Sent 8/9/11

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/28/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355064	A. BUILDING _____ B. WING _____	07/13/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENEDICTINE LIVING CENTER OF GARRISON	609 4TH AVE NE GARRISON, ND 58540

(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 July 11, 2011, and completed on July 13, 2011, the sample included 3 residents for complete review, 9 residents for focused review, and 1 closed records for review. In addition, 1 resident was added to the sample to verify specific concerns during the survey.	F 000		
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a	F 278	**F 278- Assessment accuracy** 1. Neighbor #1 was reviewed by the dietary manager, dietician, physician and interdisciplinary care plan team. An action plan was determined and immediately implemented. 2. All MDS from 07/21/2011 forward are audited to insure that section K is accurate. 3. The MDS, section K will be double checked by the dietary manager, or designee, to ensure that each MDS is entered accurately. 4. This audit will be completed for a minimum of 6 weeks. If any issues are discovered within the audit, the length of the time the audit is taking place will extend. The audit will be completed once there has been 6 consecutive weeks with no incorrect data being found on the MDS. (audit form attached- attachment #6)	07/21/201

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

administrator — 8/9/11

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 278	Continued From page 1 material and false statement. This REQUIREMENT is not met as evidenced by: Based on record review, review of the Long-Term Care Facility Resident Assessment Instrument User's Manual (Version 3.0), and staff interview, the facility staff failed to accurately complete the weight loss section of the Minimum Data Set (MDS) for 1 of 3 sampled residents (Residents #1) identified with weight loss. Failure to accurately complete portions of the MDS for all residents does not allow each resident's comprehensive assessment to direct the development of a comprehensive care plan consistent with their individual needs and problems. Findings include: The Long-Term Care Facility Resident Assessment Instrument User's Manual (Version 3.0), page 2-1 states, ". . . The RAI process is the basis for the accurate assessment of each nursing home resident . . .", and page Z-6 states, ". . . The importance of accurately completing and submitting the MDS cannot be overemphasized. The MDS is the basis for the development of: * an individualized care plan * the Medicare Prospective Payment System * Medicaid reimbursement programs * quality monitoring activities, such as the quality indicator/quality measure reports * the data-driven survey and certification process * the quality measures used for public reporting	F 278		

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F 278	Continued From page 2 * research and policy development . . ." The Long-Term Care Facility Resident Assessment Instrument User's Manual (Version 3.0), page K-6, defines coding instructions for weight loss as, "Code O, no or unknown: if the resident has not experienced weight loss . . . Code 1, yes . . . if the resident has experienced a weight loss of 5% or more in the past 30 days or 10% or more in the last 180 days, and the weight loss was planned and pursuant to a physician's order. Code 2, yes . . . if the resident has experienced a weight loss of 5% or more in the past 30 days or 10% or more in the last 180 days, and the weight loss was not planned and prescribed by a physician." On the afternoon of 04/25/11, an administrative nurse (#1) provided the survey team with a Resident/Sample matrix roster which included all the residents currently residing in the facility. The roster did not identify Resident #1 with weight loss. - Review of Resident #1's medical record occurred on July 11-13, 2011. Review of Resident #1's MDSs, completed since admission, identified the resident's weights as the following: * 11/22/10, Admission: Weight 165 pounds (lbs) * 02/14/11, Quarterly: Weight 152 lbs (a severe weight loss of 7.8% over 3 months) * 05/12/11, Quarterly: Weight 144 lbs (a severe weight loss of 12.7% over 6 months) Resident #1's quarterly MDS, dated 05/12/11, failed to indicated the resident experienced a weight loss.	F 278		

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F 278	Continued From page 3 During an interview on the morning of 07/13/11, a supervisory dietary staff member (#2) stated she agreed she failed to code Resident #1's severe weight loss.	F 278		
F 279 SS=E	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: THIS IS A REPEAT DEFICIENCY FROM THE SURVEY COMPLETED ON JUNE 3, 2010. Based on record review, review of facility policy, and staff interview, the facility failed to develop and/or review and revise the residents' comprehensive plan of care to address specific	F 279	**F 279 Develop Comprehensive Care Plans** 1. Each of the neighbors identified during the state survey- #1, 8 and 10, as not having care plans in place to address weight loss were reviewed by the dietary manager, dietician, physician and interdisciplinary care team and a appropriate care plan was put into place for each of them. 2. Weights were reviewed for every neighbor here at BLCG. A list was then made of any neighbors who had lost a significant amount of weight in the past 30 or 180 day. They were reviewed by the dietary manager, dietician, physician, and interdisciplinary care team to make sure that the care plans in place were appropriate. 3. A new weight loss/care planning system has been implemented. (see attached). 4. Each person identified on the "weight loss list" will be reviewed weekly by the interdisciplinary care plan team to make sure that their current plan of care is effective and/or appropriate. The "weight loss list" will also act as a system of checks and balances. Dietary will be able to make sure that all affected parties have been updated on the neighbor's condition, and make sure that their care plan addresses the issue.	08/10/201

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F 279	Continued From page 4 problems identified for 6 of 12 sampled residents (Resident #1, #3, #4, #5, #8 and #10). Failure to develop, review and revise the residents' care plans limits the staff's ability to communicate changes in the residents' status and care, and to ensure continuity of resident care. Findings include: Review of the facility policy "WEIGHT MONITORING AND DOCUMENTATION" occurred on 07/13/11. The policy, undated, stated, "Each resident's weight is monitored and fluctuations . . . will be assessed and appropriate individualized dietary interventions and documentation will be implemented. . . . 9. Dietician/designee will update the care plan. . . ." Review of the facility policy "Bowel and Bladder Elimination and Assessment Programs" occurred on 07/13/11. This policy, dated 12-09 (December 2009), stated, ". . . 2. The nurse will determine residents needs and specific interventions needed to maximize the independence, dignity, and comfort of the resident. 3. The resident's plan of care will reflect the elimination status. . . ." - Review of Resident #1's medical record occurred on all days of survey. Review of Resident #1's medical record identified on admission to the facility her weight was 165 pounds on 11/22/10. On 02/14/11, her weight was 152 pounds, representing an 11 pound or 7.8 % weight loss (severe) in three months. On 05/12/11 her weight was 144 pounds, representing a 21 pound or 12.7% weight loss (severe) in 6 months.	F 279		

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F 279	Continued From page 5 A nutritional status Care Area Assessment (CAA), dated 11/22/10, identified Resident #1 ". . . doesn't have any particular foods she will not eat, but she is not a big eater either. She will occasionally ask for smaller portions. . . . Functional problems that affect ability to eat . . . Inability to perform ADLs [Activities of Daily Living] without significant physical assistance . . . Family wishes for us to continue to encourage her to eat. . . . triggered this CAA . . . currently weighs 162 lbs . . . eats by herself . . . does have congnative [sic] imparements [sic] r/t [related to] Alzheimer's disease and needs cueing from . . . staff . . . for meals as well as eat and drink. . . . We will allow her to continue to eat smaller portions when she requests them. We will also continue with the assistance at meals. . . . proceeding with a care plan as we wish to continue with the assistance at meals. . . . needs some cueing and reminders as well as occasional reassurance during meals. We will also allow her to request small portions if she wants." Review of Resident #1's current care plan stated: * "CULINARY - I have relied on my husband [name] to tell me what to do for many years, now that he is gone, I feel very lost. I need some help at meals. I don't have a big appetite and I don't drink adequately" with goals of "I want my weight to be stable and i don't want to get dehydrated this quarter." Approaches included, "Assist me in making food choices, I am on a regular diet, I am on the hydration list. please watch me for any s/s [signs or symptoms] of dehydration and report them to the nurse right away. You may need to remind me that it is time to eat, or offer me reassurance during meals. Encourage me to	F 279	F-279 1. Neighbor #3,4,5 care plans were revised and care cards were updated to reflect accurate and appropriate toileting plans. These will be further updated upon completion of the B & B assessments. 2. All neighbors on current toileting program will be evaluated and looked at per IDT for appropriate toileting programs, and if not meeting the criteria will be discontinued. If appropriate to be on B&B program careplans and care cards will be updated and accuracy assured. 3. New bowel and bladder revised assessments (see Addendum A) will be implemented following training on August 10th. These will include neighbor # 3 and any questionable neighbors on current B & B plan. Otherwise this will be quarterly in conjunction with the MDS for all neighbors that are appropriate. See attached 8/11/11 pco	

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OMB NO. 093

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F 279	Continued From page 5	F 279		

A nutritional status Care Area Assessment (CAA), dated 11/22/10, identified Resident #1 ". . . doesn't have any particular foods she will not eat, but she is not a big eater either. She will occasionally ask for smaller portions. . . . Functional problems that affect ability to eat . . . Inability to perform ADLs [Activities of Daily Living] without significant physical assistance . . . Family wishes for us to continue to encourage her to eat. . . . triggered this CAA . . . currently weighs 162 lbs . . . eats by herself . . . does have congnative [sic] imparements [sic] r/t [related to] Alzheimer's disease and needs cueing from . . . staff . . . for meals as well as eat and drink. . . . We will allow her to continue to eat smaller portions when she requests them. We will also continue with the assistance at meals. . . . proceeding with a care plan as we wish to continue with the assistance at meals. . . . needs some cueing and reminders as well as occasional reassurance during meals. We will also allow her to request small portions if she wants."

Review of Resident #1's current care plan stated: "CULINARY - I have relied on my husband [name] to tell me what to do for many years, now that he is gone, I feel very lost. I need some help at meals. I don't have a big appetite and I don't drink adequately" with goals of "I want my weight to be stable and I don't want to get dehydrated this quarter." Approaches included, "Assist me in making food choices, I am on a regular diet, I am on the hydration list. please watch me for any s/s [signs or symptoms] of dehydration and report them to the nurse right away. You may need to remind me that it is time to eat, or offer me reassurance during meals. Encourage me to

F-279

1. Neighbor #3,4,5 care plans were revised and care cards were updated to reflect accurate and appropriate toileting plans. These will be further updated upon completion of the B & B assessments.

2. All neighbors on current toileting program will be evaluated and looked at per IDT for appropriate toileting programs, and if not meeting the criteria will be discontinued. If appropriate to be on B&B program careplans and care cards will be updated and accuracy assured.

3. New bowel and bladder assessments (see Addendum A) will be implemented following training on August 10th. Careplans/carecards will be updated with individualized toileting based on the findings of the B&B assessment. This will include residents #3, and any other residents currently on BB program or who are subsequently started on toileting plan following the B &B assessment. This will be quarterly with MDS and with any changes to the program for any neighbors that are appropriate.

new 8/11/11 pp

pg 6a

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F 279	Continued From page 6 eat/drink." The care plan did not identify the problem of the severe weight loss, contributing factors, and approaches to address the weight loss. The care plan did not address the resident's individuality of not being a "big eater," offering of small portions, and providing assistance with meals as addressed in the CAA. - Review of Resident #10's record occurred on July 11-12, 2011. Resident #10's medical diagnosis included senile dementia with delusions and dementia with behavioral disturbances. Review of Resident #10's Minimum Data Sets (MDSs), identified the resident experienced a severe weight loss over a six month period: * 11/02/10, Significant change: Weight 158 lbs * 02/02/11, Quarterly: Weight 138 lbs (a severe weight loss of 12.6% over 3 months). The MDS identified no nutritional approaches in place. * 05/02/11, Quarterly: Weight 129 lbs (a severe weight loss of 18% over 6 months). The MDS identified the resident on a therapeutic diet, as the physician ordered supplements on 04/28/11. A nutritional status Care Area Assessment (CAA), dated 11/03/10, identified for Resident #10 ". . . we will care plan to continue w/ [with] hydration list r/t poor fluid intake as well as continued assistance w/ setup at meals . . . She does have some confusion r/t dementia, and often is living in the past. She may need reminders that it is meal time . . . " Review of Resident #10's current care plan stated: * "CULINARY - I am sometimes independent at meals, and sometimes need assistance. I am	F 279	4. QA will be completed per neighborhood Coordinator. This will include neighbor #3 x 2 assessments. All neighbors on B & B plan will have monthly evaluation of program for next 3 months to ensure compliance and to revamp if trends noted. QA will also include all new neighbors. After January 2012 all neighbors will have been cycled through MDS process and thereafter 2 random care plans and care sheets will be audited. 5. Date Certain: August 17th, 2011	August 17th, 2011

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F 279	Continued From page 7	F 279		

confused, so may need to be reminded to come to them, or be told which meal it is. I occasionally complain that food is hard to chew or swallow. I eat well, but don't like to drink . . . I love ice cream. I don't always eat well, and am at high risk for weight loss." Approaches, with the date implemented, included the following:
* 05/01/11: "I may need encouragement at meals to eat."
* 05/01/11: "offer me 2 oz [ounces] of 2 cal HN [high nourishment] with med pass."
* 11/09/09: "bring my food to my table. You may need to help me set it up. You may need to wake me if I am sleeping, or need to remind me that it is meal time. Watch me to see if I am eating. I may need reminders or cues to eat."
* 11/09/09: "I may ask for soft foods if I have trouble chewing or swallowing something, but usually I will eat regular foods."
* 11/09/09: "My husband and I used to eat ice cream every night before bed. Please give me ice cream as a bed time [snack] as I still enjoy it."

Weight records identified an 11 pound weight loss or 6.9% weight change in 1 month between 10/15/10 (158.5 lbs) and 11/12/10 (147.6 lbs). A Nutrition Assessment, completed on 11/16/10 by the dietician, identified the resident's food likes, food and fluid intake at meals, fluid and caloric needs, eating ability and identified the resident on a regular diet, not on a therapeutic diet, on no supplements, and consistency as tolerated diet. The dietician wrote: "Unintended weight loss related to intake inconsistant [sic] with estimated energy requirements evidenced by [greater than] 10 # [lb] weight loss in 1 month and less snacking and smaller portions at meals related to more sleeping and confused at meals. Nutrition

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F 279	Continued From page 8 Interventions . . . Staff to offer assistance and monitoring at meal time to ensure an adequage [sic] intake. staff to evaluate increased confussion [sic] and or depression as it relates to food intake. Identify food preferences and honor them." The care plan did not identify Resident #10's severe weight loss, contributing factors, and approaches to address the severe weight that occurred between November and February 2011. The care plan lacked the inclusion of the dietician nutrition interventions, as written on 11/16/10, after Resident #10 experienced an unintended weight loss. - Review of Resident #8's medical record occurred on all days of survey. The facility admitted the resident in March of 2011 with diagnoses including anxiety disorder, dysphagia (difficulty swallowing), depression and a history of esophageal dilatations due to swallowing problems. Weight records identified Resident #8 experienced a severe weight loss over the three months following admission to the facility. A nutritional status Care Area Assessment (CAA), dated 03/17/11, identified Resident #8 with dysphagia and able to tolerate a regular diet and able to eat independently. The CAA stated the resident made her own food choices and was able to make independent choices regarding her health. The CAA stated, "We will care plan for [Resident #8] to have her meals delivered to her. We will follow her wishes as best as we can in allowing her to sleep in, and eat a late breakfast. We will also avoid foods that cause irritation to her diverticulitis."	F 279		

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Review of Resident #8's current care plan stated:
* "CULINARY - I don't have a big appetite, and don't drink very much. I do have some swallowing problems, but can tolerate regular foods. I should avoid eating foods with seeds or skins. I may need help at meals." The plan identified a goal of "I want to be independent and be served food that does not irritate my digestive tract." Approaches included: "Deliver my food to my table. I may need help with tougher food packets; I am on the hydration list. Please watch me for any signs of dehydration and report them immediately to the nurse; Serve me a regular diet, but avoid seeds and skins."

The care plan failed to include delivery of meals to the resident's room, lacked any evidence the resident experienced a severe weight loss, contributing factors, and approaches to address the severe weight loss.
The care plan failed to identify the resident has a diagnosis of dysphagia, swallowing difficulties, and history of esophageal dilatations.

- Review of Resident #5's medical record occurred on all days of survey and identified diagnoses of dementia, chronic kidney disease, and prostatic malignancy.

A significant change MDS, dated 01/17/11 and a Quarterly MDS, dated 04/17/11, identified Resident #5 as frequently incontinent of urine and bowel, and currently on a toileting plan.

Review of Resident #5's current care plan and "Care Plan Communication Sheet"(a tool used by the Certified Nursing Assistants (CNAs)) indicated, "Toileting: incontinent scheduled

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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 279	Continued From page 10	F 279		

toileting." The current care plan identified the approach for Resident #5's incontinence of bowel and bladder as "Please take me to the bathroom regularly so that I have less accidents." The care plan and care sheets lacked a plan for this resident regarding an individualized toileting schedule.

- Review of Resident #4's medical record occurred on all days of the survey and identified diagnoses of dementia, anxiety, and constipation.

An annual MDS, dated 06/06/11, and an quarterly MDS, dated 04/06/11, identified Resident #4 as frequently incontinent of urine, and currently on a toileting plan.

Review of Resident #4's current care plan and "Care Plan Communication Sheet" indicated, "Toileting: incontinent scheduled toileting." The current care plan identified the approach for Resident #4's incontinence of bowel and bladder as "Take me to the bathroom regularly so that I can stay as dry as possible." The care plan and care sheet lacked a plan for this resident regarding an individualized toileting schedule.

The facility failed to develop a care plan that addressed Resident #4 and #5's specific needs for toileting.

- Review of Resident #3's medical record occurred on July 11-13, 2011. Diagnoses included Alzheimer's disease and history of urinary tract infection (UTI). Resident #3's quarterly MDS, dated 04/26/11, indicated extensive assist of one for toileting, on a toileting program, and occasionally incontinent of urine

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	355064	A. BUILDING _____ B. WING _____	07/13/2011

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F 279	Continued From page 11 and bowel. Resident #3's care plan, dated 10/14/09, stated, ". . . Elimination: I do have incontinent episodes. I get confused and need cues and assistance with my toileting. Goal: . . . Maintain an effective pattern of elimination. 2. Will have toileting needs met on a daily basis. Approach: . . . assist me with my pad and toileting regularly so that I can be as continent as possible. . . ." Review of Resident #3's care card showed "scheduled toileting, usually continent, requests assist, pull up brief." Resident #3's scheduled/prompted toileting documentation form, for July 2011, failed to include the toileting schedule on the "instructions" area. During an interview on 07/12/11 at 11:20 a.m., an administrative nurse (#1) stated the care cards contain information for the staff when caring for residents related to their ADL and toileting plans. The nurse agreed Resident #3's toileting plan was not on the care plan and "scheduled toileting" was not defined on the care card. Failure to address Resident #3's specific toileting plan, whether on the care card, and/or care plan does not allow for continuity of care, and does not allow Resident #3 to achieve her maximum level of continence.	F 279		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the	F 315		

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resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.

This REQUIREMENT is not met as evidenced by:
Based on observation, review of policy and procedure, record review, and staff interview, the facility failed to provide appropriate treatment and services to restore as much normal bladder function as possible for 3 of 3 sampled residents (Resident #3, #4, and #5) on a scheduled toileting plan. Failure to assess residents' toileting patterns and level of continence, implement individualized toileting plans, and evaluate the plans for effectiveness does not allow residents to achieve their highest level of continence.

Findings include:

The Centers for Medicare and Medicaid Services (CMS) has outlined the standards of practice regarding urinary incontinence. Although aging affects the urinary tract and increases the potential for urinary incontinence, incontinence is not a normal part of aging. Because urinary incontinence may be reversible, it is important to understand the causes and to address incontinence to the extent possible. "Habit Training/Scheduled Voiding" is a behavioral technique that calls for scheduled toileting at regular intervals to match the resident's voiding habits. Habit training includes timed voiding with the interval based on the resident's usual voiding

1. Resident's #3,4,5 were reviewed. Resident # 3 will have will have bowel and bladder assessments utilizing the new assessments (see Addendum A). Scheduled toileting was deemed not appropriate for #4,5 and will be discontinues based on MDS criteria, and staff interview and review of continence. We will continue to toilet routinely and check and change these two neighbors, but will not be on plan. Following B&B assessment care plans will be updated and toileting program either continued or stopped dependent on results and evaluation of the assessment. All residents on current toileting program could be potentially affected.

2. All residents on current toileting program will be evaluated and looked at per IDT for appropriate toileting programs, and if not meeting criteria will discontinue the program. Quarterly all residents who have potential to have increased/maintained continence will be evaluated using the new BB assessment. Following the evaluation of toileting assessment, a program will be developed and care plan updated in relation to personalized needs of individual residents

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F 315	Continued From page 13 schedule or pattern. Scheduled voiding is timed voiding, usually every three to four hours while awake. Residents who cannot self-toilet may be candidates for habit training or scheduled voiding programs. Review of the facility policy "Bowel and Bladder Elimination and Assessment Programs" occurred on 07/13/11. This policy, dated 12-09 (December 2009), stated, "Policy: To provide an ongoing assessment of resident elimination ability and needs, and evaluation of interventions, to allow the resident the maximum independence, dignity normalcy and comfort. Procedure: 1. Upon admission residents will be screened for bowel and bladder status. An assessment evaluation of bowel and bladder status will be initiated at the nurses discretion to determine elimination patterns and to help assist with appropriate elimination programs. 2. The nurse will determine residents needs and specific interventions needed to maximize the independence, dignity, and comfort of the resident. 3. The resident's plan of care will reflect the elimination status. 4. Review of the resident's bowel and bladder status will be done annually, reviewed quarterly, and as indicated by a change in status." - Review of Resident #3's medical record occurred on July 11-13, 2011. Diagnoses included Alzheimer's disease and history of urinary tract infection (UTI). Resident #3's quarterly Minimum Data Set (MDS), dated 04/26/11, indicated short and long term memory impairment, moderate impairment in making daily decisions, extensive assist of two for transfers, extensive assist of one for toileting, on a toileting program, and occasionally incontinent of urine	F 315	3. New bowel and bladder assessments (see Addendum A) will be implemented following training on Wed August 10th . These will include residents #3, and any questionable residents currently on BB program. Otherwise this will be quarterly with MDS, on residents that are appropriate. 4.QA will be completed per Neighborhood Coordinator. To include residents #3 x2 assessments. Monthly current toileting programs will be evaluated next 3 months to ensure compliance, and to revamp if trends noted. After January 2012 all neighbors will have been cycled through MDS process and thereafter, 2 random assessments/plans will be audited based on needs . (see Addendum B) 5. Date certain: August 17th, 2011	August 17th, 2011

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F 315	Continued From page 14 and bowel. Resident #3's admission bladder assessment, dated 07/13/09, indicated the resident continent of bladder. Additional information stated, "neighbor [Resident #3] had very sm [small] amount urine in panties when toileted. family and neighbor report this is unusual but 'ride was long' and she had not voided prior to leaving hospital. did put small liner in panties for security." A review of the bladder assessment, dated 10/14/09, stated, ". . . did have some incontinent episodes. It is questionable whether this is a change for neighbor as she tries to hide her incontinence and may have been doing this prior to admission also. Will started [sic] on scheduled toileting." An assessment, dated 01/22/10, stated, "Neighbor is incontinent, wears disposable brief and is on scheduled toileting. . . . " Resident #3's Care Area Assessment (CAA) for urinary incontinence, dated 01/10/11, indicated the type of incontinence as "functional incontinence" defined as "can't get to toilet in time due to physical disability, external obstacles, or problems thinking or communicating." Analysis indicated, "requires extensive assist with toileting due to cognitive and physical limitations, is usually able to maintain continence on current scheduled toileting program as noted per POC [Point of Care] documentation. The CAA failed to list details of the scheduled toileting plan, or changes to the plan based on the resident's toileting pattern. Resident #3's Bowel/Bladder Point of Care (POC) History showed 13 episodes of incontinence from July 01-12, 2011; 41 episodes of incontinence in	F 315		

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F 315	Continued From page 15 June, 2011; and 37 episodes of incontinence in May, 2011. During an interview on 07/12/11 at 11:40 a.m., an administrative nurse (#1) agreed the bowel/bladder POC charting did not list every episode of toileting so the resident could have more episodes of incontinence than the charting shows. Resident #3's care plan, dated 10/14/09, stated, ". . . Elimination: I do have incontinent episodes. I get confused and need cues and assistance with my toileting. Goal: . . . Maintain an effective pattern of elimination. 2. Will have toileting needs met on a daily basis. Approach: . . . assist me with my pad and toileting regularly so that I can be as continent as possible. . . ." Review of Resident #3's current care plan communication sheet (care card) showed "scheduled toileting, usually continent, requests assist, pull up brief." Resident #3's scheduled/prompted toileting documentation form, for July 2011, failed to include the toileting schedule on the "instructions" area. During an interview on 07/12/11 at 11:20 a.m., an administrative nurse (#1) stated the care cards contain information for the staff caring for residents related to their activities of daily living (ADL) and toileting plans. This nurse stated a resident's toileting plan is normally written on the scheduled/prompted toileting form. She stated a routine toilet plan includes toileting a resident before and after meals, upon arising, and at bedtime. An extra toileting time will be added if staff notice a resident is incontinent at a particular time of the day. The nurse agreed Resident #3's toileting plan was not on the care plan or on the	F 315		

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scheduled/prompted toileting form, and "scheduled toileting" was not defined on the care card.

Failure to review the specific details of Resident #3's toileting plan, evaluate the effectiveness of the toileting plan, and change the toileting plan according to the resident's assessed continence status, failed to allow Resident #3 to achieve her maximum level of continence and places the resident at increased risk for urinary tract infections, avoidable increased bladder incontinence and also has the potential to compromise the resident's individual dignity.

- Review of Resident #5's medical record occurred on all days of survey and identified diagnoses of dementia, chronic kidney disease, and prostatic malignancy.

A significant change Minimum Data Set (MDS), dated 01/17/11, and a quarterly MDS, dated 04/17/11, identified Resident #5 as frequently incontinent of urine and bowel, currently on a toileting plan, extensive assist of one person for toilet use, and resistive to care.

A Care Area Assessment (CAA), dated 01/18/11, identified Resident #5 on a toileting plan and with functional incontinence.

Review of Resident #5's current care plan and "Care Plan Communication Sheet" (a tool used by the Certified Nurse Aides (CNAs) stated, "Toileting: incontinent scheduled toileting." The current care plan identified the approach for Resident #5's incontinence of bowel and bladder as "Please take me to the bathroom regularly so

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F 315	Continued From page 17 that I have less accidents." The care plan and care sheet lacked an individualized toileting schedule. Observations of care provided to Resident #5 include the following: *07/11/11 at 3:40 p.m., CNA (#5) assisted the resident to the bathroom and showed the resident's brief dry; the resident voided and had a bowel movement. *07/12/11 at 08:00 a.m., CNA (#6) assisted the resident to the bathroom and showed his brief wet. *07/12/11 at 11:55 a.m., CNA (#6) assisted the resident to the bathroom, but the resident resisted toileting. *07/12/11 at 1:45 p.m., CNA (#6) assisted the resident to the bathroom and showed his brief wet. *07/12/11 at 3:05 p.m., CNA (#7) assisted the resident to the bathroom and showed his brief dry. Review of Resident #5's "Point of Care" charting for bladder function from 05/13/11 to 07/13/11 indicated the resident as daily incontinent and failed to identify a toileting plan. - Review of Resident #4's medical record occurred on all days of the survey and identified diagnoses of dementia, anxiety, and constipation. An annual MDS, dated 06/06/11, and a quarterly MDS, dated 04/06/11, identified Resident #4 frequently incontinent of urine, on a toileting plan, extensive assist of one person for toilet use, and resistive to care.	F 315		

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F 315	Continued From page 18 The CAA, dated 06/13/11, stated, "requires extensive assistance with toileting and total assistance with personal hygiene . . . incontinence is primarily functional." Review of Resident #4's current care plan and "Care Plan Communication Sheet" indicated, "Toileting: incontinent scheduled toileting." The current care plan identified the approach for Resident #4's incontinence of bowel and bladder as "Take me to the bathroom regularly so that I can stay as dry as possible." The care plan and care sheet lacked a plan for this resident regarding an individualized toileting schedule. Observations of care provided to Resident #4 include the following: *07/12/11 at 9:20 a.m., CNA (#6) assisted the resident to the bathroom and showed his brief and t-shirt wet with urine. *07/12/11 at 12:05 p.m., CNA (#6) assisted the resident to the bathroom and showed his pants visibly wet with urine. * 07/12/11 at 4:10 p.m., CNA (#7) assisting the resident with personal cares after an incontinent bowel movement. Review of Resident #4's "Point of Care" charting for bladder function from 05/13/11 to 07/13/11 indicated the resident as daily incontinent and failed to identify a toileting plan. During an interview on 07/13/11 at 7:50 a.m., when asked what Resident #4 and Resident 5's toileting plan consisted of, an administrative nurse (#1) stated, "It is the standard, before and after meals and/or every two hours."	F 315		

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F 315	Continued From page 19 The facility failed to assess Resident #4 and #5 and develop, if indicated, an individualized toileting plan. Facility staff failed to complete a Bowel and Bladder Assessment to re-assess increased bladder incontinence, determine voiding patterns and frequency to minimize episodes of incontinence and failed to implement individualized interventions to manage, maintain or improve the resident's level of continence.	F 315		
F 325 SS=G	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: 1. Based on observation, record review, review of facility policy, review of a professional reference, and staff interview, facility staff failed to adequately assess the nutritional status, needs and risk factors, and implement appropriate interventions to restore/maintain adequate nutritional status for 3 of 3 sampled residents (Resident #1, #8 and #10) identified with severe weight loss. Failure to monitor residents, implement, and evaluate the nutritional needs of compromised residents, consistent with their	F 325	**F 325 Maintain nutrition status unless unavoidable** 1. Neighbors #1, 8 and 10, were reviewed by the dietary manager, dietician, physician and interdisciplinary care team. Their condition was also discussed with their responsible parties- neighbor #1 is able to make decisions regarding her own health, so we discussed it directly with her, and their input/wishes were taken into consideration. An action plan was developed for each, and implemented. 2. A report of each neighbor's weight was run. Each neighbor was reviewed by the dietary manager to determine if a significant weigh loss had occurred. Each individual identified was then added to our new "weight loss list"- see form attached.	

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F 325	Continued From page 20 comprehensive assessment, resulted in severe weight loss in each of these residents. 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% 3 months — 7.5% — Greater than 7.5% 6 months — 10% — Greater than 10% Review of the facility policy "WEIGHT MONITORING AND DOCUMENTATION" occurred on 07/13/11. The policy, undated, stated, "Each resident's weight is monitored and fluctuations of [greater than or equal to] 5% in one month, or [greater than or equal to] 7.5% in 3 months, or [greater than or equal to] 10% over the past six months will be assessed and appropriate individualized dietary interventions and documentation will be implemented. The facility must ensure that a resident maintains parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible. . . . PROCEDURE . . . a. Nursing staff is to verify the accuracy if the weight change. [sic] Reweighs are recommended for residents with a 5-pound or greater change in weight. b. Dietician/designee will meet with the licensed nursing staff to determine possible causes and intervention for resident [sic] with significant	F 325	3. A new weight loss tracking and monitoring system is put into place.-see attached procedure. Staff will be in-serviced on the new procedures and expectations. 4. Weight loss will be reviewed each week at an interdisciplinary meeting, to ensure that everything is being done to maintain each individual's nutritional status, and to monitor the effectiveness of plans currently in place.	07/21/201

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F 325	Continued From page 20	F 325	2. We borrowed a scale from the local hospital. A mass weigh was taken on 07/20/2011. A report of each neighbor's weight was run. Each neighbor was reviewed by the dietary manager to determine if a significant weigh loss had occurred. Each individual identified was then added to our new "weight loss list"-(attachment #4). A new scale has since been purchased and is in use.	

comprehensive assessment, resulted in severe weight loss in each of these residents.

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%
3 months	7.5%	Greater than 7.5%
6 months	10%	Greater than 10%

Review of the facility policy "WEIGHT MONITORING AND DOCUMENTATION" occurred on 07/13/11. The policy, undated, stated, "Each resident's weight is monitored and fluctuations of [greater than or equal to] 5% in one month, or [greater than or equal to] 7.5% in 3 months, or [greater than or equal to] 10% over the past six months will be assessed and appropriate individualized dietary interventions and documentation will be implemented. The facility must ensure that a resident maintains parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible. . . .

PROCEDURE. . .

a. Nursing staff is to verify the accuracy if the weight change. [sic] Reweighs are recommended for residents with a 5-pound or greater change in weight.

b. Dietician/designee will meet with the licensed nursing staff to determine possible causes and intervention for resident [sic] with significant

3. A new weight loss tracking and monitoring system is put into place.-(see attachment #3)

procedure. Staff will be in-serviced on the new procedures. (new weight tracking form- Attachment #5)

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F 325	Continued From page 22	F 325		

* admission MDS, dated 11/22/10, identified the resident usually understood, usually able to understand others, severe impairment in cognitive function (BIMS score of 5), and required limited assist of one person with eating
* quarterly MDS, dated 02/14/11, identified the resident required extensive assistance from one person with eating
* quarterly MDS, dated 05/12/11, identified the resident usually understood, usually able to understand others, with a short and long term memory problem, moderately impaired in daily decision making, and required limited assist of one person with eating.

Review of Resident #1's MDSs, completed since admission, identified the resident experienced severe weight loss over a six month period:
* 11/22/10, Admission: Weight 165 pounds (lbs)
* 02/14/11, Quarterly: Weight 152 lbs (a severe weight loss of 7.8% over 3 months)
* 05/12/11, Quarterly: Weight 144 lbs (a severe weight loss of 12.7% over 6 months)

Review of Resident #1's weight records identified these additional weights:
* 05/07/11: 144.4 lbs
* 05/28/11: 137.4 lbs, a 4.8% weight loss in less than 2 weeks
* 06/01/11: 143.2 lbs. The record lacked evidence of a re-weigh as per facility policy.
* 06/08/11: 133.0 lbs, a 7.6% weight loss in 1 month

The record lacked evidence of weights recorded after this date.

Review of Resident #1' s medical record, including physician progress notes, lacked

4. Weight loss will be reviewed each week at an interdisciplinary meeting, to ensure that everything is being done to maintain each individual's nutritional status, and to monitor the effectiveness of plans currently in place. The dietary manager or designee willl be monitoring to make sure that the new weight procedure is understood and followed. Audit will be completed for 6 week minimum. It will be extended if compliance is not met. It may be discontinued once 6 weeks of continued compliance have been met. (audit form- attachment #6)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENEDICTINE LIVING CENTER OF GARRISON	609 4TH AVE NE GARRISON, ND 58540

(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 325	Continued From page 21 weight loss and well as [sic] for those as risk [sic] for unintended weight loss. * Reassess actual food and fluid intake * Assess potential contributing factors: * Acute illness * Multiple medical problems/diseases * Chewing and/or swallowing difficulties * Change in functional eating ability * Changes in cognition . . . * Medication side effects . . . c. Reassess diet order 8. The dietitian/designee will document progress and assessing weight concerns using the following suggested guidelines: * Current weight * Amount of weight loss or gain * Caloric needs . . . * Diet order including supplement use * Estimation of calories provided including snacks * Estimation of calories actual consumed * Possible reason for weight change * Plan/approach for intervention 9. Dietician/designee will update the care plan. . . ." - Review of Resident #1's medical record occurred on all days of survey. The facility admitted the resident in November of 2010 with diagnoses including Alzheimer's disease, dementia, and depressive disorder. The record identified the resident on a regular diet and no supplements. Review of Resident #1's Minimum Data Set (MDS), completed since admission identified the resident's cognitive function and feeding assistance ability as:	F 325		

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F 325	Continued From page 22 * admission MDS, dated 11/22/10, identified the resident usually understood, usually able to understand others, severe impairment in cognitive function (BIMS score of 5), and required limited assist of one person with eating * quarterly MDS, dated 02/14/11, identified the resident required extensive assistance from one person with eating * quarterly MDS, dated 05/12/11, identified the resident usually understood, usually able to understand others, with a short and long term memory problem, moderately impaired in daily decision making, and required limited assist of one person with eating. Review of Resident #1's MDSs, completed since admission, identified the resident experienced severe weight loss over a six month period: * 11/22/10, Admission: Weight 165 pounds (lbs) * 02/14/11, Quarterly: Weight 152 lbs (a severe weight loss of 7.8% over 3 months) * 05/12/11, Quarterly: Weight 144 lbs (a severe weight loss of 12.7% over 6 months) Review of Resident #1's weight records identified these additional weights: * 05/07/11: 144.4 lbs * 05/28/11: 137.4 lbs, a 4.8% weight loss in less than 2 weeks * 06/01/11: 143.2 lbs. The record lacked evidence of a re-weigh as per facility policy. * 06/08/11: 133.0 lbs, a 7.6% weight loss in 1 month The record lacked evidence of weights recorded after this date. Review of Resident #1' s medical record, including physician progress notes, lacked	F 325		

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F 325	Continued From page 23 evidence the facility informed the resident's provider of the resident's severe weight loss. A nutritional status Care Area Assessment (CAA), dated 11/22/10, identified Resident #1 ". . . doesn't have any particular foods she will not eat, but she is not a big eater either. She will occasionally ask for smaller portions. . . . Functional problems that affect ability to eat . . . Inability to perform ADLs [Activities of Daily Living] without significant physical assistance . . . Family wishes for us to continue to encourage her to eat. . . . triggered this CAA . . . currently weighs 162 lbs . . . eats by herself . . . does have congnative [sic] imparements [sic] r/t [related to] Alzheimer's disease and needs cueing from either her husband . . . or staff to come for meals as well as eat and drink. . . . is not a big eater . . . We will allow her to continue to eat smaller portions when she requests them. We will also continue with the assistance at meals. . . . proceeding with a care plan as we wish to continue with the assistance at meals. . . . needs some cueing and reminders as well as occasional reassurance during meals. We will also allow her to request small portions if she wants." Review of Resident #1's current care plan identified the following problem: * "CULINARY - I have relied on my husband [name] to tell me what to do for many years, now that he is gone, I feel very lost. I need some help at meals. I don't have a big appetite and I don't drink adequately" with goals of "I want my weight to be stable and i don't want to get dehydrated this quarter." Approaches included, "Assist me in making food choices, I am on a regular diet, I am on the hydration list. please watch me for any s/s	F 325		

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F 325	Continued From page 24	F 325		

[signs or symptoms] of dehydration and report them to the nurse right away. You may need to remind me that it is time to eat, or offer me reassurance during meals. Encourage me to eat/drink." The care plan did not identify the problem of weight loss, nor the the areas addressed in the CAA including how to address the resident's individuality of not being a "big eater," offering of small portions, and providing assistance with meals.

An admission Nutrition Assessment, completed on 12/02/10, identified Resident #1 with the following:
* ". . . enjoys drinking milk, juice and coffee. She is not a big eater. . . . regular diet. . . . Supplements . . . none at this time . . . [estimated calorie needs] 1467 kcal . . . Est Fluid Needs = 1875 ccs [cubic centimeters] . . . No or unknown [weight loss] . . . Eating ability . . . Feeds self after set-up . . . Requires Supervision and/or Cueing . . . Inadequate energy intake evidenced by oral intake of meals and snacks of approximately 50% secondary to lack of interest in food related to dementia . . . staff assist with cueing and assist as necessary to support adequate intake to reduce indidence [sic] of weight loss. regular diet."

Dietary progress notes, completed by the dietary manager, stated:
* 11/23/10: ". . . new neighbor . . . She is confused so will need . . . cueing to come to meals . . . She is a small eater, and has been eating around 50% at meals so far. Her fluid intake is often less than 1000 cc/day so I have put her on the hydration list. . . ."
* 02/15/11: "Quarterly assessment complete.

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F 325	Continued From page 25 [Resident] doesn't have any oral problems. her [sic] weight is 152 lbs and is down about 12.6 lbs in the past 6 months. She has not been eating a lot at meals and needs a lot of encouragement and cueing to keep eating once her meal has been set up for her. She is on a regular diet. We will continue with our current plan of care." A mini-nutritional assessment, (same date) completed by the dietary manager, indicated the following: no nutritional supplement, no therapeutic diet, weight change greater than a 7.5% (severe weight loss in 3 months), current oral intake fair (50-75%) with meals, moderate loss of appetite, "Feeds Self With Some Difficulty." The assessment failed to identify the need for an evaluation by the dietician or a change in the plan of care. * 02/17/11: ". . . has not been eating breakfast very well. We have tried offering a variety of different things, with little success. She does do somewhat better at lunch and supper, but is still not eating very well then either. We will continue to offer cueing and physical support, when needed." * 04/05/11: "[Resident's] intake continues to be fair at best. She needs a lot of encouragement from staff to eat. breakfast [sic] is her poorest meal. Sometimes we are successful and get her to eat some, sometimes not. I have considered a liquid supplement, but she drinks less than she eats. Her weight has been pretty stable for the past month. I will continue to watch her." * 05/12/11: "Quarterly assessment complete. [Resident] doesn't have any oral problems. . . . weight is 144.4 lbs and has been pretty stable since March, but is still greater that 10% loss over 6 months. She is on a regular diet. She needs a lot of reminders and cueing at meals to get her to	F 325		

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F 325	Continued From page 26 eat. She has been eating poorly in the morning - seldome [sic] over 25% at breakfast, about 26-50% at lunch and 51-75% at supper. Her fluid intake continues to be insufficient. She is at risk for dehydration with her current fluid intake. I will continue to monitor her weight and her intake as we would like her weight to remain stable." A mini-nutritional assessment, (same date) completed by the dietary manager, indicated the following: no nutritional supplement, no therapeutic diet, weight change greater than 10% (severe weight loss) in six months, poor to fair oral intake (50-75%), and not meeting her current intake needs. The assessment failed to identify the need for an evaluation by the dietician or a change in the plan of care. * 05/16/11: "[Resident's] weight is 141.8 and is down a few lbs since her last weight on the 4th. I don't see a change in her intake. I will continue to watch her." * 06/08/11: "Last weight was 143.2 lbs and is up a few lbs since her last weight on the 4th. Continue plan of care." * 07/04/11: "[Resident's] appetite has not been good. We have been struggeling [sic] to get her to feed herself, so we have moved her to and [sic] assist table, where she can get some help with meals. Her weight has declined also and is 133 lbs currently [this is the 06/08/11 recorded weight]." Record review identified facility staff documented Resident #1 had four HS snacks given in the 4 week period between June 13 and July 11, and documentation identified "None" on 15 of 28 of those days. Review of care conference notes, dated 02/11/11	F 325		

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F 325	Continued From page 27 and 05/20/11, lacked evidence the interdisciplinary team recognized Resident #1's severe weight loss and informed the resident's physician. During an interview on the morning of 07/13/11, an administrative staff member (#1) stated nursing staff informed the provider/physician on rounds, however could provide no documentation to support Resident #1's physician had been informed of her severe weight loss. Observation on all days of survey identified the following: * On the evening of 07/11/11, Resident #1 sat at a feeding assist table, actively participated in eating, and then received cueing and feeding assistance from a staff member until she ate almost 50% of the evening meal. * On 07/12/11 at 8:20 a.m., one staff nurse (#8) and one certified nursing assistant (CNA) (#9) transferred Resident #1 from her wheelchair to recliner in her room. The staff nurse (#8) stated Resident #1 ate "poorly" for breakfast, and so the staff nurse stated she gave Resident #1 "part of" a health shake for breakfast. Intake records identified Resident #1 consumed 1-25% of breakfast and 60 cubic centimeter (cubic centimeters) of fluid for breakfast. * 07/12/11 at 11:45 a.m., after Resident #1 sat in the recliner since 8:20 a.m., two CNAs (#9 and #10) transferred Resident #1 to her wheelchair, gave her a drink of water which she took a sip, asked her if she was hungry, to which she said "no" and transported Resident #1 to the dining room. * 07/12/11 from 12-12:30 p.m., Resident #1 sat at an assisted table, and fed herself a few bites of her meal. Part way through the meal, a staff	F 325		

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F 325	Continued From page 28 member, sitting at the table, provided assistance and cueing. Resident #1 consumed less than 25% of the meal, and documentation stated she consumed 360 cc of fluid. * 07/13/11 at 8:20 a.m., Resident #1 sat alone at a dining room table with her meal which included a cut up pancake, sausage, a glass of juice and a glass of liquid shake. Observation showed the resident had consumed a portion of the pancake and sausage. A staff nurse, while standing at her medication cart, stated, "I am going to come and assist her after awhile." Ten minutes later, a supervisory staff nurse (#1) arrived and started assisting Resident #1 to eat. During observation of cares on all days of survey, various staff offered Resident #1 water during cares, and Resident #1 never refused, although she took a small quantity each time. During interview on the morning of 07/12/11, a supervisory dietary staff member (#2) stated the following regarding Resident #1's weight loss: * Resident #1 experienced a severe weight loss since her admission in November * the dietician had not evaluated Resident #1's severe weight loss * no dietary measures have been implemented to offer additional food between meals for Resident #1 * Resident #1 eats breakfast poorly, and she does not get anything offered in the a.m. for additional nourishment after breakfast as she is resting during that time * Resident #1 refuses most liquids, so supplements between meals and/or with med pass have not been attempted * dietary has not attempted to add enhanced	F 325		

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(additional calories) to Resident #1's foods
* there is, and has not been a written plan developed and implemented to prevent Resident #1's weight loss

- Review of Resident #10's record occurred on July 11-12, 2011. Resident #10's medical diagnosis included senile dementia with delusions and dementia with behavioral disturbances.

Review of Resident #10's MDSs, identified the resident experienced a severe weight loss over a six month period:
* 11/02/10, Significant change: Weight 158 lbs
* 02/02/11, Quarterly: Weight 138 lbs (a severe weight loss of 12.6% over 3 months). The MDS identified no nutritional approaches in place.
* 05/02/11, Quarterly: Weight 129 lbs (a severe weight loss of 18% over 6 months). The MDS identified the resident on a therapeutic diet, and physician ordered supplements on 04/28/11.

Review of Resident #10's weight records identified the last recorded weight on 06/10/11 as 129.4 lbs. and no weights after that date.

Review of Resident #10' s medical record for the months of December 2010 through April 28, 2011 lacked evidence the facility informed Resident #10's provider of the severe weight loss.

A nutritional status CAA, dated 11/03/10, stated ". . . we will care plan to continue w/ [with] hydration list r/t poor fluid intake as well as continued assistance w/ setup at meals . . . She does have some confusion r/t [related to] dementia, and often is living in the past. She may need reminders that it is meal time . . . "

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Review of Resident #10's current care plan identified the following problem:
* "CULINARY - I am sometimes independent at meals, and sometimes need assistance. I am confused, so may need to be reminded to come to them, or be told which meal it is. I occasionally complain that food is hard to chew or swallow. I eat well, but don't like to drink . . . I love ice cream. I don't always eat well, and am at high risk for weight loss." Approaches, with the date implemented, included the following:
* 05/01/11: "I may need encouragement at meals to eat."
* 05/01/11: "offer me 2 oz [ounces] of 2 cal HN [high nourishment] with med pass."
* 11/09/09: "bring my food to my table. You may need to help me set it up. You may need to wake me if I am sleeping, or need to remind me that it is meal time. Watch me to see if I am eating. I may need reminders or cues to eat."
* 11/09/09: "I may ask for soft foods if I have trouble chewing or swallowing something, but usually I will eat regular foods."
* 11/09/09: "My husband and I used to eat ice cream every night before bed. Please give me ice cream as a bed time [snack] as I still enjoy it."

A dietary progress note, dated 11/02/10, stated, ". . . Her weight is 158 lbs and is stable. There is a more recent weight of 150 lbs, but I don't believe it to be correct. I don't have any concerns for her at this time. The dietician will complete the assessment."

Review of Resident #10's weight records identified the following weights:
* 10/15/10: 158.5 lbs

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F 325	Continued From page 31 * 10/22/10: 158.2 lbs * 10/29/10: 149.8 lbs, an 8 pound weight loss. The record lacked evidence of a reweigh according to facility policy. * 11/12/10: 147.6 lbs., an 11 pound weight loss or 6.9% weight loss in 1 month * 11/27/10: 142.1 lbs A Nutrition Assessment, completed on 11/16/10, by the dietician, identified the resident's food likes, food and fluid intake at meals, fluid and caloric needs, eating ability and identified the resident on a regular diet, not on a therapeutic diet, on no supplements, and consistency as tolerated diet. The dietician wrote: "Unintended weight loss related to intake inconsistant [sic] with estimated energy requirements evidenced by [greater than] 10 # [lb] weight loss in 1 month and less snacking and smaller portions at meals related to more sleeping and confused at meals. Nutrition Interventions . . . Staff to offer assistance and monitoring at meal time to ensure an adequage [sic] intake. staff to evaluate increased confussion [sic] and or depression as it relates to food intake. Identify food preferences and honor them." Dietary progress notes continued to show Resident #10's weight loss without interventions: * 01/17/11: Weight is 138 lbs . . . continues to eat about half of her food at meals, and is not drinking well. Her weight does however seem to holding [sic] it's own in the upper 130- lb range. She has been neededing [sic] extensive assistance at meals." * 02/01/11: Quarterly assessment complete . . . weight is 138 . . . stable for over a month, but is still triggering a weight loss over 6 months. Her	F 325		

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F 325	Continued From page 32 weight 6 months ago was 158 lbs. . . . * 02/17/11: ". . . has been eating about the same. . . she often will yell at staff and bang her cup, or other items on the table to get staff attention. Staff respond to her, but she usually either doesn't want anything, or is not sure what she wants . . . She is seated by the CNAs in the dining room so she can be assisted easier." * 02/22/11: "Weight is 131.4 lbs and has declined since her last weight- which was 137.2 lbs a week ago . . . continues to eat poorly at times . . . I will continue to watch her." * 03/30/11: "Weight has dropped a little again . . . is . . . 129 lbs. . . . has been sleepy at meals. Likely due to medications. However, when her medication is not given, she is very restless and doesn't eat either. She is not a good drinker, and is pretty particular about what she will drink, so it is pretty unlikely that she would accept a liquid supplement. she likes ice cream, but even has not been eating that well lately. We will continue to offer her encouragement and cueing. I will continue to monitor her." * 04/05/11: ". . . weight is down again. 127.5 lbs. . . . I will talk with the RN [registered nurse] coordinators to see if there would be a possibility of adding something between meals or with med pass." * 05/01/11: "Quarterly assessment . . . recently started giving her 2 cal HN with med pass- 2 oz. . . ." Review of care conference notes, dated 02/02/11 and 05/11/11, lacked evidence the interdisciplinary team developed measures to address Resident #10's severe weight loss, or informed the resident's physician of the severe weight loss.	F 325		

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	355064	A. BUILDING _____ B. WING _____	07/13/2011

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F 325	Continued From page 33 Observation on all days of survey showed Resident #10 sat at a table where staff did not provide feeding assistance during meal time unless they moved from an adjacent feeding assist table. During interview on the morning of 07/13/11, a supervisory dietary staff member (#2) stated the following regarding Resident #10's weight loss: * Resident #10 experienced a severe weight loss between November 2010 and May 2011 * Resident #10's weight loss was not a planned weight loss * Resident #10 sat at an assist table "for a period of time", but has not always * Resident #10's care plan did not reflect changes in care to address the weight loss The facility failed to develop, implement and evaluate interventions to address Resident #1's and #10's decreased food intake and severe weight loss. The facility failed to develop an interdisciplinary team approach to Resident #1's and #10's weight loss. The facility failed to closely monitor these resident's meal intake records, including HS snacks. The facility failed to provide both residents consistent meal time assistance, and closely monitor both resident's weights. - Review of Resident #8's medical record occurred on all days of survey. The facility admitted the resident in March of 2011 with diagnoses including anxiety disorder, dysphagia (difficulty swallowing), depression and a history of esophageal dilatations due to swallowing problems.	F 325		

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F 325	Continued From page 34	F 325		

A clinic progress note, dated 04/06/11, stated ". . . ASSESSMENT: 1. Dysphagia. 2. Meal-related abdominal pain. PLAN: At this time I discussed proceeding with an upper endoscopy both to investigate her difficulty swallowing as well as her abdominal discomfort. . . ." The medical record identified the resident had a endoscopy and dilation of the esophagus on 04/29/11.

Review of Resident #8's record occurred on all days of survey. Resident #8's weight records identified the following weights recorded since admission:
* 03/16/11: 125.4 pounds (lbs) (recorded on the resident's admission MDS)
* 04/05/11: 122 lbs
* 04/27/11: 120 lbs
* 05/04/11: 116.4 lbs
* 05/11/11: 117.0 lbs
* 05/18/11: 111.8 lbs
* 05/25/11: 115 lbs
* 06/01/11: 119.4 lbs (recorded on the resident's 06/06/11 quarterly MDS)
* 06/08/11: 115.4 lbs; a 10 lb wt loss (a severe weight loss of 7.9% in less than 3 months)

Review of Resident #8's medical record, including physician progress notes, lacked evidence the facility informed the resident's provider of the resident's severe weight loss.

A nutritional status CAA, dated 03/17/11, identified Resident #8 with dysphagia and able to tolerate a regular diet and able to eat independently. The CAA stated the resident made her own food choices and was able to make independent choices regarding her health. The CAA stated, "We will care plan for [Resident

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F 325	Continued From page 35 #8] to have her meals delivered to her. We will follow her wishes as best as we can in allowing her to sleep in, and eat a late breakfast. We will also avoid foods that cause irritation to her diverticulitis." Review of Resident #8's current care plan stated: * "CULINARY - I don't have a big appetite, and don't drink very much. I do have some swallowing problems, but can tolerate regular foods. I should avoid eating foods with seeds or skins. I may need help at meals." The plan identified a goal of "I want to be independent and be served food that does not irritate my digestive tract." Approaches included: "Deliver my food to my table. I may need help with tougher food packets; I am on the hydration list. Please watch me for any signs of dehydration and report them immediately to the nurse; Serve me a regular diet, but avoid seeds and skins." The care plan failed to included delivery of meals to the resident's room, lacked any evidence the resident experienced a severe weight loss, contributing factors, and approaches to address the severe weight loss. The care plan failed to identify the resident has a diagnosis of dysphagia, swallowing difficulties, abdominal discomfort, and history of esophageal dilatations. A Nutrition Assessment, completed on 03/30/11, by the dietician, identified the resident "likes to sleep in and eat breakfast late. when she does she does not wish to eat lunch. . . . she does not like drinking milk. . . ." The assessment identified the resident "Coughs or chokes during meals or when swallowing medications."	F 325		

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F 325	Continued From page 36 Dietary progress notes stated: * 05/16/11: ". . . weight is 117 lbs and is down a few lbs since moved into [facility]. This is not suprising [sic] as she likes to skip meals frequently. She often eats breakfast late and then will refuse lunch, but then will eat supper. She does snack some between meals, and does take food from the den frequently. I will continue to watch her as we don't want her skipping meals to hurt her health." * 06/08/11: Quarterly assessment complete . . . dx [diagnosis] of dysphagia. She has not however, had any symptoms of swallowing problems lately. Her weight is 119.4 lbs and is down about 6 lbs in the past quarter, which is not enough to be considered significant, but is up this past month. She continues on a regular diet, but we avoid seeds . . . will skip meals almost daily. . . . does snack on food in her room as well as food that we keep in the den area. She is independent in her mobility and is able to get food on her own. . . ." * 07/04/11: ". . . has been eating around 50-100% at meals. She continues to skip a lot of meals, usually lunch, and sometimes supper. Her weight is 115 lbs and is within a healthy weight range." Observation on all days of survey showed Resident #8 did not attend the open breakfast meal, and did not eat lunch on 07/12/11. During interview on the morning of 07/13/11, a supervisory dietary staff member (#2) stated the following regarding Resident #8's weight loss: * Resident #8 experienced a severe weight loss since admission to the facility * Agreed the facility failed to recognize the severe weight loss	F 325		

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F 325	Continued From page 37 * The facility failed to develop and implement measures to prevent the weight loss from occurring * Resident #8's care plan did not reflect changes in care to address the weight loss * Resident #8's weight loss was not a planned weight loss The facility failed to recognize Resident #8's severe weight loss which occurred over a 4 month period. As a result, the facility failed to develop, implement and evaluate interventions to address Resident #8's decreased food intake. During interview on the morning of 07/13/11, two administrative staff members (#1 and #11) stated the facility sit/stand lift scale became inoperable five weeks ago and attempts to repair the scale were unsuccessful. The administrative staff member (#1) stated nursing staff weigh residents weekly so they can tell if the scale is a problem, rather than do reweighs. The administrative staff members (#1 and #11) provided no additional information regarding the weight loss for Resident #1, #8 and #10. 2. Based on record review, review of facility policy, review of professional reference, and staff interview, the facility failed to ensure the accuracy of resident weights, and failed to ensure weighing of residents occurred, including residents identified with severe weight loss (Resident #1, #8, and #10) due to the lack of a sit/stand lift scale for over a five week period. Failing to ensure staff obtained accurate weights, including reweighs, and failing to obtain weights of residents who experienced unplanned weight loss limits the facility's ability to monitor resident's	F 325		

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F 325	Continued From page 38 changing conditions. Findings include: The Centers for Medicare and Medicaid Services (CMS) has outlined the current standards of practice for weighing the resident. Obtaining accurate weights for each resident may be aided by having staff follow a consistent approach to weighing & by using an appropriately calibrated & functioning scale (e.g., wheelchair scale or bed scale). Since weight varies throughout the day, a consistent process & technique (e.g., weighing the resident wearing a similar type of clothing, at approximately the same time of the day, using the same scale, either consistently wearing or not wearing orthotics or prostheses, & verifying scale accuracy) can help make weight comparisons more reliable. Review of the facility policy "WEIGHT MONITORING AND DOCUMENTATION" occurred on 07/13/11. The policy, undated, stated, "Each resident's weight is monitored . . . and documentation will be implemented. The facility must ensure that a resident maintains parameters of nutritional status, such as body weight . . . unless the resident's clinical condition demonstrates that this is not possible. . . . PROCEDURE . . . a. Nursing staff is to verify the accuracy if the weight change. [sic] Reweighs are recommended for residents with a 5-pound or greater change in weight. . . ." A system to verify weights can help to ensure accuracy. Weights obtained in different settings may differ substantially. For example, the last weight obtained in the hospital may differ	F 325		

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F 325	Continued From page 39 markedly from the initial weight upon admission to the facility, & is not to be used in lieu of actually weighing the resident. Approaches to improving the accuracy of weights may include reweighing the resident & recording the current weight, reviewing approaches to obtaining & verifying weight, & modifying those approaches as needed. - Review of Resident #1's record occurred on all days of survey. Resident #1's weight records identified the following weights: * 05/07/11: 144.4 lbs * 05/28/11: 137.4 lbs, a 4.8% weight loss in less than 2 weeks. The record lacked evidence of a reweigh. * 06/01/11: 143.2 lbs * 06/08/11: 133.0 lbs, a 7.6% weight loss in 1 month and a 7.1 % loss in one week. The record lacked evidence of a reweigh. The record lacked evidence of weights recorded after this date. - Review of Resident #8's record occurred on all days of survey. Resident #8's weight records identified the following weights recorded since admission: * 03/16/11: 125.4 lbs * 04/05/11: 122 lbs * 04/27/11: 120 lbs * 05/04/11: 116.4 lbs, a weight loss of 4.6 lbs in one week. The record lacked evidence of a reweigh. * 05/11/11: 117.0 lbs * 05/18/11: 111.8 lbs, a weight loss of 6.2 lbs in one week. The record lacked evidence of a reweigh. * 05/25/11: 115 lbs	F 325		

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F 325	Continued From page 40 * 06/01/11: 119.4 lbs, a weight gain of 4.4 lbs in one week. The record lacked evidence of a reweigh. * 06/08/11: 115.4 lbs; a 10 lb wt loss (a severe weight loss of 7.9% in less than 3 months) The record lacked evidence of weights recorded after this date. - Review of Resident #10's record identified the resident experienced a severe weight loss over a six month period between November 2010 and May 2011. Review of weight records identified the following: * 10/22/10: 158.2 lbs * 10/29/10: 149.8 lbs, a weight loss of 8.4 lbs. The record lacked evidence of a reweigh. * 11/12/10: 147.6 lbs (next recorded weight after the above weight) * 02/11/11: 137.2 lbs * 02/18/11: 131.4 lbs, a weight loss of 5.8 lbs. The record lacked evidence of a reweigh. * 03/04/11: 132.3 lbs (next recorded weight after the above weight) * 06/10/11: 129.4 lb Resident #10 last logged weight occurred on 06/10/11. The record lacked evidence of weights recorded after this date. During an interview with two administrative staff members (#1 and #11) on the morning of 07/13/11, an administrative staff member (#1) stated nursing staff weigh residents weekly so they can tell if the scale is a problem, rather than do reweighs. The staff members stated the facility sit/stand lift scale became inoperable five weeks ago and attempts to repair the scale were unsuccessful on two occasions. The staff members stated residents requiring weights with	F 325		

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F 325	Continued From page 41 the sit/stand scale have not been done since then. The staff member (#11) stated residents determined to need weights could be weighedwith the facility Hoyer lift scale or transported to the local hospital. At the request of the surveyor on the morning of 07/13/11, nursing staff weighed Resident #1 with the facility Hoyer lift scale, and obtained a weight of 136.1 pounds.	F 325		
F 371 SS=C	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 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to handle dishes in a sanitary manner on 2 of 2 days of survey during observations of dishwashing (July 12-13, 2011). Failure handle dishes in a sanitary manner has the potential to cause foodborne illness. Findings include: On 07/12/11 at 1:53 p.m. and 07/13/11 at 1:50 p.m. observations of facility dishwashing practices showed the following:	F 371	**F 371 Food procedure, store/prepare/serve-sanitary** 1 and 2. All neighbors were potentially affected by this tag. 3. A new procedure was written up on how to remove dishes, from the dish machine, in a sanitary manner. Staff will be in-serviced on the new procedure. 4. Dish washing procedures will be audited x12 weeks, by the culinary director, or designee, to ensure that the appropriate procedure is being followed. See Attached Need 8/11 11 pos	7-21-11

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F 325	Continued From page 41 the sit/stand scale have not been done since then. The staff member (#11) stated residents determined to need weights could be weighedwith the facility Hoyer lift scale or transported to the local hospital. At the request of the surveyor on the morning of 07/13/11, nursing staff weighed Resident #1 with the facility Hoyer lift scale, and obtained a weight of 136.1 pounds.	F 325		
F 371 SS=C	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 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to handle dishes in a sanitary manner on 2 of 2 days of survey during observations of dishwashing (July 12-13, 2011). Failure handle dishes in a sanitary manner has the potential to cause foodborne illness. Findings include: On 07/12/11 at 1:53 p.m. and 07/13/11 at 1:50 p.m. observations of facility dishwashing practices showed the following:	F 371	**F 371 Food procedure, store/prepare/serve-sanitary** 1 and 2. All neighbors were potentially affected by this tag. 3. A new procedure was written up on how to remove dishes, from the dish machine, in a sanitary manner. Staff will be in-serviced on the new procedure. (see attachment #1) 4. Dish washing procedures will be audited x 12 weeks, by the culinary director, or designee, to ensure that the appropriate procedure is being followed. (Audit form- attachment #2) 08/10/2011	

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F 371	Continued From page 42 A culinary services staff member (#4) washed dishes while wearing disposable gloves. The staff member (#4) rinsed the dirty dishes, placed them in a dishwasher rack and placed the filled rack into the low temperature, chemical sanitizer, dishwasher. While the wash/rinse cycles ran, the staff member (#4) rinsed and filled another rack with dirty dishes. When the staff member (#4) had the rack ready for the dishwasher, she ran water over her gloved hands with the same sprayer used to rinse the dirty dishes. The staff member (#4) then crossed the space from the sink to the opening in the wall (the wall separated the dish washing room from the clean kitchen), and obtained hand sanitizer with her wet gloved hands from a dispenser mounted next to the opening. The staff member (#4) sanitized her gloved hands, gripped the rack of clean wet dishes and pulled/pushed the rack from the dishwasher with the same gloves used to handle the dirty dishes. Observations showed the staff member (#4) sanitized her gloved hands three times on 07/12/11 and twice on 07/13/11. During an interview, 07/13/11 at 1:58 p.m., with the culinary services staff member (#4) observed doing dishes, she indicated she was taught to sanitize her hands before removing the dishes from the dishwasher. This staff member (#4) identified she could not remember who taught her to wash dishes in this fashion. During an interview, on 07/13/11 at 2:00 p.m., an administrative staff member (#2) confirmed staff should not sanitize gloves and then handle clean dishes.	F 371		