarterly Minimum Data Set (MDS), dated 12/03/12, identified the resident	F 325	will be implemented along with weight loss documentation labels containing pertinent documentation on implementation of fortified diets and supplements, education of resident and or family, and Physician notification. Dietary staff will be educated on the new policies on 2-20-13. Nursing and CNA's will be educated on new policies on 2-27-13. 4. QA studies will be conducted by the QA committee weekly times one month and monthly times one quarter and quarterly times one year on the proper use of weight loss documentation labels, observation of those needing assistance with meals, and compliance with the diet exception log with documentation, results will be reported to QA coordinator or DON at weekly QA meetings. 5. February 27, 2013	

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with severe cognitive impairment, required set up help with eating, and did not identify a significant weight loss.

Resident #8's care plan, dated 11/16/12 stated the problem as, "Strength--dines independently. Good appetite" with the goal of "His weight will remain stable" and approaches included: a liberal diet, independent with dining, and requires setup assistance. The care plan, updated on 01/08/13, changed the problem to "Decreased appetite with decline in weight" with the goal of "He will have no further weight loss" and the interventions included liberal diet, supervision and prompting with dining, set up assistance, and "Kemps [a nutritional supplement] as outlined." Review of Resident #8's medication administration record identified "Kemps" two times a day added on 01/22/13.

Observation of Resident #8 on 01/28/13 at 3:22 p.m. showed a CNA (#2) assisted the resident to pull up his pants. The CNA hooked the resident's belt which appeared loose and stated the belt needed to have another "notch" added as the belt was too loose.

Observation of Resident #8 at the breakfast meal on 01/29/13 showed the resident used three sugar substitute packages on his hot cereal and drank six ounces of milk. A dietary staff member (#12) stated Resident #8 received skim milk per his preference.

Observation of Resident #8 on 01/29/13 at 12:20 p.m., showed the resident pushed his plate to the middle of the dining room table after taking a few bites of his lunch. Staff failed to cue or encourage the resident to eat. At 12:42 p.m. the resident

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F 325	Continued From page 12 stood and walked away from the table, consuming only 5% of his meal. Observation of Resident #8 on 01/30/13 at 7:30 a.m., showed the resident received and drank six ounces of skim milk. Review of the facility menus identified a liberal diet included "2%" milk. The menu did not identify sugar substitutes on a liberal diet. Review of the resident's weekly weights identified the following: August 26 to 31: 134.3 lbs (pounds) September 23 to 30: 141.6 lbs October 21 to 27: 129.6 lbs (down 8.5% in less than one month - severe weight loss) November 25 to 30: 127.5 lbs December 30 to 31: 125. 0 lbs (down 11.7% in 3 months for severe weight loss) January 27 to 31: 118.2 lbs (down 5.4% in one month and 8.8% in 3 months - severe weight loss) Review of Resident #8's dietary notes identified the following from the RD: * 08/29/12 - ". . . Reviewed nutrition note. Current wt [weight] 134# [pounds], [down arrow] 10# since July - Unsure of cause. Liberal diet eating 85-100% [at] meals. Current labs WNL [within normal limits] . . . CDM [certified dietary manager] to continue to monitor weight . . ." * 01/16/13 - "Wt 119#, [down arrow] 9# in 1	F 325		

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F 325	Continued From page 13 month r/t [related to] recent illness? Poor appetite staff having to remind and encourage resident to eat. . . . 12/28/12 HgbA1C 6.4 [a lab measuring average blood sugars which is within normal limits]. Continue to offer and encourage intake. Provide supplements if meal intake is poor. . . " Facility staff failed to notify the registered dietitian, as per policy, of Resident #8's severe weight loss. This lack of assessment and monitoring resulted in the resident experiencing severe weight loss. Review of Resident #8's CDM notes identified the following: * 08/22/12 - "Initial nutrition note: . . . This is [resident's name] 2nd admit to this facility. Previously short term resident in 2010. Wt records indicate approx. [approximately] 10 lb. wt. loss since then with gradual decline . . . presently has a good appetite . . . makes meal choice from available options . . . . ordered for wkly [weekly] monitoring of glucose levels . . . Plan of Care: liberal diet as ordered, monitor food intake, weight, labs as available and for effectiveness of scheduled laxative . . ." * 10/26/12 - "res [resident] wts. [weights] had been quite stable until increase to 141 lbs. last wk [week], then dropped to 128 lbs this week. Contributing factors are acute urinary retention r/t [related to] malfunction of catheter, as well as decline in appetite and intake r/t such. Other considerations is frequent, and current UTI [urinary tract infection] and antibiotic use. This writer spoke [with] res. daughter [daughters name] re [regarding] wt concerns. Her suggestion is to monitor closely now for trends [with] intake/weight . . ." * 11/15/12 - "Weight is now 127.8, and more	F 325		

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F 325	Continued From page 14 stable meal intake seems to be improved. . . . dines independently . . . glucoses cont. [continue] to be mostly above normal. MD [medical doctor] is aware. . . . will cont. to monitor . . ." * 12/03/12 - "wt. is [up] slightly, now 129.6. This is recovery from previous wt. decline. Intake at meals has been usually good . . . Zantac was started . . . prn [as needed] dietary interventions are provided for bowel assist. Will monitor . . ." * 01/08/13 - "noted wt. decline to 121.9 lbs. Res. has been ill and antibiotic started for acute bronchitis. [resident's name] has also had times of needing dining assist. Tray service has been provided to res. room Will anticipate resolve from illness, with improved intake and wt. Monitor closely . . ." * 01/22/13 - "wt is 119 lbs. . . . will offer high calorie supplements to provide [increased] calories and RDA's [recommended dietary allowances] . . ." During an interview on 01/30/13 at 9:45 a.m., a dietary manager (#7) stated she reviewed weekly weights on Fridays and presented them to the WIPP committee every Tuesday. The manager reported the facility does not add "Calorie boosters," as identified in facility policy, for residents with weight loss. This staff member stated Resident #8's wife limits the residents sugar intake and, in the past, the resident requested a sugar substitute and skim milk. When requested, no record of Resident #8's preferences was provided by the facility. During an interview on 01/30/13 at 9:45 a.m., an administrative nurse (#9) stated when staff sit with and encourage Resident #8 to eat, the resident will stand up and leave the table, so staff	F 325		

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have not been sitting and encouraging the resident to eat. The medical record lacked evidence of this intervention.

During an interview on 01/30/13 at 9:45 a.m., four administrative nurses (#6, #8, #9, and #10) agreed a diabetic resident with good blood sugar control who does not require insulin and who is losing weight would not need strict sugar limitations. The facility failed to educate the resident's wife about preferences, including skim milk, which limited calorie intake.

Resident #8, identified on admission as having a history of weight loss, lost over 12% of his weight, going from an admission weight of 134.3 lbs to 118 lbs (in approximately 5 months). The dietary progress notes identified staff failed to review, revise, and implement interventions to promote nutritional status and prevent severe weight loss starting the end of October. The facility implemented measures in January when the resident had another severe weight loss, and failed to consistently carry out the interventions and modify these interventions when staff noticed the resident typically refused encouragement at meals.

- Review of Resident #5's medical record occurred on January 28-30, 2013. The facility admitted the resident in November 2012 from the local swing bed unit. Resident #5 experienced an acute hospital stay December 12-17, 2012 related to a UTI and coronary artery disease. The resident's admission diagnoses included pain, spinal compression fracture, gout, anemia, benign prostatic hypertrophy, and a sacral pressure ulcer. On his return to the facility on

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F 325	Continued From page 16 12/17/12, the facility staff identified a new pressure ulcer on the resident's right heel. Resident #5's quarterly MDS, dated 12/24/12, identified the resident was cognitively intact and independent in eating. The resident's Comprehensive Nutrition Assessment, dated 12/19/12, identified a seven pound weight gain since admission, 75 to 100% food intake, nutritional supplements "lutein, Arginaid BID [two times each day]," and "Monitor wt. [weight], pressure sores, and food intake." Arginaid is a high protein, non-fat supplement used to assist in wound healing. Resident #5's current care plan, dated 01/17/13, stated "Problem, Strength: Independent with dining, may need set up assist. Goals, His weight will remain stable TNR [to next review.] Approaches, Liberal diet. . . . Problem, Prone to skin breakdown related to decreased mobility and 2 unstageable pressure ulcers to left and right heels. . . . Approaches . . . Argainaid [sic] as outlined. . . ." Resident #5's weekly weight records identified the following: December: 23-29 - 155.6 lbs. January: 27-31 - 146.0 lbs., a 9.6 lbs. (6.2%) severe weight loss. Resident #5's meal intake records for January 01-29, 2013 showed the resident consumed 50% or less for 25 of 87 (28.7%) meals offered. Intake of 50% or less occurred for 17 of 51 (33.3%) meals offered from January 13-29, 2013.	F 325		

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F 325	Continued From page 17 Resident #5's Dietary Progress Notes included the following: *01/11/13, "Nutrition: wt. is 148.3 lbs., [arrow down] 7 lbs. in the past two wks. [weeks]. [4.7% weight loss] . . . Arginaid is cont. [continued] for healing of wounds. Meal intakes has been fairly good. Will monitor for wt. to stabilize for increase, or make changes as needed." *01/28/13, "Nutrition: wt. from last wk. 146.2 lbs., and more stable. Meal intake varies, and res. [resident] occ. [occasionally] has c/o [complained of] nausea. His antibiotic was dc'd [discontinued], hoping to resolve this issue. Other Rx [medication] changes are the dc of hyperlipidemia med. [medication], start of antidepressant Rx Cymbalta. Will monitor for effects of recent changes made to determine if additional dietary interventions are needed." Resident #5's medical record identified a left heel ulcer developed on 12/07/12; the sacral ulcer healed on 12/26/12; and both heel ulcers were healing and reduced in size during observation on 01/29/13. Observation on the morning of January 29 and 30, 2013 identified Resident #5 supine in bed with the head of the bed elevated. Observation showed a breakfast meal tray present on both days and the resident did not consume any of the meal items or fluids. On 01/29/13 he did not eat any noon meal items and did receive and eat a replacement meal of pudding, toast, juice, and a banana at 1:35 p.m. When questioned, Resident #5 reported he did not feel well due to "gout." During interview, on 01/30/13 at 10:15 a.m., an	F 325		

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administrative nursing staff member (#6), supervisory nursing staff members (#8, #9, and #10), and a dietary management staff member (#7) were asked to provide additional information regarding interventions implemented to address Resident #5's weight loss. No additional information was provided.

The record lacked evidence Resident #5's weight of 161.6 pounds on 12/19/12 after his return from hospitalization may have been related to additional fluids received while hospitalized. The Dietary Progress Notes failed to identify Resident #5's more than five pound weight loss January 13-19, continued severe weight loss, and, dated 01/28/13, stated "more stable." The facility staff failed to refer Resident #5 to the facility's WIPP Committee, failed to refer the resident to the consultant dietitian, and failed to initiate any weight loss interventions, such as supplements or high calorie foods. These failures resulted in Resident #5 experiencing a severe weight loss, not identified by the facility staff.

- Review of Resident #10's medical record occurred on all days of survey. The resident was re-admitted to the facility June, 2012. Diagnoses included hypertension, anxiety, depression, and hypothyroidism. A 5-Day MDS, dated 06/14/12, identified a weight of 163 lbs. A quarterly MDS, dated 12/06/12, identified a weight of 146 lbs and a weight loss - not physician prescribed.

Review of Resident #10's dietary progress notes identified the following:
* 06/24/12: ". . . wt is now 161.4 lbs. . ."
* 07/13/12: ". . . wt is now 151.8 lbs, [down arrow] 10 [lbs] from last review with most occurring in

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F 325	Continued From page 19 the past week. . . Weight loss may cont [continue] to occur if unchanged appetite." * 08/28/12: ". . . wt is 151.5 lbs., and more stable than previous. . ." * 12/03/12: ". . . wt is 146.1 lbs. . . Appetite is usually good. . ." * 01/07/13: ". . . wt has declined to 138.9 lbs. . . and now acute illness related loss has developed into a sig [significant] change wt loss of 10% in six months. . ." Resident #10's monthly weights identified the following: June 2012 - 163.2 lbs July 2012 - 159.8 lbs August 2012 - 156 lbs September 2012- 151.9 lbs October 2012- 152.4 lbs November 2012- 149.9 lbs December 2012 - 146.1 lbs January 2013 - 138.9 lbs (13% in 6 months, severe wt loss) Resident #10's current care plan, dated 12/06/12 and updated on 01/16/13, stated, "Problem, Strength: independent with dining and weight loss. Goal, she will have no further weight loss TNR. Approaches, Liberal diet, independent with dining, and encourage increased meal intakes." During interview on 01/30/13 at 10:40 a.m., a dietary staff member (#7) stated there were no nutritional interventions such as high calorie supplements, or calorie boosting foods in place to prevent further weight loss by Resident #10. A nutritional assessment, dated 01/07/13, identified Resident #10's significant weight loss.	F 325		

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F 325	Continued From page 20 The facility staff failed to refer the resident to the consultant dietician, failed to refer to the care plan team for review, and failed to initiate any weight loss interventions, such as supplements or high calorie foods. These failures placed the resident at risk for continued weight loss. - Review of Resident #4's medical record occurred on all days of survey. Diagnoses included severe dementia and a left radial fracture which occurred on 11/11/12. The annual MDS, dated 06/28/12, identified Resident #4 weighed 130 pounds (lbs) and had no weight loss. A quarterly MDS, dated 09/28/12, identified a weight of 119 lbs and had no weight loss. A quarterly MDS, dated 12/28/12, identified the resident weighed 113 lbs and had experienced a weight loss - not physician prescribed. The record showed, prior to the fall and fracture on 11/11/12, Resident #4 maintained a weight of approximately 120 lbs. Following the fracture, the resident began losing weight. Weight logs identified the following: 11-11 to 11-17: 120.9 lbs 12-16 to 12-22: 113.9 lbs - a 5.8% loss in one month indicating severe weight loss 01-20 to 01-26: 108.7 lbs - a 4.6% loss in one month Review of Resident #4's dietary notes identified the following: 11/4/12: "Wt 119# [pounds], stable . . . Intake [approximately] 50% @ [at] meals. Current wound on L) [left] buttock is healing. Resident taking Breeze [a supplement] for added protein . . .continue current plan." 12/28/12: ". . . wt [weight] is [arrow down] to 112.6	F 325		

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F 325	Continued From page 21 lbs., which is a significant 10% wt. decline in the past six mos [months]. Appetite is only fair. Dining assist is provided as [Resident #4] allows . . . Will review at wkly [weekly] WIPP meeting to discuss options for increasing calories." (This note failed to identify the 5.8% severe weight loss in one month.) 01/08/13: ". . . wt. now 111 lbs. . . . will start offering [arrow up] calorie supplements." (This note failed to identify the 4.6% loss in one month.) The record lacked evidence staff notified the dietician of Resident #4's weight loss on 12/28/12 or 01/08/13. During an interview on 01/30/13 at 11:00 a.m. a dietary staff member (#7) was asked about the 10 day delay from the date dietary staff identified the 10% weight loss until they added supplements. The staff member (#7) stated she waited until the WIPP committee met to discuss the weight loss and recommend interventions. Failure to promptly implement interventions to address Resident #4's weight loss resulted in continued weight loss and placed the resident at risk for malnutrition.	F 325		
F 371 SS=F	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	F 371		

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F 371	Continued From page 22 This REQUIREMENT is not met as evidenced by: Based on observation, policy and procedure review, review of dietary logs, and staff interview, the facility failed ensure safe and proper sanitizing of dishware in 1 of 1 kitchen, and failed to clean a fan inside the walk-in cooler. The facility failed to ensure proper temperature levels during dish washing which placed residents at risk of foodborne illness and failed to clean dust buildup off the fan cooling unit in the walk-in cooler which may result in the potential for contamination of food. Findings include: Review of the facility policy titled "Warewashing" occurred on 01/29/13. This undated dated policy stated, ". . . Temperatures of wash and rinse cycles are monitored and recorded twice daily to assure requirements of 150 degrees F [Fahrenheit] for the wash cycle, and 180 degrees F for the rinse cycle. If required temperatures are not consistently met, maintenance will be notified to diagnose and correct the problem. . . ." - Observation on 01/29/13 at 10:15 a.m., showed an administrative dietary staff member (#7) ran dishes through the dish machine with the rinse cycle reaching 176 degrees F. The staff member then proceeded to run 4 more cycles with the following rinse temperatures: 174 degrees F; 146 degrees F; 157 degrees F, and 165 degrees F. A dietary staff member (#12) in the process of putting away dishes, stopped, and after the observation, an administrative dietary staff member (#7) started removing dishes recently	F 371	F 371 1. Proper sanitation practices will be provided within food service operations to protect all residents from risk of food borne illness. Immediate cleaning of cooler fans and repairs made to booster heater were implemented to correct areas identified. 2. All residents dining at this facility have the potential to be affected by improper sanitation practices identified. 3. The current policy related to food service sanitation for warewashing will be provided to, and reviewed at a mandatory dietary staff inservice on Feb. 20, 2013 to provide education on policy and monitoring requirements. The current monitoring log for recording wash and rinse temperatures has been revised to include suspension of warewashing, and	

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F 371	Continued From page 23 washed from cupboards and drawers to be rewashed to ensure sanitation of the dishware. Review of the "Dishwasher Temperature Record" from October 1, 2012 through January 28, 2013 identified the following: * October: 3 out of 30 wash and rinse temperatures failed to meet minimum temperatures and showed 32 out of 62 wash and rinse temperatures not documented. * November - 3 out of 19 rinse temperatures failed to meet minimum temperatures and showed 40 out of 60 wash temperatures and 41 out of 60 rinse temperatures not documented. The log identified a low rinse temperature on 11/13/12 with no rinse temperature monitored until 2 days later. * December - 3 out of 31 wash and 3 out of 29 rinse temperatures failed to meet minimum temperatures and showed 31 out of 62 wash and 33 out of 62 rinse temperatures not documented. The log identified a low rinse temperature on 12/11/12 and 12/13/12 with no monitoring in-between, and an appropriate rinse temperature documented 12/15/12. * January - 6 out of 37 wash and 14 out of 36 rinse temperatures failed to meet minimum temperatures and showed 19 out of 28 missing wash temperatures and 20 out of 28 missing rinse temperatures. The log identified a low rinse temperature on the morning of 01/12/13 with the next appropriate rinse temperature in the afternoon on 01/19/13 (7 days later). - Observations in the walk-in cooler on 01/28/13 at 10:20 a.m. and 01/29/13 at 10:45 a.m., showed a fan with black dust blowing air inside the cooler. During the observation on 01/28/13, the fan blew	F 371	maintenance notification of inadequate temperatures for sanitizing. All dietary staff will be responsible to monitor and report inadequate sanitation for immediate corrective action. Routine cleaning of cooler fans has been added to the maintenance cleaning schedule for dietary operations. 4. The dietary manager will provide a copy of ware washing temperature log , and report of visual inspection of cooler fans and guards to the QA committee weekly for one month, monthly for three months, and quarterly thereafter for a one year time frame. 5. Date of correction: January 29,2013. Dietary staff inservice date: February 20,2013.	

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(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 371	Continued From page 24 a piece paper, which had covered a tray full of poured beverages, onto the floor. An administrative dietary staff member (#7) then obtained a new covering and placed it over the beverages. During an interview on 01/29/13 at 1:30 p.m., a administrative maintenance employee (#14) stated a repair person came today and adjusted the temperature switch on the booster heater of the dish machine. The staff member reported the facility replaced the booster heater in October and he adjusted the temperature gauge to be at the highest setting. This staff member stated staff should notify the maintenance department of low temperatures and was not aware of previous low temperatures in the past month. Also at this time, the administrative maintenance employee (#14) and the administrative dietary employee (#7) stated the facility lacked a process for cleaning of the fan in the walk-in cooler. During an interview on 01/29/13 at 2:15 p.m., a administrative dietary staff member (#7) stated dietary staff are responsible for letting maintenance know about low dish washing temperatures and stated she was not aware of staff notifying maintenance of previous low temperatures documented on the January log.	F 371		
F 467 SS=B	483.70(h)(2) ADEQUATE OUTSIDE VENTILATION-WINDOW/MECHANIC The facility must have adequate outside ventilation by means of windows, or mechanical ventilation, or a combination of the two. This REQUIREMENT is not met as evidenced	F 467		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355046	A. BUILDING _____ B. WING _____	01/30/2013

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F 467	Continued From page 25 by: Based on observation, resident interview, and staff interview, the facility failed to ensure adequate outside ventilation for 3 of 3 days of survey (January 28-30, 2013) on 4 of 4 resident care units (100, 200, 300, and 400 wings). Failure to ensure the bathroom exhaust fans were operating resulted in limited air flow and a resident request for a humidifier. Findings include: During the initial facility tour, on 10/28/13 at 10:20 a.m., observation identified the resident rooms on the 300 wing had a reduced air flow. Placement of a tissue at the bathroom exhaust vents in Room 308, 310, and 311 showed a lack of exhaust ventilation. During interview, on 01/28/13 at 3:35 p.m., Resident #3 reported his room was "stuffy" and he thought a "humidifier" would be helpful. The resident reported he had not brought this to the attention of the facility staff. During random checks, on 01/28/13 at 5:45 p.m., observation identified a lack of exhaust ventilation at bathroom exhaust vents in Room 404, 407, 208, 210, 104, and 110. During the facility environmental tour, on 01/29/13 at 2:45 p.m., the lack of exhaust ventilation was confirmed with a maintenance management staff member (#11). This staff member reported the facility did have some heating and cooling repair work completed "couple weeks ago" and was waiting for a repair person to complete the work on the 300 wing exhaust system. This staff	F 467	1. A licensed plumbing and heating professional, made the necessary repairs to the ventilation system. He was here on the day of the survey. All parts of the system are now functioning properly. 2. All residents of Golden Acres Manor have the potential to be affected. 3. A new policy has been created, pertaining to the ventilation system and its maintenance. A check of the ventilation system has also been added to a maintenance schedule. Documentation will be included on the maintenance schedule. All maintenance employees will be trained on the policy and procedure. 4. The QA committee will monitor the new policy and documentation. This will be done weekly for one month, monthly for one quarter and quarterly for one year. 5. Training on the policy will be done on 2/21/2013. The policy will be implemented on 2/22/2013.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355046	A. BUILDING _____ B. WING _____	01/30/2013

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F 467	Continued From page 26 member (#11) was uncertain of the date of the repairs. This staff member was unaware of the lack of exhaust ventilation for the 400 wing and reported the 100 and 200 wings were "old buildings" and did not have exhaust ventilation. Additional information, such as scheduled maintenance checks of the exhaust systems and verification of the need for exhaust ventilation for the 100 and 200 wings was requested. On 01/29/13 at 3:25 p.m., a maintenance management staff member (#11) reported the 400 wing exhaust ventilation system belt had broken and was repaired and the 300 wing was repaired. This staff member reported he did not routinely check the operation of the exhaust ventilation system, did not have a maintenance schedule, and could not provide a time period for when the 300 wing exhaust was not working. No information was provided regarding the 100 and 200 wing exhaust ventilation systems. Observation of random resident rooms on each wing, on 01/30/13 at 11:45 a.m., identified exhaust ventilation in the 300 and 400 wings and identified a lack of ventilation in the 100 and 200 wings.	F 467		