STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355099	A. BUILDING _____ B. WING _____	06/08/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - MOTT	401 MILLIONAIRE AVE MOTT, ND 58646

(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 06/05/17 and completed on 06/08/17, the sample included 2 residents for complete review, 7 residents for focused review, and 1 closed record for review. The sample included 3 additional residents to verify specific concerns during the survey.	F 000		
F 156 SS=C	483.10(d)(3)(g)(1)(4)(5)(13)(16)-(18) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES (d)(3) The facility must ensure that each resident remains informed of the name, specialty, and way of contacting the physician and other primary care professionals responsible for his or her care. §483.10(g) Information and Communication. (1) The resident has the right to be informed of his or her rights and of all rules and regulations governing resident conduct and responsibilities during his or her stay in the facility. (g)(4) The resident has the right to receive notices orally (meaning spoken) and in writing (including Braille) in a format and a language he or she understands, including: (i) Required notices as specified in this section. The facility must furnish to each resident a written description of legal rights which includes - (A) A description of the manner of protecting personal funds, under paragraph (f)(10) of this section; (B) A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an	F 156		6/9/17

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

Electronically Signed | 06/21/2017

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 156	Continued From page 1 assessment of resources under section 1924(c) of the Social Security Act. (C) A list of names, addresses (mailing and email), and telephone numbers of all pertinent State regulatory and informational agencies, resident advocacy groups such as the State Survey Agency, the State licensure office, the State Long-Term Care Ombudsman program, the protection and advocacy agency, adult protective services where state law provides for jurisdiction in long-term care facilities, the local contact agency for information about returning to the community and the Medicaid Fraud Control Unit; and (D) A statement that the resident may file a complaint with the State Survey Agency concerning any suspected violation of state or federal nursing facility regulations, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, non-compliance with the advance directives requirements and requests for information regarding returning to the community. (ii) Information and contact information for State and local advocacy organizations including but not limited to the State Survey Agency, the State Long-Term Care Ombudsman program (established under section 712 of the Older Americans Act of 1965, as amended 2016 (42 U.S.C. 3001 et seq) and the protection and advocacy system (as designated by the state, and as established under the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (42 U.S.C. 15001 et seq.) [§483.10(g)(4)(ii) will be implemented beginning	F 156		

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F 156	Continued From page 2 November 28, 2017 (Phase 2)] (iii) Information regarding Medicare and Medicaid eligibility and coverage; [§483.10(g)(4)(iii) will be implemented beginning November 28, 2017 (Phase 2)] (iv) Contact information for the Aging and Disability Resource Center (established under Section 202(a)(20)(B)(iii) of the Older Americans Act); or other No Wrong Door Program; [§483.10(g)(4)(iv) will be implemented beginning November 28, 2017 (Phase 2)] (v) Contact information for the Medicaid Fraud Control Unit; and [§483.10(g)(4)(v) will be implemented beginning November 28, 2017 (Phase 2)] (vi) Information and contact information for filing grievances or complaints concerning any suspected violation of state or federal nursing facility regulations, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, non-compliance with the advance directives requirements and requests for information regarding returning to the community. (g)(5) The facility must post, in a form and manner accessible and understandable to residents, resident representatives: (i) A list of names, addresses (mailing and email), and telephone numbers of all pertinent State agencies and advocacy groups, such as the State Survey Agency, the State licensure office, adult protective services where state law	F 156		

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F 156	Continued From page 3 provides for jurisdiction in long-term care facilities, the Office of the State Long-Term Care Ombudsman program, the protection and advocacy network, home and community based service programs, and the Medicaid Fraud Control Unit; and (ii) A statement that the resident may file a complaint with the State Survey Agency concerning any suspected violation of state or federal nursing facility regulation, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, and non-compliance with the advanced directives requirements (42 CFR part 489 subpart I) and requests for information regarding returning to the community. (g)(13) The facility must display in the facility written information, and provide to residents and applicants for admission, oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits. (g)(16) The facility must provide a notice of rights and services to the resident prior to or upon admission and during the resident's stay. (i) The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. (ii) The facility must also provide the resident with the State-developed notice of Medicaid rights and	F 156		

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F 156	Continued From page 4 obligations, if any. (iii) Receipt of such information, and any amendments to it, must be acknowledged in writing; (g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in paragraphs (g)(17)(i)(A) and (B) of this section. (g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide	F 156		

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F 156	Continued From page 5 notice to residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. This REQUIREMENT is not met as evidenced by: Based on review of Medicare Part A notices/files and staff interview, the facility failed to provide adequate written notices for 3 of 3 residents (Resident #5, #12, and #13) reviewed for termination of Medicare coverage. Failure of the facility to provide notices that contained the correct contact information for the Fiscal Intermediary (FI)/Medicare Administrative Contractor (MAC) limits the residents' ability to	F 156	1) F 156 □ The corrective action accomplished for Residents #5, #12, and #13 whose Beneficiary Notice(SNFABN) forms (CMS-10055) were found to not contain the FI/MAC□s (Noridian Healthcare Solutions) name and address is that the Beneficiary Notice (SNFABN) form (CMS-10055) has been revised on 06/07/2017 to include the FI/MAC□s	

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F 156	Continued From page 6 exercise their rights related to Medicare Part A. Findings include: Review of Medicare Part A denial notices occurred on 06/07/17 in the afternoon. The facility's Skilled Nursing Facility Advanced Beneficiary Notice (SNFABN) form (CMS-10055) failed to contain the FI/MAC's (Noridian Healthcare Solutions) name and address. The following SNFABN forms failed to have the correct contact name and address: * Resident #5 - signed on 03/07/17 * Resident #12 - signed on 01/30/17 * Resident #13 - signed on 04/18/17 During an interview on 06/07/17 at 4:00 p.m. an administrative nurse (#1) stated she was unaware the denial forms required an address for Noridian.	F 156	(Noridian Healthcare Solutions) name and address. 2) Other residents who are receiving Medicare skilled coverage and who are issued the Beneficiary Notice (SNFABN) form (CMS-10055) have the potential to be affected. 3) Measures put into place to ensure the practice will not recur is that the Beneficiary Notice (SNFABN) form (CMS-10055) has been revised to include the FI/MAC□s (Noridian Healthcare Solutions) name and address on 06/07/2017. 4) The facility plans to monitor its performance to make sure solutions are sustained by assigning the Health Information Manager to monitor by using audits to ensure that the Beneficiary Notice (SNFABN) form (CMS-10055) includes the FI/MAC□s (Noridian Healthcare Solutions) name and address with every notice. Audits will be completed weekly x4, monthly x 3, then quarterly x 1 year. Results will be reported to the QA team with corrective action implemented	
F 281 SS=D	483.21(b)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS (b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-	F 281		6/27/17

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F 281	Continued From page 7 (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on record review, policy review, and staff interview, the facility failed to carry out physician's orders for 2 of 9 sampled residents (Resident #3 and #6). Failure to ensure an available supply of nutritional supplements/medications and provide them as ordered has the potential to delay the healing process of ulcers. Findings include: Review of the following facility policies occurred on 06/08/17: * "Medical Nutritional Supplements," revised February 2016, stated, ". . . PURPOSE: . . . To provide medical nutritional supplements between meals to residents with decreased appetite, weight loss or special medical conditions when needed. . . . POLICY: . . . Medical nutritional supplements will be provided by physician order. . . . PROCEDURE: . . . 9. The DDS [Director of Dietary Services] is responsible for ordering the medical nutrition supplements . . ." * "Medication Administration, Including Scheduling and Medication Aides," revised May 2016, stated, ". . . Medication Errors: . . . If a medication is not available for 24 hours, the provider must be notified that the medication is not available and must give direction for how to proceed. . . ." - Review of Resident #6's medical record occurred on all days of survey. The significant change Minimum Data Set (MDS), dated	F 281	1) F 281 □ The corrective action accomplished for Residents #3 and #6 related to failure to order medication and supplements in a timely manner and having them available for administration as ordered is that the DNS will educate licensed nursing staff, including Medication Aides II, on the process for ordering medications and supplements at a Nursing Meeting on 6/27/2017. 2) The facility recognizes that all residents have the potential to be affected by the same practice. 3) Measures put into place to ensure the practice will not recur is that licensed nursing staff and Medication Aides II will be educated on 6/27/2017 by the DNS on the process for ordering medications and supplements to ensure timely administration as ordered. The process will include the DDS (Director of Dietary Services) as the responsible person for ordering the medical nutritional supplements and the Purchasing Director responsible for ordering of stock medications. Nursing staff will be educated to sign the item out on a clipboard from the supply room (for stock medications) and the kitchen (for nutritional supplements). The DDS and Purchasing Director will each check their designated clipboard and current supply	

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F 281	Continued From page 8 12/19/16, showed significant weight loss, one stage 2 pressure ulcer, and one unstageable pressure ulcer. The quarterly MDS, dated 04/04/17 showed one stage 3 pressure ulcer. Physician orders included: * 12/01/16, ProSource Liquid 1 ounce (oz) twice daily for "pressure ulcer buttocks" * 12/13/16, Ensure Plus 8 oz twice daily related to "unspecified open wound of unspecified buttock" and "pressure ulcer of left heel, unstageable." Review of Resident #6's Medication Administration Records (MARs) for April - May 2017 showed the following: * ProSource Liquid "not available" to administer 13 scheduled times from April 16-24, and four scheduled times in May * Ensure Plus "not available" to administer five scheduled times in May - Review of Resident #3's medical record occurred June 5-8, 2017. An annual MDS, dated 10/07/16, identified the resident had a skin tear. A quarterly MDS, dated 04/07/17, identified one new or worsened pressure ulcer stage two since the previous MDS. Physician orders included: * Glucerna eight ounces, one can in the morning and afternoon for "anorexia." * Multivitamin and mineral liquid, one tablespoon daily, for "anorexia" and "unspecified protein-calorie malnutrition." Review of Resident #3's MARs showed the following: * Glucerna "not available" to administer 12 scheduled times from April 9-26, 2017 * Multivitamin and mineral liquid "not available"	F 281	weekly to ensure an adequate supply of medication and supplements are available and will re- order weekly as needed. In addition, nursing staff will be educated that if a medication is not available for 24 hours, the provider must be notified that the medication is not available and must give direction on how to proceed. 4) The facility plans to monitor its performance to make sure solutions are sustained by assigning theMDS/Nurse Manager or designee to monitor by using audits that medication and supplements are given and an adequate supply is available for administration. Audits will be done weekly x4, monthly x3, then quarterly x1 year. Results will be reported to the QA team with corrective action implemented.	

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F 281	Continued From page 9 to administer 10 scheduled times from 11/28/16 through 12/12/16, a total of 15 days During an interview on the afternoon of 06/07/17, an administrative nurse (#1) stated the facility process is when a nurse obtains supplies (i.e. stock medication) from the supply room, the nurse is to sign the item out on a clipboard, and leave a note if he/she took the last item. If the nurse forgot to leave a note, then the supply would not get reordered. During an interview on 06/08/17 at 8:45 a.m., a licensed nurse (#3) stated dietary staff order the supplements and bring a full box of a particular supplement to the medication room. When asked why a supplement was "not available," the nurse stated a communication problem may have contributed to the supplements not ordered timely. Failure to ensure staff ordered medication and supplements in a timely manner and had them available for administration as ordered has the potential to delay the healing process of ulcers.	F 281		
F 314 SS=D	483.25(b)(1) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES (b) Skin Integrity - (1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition	F 314		6/27/17

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F 314	Continued From page 10 demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, record review, policy review, and staff interview, the facility failed to provide the necessary care and services for 1 of 3 sampled residents (Resident #6) with a current/history of pressure ulcers. Failure to follow physician's orders and consistently implement interventions to reduce pressure on susceptible areas may contribute to the development or delayed healing of a pressure ulcer. Findings include: Review of the facility policy titled "Pressure Ulcer Practice Guidelines" occurred on 06/08/17. This policy, revised September 2016, stated, ". . . Initial Risk Assessment: Risk factors are factors that increase a resident's susceptibility to develop or impact healing times of pressure ulcers. They include . . . *Impaired/decreased mobility and decreased functional ability . . . *Cognitive impairments . . . *History of a previous ulcer/healed stage III or IV ulcer . . . Prevention strategies are ongoing and will be individualized based on the areas or the level of risk determined. Include these prevention strategies on the resident's care plan. . . . Ensure competence of caregiver implementation of care plan. Observe or demonstrate, if necessary. . . ."	F 314	1) F 314 □ The corrective action accomplished for Resident #6 related to failure to float her heels off the bed and apply quilted heel booties as per the resident□s care plan is that Resident #6 was given different heel booties that allow for a more secure fit to her feet on 6/8/17. In addition, all nursing staff will be re-educated on 6/27/2017 by the DNS on pressure ulcer reduction interventions, including application of heel booties and floating of heels off the bed with pillows or other devices to reduce pressure on the skin/tissue of the heels. In addition, nursing staff will be re-educated on reviewing the resident□s care plan (kardex) to stay informed of current care plan interventions. 2) The facility recognizes that all residents at risk for pressure ulcer development have the potential to be affected by the same practice. 3) Measures put into place to ensure the practice will not recur is that all nursing staff will be educated on 6/27/2017 by the DNS on pressure ulcer interventions, including application of heel booties and	

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F 314	Continued From page 11 Review of Resident #6's medical record occurred on all days of survey. Diagnoses included dementia and current/history of pressure ulcers. The quarterly Minimum Data Set (MDS), dated 04/04/17, showed severely impaired cognition, extensive assistance of two staff for bed mobility, total assistance for transfers, and one stage III pressure ulcer. Resident #6's current care plan stated, ". . . Focus: The resident has potential for pressure ulcer development R/T [related to] incontinence, functional limitations with decreased mobility from degenerative arthritis. . . . Interventions: . . . Provide heel booties at all times. Float heels while in bed. . . ." On 06/05/17 at 3:40 p.m., observation showed two certified nurse aides (CNAs) (#4 and #5) entered Resident #6's room to get her up. The resident had laid on the bed with quilted booties on both feet and her heels not floated (elevated with pillows or other device to keep the heels off the mattress to reduce pressure on the skin/tissue of the heels). On 06/06/17 at 7:10 a.m., observation showed a licensed nurse (#6) changed the dressing to Resident #6's right ischial ulcer and then applied a dressing to the left lateral heel. Observation showed a small scabbed area on the left lateral heel with a smaller open area. The nurse measured the area as 1.2 x [by] 1.1 centimeters. The nurse stated the area had healed and now reopened, and the podiatrist planned to see the resident today. At 7:40 a.m., two CNAs (#7 and #8) dressed, placed slipper socks on the	F 314	floating of heels off any surface with pillows or other devices to reduce pressure on the skin/tissue affected. In addition, nursing staff will be re-educated on reviewing the resident□s care plan (kardex) to stay informed of current care plan interventions. 4) The facility plans to monitor its performance to make sure solutions are sustained by assigning the MDS/Nurse Manager or designee to monitor by using audits that resident□s at risk for pressure ulcers have care plan interventions implemented and followed . Audits will be done weekly x 4, monthly x 3, then quarterly x 1 year. Results will be reported to the QA team with corrective action implemented.	

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F 314	Continued From page 12 resident's feet, and transferred her to the wheelchair. The CNAs failed to put the resident's quilted booties on. On 06/06/17 at 9:00 a.m., observation showed two CNAs (#7 and #9) transferred Resident #6 to bed, positioned her on her left side, applied quilted booties, but failed to float her heels. On 06/07/17 at 4:20 p.m., observation showed two CNAs (#4 and #10) entered Resident #6's room to get her up. Resident #6 had laid on the bed with the quilted booties partially off her feet, legs crossed, and heels not floated. Failure to float Resident #6's heels off the mattress and apply the quilted booties as per the resident's care plan may have contributed to redevelopment of the left lateral heel pressure ulcer. Refer to F281.	F 314		
F 323 SS=D	483.25(d)(1)(2)(n)(1)-(3) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES (d) Accidents. The facility must ensure that - (1) The resident environment remains as free from accident hazards as is possible; and (2) Each resident receives adequate supervision and assistance devices to prevent accidents. (n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and	F 323		6/27/17

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	355099	A. BUILDING _____ B. WING _____	06/08/2017

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F 323	Continued From page 13 maintenance of bed rails, including but not limited to the following elements. (1) Assess the resident for risk of entrapment from bed rails prior to installation. (2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. (3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. This REQUIREMENT is not met as evidenced by: Based on observation, record review, policy review, and staff interview, the facility failed to ensure staff appropriately used assistive devices for 1 of 2 sampled residents (Resident #8) observed transferred/ambulated with a gait belt and 1 supplemental resident (Resident #11) observed transported in a wheelchair. Failure to properly use a gait belt and utilize wheelchair pedals increased the risk for sustaining a fall or injury. Findings include: Review of the facility policy titled "Gait (Transfer) Belt" occurred on 06/08/17. This policy, revised March 2017, stated, "PURPOSE: *To safely stabilize a transfer *To ambulate with a resident *To aid residents in maintaining balance *To avoid injury to both resident and staff member . . . PROCEDURE: . . . 3. Place belt around resident's waist . . . 4. Keep the belt low on the resident's waist. 5. Make sure belt is securely buckled so it does not slide. Belt should not be twisted and should be just snug enough so you	F 323	1) The corrective action accomplished for Resident #8 and Resident #11 related to failure to properly use a gait belt and utilize wheelchair pedals is that all nursing staff will be educated on 06/27/2017 by the DNS on appropriate use of assistive devices, such as gait belts and placement of wheelchair pedals to ensure resident□s safety during all transfers/ambulation/mobility. 2) The facility recognizes that all residents have the potential to be affected by the same practice. 3) Measures put into place to ensure the practice will not recur is that all nursing staff will be educated on 06/27/17 by the DNS to include appropriate use of assistive devices, such as gait belts and placement of wheelchair pedals to ensure safety during all transfers/ambulation/mobility to ensure residents□ safety.	

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F 323	Continued From page 14 can get your fingers under it. This will prevent the belt from sliding up under the breasts, rib cage or axillae. . . ." - Review of Resident #8's medical record occurred on June 7-8, 2017. The current care plan stated, "Focus: The resident has an ADL [activity of daily living] self care performance deficit R/T [related to] blindness and right hip fracture E/B [evidenced by] pain and limited ROM [range of motion]. . . . Interventions: . . . Mobility: . . . May ambulate with 1 person assist using FWW [front wheeled walker] and gait belt . . . Toilet Use: Assist x [times] 1, gait belt, and FWW. . . ." On 06/07/17 at 3:58 p.m., two certified nurse aides (CNAs) (#5 and #11) entered Resident #8's room to assist her up for supper. The CNAs assisted the resident to sit on the edge of the bed, applied a gait belt loosely around her upper waist, ambulated the resident with assistance and a steady gait into the bathroom, and sat her on the toilet. After several minutes, the resident stood from the toilet with minimal assistance, and the CNAs assisted her to ambulate out of the bathroom, now with a noticeable limp. Resident #8 stated, "Come on leg." The CNAs held on to the gaitbelt, which fit loosely under her breasts and slid up towards the top of the resident's back. - On the morning of 06/06/17, observation showed Resident #11 in a wheelchair without foot pedals as she used her feet to push herself. At 7:45 a.m., a licensed nurse (#12) pushed Resident #11 in her wheelchair from the dining room to a private room to administer medication, then back to the dining room. Resident #11 held her feet up, but on at least four occasions they	F 323	4) The facility plans to monitor its performance to make sure solutions are sustained by assigning the MDS/Nurse Manager or designee to monitor by using audits for appropriate use of gait belts and utilization of wheelchair pedals during transfers/ambulation/mobility. Audits will be done weekly x 4, monthly x 3, then quarterly x 1 year. Results will be reported to the QA team with corrective action implemented.	

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F 323	Continued From page 15 touched the floor during the transport. The nurse failed to remind the resident to hold her feet up or place foot pedals on the wheelchair before transporting the resident. During an interview on 06/07/17 at 5:00 p.m., an administrative nurse (#1) stated a gait belt "should be snug" around the resident's waist, and staff should use foot pedals if pushing a resident in a wheelchair who is unable to hold his/her feet up.	F 323		
F 363 SS=E	483.60(c)(1)-(7) MENUS MEET RES NEEDS/PREP IN ADVANCE/FOLLOWED (c) Menus and nutritional adequacy. Menus must- (c)(1) Meet the nutritional needs of residents in accordance with established national guidelines.; (c)(2) Be prepared in advance; (c)(3) Be followed; (c)(4) Reflect, based on a facility's reasonable efforts, the religious, cultural and ethnic needs of the resident population, as well as input received from residents and resident groups; (c)(5) Be updated periodically; (c)(6) Be reviewed by the facility's dietitian or other clinically qualified nutrition professional for nutritional adequacy; and (c)(7) Nothing in this paragraph should be construed to limit the resident's right to make	F 363		6/29/17

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F 363	Continued From page 16 personal dietary choices. This REQUIREMENT is not met as evidenced by: Based on observation, review of facility menus, facility policy review, and staff interview, the facility failed to meet the nutritional needs of residents receiving modified diets by serving incorrect portions of mechanically altered meats during 2 of 3 observations of preparation of pureed food or serving of mechanically altered foods (06/05/17 and 06/06/17 noon meals). Failure to follow the menu regarding portion sizes and contents of the pureed meat may result in weight changes and/or inadequate nutritional intake for residents receiving a modified diet. Findings include: Review of the facility policy/procedure titled "Texture Altered Diets" occurred on 06/08/17. This policy, dated February 2016, stated, ". . . Texture altered diets will be served attractively and prepared by methods that conserve nutritive value, flavor and appearance. . . ." Review of the facility policy/procedure titled "Portion Control" occurred on 06/08/17. This policy, dated February 2013, stated, ". . . The portion listed on the menu extensions will be followed. . . ." - Observation on 05/05/17, at 9:32 a.m., during the initial dietary tour, showed an unidentified staff member preparing the pureed ham for the noon meal. The staff member put an unmeasured amount of juice from the ham, pork gravy mix, water, four slices of bread and a measured amount of ham in the food processor. When	F 363	1) F 363 □ The corrective action accomplished regarding failure to meet the nutritional needs of residents receiving modified diets by serving incorrect contents and portions of mechanically altered meats is that dietary staff will be educated by the Dietary Manager on 06/29/17 regarding preparation of altered diets and correct portion control. 2) The facility recognizes that all residents who are receiving modified diets and require portion control have the potential to be affected. 3) Measures put into place to ensure the practice will not recur is that the all dietary staff will be educated by the Dietary Manager on 06/29/17 on the policy/procedure titled Texture Altered Diets and Portion Control. 4) The facility plans to monitor its performance to make sure solutions are sustained by assigning the Dietary Manager to monitor by using audits to ensure that modified diets contain the proper nutritional value and contain the correct portion for each resident . Audits will be completed weekly x4, monthly x 3, then quarterly x 1 year. Results will be reported to the QA team with corrective action implemented.	

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F 363	Continued From page 17 asked, the staff member identified the ham would serve 15 pureed diets for the noon meal. Review of the recipe for preparation of the ham showed the plated food should consist of three ounces of ham, cooked with pineapple juice. The menu recipe groups listed, "Ham; Meat." The menu ingredient groups listed, "Fruit; Fruit Acidic; Ham; Juice; Juice, Acidic; Juice, Pineapple; Legume; Meat; Meat, Processed; Oil, Palm; Pineapple; and Pork." The menu failed to list bread, a starch, as an ingredient of the pureed ham served. Facility staff altered the nutritional value of the ham by adding bread to the pureed diet. The portion served would not contain the full nutritive value of protein for the resident when mixed with bread. - Observation of tray line occurred on 05/06/17 at 11:46 a.m. during the noon meal, and showed the following inconsistencies between portion sizes listed on the facility's menus and the actual amount served to residents: * Puree savory meatloaf served with a three-ounce scoop. The menu identified a four-ounce scoop. * Ground savory meatloaf served with a three-ounce scoop. The menu identified a four-ounce scoop. During an interview on the morning of 06/08/17, an administrative dietary staff member (#2) confirmed staff should follow the portion size identified by the menu and not add bread to pureed meat.	F 363		
F 371	483.60(i)(1)-(3) FOOD PROCURE,	F 371		6/29/17

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F 371 SS=E	Continued From page 18 STORE/PREPARE/SERVE - SANITARY (i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. (i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. (i)(3) Have a policy regarding use and storage of foods brought to residents by family and other visitors to ensure safe and sanitary storage, handling, and consumption. This REQUIREMENT is not met as evidenced by: Based on observation, review of facility procedure, review of manufacturer's instructions, and staff interview, the facility failed to thaw food in a safe and sanitary manner and properly maintain the walk in freezer on 2 of 2 days of survey (06/05/17 and 06/07/17). Failure to follow safe food sanitation practices when thawing food has the potential to result in food borne illness and can affect all residents who consume this	F 371	1) F 371 □ The corrective action accomplished regarding failure to follow safe food sanitation practices when thawing food and failure to maintain the walk-in freezer so food packaging remains free of ice buildup is that the Dietary Manager will educate all dietary staff on correct procedure for thawing of food and the corrective action in place to	

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F 371	Continued From page 19 food. Failure to maintain the walk-in freezer so food packaging remains free of ice build up has the potential to contaminate the food consumed by residents and their guests. Findings include: Review of the facility procedure titled "Thawing Food" occurred on 06/08/17. This policy, dated February 2013, stated, ". . . Proper Thawing Methods . . . In the refrigerator . . . Under running water . . . As part of the cooking process . . . In a microwave . . ." Manufacturer labeling on the Kemp's Plus 2 container stated, "Store Frozen. Thaw at or below 40 [degrees] F [Fahrenheit]. Use thawed product within 14 days. Keep Refrigerated." - During the initial kitchen tour on 06/05/17 at 9:32 a.m., observation showed the following items were covered with ice buildup: * The wall behind the condenser * Food below the condenser: a plastic wrapped box of croissants bags of buns two sealed boxes of fish - Observations during the kitchen tour on 06/07/17 at 1:14 p.m., showed the following: * Six cartons of Kemp's Plus 2 thawing in a tray of still water in the food preparation sink. The administrative dietary staff member (#2) measured the temperature of the water as 42.3 degrees F and confirmed the Kemp's as fully thawed. * The wall and the food observed with ice buildup on the initial tour continued to have the	F 371	prevent ice build up on food packaging materials on 06/29/17. In addition, the Dietary Manager will remove the ice build up from the food packaging in the walk-in freezer and obtain a large pan to fully cover any potential food items from having potential for ice build up on other surfaces or packages by 06/29/17. 2) The facility recognizes that all residents have the potential to be affected by the same practice. 3) Measures put into place to ensure the practice will not recur is that the Dietary Manager will educate all dietary staff on policy/procedure titled Thawing Food and the corrective action in place to prevent ice build up on food packaging materials on 06/29/17. In addition, the Dietary Manager will remove the ice build up from the food packaging in the walk-in freezer and obtain a large pan to fully cover any potential food items from having potential for ice build up on other surfaces or packages by 06/29/17. 1) The facility plans to monitor its performance to make sure solutions are sustained by assigning the Dietary Manager to monitor by using audits that food is thawed correctly and that the walk-in freezer is free from any ice build up that may potentially contaminate any food consumed by residents. Audits will be done weekly x4, monthly x3, then quarterly x1 year. Results will be reported to the QA team with corrective action implemented.	

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F 371	Continued From page 20 same ice build up. Staff placed a tray over the food to catch the condensation, but failed to fully cover the food. During an interview on the morning of 06/08/17, an administrative dietary staff member (#2) confirmed staff should thaw frozen supplements in the refrigerator. This same staff member (#2) agreed plastic wrapped food should not be stored under the condenser and indicated larger trays should be placed on top of boxed food to protect the food from condensation and ice buildup. Failure to thaw a high protein, milk-based food product using a proper thawing method, including a controlled temperature, placed the thawing product at risk of temperatures above 40 degrees F, increasing bacterial growth and the risk for food borne illness. Failure to protect food in the freezer from condensation and ice buildup can cause contamination, affect the quality of the food, and may increase the risk for food borne illness.	F 371		