STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355069	A. BUILDING _____ B. WING _____	04/19/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEARTLAND CARE CENTER	620 14TH 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 standard Medicare/Medicaid recertification survey started on April 16, 2012 and completed on April 19, 2012, the sample included four (4) residents for complete review, nine (9) residents for focused review, and two (2) closed records for review. The sample included 17 additional residents to verify specific concerns during the survey.	F 000		
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.	F 157		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Karissa Olson
TITLE: Administrator
(X6) DATE: 5/22/12

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 157	Continued From page 1 The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on record review, review of facility policy and procedure, and staff interview, the facility failed to notify the legal representative of 2 of 4 resident to resident altercations. Failure to notify Resident #11's legal representative after the resident to resident altercations limited their ability to fully participate in the resident's care and treatment. Findings include: Review of the facility's policy and procedure, "Notification of Accident and Incidents," occurred on 04/19/12. This undated document stated "PROCEDURE: Upon a resident's admission, the Notification of Accidents/Incidents Form will be completed. This will inform caregivers of specific incidents and individuals to be notified in the event of an occurrence by/with the resident. This form will be placed at the front of the resident's Medical Record." Review of Resident #11's medical record occurred on April 16-19, 2012. The facility admitted the resident in May 2009. The quarterly Minimum Data Set, dated 02/09/12, identified moderate cognitive impairment. Resident #11's current care plan, dated 01/05/11, stated "Problem, Behavior: . . . Does exhibit	F 157	1. Resident #11's legal representative will be notified of incidents dated 11/12/11 and 3/1/12 by front unit manager. Resident #1's legal representative will be notified of above incidents by new wing unit manager. 2. Interdisciplinary team will follow up complaints made in Voice of the People, Care Conferences and any other complaint verbalized by a specific resident. 3. Policy and procedure has been updated from Exhibit A to Exhibit B. Resident to resident abuse form has been updated from exhibit C to exhibit D to include families of both parties to be notified on all altercations between both residents involved. The form includes the name of person contacted, time and date notified. Nurses updated per memo placed 5/18/12. See exhibit E. Administrator, Director of Nursing and Social Services will review each incident for any follow up required. 4. Mandatory all nursing meeting on 5/31/12 will review new policy and procedure and new forms. All incidents will be reviewed at weekly Interdisciplinary Team meetings for 3 months, then monthly for 9 months. See exhibit F. QA will be reviewed @ quarterly QA meetings for 1 year, beginning at July 2012 meeting.	5/18/12 5/18/12 5/18/12 5/31/12

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F 157	Continued From page 2 aggression towards another residents [sic] if they enter his room or knock into his chair. . . . 03/02/12, Physical aggression toward another resident. . . . Approaches . . . Keep hallways clear as possible so residents can propel wheelchair easily. . . . Intervene if wandering residents come too close to his chair. . . ." Nursing Notes identified the following: *11/12/11, 3:00 p.m. to 11:00 p.m. - "Behavior, Writer heard Res. [Resident #11] yelling in his room, stating 'Get the hell out of my room.' When writer entered the room writer found another Res. [Resident #1] inside pushed up against the Res. [Resident #11] in his w/c [wheelchair]. The Res. [Resident #1] who was in the room had coffee spilled all over him and the floor. Writer took the other res. [Resident #1] out of room. Writer went back in to room & [and] asked res. [Resident #11] if he was okay. Res. [Resident #11] denied pain but was upset." - Resident #1's Nursing Notes for this incident stated " . . . Slightly reddened areas on the chest that went away were noted. The Res. denied pain . . ." *03/01/12, 5:00 p.m. - "Reported to writer that Res. was sitting in hallway outside his room et [and] [Resident #1] wheeled up next to [Resident #11]. [Resident #11] stated [Resident #1] 'smarted off so I gave him one of these' [Resident #11] holding his fist up. [Resident #11] was seen by CNA [certified nursing assistant] punching [Resident #1] in right arm/chest x [times] 3 until CNA removed [Resident #1] et brought to supper. Writer spoke [with] [Resident #11] et he had stated that he knew he shouldn't have punched the other res. but he had a smart mouth. [No] marks/injury to [Resident #1]."	F 157		

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F 157	Continued From page 3 - Resident #1's medical record included the same information for this incident. Resident #11's Nursing Notes and the Incident/Accident Reports failed to show the facility staff notified his responsible party of these two incidents. During interview, on 04/19/11 at 9:00 a.m., a nursing management staff member (#1) confirmed the facility staff failed to notify Resident #11's responsible party of the incidents on 11/12/11 and 03/1/12.	F 157		
F 250 SS=E	483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policy and procedure, individual resident interview, family interview, resident group interview, and staff interview, the facility failed to provide medically-related social services for 2 of 13 sampled residents (Resident #1 and #13) who exhibited wandering behavior which negatively affected other residents (Resident #7, #9, #10, #12, #32, and Resident A and B). Failure to adequately assess and monitor the wandering behaviors resulted in Resident #1 and #13 irritating/annoying other residents and intruding on their privacy and may also negatively effect	F 250		

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F 250	Continued From page 4 residents' quality of life and overall well-being. Findings include: Review of the facility policy titled "Resident Abuse" occurred on 04/19/12. This policy, revised 06/04/10, stated, "The resident has the right to be free from verbal, physical, mental . . . abuse . . . This right applies to all residents. . . . Residents must not be subjected to abuse by anyone, including . . . other residents . . . - Observation during the initial tour of the facility, on 04/16/12 at 1:15 p.m., showed a plastic chain across the doorway of Resident #12's private room. When asked why she had a chain across the door, the resident stated, "So people don't walk in on you." The facility identified Resident #12 as an interviewable resident. Review of Resident #12's care plan, on 04/19/12, identified "Resident requests wander gate (chain)." - Observation during the initial tour and all days of survey showed a plastic chain across the doorway of Resident #7's private room on the "New Wing." During the initial tour, Resident #7 stated the reason for the chain across her door was because a couple of men came into her room, which she described as "scary." - During the initial facility tour, on 04/16/12 at 1:35 p.m., observation identified plastic chains across the doorways of three rooms in the resident care unit identified by facility staff as the "New Wing." During interview, Resident #32, who resided in one of the rooms, reported the chain was in place to prevent a male resident who "likes to peek in" from coming into her room. During interview, a	F 250	1. Residents that are affected by wandering residents will have approaches in the Care Plan to address their quality of life and overall well-being. A Wandering Resident Assessment will be completed on all current residents who have been affected and families notified. 2. Social Service Designee will interview residents quarterly to determine if they are affected by wandering residents. Residents attending the Voice of the People will be asked monthly if they are affected by wandering residents. If residents are identified to be affected by other residents wandering, their care plans will be updated. 3. An assessment will be developed to allow resident to participate in their plan of care when affected by wandering residents. See exhibit G. 4. Social Services will review this assessment quarterly with all affected residents. These will be monitored quarterly at QA.	6/4/12

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F 250	Continued From page 5 supervisory nursing staff member (#6) identified Resident #1 opens doors to look in, has entered some rooms, is re-directed, and facility staff have placed the chains across doorways to deter his entering rooms. - During the group interview, held 04/17/12 at 10:25 a.m., Resident B stated two "lady" residents wander into her room. When asked, Resident B identified Resident #13 as one of the women who wander into her room. Resident B identified she is not afraid of Resident #13 and when she summons staff, they remove Resident #13 from her room. Resident A stated Resident #13 came into his room while he was in bed, began "packing" his belongings, and then removed his blankets. Eleven residents attended the group interview and eight agreed with Resident A and B that Resident #13 wanders, and nine residents identified Resident #1 peeks into resident rooms. - Review of Resident #13's medical record occurred on April 18-19, 2012. Diagnoses included dementia and anxiety. The resident's current Minimum Data Set (MDS), dated 01/19/12, identified a Brief Interview for Mental Status (BIMS) score of 4, indicating severely impaired cognition; and inattention and disorganized thinking present constantly. The MDS identified no other behaviors. Current medications included Zoloft (an antidepressant) 100 milligrams (mg) once per day. Review of Resident #13's nursing notes revealed the following: *04/05/12 at 5:45 p.m.: ". . . Heard alarm going off- Res [resident] out both doors et [and] going	F 250		

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F 250	Continued From page 6 down the sidewalk. Looked like she followed another Res out the doors. . . ." *03/25/12: ". . . Res wandering in hallway going in/out of other residents rooms. Going back et forth from DR [dining room]. Res taking food off other Res's trays. Has needed much redirection et supervision this shift. . . ." *01/28/12 from 6:00 p.m. to 9:00 p.m.: ". . . Res cont. [continues] to get up et wander in hallway et in et out of other Res rooms. . . ." *01/24/12 at 4:30 p.m.: ". . . Res wandering on NW [new wing], tried to lay down on a Res bed. Brought back to her room. . . ." *12/13/11 at 4:00 a.m.: ". . . Res has not slept yet tonite [sic]. When you remind her of the time [and] that it's time for bed she says she's been sleeping for hours. Res has been in the hallway wandering into other Res rooms. Starting to get upset [with] staff when they repeatedly try to redirect her from another Res room. . . ." *09/06/11 at 3:00 p.m.: ". . . CNA found Res about to pull pants down in [Resident #11's room]. CNA redirected Res to own room. 1/2 hr [hour] later CNA reported found Res using BR [bathroom] in [a different resident's room]. . . ." Resident #13's medical record included a document titled "Behavior Monitoring Form" dated April 2012. This form identified Resident #13's "target behaviors" as "anxious behavior" and "repetitive statements" and also identified the use of Zoloft. During an interview on the morning of 04/19/12, a supervisory nursing staff member (#1) stated Resident #13 is not monitored for wandering behaviors, except during a seven day period prior to the completion of an MDS. A social services staff member (#5) stated Resident #13 "doesn't wander." Resident #13 was observed	F 250		

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F 250	Continued From page 7 during the survey to wander about the facility. Facility staff failed to assess Resident #13's wandering behavior, failed to develop a care plan and implement interventions to address the behavior, and failed to consider the effects of Resident #13's wandering on other residents who reside at the facility. - Review of Resident #1's medical record occurred on April 16-19, 2012. Diagnoses included Alzheimer's disease, dementia, depression, agitation, and anxiety. Current medications included Zoloft. Resident #1's quarterly MDS, dated 01/11/12, identified a BIMS score of 3, indicating severe cognitive impairment, verbal behavioral symptoms directed toward others, and a behavior of wandering. Review of the care plan, dated 01/12/12, identified, "Problem: Behavior problems as demonstrated by wandering in the hallway and will open the residents rooms [sic] door if they are closed." Resident #1's medical record included a document titled "Behavior Monitoring Form" dated April 2012. This form identified Resident #1's "target behaviors" as "short tempered [with] staff" and "resisting cares." Review of Resident #1's progress notes identified the following: * 11/12/11 from 3:00 p.m. - 11:00 p.m.: "Behavior . . . Res. was in [Resident #11's] room, when writer entered found Res. pushed up against [Resident #11] in w/c [wheelchair]. The Res. was covered in coffee. Writer removed Res. from	F 250		

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F 250	Continued From page 8	F 250		

room and assessed for injuries. Slightly reddened areas on the chest that went away were noted. The Res. denied pain but stated, '[expletive] I don't care.' Res. was washed up & clothes were changed."
* 11/24/11 - Days: "Resident called writer a "fat woman" when writer tried to redirect him out of another residents room."
*11/27/11 - 4:00 p.m.: "Note - Res. found going out front doors. When asked where he was going res. responded 'I don't know where the hell I am going.' Res. easily turned around."
*12/28/11 from 11:00 p.m. - 7:00 a.m.: "Res. awake all NOC, wheeling around trying to get into other Resident's room. Res. was very rude when he was redirected out of the rooms."
*01/08/12 - 7:00 a.m.: "Behavior - res. up most of NOC, informed by front nurse res went in [Resident #10's room]. [Resident #10] was upset [with] [Resident #1] removed by front nurse and redirected."
*01/09/12 - 3:00 a.m.: "Behavior - res up in w/c, roaming. Went into room [number]. Attempted to go into [Resident #10's room] but was redirected by front nurse."
*03/01/12 - 5:00 p.m.: "Res. was wheeling self down the hall to supper, him & [and] [Resident #11] met up @ [at] the same time & having trouble getting around a pal lift. Res. said something to upset [Resident #11], then [Resident #11] started punching res. in R) [right] arm & chest. [Resident #11] stated he probably shouldn't have done that, but he's getting 'sick of him running his mouth.' They were separated & a status [change] was put out re: [regarding] keeping them away from each other."
* 04/10/12 - 3:30 p.m.: "Res. was wandering around A-wing hall. When went to go get him,

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F 250	Continued From page 9 CNA seen him opening an envelope. CNA noticed it was another resident's mail. That res. mail was returned & res. redirected to nurses station." Review of Activity Notes identified the following: *04/09/12 ". . . Res. not in a very good mood, recently moved to a new room. . . [Resident] has been wandering in the evening looking in peoples rooms and opening doors. . . ." Review of Resident #1's social services notes identified the following: *04/10/12 ". . . Moods of being short tempered are not uncommon for Resident. . . . He stops at other resident's doorways to look in but doesn't attempt to go inside. . . ." These notes are inaccurate based on progress notes dated 11/12/11, 12/28/11, 01/08/12, and 01/09/12. Facility staff failed to adequately assess/monitor Resident #1's wandering behavior and failed to develop a comprehensive care plan with interventions to decrease further behaviors which resulted in Resident #1 being hit and having coffee thrown on him by a resident. - During an interview on 04/18/12 at 9:30 a.m., Resident #9 stated a male resident sits outside her door and sometimes opens the door to her room. She identified the resident as Resident #1. She indicated Resident #1 does not scare her, but his intrusions annoy her. Review of Resident #9's medical record identified a BIMS of 15, indicating intact cognition. Review of Resident #9's social services notes identified the following:	F 250		

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F 250	Continued From page 10 *03/16/11: ". . . She [Resident #9] said one of the residents comes by her door once in awhile, but it did not bother her. . . ." *02/28/12: ". . . She [Resident #9] gets irritated with a resident who parks outside her room, but denies being afraid of him. She uses her call light to have staff remove him. . . ." *03/15/12: ". . . She [Resident #9] indicates that she is not afraid of any other residents, but a gentleman comes by to sit outside her room. Staff are trying to intervene and she said its [sic] getting better. . . . " The examples above indicates Resident #9 has become tolerant to these wandering behaviors. The potential for injury to Resident #9 increases as these episodes increase without staff addressing the fact that Resident #9 is annoyed by Resident #1. Resident #9's medical record and care plan failed to identify Resident #1's behavior toward Resident #9 and failed to include any approaches/interventions to address Resident #1's intrusions on Resident #9's daily life. -Review of Resident #10's medical record occurred on April 18-19, 2012. Resident #10's annual MDS, dated 03/31/12, identified a BIMS score of 15, indicating intact cognition. Observation on all days of survey showed a plastic chain across the doorway of Resident #10's room. During an interview on the afternoon of 04/18/2012, Resident #10 identified one resident (Resident #1) who opens the door to her room and looks in, and two other residents (not identified) have wandered in her room many	F 250		

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F 250	Continued From page 11 times. Resident #10 stated, "I slammed the door shut on him [Resident #1] . . . staff told me not to slam the door, I could hurt him [Resident #1] . . . I should use my call light for help." Resident #10's medical record and care plan failed to address the wandering behavior of residents who intruded into Resident #10's room and which required a plastic chain across her doorway to prevent these continued intrusions.	F 250		
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, medical record review, and staff interview, the facility failed to provide care and services in accordance with the plan of care for 1 of 1 sampled resident (Resident #2) with a physician's order for TED (Thrombo-Embolic Deterrent) hose (a medically prescribed tight-fitting stocking used to help prevent the pooling of blood and formation of blood clots). Failure to ensure Resident #2 wore the TED hose 24 hours per day as ordered may result in negative physical effects such as blood clot formation, pulmonary embolism, or stroke. Findings include:	F 309		

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	355069	A. BUILDING _____ B. WING _____	04/19/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEARTLAND CARE CENTER	620 14TH 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 309	Continued From page 12 Review of Resident #2's medical record occurred on April 17-19, 2012. Diagnoses included a history of cerebral artery occlusion with cerebral infarction (stroke), a history of transient ischemic attacks (TIA's), and hypertension. Resident #2's current Minimum Data Set (MDS), dated 02/09/12, identified severely impaired daily decision-making skills and total assistance from one person for dressing. A physician's order, dated 12/12/11, stated, ". . . Knee high Ted hose on 24 hrs [hours]. Remove 1/2 [hour] bid [twice per day] for AM and HS [bedtime] cares. Dx: [diagnosis] CVA [cerebrovascular accident] . . ." Observation during the initial tour on 04/16/12 at 12:45 p.m. showed Resident #2 asleep on her bed without TED hose on her lower legs/feet. Observations throughout the survey showed Resident #2 did not wear TED hose until the morning of 04/19/12. During observation of cares on 04/17/12 at 9:53 a.m., a certified nursing assistant (CNA) (#2) stated, "I just noticed she's [Resident #2] not wearing her TED hose. Nights [the night shift] must have forgot to put them on." Later that day, the CNA indicated the TED hose were in the laundry and therefore, unavailable for Resident #2 to wear. Resident #2's treatment records identified the following treatment: "Knee high Ted hose on 24 hours - remove 1/2 hour bid for am and hs cares: CVA." The record contained two spaces ("a.m."	F 309	1. Both nurses that were in non-compliance were educated on the importance of following resident #2 individualized plan of care. 2. All residents have been identified by reviewing treatment sheets for residents with orders for antiembolism socks and we have included residents with compression hose. Further identification will be identified per doctor's orders and Occupation Therapy recommendations. Will be monitored per treatment records. 3. All residents identified will have an extra pair of socks in their room to be available for laundering. All sizes for each individual will be placed on the Treatment Administration Record and extra pairs will be available located in the office of the Skin Nurse. All care cards located in all residents closets will be reviewed to make sure orders for TED socks/compression hose are on care cards for CNA's to use. 4. Staff education will be done at mandatory nursing meeting scheduled for 5/31/12. Unit managers or other designated personnel will do random weekly audits on all individuals with TED socks/compression hose for 3 months, then monthly for 9 months. See exhibit H. Any noncompliance to follow individualized plan of care will result in disciplinary action. QA will be reviewed quarterly at QA meetings beginning in July for 1 year.	4/19/12 5/18/12 5/31/12 5/31/12

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F 363	Continued From page 14 -Observation on 04/16/12 at 5:17 p.m. showed Resident #2 (who recently experienced weight loss) eating supper in the assisted dining room. The resident's tray card (identifying the meal's food items) stated, "Provide soup with dinner and supper meals," and identified banana gelatin as the meal's dessert. Observation showed staff failed to provide Resident #2 with the soup or gelatin as identified on her tray card. Staff also failed to provide soup during the supper meal on 04/17/12. -Observation on 04/16/12 at 5:22 p.m. showed Resident #8 eating supper in the dining room. The resident's tray card identified banana gelatin and green bean bake as meal items. However, observation showed staff did not serve Resident #8 gelatin and the resident received tomato slices instead of green bean bake. -Observation of the supper meal on 04/18/12, showed Resident #8 and #27 received ground beef with gravy and mashed potatoes, although their tray cards identified ground beef on a croissant. Observation showed Resident #16 did not receive tapioca fruit salad, as listed on his tray card, and Resident #20 did not receive tapioca fruit salad or ice cream, as listed on her tray card. -The menu identified wheat bread and margarine served at the noon meals on 04/17/12 and 04/18/12. However, observations in the assisted dining room showed no residents received bread, regardless of the type of diet texture ordered (Resident #2, #5, #8, #16, #19, #20, #26, #27, #28, #29, #30, and #31).	F 363	1. Each staff member was individually educated by the dietary manager on 4/19/12 regarding procedures for following menus and diet cards. 2. All residents that are unable to voice their preferences have the potential to be affected. 3. An audit has been developed to ensure that menus and tray cards are followed for residents unable to voice their preferences. 4. The Menu/Tray Card Accuracy Audit will be completed by the Dietary Manager weekly for 3 months. See Exhibit I.	4/19/12 6/5/12

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F 363	Continued From page 15 -The menu identified a baked potato served at the noon meal on 04/18/12. However, observations in the assisted dining room showed only one resident received a baked potato. The other residents received mashed potatoes. -During the noon and evening meals on 04/17/12 and 04/18/12, observations in the assisted dining room showed no resident received coffee, even though it was listed as a menu item on their tray cards. During an interview on 04/19/12 at 8:27 a.m., a supervisory dietary staff member (#4) stated staff should have served Resident #8 and #27 croissants on 04/18/12 and should have served the residents bread on 04/17/12 and 04/18/12, as identified on their tray cards.	F 363		
F 365 SS=F	483.35(d)(3) FOOD IN FORM TO MEET INDIVIDUAL NEEDS Each resident receives and the facility provides food prepared in a form designed to meet individual needs. This REQUIREMENT is not met as evidenced by: Based on observation, review of resident diet orders and facility menus, review of facility policy, and staff interview, the facility failed to provide food in a form designed to meet individual needs for 1 of 1 sampled resident (Resident #8) observed during two evening meals (04/16/12 and 04/17/12) and 13 additional residents (Resident #1, #16, #17, #18, #19, #20, #21, #22, #23, #24, #25, #26, and #27) receiving a ground meat or Level II (mechanically soft) diet. Failure	F 365		

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F 365	Continued From page 16 to provide the correct texture of meat has the potential to result in choking, aspiration, decreased intake, and/or inadequate nutrition. Findings include: Review of the facility policy "Description of Diets" occurred on 04/19/12. This undated policy stated, ". . . Description of Diets . . . Regular with ground meats . . . Level II - Mechanically Altered Foods: This diet consists of foods that are mechanically altered by blending, chopping, grinding, or mashing so that they are easy to chew and swallow. Foods in large chunks or foods that are too hard to be chewed thoroughly should be avoided. . . ." Review of resident diet orders revealed the following: *Level II diet: Resident #1, #16, #18, #19, #20, #24, and #26 *Regular diet with ground meats: Resident #8, #17, #21, #22, #23, #25, and #27 Review of the facility's menus identified the following food items: *04/16/12 evening meal: Hot beef on a bun *04/17/12 evening meal: Chicken a la king over toast -Review of Resident #8's medical record occurred on April 17-19, 2012. Diagnoses included Alzheimer's disease. A physician's order, dated 03/06/12, identified "ground meats." During observation of cares on 04/17/12 at 8:23 a.m., a certified nursing assistant (CNA) (#3) stated Resident #8 "has a few of her own teeth. She used to have a partial, but she won't let us put	F 365	1. Each cook was individually educated by the dietary manager on 4/19/12 regarding procedures for preparing and serving Level 2 textures or ground meats. 2. All residents receiving Level 2 textures or ground meats have the potential to be affected. 3. An audit has been developed to ensure that textures are properly prepared and served in accordance with resident's diet orders. 4. The Food Texture Audit will be completed by the Dietary Manager 5 days a week for 6 months. See exhibit J.	4/19/12 6/5/12

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F 365	Continued From page 17 that in anymore." Observation on 04/16/12 at 5:22 p.m. showed Resident #8 eating her evening meal, which consisted of hot beef on a bun. The beef was cut in approximately 1/2 inch to 1 inch pieces, not ground as per physician order. Observation and review of meal intake records showed Resident #8 did not consume any of the beef. Review of the tray line on 04/16/12 at 5:52 p.m. identified a pan of "regular" texture beef (in 1/2 inch to 1 inch pieces) and a pan of "pureed" beef. An unidentified dietary staff member stated she served the "regular" texture beef to those residents who received a regular texture diet and a mechanical soft/ground meat diet. Observation on 04/17/12 at 5:50 p.m. showed Resident #8 eating her evening meal, which consisted of chicken a la king over toast. The chicken was cut in approximately 1/2 inch to 1 inch pieces, no ground as per physician order. Observation and review of meal intake records showed Resident #8 did not consume any of the chicken. Review of the tray line on 04/16/12 at 6:00 p.m. identified a pan of "regular" texture chicken a la king (in 1/2 inch to 1 inch pieces) and a pan of "pureed" chicken a la king. An unidentified dietary staff member stated she served the "regular" texture chicken to those residents who received a regular texture diet and a mechanical soft/ground meat diet. Because the dietary staff only had "regular" and "pureed" texture options available for the evening	F 365		

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F 365	Continued From page 18 meals on 04/16/12 and 04/17/12, all residents with a ground meat or Level II diet (#1, #8 #16, #17, #18, #19, #20, #21, #22, #23, #24, #25, #26, and #27) received the incorrect consistency of meat. During an interview on 04/19/12 at 8:27 a.m., a supervisory dietary staff member (#4) stated she expected staff to pulse the meats (in a food processor) for the ground meat/mechanically altered diets unless the pieces were really small and soft. She agreed 1/2 inch to 1 inch pieces of meat were too large for the ground meat/mechanically altered diets.	F 365		