STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355106	A. BUILDING _____ B. WING _____	10/05/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANFORD HEALTH CONTINUING CARE CENTER OFF COLLINS	201 14TH ST NW MANDAN, ND 58554

(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 10/03/16 and completed on 10/05/16, the sample included four (4) residents for complete review, nine (9) residents for focused review, and two (2) closed resident records for review.	F 000		
F 242 SS=D	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview, the facility failed to ensure the resident has the right to make a choice regarding menu choices for 2 of 2 sampled residents (Resident #3 and #10) identified on a pureed diet. Failure to allow each resident to choose what they want to eat for meals may result in a loss of the resident's right to exercise his or her autonomy. Findings include: Upon request on the morning of 10/05/16, a dietary manager (#1) stated there is no policy regarding menu choices for residents on pureed diets. - Review of Resident #3's medical record	F 242	It is the intent of Sanford Off Collins to remain in compliance with F-242 and allow residents to make choices about aspects of his or her life in the facility. To ensure each resident has the opportunity to make menu choices, the following will be completed: Education was provided on 10-5-16 by Administrator for Dietician and Dietary manager related to resident's right to choose menu items. Tray cards were updated with a choice for all pureed diets 10-6-16. Education was provided to dietary staff 10-11-16 to ensure staff is informing residents of meal options giving each resident a choice of foods for each	11/9/16

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

Electronically Signed | 10/21/2016

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F 242	Continued From page 1 occurred on all days of survey. Diagnoses included dysphagia (difficulty swallowing), diabetes mellitus, peripheral vascular disease, and aftercare following amputation below the left knee on 07/14/16. A significant change Minimum Data Set (MDS), dated 08/29/16, and an admission MDS, dated 07/21/16, identified the resident as cognitively intact. Resident #3's current care plan identified a problem (dated 08/29/16) regarding the residents "Nutritional Status" of ". . . triggering high nutrition risk r/t [related to] therapeutic diet is indicated, need for altered textures & swallow guide, use of supplements PRN [as needed], abnormal nutrition-related lab values, medications, diagnoses." Approaches included a regular dysphagia diet of pureed textures and honey thickened liquids. The care plan also identified the problem of swallowing and the resident at risk for aspiration. An approach included "Line of Sight Supervision." During interviews on the afternoon of 10/04/16, a family member (#1) stated the resident did not care for the pureed diet, but understood it was necessary. The family member (#2) questioned whether the resident could have a choice to chose his meals and expressed frustration the resident received pureed chili for one of his meals. The family member (#2) stated he has asked the resident put his finger into his pureed food to try and identify the food item. During an interview on 10/05/16 at 1:00 p.m. Resident #3, while eating his meal, stated he does not get to choose his meals. Observation of Resident #3's tray card, dated 10/05/16,	F 242	meal. This education was also provided to certified nursing assistants on 10-20-16. 4 residents were identified who receive pureed diets. Monitoring will be completed 10-21-16 to ensure resident's choice of menu item was served. This includes residents #3 and #10. Starting the week of October 23rd 2016, CQI coordinator and/or her designee will audit 1 tray card for pureed diets for all three meals weekly X4 and then monthly X2. Family has requested that the kitchen staff choose meal options for resident #10. CQI coordinator and/or her designee will report results of the QI monitoring as part of the monthly CQI meetings and then summarized at the quarterly meetings to be held with the medical director in attendance. The need for further monitoring will be determined based upon these results. Date Certain: 11-9-16	

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F 242	Continued From page 2	F 242		

identified the resident on a regular pureed dysphagia diet with honey thickened liquids. The meal card lacked any check marks/choices made by the resident.

During interview on 10/05/16 at 1:40 p.m., a dietary manager (#1) stated residents on pureed diets do not get a choice and are not informed what is being served for their meal.

During interview on 10/05/15 at 2:30 p.m., a dietary manager (#1) stated the cook will decide what residents on a pureed diet can have for the meal because not all foods puree well. The manager said the certified nursing assistants (CNAs) can look at the menu posted in the dining room and let the resident know what is being served when the resident receives a pureed diet. A dietician (#2) present during the interview confirmed Resident #3 is not given a choice from the main menu.

- Review of Resident #10's medical record occurred on 10/05/16. Diagnoses included dementia, cerebrovascular accident (CVA), aphasia (speech language deficits), and facial weakness/hemiplegia (paresis on one side of the body). The quarterly MDS, dated 09/24/16, identified problems with memory, severe problem solving deficits, extensive assistance required during meals, and weight loss.

The progress note, dated 09/23/16, identified, ". . . NUTRITION . . . Current weight is 96# [pounds] - showing significant loss over the past 30 d [days], 90 d, & 180 d. . . ."

The tray card, dated 10/05/16, identified, ". . .

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F 242	Continued From page 3 Puree . . . Breeze + Promod [supplement] . . . Fortified Foods . . . Ice Cream . . ." Resident #10's tray card failed to identify the food options available to her from the 10/05/16 menu. During an interview on 10/05/16 at 3:15 p.m., when asked what type of diet Resident #10 received, a member of her family reported, "She's on a pureed diet. It's bland. Everything looks the same." When asked if he assists her with choosing preferred menu items, he stated, "Oh, I don't know what they have on the menu. We just get what they bring us. [Resident #10] doesn't have a choice." Facility staff failed to provide residents receiving an altered textured diet the opportunity to make choices for menu selection.	F 242		