STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345541	A. BUILDING _____ B. WING _____	C 12/19/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OLDE KNOX COMMONS AT THE VILLAGES OF MECKLENBURG	13825 HUNTON LANE HUNTERSVILLE, NC 28078

(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 170 SS=C	483.10(i)(1) RIGHT TO PRIVACY - SEND/RECEIVE UNOPENED MAIL The resident has the right to privacy in written communications, including the right to send and promptly receive mail that is unopened. This REQUIREMENT is not met as evidenced by: Based on resident and staff interviews, the facility failed to deliver mail on Saturdays. The findings included: Interview with the resident council president, Resident #56, on 12/19/14 at 10:00 AM revealed the United States Postal Service (USPS) did not deliver mail to the facility on Saturdays. Interview with the Activity Director (AD) on 12/19/14 at 10:15 AM revealed the facility did not receive mail on Saturday. The AD reported the residents received this information upon admission. The AD explained the activity department delivered resident mail Monday through Friday. Interview with Resident #199 on 12/19/14 at 11:37 AM revealed he would want to receive mail on Saturday. Resident #199 explained every message and everyday was important. Interview with the Administrator on 12/19/14 at 11:45 AM revealed mail delivery ceased prior to his employment three years ago for an unknown reason. The Administrator reported Saturday mail delivery could be resumed in order for residents to receive Saturday mail.	F 170	ADDRESS HOW CORRECTIVE ACTION (S) WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: On January 9, 2015 the U.S. Mail letter carrier for the facility was contacted about resuming mail delivery to the facility and stated that delivery could resume at any time at facility request. On January 13, 2015 again the Mail carrier was notified to resume mail delivery on Saturday, January 17, 2015 with written notification and signed by the Letter Carrier. The weekend Nurse Manager will check every Saturday afternoon to ensure mail was delivered and once received will deliver all personal resident mail to residents. The weekend Nurse Manager will complete and sign a tracking log indicating that Mail was received and delivered to the appropriate resident. ADDRESS HOW CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS HAVING POTENTIAL TO BE AFFECTED BY THE SAME	1/16/15

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		01/15/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 170	Continued From page 1	F 170	DEFICIENT PRACTICE: On January 9, 2015 the U.S. Mail letter carrier for the facility was contacted about resuming mail delivery to the facility and stated that delivery could resume at any time at facility request. On January 13, 2015 again the Mail carrier was notified to resume mail delivery on Saturday, January 17, 2015 with written notification and signed by the Letter Carrier. The weekend Nurse Manager will check every Saturday afternoon to ensure mail was delivered and once received will deliver all personal resident mail to residents. The weekend Nurse Manager will complete and sign a tracking log indicating that Mail was received and delivered to the appropriate resident. ADDRESS WHAT MEASURES WILL BE PUT INTO PLACE OR SYSTEMIC CHANGES MADE TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT OCCUR: On January 9, 2015 the U.S. Mail letter carrier for the facility was contacted about resuming mail delivery to the facility and stated that delivery could resume at any time at facility request. On January 13, 2015 again the Mail carrier was notified to resume mail delivery on Saturday, January 17, 2015 with written notification and signed by the Letter Carrier. The weekend Nurse Manager will check every Saturday afternoon to ensure mail	

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F 170	Continued From page 2	F 170	was delivered and once received will deliver all personal resident mail to residents. The weekend Nurse Manager will complete and sign a tracking log indicating that Mail was received and delivered to the appropriate resident. INDICATE HOW THE FACILITY PLANS TO MONITOR IT□S PERFORMANCE TO MAKE SURE THAT SOLUTIONS ARE SUSTAINED. THE FACILITY MUST DEVELOP A PLAN FOR ENSURING THAT CORRECTION IS ACHIEVED AND SUSTAINED. THE PLAN MUST BE IMPLEMENTED AND THE CORRECTIVE ACTION EVALUATED FOR ITS EFFECTIVENESS. THE POC IS INTEGRATED INTO THE QUALITY ASSURANCE SYSTEM OF THE FACILITY: The Mail Received and Delivered Log will be reviewed by the Quality Assurance Committee to ensure the facility is in compliance with facility/state/federal policies, guidelines and laws on sending and receiving unopened mail to facility residents. The QA Committee will be responsible to ensure that corrective action is achieved and sustained. The QA Committee will be responsible for implementing new policies and procedures and/or systems if current policies and procedures and/or systems are identified as insufficient to maintain corrective action and sustain solutions. The QA Committee meets weekly, monthly, and quarterly.	

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F 242	Continued From page 3	F 242		
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 observations, staff interviews, and the medical record, the facility failed to provide a resident with breakfast foods per her choice for 1 of 3 sampled residents reviewed. (Resident #104) The findings included: Resident #104 was re-admitted to the facility on 08/24/13. Diagnoses included in part anorexia, abnormal weight loss, diabetes mellitus II and an unhealed pressure ulcer. Review of the most recent Minimum Data Set, a quarterly, dated 10/20/14 revealed Resident #104 was assessed with a cognitive patterns summary score of 10 (an indication of moderately intact cognition) and independent with eating after tray set-up. The care plan for Resident #104, dated 10/20/14, identified a potential for nutritional deficits due to a diagnosis of diabetes mellitus II, a history of a weight loss and frequent changes to food preferences. Staff interventions included meal tray set-up, large portion of eggs at breakfast for	F 242	ADDRESS HOW CORRECTIVE ACTION (S) WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: Resident #104 as identified in the statement of deficiencies had the eggs discontinued on 12/19/2014 and Boost added for the protein. The Dietary Manager interviewed the resident to determine current likes and dislikes and her tray card was changed to reflect eggs as a dislike. No additional preferences were noted. ADDRESS HOW CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS HAVING POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE: Current communication procedure has been enhanced to ensure that all resident's likes and dislikes are communicated to Dietary Staff. Upon admission to the facility the Dietary	1/16/15

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F 242	Continued From page 4 additional protein, attempt to determine the cause for meal refusals, and offer a substitute meal or alternative source of nutrition. Review of dietary communication records and physician's orders revealed Resident #104 received a regular diet. On 10/29/14 per recommendation of the consultant registered dietitian (RD), large portion of eggs was added at breakfast for additional protein. The most recent RD progress note, dated 12/07/14, noted Resident #104 continued to receive a regular diet with a large portion of eggs for breakfast. The RD recommendation was to continue the current plan of care. Review of December 2014 meal intake reports revealed Resident #104 refused 7 meals and had an average meal intake of 60%. Resident #104 received her breakfast meal in her room on 12/18/14 at 08:40 AM. Nurse aide (NA) #1 delivered a breakfast meal of a regular diet (bacon, two slices of toast, skim milk, orange juice, cranberry juice, sliced grapefruit, banana, Special K dry cereal) with a double portion of eggs. Review of the tray card revealed French toast, oatmeal, banana and Special K cereal were listed as breakfast meal preferences and eggs were to be provided as a double portion. Resident #104 stated in interview during the observation that she had previously reported to staff that she did not like eggs, but that she did like to snack on Special K cereal dry without the milk and that she liked oatmeal. Resident #104 was observed to eat less than 25% of her breakfast meal. On 12/18/14 at 08:49 AM, NA #1 returned to the room of Resident #104 with coffee and syrup for	F 242	Manager interviews the resident to determine likes and dislikes. If the resident is unable to provide the information to the Dietary Manager, then the Dietary Manager will speak with the family member if present. If not present they will then contact the family member via telephone to obtain the information. After information is obtained it will then be placed in the dislike section on the tray card. After admission if resident expresses a dislike the following procedure will be carried out: 1. If noted by a CNA or other staff member that resident complains about a food that is served they are to determine from the resident if it a dislike and the resident does not want it to be served again. 2. The CNA or other staff member will inform the Nurse of the dislike and the Nurse will be responsible to complete a Dietary Communication slip (pink slip) and take it to the Dietary Department and place in the Communication Folder on the Dietary Manager's Door. The (yellow copy) remains in the chart under the Dietary Section. 3. The Dietary Manager or Kitchen Supervisor will be responsible to enter the changes in the Diet Card Program and a new card will be printed. If the change is made after the daily tray cards are printed the Dietary Manager or Kitchen Supervisor will manually change it on the printed cards for that day. On a quarterly basis in the care plan meeting likes and dislikes are discussed	

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F 242	Continued From page 5 her toast. Resident #104 stated to NA #1 "I don't like eggs and I've told them, why do they send so many eggs?" NA #1 responded "I don't know, what about the milk, you don't like that either?" Resident #104 responded "I hardly ever drink it." NA #1 stated to Resident #104 "I don't know why they keep sending it (milk)." After looking at the tray card, NA #1 then stated to Resident #104 "You keep getting the eggs because your tray card lists double portion eggs, I will tell them again." On 12/18/14 at 08:50 AM, NA #1 exited the room of Resident #104 without offering her a substitute meal or alternate source of nutrition for the eggs and milk. During an interview on 12/18/14 at 09:34 AM, NA #1 stated that Resident #104 typically ate her toast and bacon and drank her coffee for breakfast. NA #1 also stated that Resident #104 "did not like eggs or any of the other stuff." NA #1 further stated that she had informed staff in the kitchen that Resident #104 did not like eggs, but did not know why Resident #104 continued to receive eggs for breakfast. NA #1 stated she did not offer Resident #104 anything else to eat/drink because she usually ate her toast, bacon and drank her coffee. On 12/19/14 NA #1 brought Resident #104 her breakfast meal to her room at 08:15 AM. Resident #104 received a double portion of scrambled eggs, toast, bacon, oatmeal, skim milk, orange juice, and cranberry juice. Resident #104 refused her breakfast meal and stated "It's the same as yesterday." Resident #104 was offered a high calorie nutritional supplement which she accepted. On 12/18/14 at 2:29 PM, the certified dietary	F 242	with the resident and/or the family members to ensure there are no changes. An in-service was completed on January 13, 2015 by Staff Development to the CNA's and Nurses concerning the procedure to follow (procedure listed above) when a resident expresses a dislike of a food or a preference they may want that is served to the resident. ADDRESS WHAT MEASURES WILL BE PUT INTO PLACE OR SYSTEMIC CHANGES MADE TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT REOCCUR: Current communication procedure has been enhanced to ensure that all resident's likes and dislikes are communicated to Dietary Staff. Upon admission to the facility the Dietary Manager interviews the resident to determine likes and dislikes. If the resident is unable to provide the information to the Dietary Manager, then the Dietary Manager will speak with the family member if present. If not present they will then contact the family member via telephone to obtain the information. After information is obtained it will then be placed in the dislike section on the tray card. After admission if resident expresses a dislike the following procedure will be carried out: 1. If noted by a CNA or other staff member that resident complains about a food that is served they are to determine from the resident if it a dislike and the resident does not want it to be served again.	

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F 242	Continued From page 6 manager (CDM) was interviewed. The CDM stated that resident food preferences was captured during the admission process and that the facility did not have a formal system to update food preferences after admission. The CDM stated that if a resident communicated a change in food preferences after admission, the CDM was notified by staff and then she updated the resident's food preferences in the computer. The CDM stated that Resident #104 had a long history of changing her mind regarding her food preferences and she routinely expressed these changes to staff or to the CDM. The CDM stated that Resident #104 routinely expressed a dislike for the facility food and received family support with meals and snacks. The CDM also stated that Resident #104 had recently communicated that she did not like eggs, but since this was a RD recommendation to increase her protein, "We still give her eggs." The CDM further stated that Resident #104 continued to receive skim milk because she had previously requested it. The CDM stated she expected staff to inform dietary staff of any changes to food preferences they were made aware of or any food items missed on a resident's meal tray. The CDM stated that Resident #104 should receive oatmeal for breakfast, this was just missed. On 12/18/14 at 3:17 PM, an interview with the RD revealed that she recommended that Resident #104 receive a double portion of eggs for breakfast to increase her protein intake, but the RD was not made aware that Resident #104 communicated that she did not like eggs. The RD stated that she would have expected the facility to provide her with an appropriate protein substitute after Resident #104 communicated a dislike for eggs.	F 242	2. The CNA or other staff member will inform the Nurse of the dislike and the Nurse will be responsible to complete a Dietary Communication slip (pink slip) and take it to the Dietary Department and place in the Communication Folder on the Dietary Manager's Door. The (yellow copy) remains in the chart under the Dietary Section. 3. The Dietary Manager or Kitchen Supervisor will be responsible to enter the changes in the Diet Card Program and a new card will be printed. If the change is made after the daily tray cards are printed the Dietary Manager or Kitchen Supervisor will manually change it on the printed cards for that day. On a quarterly basis in the care plan meeting likes and dislikes are discussed with the resident and/or the family members to ensure there are no changes. The Activity Director in the monthly Resident Council Meeting obtains a list of the residents and gives to the Dietary Manager if any food issues are noted. An in-service was completed on January 13, 2015 by Staff Development to the CNA's and Nurses concerning the procedure to follow (procedure listed above) when a resident expresses a dislike of a food or a preference they may want that is served to the resident. The Dietary Manager will interview ten (10) residents monthly and document on a QA Sheet that indicates the residents interviewed and any new likes or dislikes for three months for satisfaction of food and choices are being acknowledged. If at the end of three (3) months there are no	

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F 242	Continued From page 7	F 242		

further issues with food preferences, then we will follow the procedures that have been implemented.
INDICATE HOW THE FACILITY PLANS TO MONITOR IT□S PERFORMANCE TO MAKE SURE THAT SOLUTIONS ARE SUSTAINED. THE FACILITY MUST DEVELOP A PLAN FOR ENSURING THAT CORRECTION IS ACHIEVED AND SUSTAINED. THE PLAN MUST BE IMPLEMENTED AND THE CORRECTIVE ACTION EVALUATED FOR ITS EFFECTIVENESS. THE PoC IS INTEGRATED INTO THE QUALITY ASSURANCE SYSTEM OF THE FACILITY:
The Dietary Manager will bring the results of the interview for the ten (10) residents to the Quality Assurance Committee on a monthly basis for the committee to review monthly for three (3) months. If after three (3) months the new procedure is effective then the QA Committee will only review if additional issues occur.
The QA Committee will review the systemic changes to ensure the facility□s progress towards implementation of corrective action(s) and the facility□s performance, to ensure that corrective performance is achieved and sustained.
The QA Committee will review the facility□s progress monthly for effectiveness and revise or develop new measures as necessary to ensure that corrective action is integrated and the system is sustained or revised as needed to achieve and maintain corrective solutions.

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F 325	Continued From page 8	F 325		
F 325 SS=D	483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem. This REQUIREMENT is not met as evidenced by: Based on dining observations, staff interviews and review of the medical record, the facility failed to identify unplanned significant weight loss and failed to implement current care plan interventions to prevent further weight loss for 1 of 3 sampled residents at risk for nutritional deficits. (Resident #104) The findings included: Resident #104 was re-admitted to the facility on 08/24/13. Diagnoses included in part anorexia, abnormal weight loss, diabetes mellitus II, depressive disorder, and pressure ulcer. Review of the most recent Minimum Data Set (MDS), a quarterly, dated 10/20/14 revealed Resident #104 was assessed with a cognitive patterns summary score of 10 (an indication of moderately intact cognition), independent with eating after tray set-up, no weight loss, weighing	F 325	ADDRESS HOW CORRECTIVE ACTION (S) WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: Resident #104 was placed on the Nutrition at Risk Committee 12/24/2014. Resident's weight is being monitored on a weekly basis. The double portion of eggs were discontinued and order was received to add Boost BID on 12/19/2014. Committee is monitoring intake of resident on a weekly basis. Resident continues to frequently refuse to be weighed. Restorative CNA's who obtain weights have been instructed to attempt her weights on the days of Bingo (3 times per week) since this is the only time she will come out of her room, and record attempts on Weight Record. ADDRESS WHAT MEASURES WILL BE	1/16/15

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F 325	Continued From page 9 165 pounds, and with an unhealed pressure area. The care plan for Resident #104, dated 10/20/14, identified a potential for nutritional deficits due to a diagnosis of diabetes mellitus II and a history of a prescribed weight gain plan. The care plan goal outlined that staff would implement interventions to reduce Resident #104's risk of significant weight loss as evidenced by no significant weight loss noted through the next review in January 2015. Staff interventions included meal tray set-up, large portion of eggs at breakfast for additional protein, attempt to determine the cause for meal refusals, offer a substitute meal or alternative source of nutrition, monitor weights for any downward trends and implement interventions to prevent significant weight loss. Review of dietary communication records and physician's orders revealed Resident #104 received a regular diet. On 10/29/14 per recommendation of the consultant registered dietitian (RD), large portion of eggs was added at breakfast for additional protein for wound healing. On 11/14/14, a physician's order was written to gradually decrease and then discontinue Remeron (an antidepressant which is also used to stimulate appetite) over a two week period, secondary to excessive weight gain. The most recent RD progress note, dated 12/07/14, noted Resident #104 continued to receive a regular diet with a large portion of eggs for breakfast for wound healing, refused November 2014 weight and the December 2014 weight was pending. The RD recommendation was to continue the current plan of care.	F 325	PUT INTO PLACE OR SYSTEMIC CHANGES MADE TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT REOCCUR: Upon admission all new admissions and re-admissions are placed on weekly weights for at least one month. If resident's weight is not stable at that point they will continue on the Nutrition at Risk Committee until intake and weight is stable. The resident will be care planned for the appropriate problem, i.e. weight loss/gain or poor intake. Any resident who refuses to be weighed will be re-visited at least three (3) times to attempt to obtain the weight and attempts will be documented on the Weight Record. The Dietary Manager is responsible to report to the Staff in the Morning Meeting of any resident that has a weight gain or loss of five (5) pounds or more based on input into the software that gives us the 5%, 7.5% and 10% losses or gains. The Director of Nursing will then determine if the resident has been re-weighed for accuracy and if so she will refer the resident to the Nutrition at Risk Committee. The Nutrition at Risk Committee is responsible to notify the physician of the weight loss or gain for direction of adding an intervention i.e., supplements or lab work. ADDRESS WHAT MEASURES WILL BE PUT INTO PLACE OR SYSTEMIC CHANGES MADE TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT REOCCUR: Upon admission all new admissions and	

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OLDE KNOX COMMONS AT THE VILLAGES OF MECKLENBURG	13825 HUNTON LANE HUNTERSVILLE, NC 28078

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F 325	Continued From page 10 The 90 day weight history for Resident #104 included the following: 09/01/14 - 168 pounds 10/28/14 - 164.8 pounds November weight refused 12/04/14 - 155 pounds (13 pound loss or 8.4%) Review of meal intake reports revealed the following average meal intakes: · October 2014 - 76%, refused 1 meal · November 2014 - 66%, refused 2 meals · December 2014 - 60%, refused 7 meals Resident #104 received her breakfast meal in her room on 12/18/14 at 08:40 AM. Nurse aide (NA) #1 delivered a breakfast meal of a regular diet (bacon, two slices of toast, skim milk, orange juice, cranberry juice, sliced grapefruit, banana, dry cereal) with a double portion of eggs, but did not provide tray set-up prior to leaving the room. Review of the tray card revealed French toast, oatmeal, banana and Special K cereal were listed as breakfast meal preferences and eggs were to be provided as a double portion. Resident #104 stated in interview during the observation that she had previously reported to staff that she did not like eggs, but that she did like to snack on Special K cereal dry without the milk and that she liked oatmeal. Resident #104 was observed to eat less than 25% of her breakfast meal. On 12/18/14 at 08:49 AM, NA #1 returned to the room of Resident #104 with coffee and syrup for her toast. Resident #104 stated to NA #1 "I don't like eggs and I've told them, why do they send so many eggs?" NA #1 responded "I don' t know, what about the milk, you don't like that either?" Resident #104 responded "I hardly ever drink it." NA #1 stated to Resident #104 "I don't know why	F 325	re-admissions are placed on weekly weights for at least one month. If resident's weight is not stable at that point they will continue to be reviewed by the Nutrition at Risk Committee until intake and/or weight is stable. The resident will be care planned for the appropriate problem, i.e. weight loss or poor intake. Any resident who refuses to be weighed will be re-visited at least three (3) times to attempt to obtain the weight and attempts will be documented on the Weight Record. The Dietary Manager is responsible to report to the Staff in the Morning Meeting of any resident that has a weight gain or loss of five (5) pounds or more based on input into the software that gives us the 5%, 7.5% and 10% losses or gains. The Director of Nursing will then determine if the resident has been re-weighed for accuracy and if so she will refer the resident to the Nutrition at Risk Committee. The Nutrition at Risk Committee is responsible to notify the physician of the weight loss or gain for direction of adding an intervention. The Nutrition at Risk Committee is responsible to notify the physician of the weight loss or gain for direction of adding an intervention i.e., supplements or lab work. INDICATE HOW THE FACILITY PLANS TO MONITOR IT□S PERFORMANCE TO MAKE SURE THAT SOLUTIONS ARE SUSTAINED. THE FACILITY MUST DEVELOP A PLAN FOR ENSURING THAT CORRECTION IS ACHIEVED AND SUSTAINED. THE PLAN MUST BE IMPLEMENTED AND THE CORRECTIVE	

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F 325	Continued From page 11 they keep sending it (milk)." After looking at the tray card, NA #1 then stated to Resident #104 "You keep getting the eggs because your tray card lists double portion eggs, I will tell them again." On 12/18/14 at 08:50 AM, NA #1 exited the room of Resident #104 without offering her a substitute meal or alternate source of nutrition for the eggs and milk. During an interview on 12/18/14 at 09:34 AM, NA #1 stated that Resident #104 typically set up her own meal tray, ate her toast and bacon and drank her coffee for breakfast. NA #1 also stated that Resident #104 "did not like eggs or any of the other stuff." NA #1 further stated that she had informed staff in the kitchen that Resident #104 did not like eggs, but did not know why Resident #104 continued to receive eggs for breakfast. NA #1 stated she did not offer Resident #104 anything else to eat because she usually ate her toast, bacon and drank her coffee. On 12/18/14 at 12:34 PM, Resident #104 was observed in her room with her lunch meal covered and on the over bed table next to her bed. Resident #104 was lying in bed with her eyes closed. On 12/18/14 at 12:45 PM, Resident #104 uncovered her lunch meal and began to eat. Resident #104 received a regular diet which included a slice of cake, mashed potatoes with gravy, chicken breast, green beans, a roll, coffee, skim milk, ice water, butter, two sugar packets, and salt. Resident #104 ate less than 25% of her lunch meal. Resident #104 was interviewed during the meal and stated her chicken was too tough and that she could not eat it. On 12/18/14 at 1:10 PM, NA #1 entered the room of Resident #104, asked her if she was finished with her lunch, Resident #104 said she did not want	F 325	ACTION EVALUATED FOR ITS EFFECTIVENESS. THE PoC IS INTEGRATED INTO THE QUALITY ASSURANCE SYSTEM OF THE FACILITY: The Director of Nursing will review the weights and initial on the weight record on a weekly and monthly basis for three (3) months to ensure that residents are being weighed and if weight loss or gain is noted that interventions have been initiated. She will bring the Nutrition at Risk Report and Weight Records to the Monthly Quality Assurance Committee for review. The QA Committee will review the systemic changes to ensure the facility□s progress towards implementation of corrective action(s) and the facility□s performance, to ensure that corrective performance is achieved and sustained. The QA Committee will review the facility□s progress monthly for effectiveness and revise or develop new measures as necessary to ensure that corrective action is integrated and the system is sustained or revised as needed to achieve and maintain corrective solutions.	

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anymore of her food and NA #1 removed the lunch meal tray without an attempt made to determine the cause of the meal refusal or offering a substitute meal or alternate source of nutrition. NA #1 was interviewed during this observation and stated she did not offer Resident #104 anything else "because she stated she did not want anymore."

On 12/18/14 at 2:29 PM, the certified dietary manager (CDM) was interviewed. The CDM stated that restorative staff obtained the weight data, which was reviewed for any significant changes by the CDM or the MDS nurse. The CDM stated she entered weight data into the computer after restorative staff obtained the weights and the computer software provided an alert for any significant changes. Either the MDS nurse or the CDM provided this report to the physician (MD) or the nurse practitioner (NP) and the CDM notified the RD, in person if she were in the facility or via phone/email. Any significant weight changes were discussed for interventions during the facility's 'Nutrition at Risk' meeting held each Wednesday. This meeting was attended by the director of nursing (DON), MDS nurse, unit coordinator, and CDM. The team made collective recommendations during the 'Nutrition at Risk' meeting for any interventions which was communicated to the MD/NP. The CDM stated Resident #104 did not currently have any significant weight changes and was not currently on case load to determine the need for additonal weight loss interventions. The CDM also stated that Resident #104 had recently communicated that she did not like eggs, but since this was a RD recommendation, "We still give her eggs." The CDM stated she expected staff to inform dietary of any food preferences they were made aware of

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or any food items missed on a resident's meal tray. The CDM stated that Resident #104 should receive oatmeal for breakfast, this was just missed.

On 12/18/14 at 3:17 PM, an interview with the RD revealed that she provided the facility clinical support, twice monthly, which included follow-up to residents with weight loss. The RD stated that she did not routinely attend the weekly 'Nutrition at Risk" meetings. The RD stated during her visits, the CDM provided her a report from the "Nutrition at Risk" meetings for review and a report of residents, if any, who had experienced significant weight changes for follow-up. The RD stated she was not made aware that Resident #104 communicated that she did not like eggs and that the RD would have expected the facility to provide her with an appropriate protein substitute. The RD further stated that when she visited the facility the first week in December 2014 the monthly weight data was not available and she had not been made of aware of any significant weight changes for this Resident.

On 12/18/14 at 4:18 PM a follow-up interview with the CDM and review of the minutes from the 12/17/14 'Nutrition at Risk' committee meeting revealed that the significant weight loss for Resident #104 was not discussed in the most recent committee meeting. The CDM stated that Resident #104 did experience significant weight loss after Remeron was discontinued and that no other weight loss interventions had been implemented in response to this recent weight loss.

An interview occurred on 12/19/14 at 9:50 AM with the NP and revealed that Resident #104 had

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F 325	Continued From page 14 previously experienced significant weight gain and the Remeron was discontinued due to this weight gain. The NP further stated that some weight loss may have been expected, but she did not recall being informed of any recent significant weight changes for Resident #104. The NP also stated that she would like to see additional protein added that the Resident would accept and a supplement to also address the current significant weight loss. The DON was interviewed on 12/19/14 at 10:00 AM. The interview revealed that she attended the weekly 'Nutrition at Risk' committee meetings and that Resident #104 had previously been discussed when she had some weight loss, but the Resident came off the weight loss report once her weight stabilized. The DON further stated that Resident #104 was not added back to the weight loss report for discussion because the committee typically responded to weight changes of 10% or more in 90 days as significant.	F 325		
F 363 SS=E	483.35(c) MENUS MEET RES NEEDS/PREP IN ADVANCE/FOLLOWED Menus must meet the nutritional needs of residents in accordance with the recommended dietary allowances of the Food and Nutrition Board of the National Research Council, National Academy of Sciences; be prepared in advance; and be followed. This REQUIREMENT is not met as evidenced by: Based on observations, dietary staff interviews and review of facility menus, the facility failed to provide a vegetable and pasta salad in a portion	F 363	ADDRESS HOW CORRECTIVE ACTION (S) WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE	1/16/15

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F 363	Continued From page 15 according to the approved menu. During the dinner tray line 18 residents who ate in the main dining room were served a 2/3 cup portion of the vegetable and pasta salad (Residents #83, 51, 147, 46, 97, 10, 64, 37, 76, 84, 184, 61, 117, 24, 1, 14, 26, and 7) and 11 residents who ate in their rooms on the 300 hall received a one fourth cup portion of vegetable and pasta salad (Residents #2, 141, 118, 112, 130, 91, 123, 34, 111, 156, and 106) instead of the 1/2 cup portion required by the approved menu for 2 of 5 dining areas observed. The findings included: An observation occurred on 12/14/14 at 4:43 PM of the dinner meal tray line. Dietary staff #1 was observed serving the dinner meal for residents eating in the main dining room. Review of the dinner menu, approved and signed by the registered dietitian, revealed the following items and portions were to be served: · Pimento cheese sandwich, 1 sandwich · Chicken noodle soup, 1 cup · Broccoli and cauliflower macaroni salad, 1/2 cup Dietary staff #1 was observed to serve broccoli and cauliflower macaroni salad using a #12 or a 2/3 cup serving utensil instead of a 1/2 cup serving utensil to Residents #83, 51, 147, 46, 97, 10, 64, 37, 76, 84, 184, 61, 117, 24, 1, 14, 26, and 7 who ate in the main dining room. During the observation, an interview with dietary staff #1 revealed that he did not typically use a utensil guide to determine which serving utensils to use when plating meals, but that he used the same serving utensils he always used. Dietary staff #1 further stated that he did not have access to the dinner meal spread sheet which recorded the	F 363	BEEN AFFECTED BY THE DEFICIENT PRACTICE: On December 26, 2014 and January 12, 2015 an in-service was conducted with dietary staff on the proper utilization of portions and proper utilization of serving utensils. In addition a new utensil guide chart was implemented and posted in the kitchen to ensure that the proper sized serving utensil is utilized as directed by the facility menu. In addition a system was put into place that required the cook responsible for the meal being prepared and served where they must sign a menu spread sheet log indicated that menus have been reviewed for appropriate serving size for every menu item. Also a section was added to the Food and Beverage Temperature Chart Log that the cook must indicate for each food item being served what scoop size is to be used for that item. On January 12, 2015 a system was put into place where all current facility menus are placed into a three ring binder that is kept in the serving area so that the cook has constant access to menus. In the front of the binder is where the cook Spread Sheet Sign Out Log is kept and cook is to sign indicating review of the menu. In addition the Dietary Manager will sign and date all menus when they are posted to the menus book and the Administrator will conduct QA rounds to ensure that	

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F 363	Continued From page 16 portion sizes, but rather he thought the spread sheet was locked in the dietary manager's office and the dietary manager was not in the facility at that time. An interview with the certified dietary manager (CDM) occurred on 12/14/14 at 4:55 PM and revealed staff did not have access to a hard copy of the dinner meal spread sheet which recorded meal portions, but that she would have to print it from her computer. The CDM was asked to verify if the broccoli and cauliflower macaroni salad was served at the correct portion and she stated that the #12 serving utensil used provided a 6 ounce portion, but staff should use a #16 serving utensil to provide a 1/2 cup portion. The CDM was asked to verify the serving utensil sizes using a vendor's utensil guide. On 12/14/14 at 5:00 PM, the CDM removed the #12 (2/3 cup) serving utensil used for the broccoli and cauliflower macaroni salad and instructed Dietary staff #1 to use a #16 serving utensil (1/4 cup) to serve the broccoli and cauliflower macaroni salad and stated this would provide the residents with a 1/2 cup portion. Dietary staff #1 served 11 residents on the 300 hall a 1/4 cup serving of broccoli and cauliflower macaroni salad, Residents #2, 141, 118, 112, 130, 91, 123, 34, 111, 156, and 106. The CDM was asked to verify the serving utensil sizes using a vendor's utensil guide. A follow up interview with the CDM occurred on 12/14/14 at 6:31 PM and revealed that according to the vendor utensil guide a #12 serving utensil provided a 2/3 cup portion and a #16 serving utensil provided a 1/4 cup portion. The CDM stated she made a mistake with the portions. The CDM stated she did not routinely monitor the tray	F 363	menus are posted to the menus book and book is readily available for the cook to use. ADDRESS HOW CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS HAVING POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE: On December 26, 2014 and January 12, 2015 an in-service was conducted with dietary staff on the proper utilization of portions and proper utilization of serving utensils. In addition a new utensil guide chart was implemented and posted in the kitchen to ensure that the proper sized serving utensil is utilized as directed by the facility menu. In addition a system was put into place that required the cook responsible for the meal being prepared and served where they must sign a menu spread sheet log indicated that menus have been reviewed for appropriate serving size for every menu item. Also a section was added to the Food and Beverage Temperature Chart Log that the cook must indicate for each food item being served what scoop size is to be used for that item. On January 12, 2015 a system was put into place where all current facility menus are placed into a three ring binder that is kept in the serving area so that the cook has constant access to menus. In the front of the binder is where the cook Spread Sheet Sign Out Log is kept and	

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F 363	Continued From page 17 line on the weekends for correct portions, but rather staff knew to routinely serve 4 ounces or 1/2 cup of vegetables.	F 363	cook is to sign indicating review of the menu. In addition the Dietary Manager will sign and date all menus when they are posted to the menus book and the Administrator will conduct QA rounds to ensure that menus are posted to the menus book and book is readily available for the cook to use. ADDRESS WHAT MEASURES WILL BE PUT INTO PLACE OR SYSTEMIC CHANGES MADE TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT OCCUR: On December 26, 2014 and January 12, 2015 an in-service was conducted with dietary staff on the proper utilization of portions and proper utilization of serving utensils. In addition a new utensil guide chart was implemented and posted in the kitchen to ensure that the proper sized serving utensil is utilized as directed by the facility menu. In addition a system was put into place that required the cook responsible for the meal being prepared and served where they must sign a menu spread sheet log indicated that menus have been reviewed for appropriate serving size for every menu item. Also a section was added to the Food and Beverage Temperature Chart Log that the cook must indicate for each food item being served what scoop size is to be used for that item.	

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F 363	Continued From page 18	F 363	On January 12, 2015 a system was put into place where all current facility menus are placed into a three ring binder that is kept in the serving area so that the cook has constant access to menus. In the front of the binder is where the cook Spread Sheet Sign Out Log is kept and cook is to sign indicating review of the menu. In addition the Dietary Manager will sign and date all menus when they are posted to the menus book and the Administrator will conduct QA rounds to ensure that menus are posted to the menus book and book is readily available for the cook to use. INDICATE HOW THE FACILITY PLANS TO MONITOR IT□S PERFORMANCE TO MAKE SURE THAT SOLUTIONS ARE SUSTAINED. THE FACILITY MUST DEVELOP A PLAN FOR ENSURING THAT CORRECTION IS ACHIEVED AND SUSTAINED. THE PLAN MUST BE IMPLEMENTED AND THE CORRECTIVE ACTION EVALUATED FOR ITS EFFECTIVENESS. THE POC IS INTEGRATED INTO THE QUALITY ASSURANCE SYSTEM OF THE FACILITY: The Spread Sheet Sign-out Log, as well as the Food and Beverage Temperature Chart will be reviewed by the Quality Assurance Committee to ensure the facility is in compliance with facility/state/federal policies, guidelines and laws to ensure proper menus are	

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F 363	Continued From page 19	F 363	being used as well as appropriate portion sizes are being served. The QA Committee will be responsible to ensure that corrective action is achieved and sustained. The QA Committee will be responsible for implementing new policies and procedures and/or systems if current policies and procedures and/or systems are identified as insufficient to maintain corrective action and sustain solutions. The QA Committee meets weekly, monthly, and quarterly.	