STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165249	A. BUILDING _____ B. WING _____	01/05/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - NEWELL	415 WEST HIGHWAY 7 NEWELL, IA 50568

(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 Correction Date: 1/27/17 The following deficiencies are the result of the recertification survey completed 1/3 - 1/5/2017. See Code of Federal Regulations (42CFR) Part 483, Subpart B-C.	F 000		
F 279 SS=D	483.20(d);483.21(b)(1) DEVELOP COMPREHENSIVE CARE PLANS 483.20 (d) Use. A facility must maintain all resident assessments completed within the previous 15 months in the resident's active record and use the results of the assessments to develop, review and revise the resident's comprehensive care plan. 483.21 (b) Comprehensive Care Plans (1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and	F 279		

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

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 279	Continued From page 1 (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative (s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to develop the care plan to prevent pressure ulcers and update the care plan to promote healing and prevent additional pressure sores for 1 of 9 residents reviewed (Resident #2). The facility reported a census of 29 residents.	F 279		

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F 279	Continued From page 2 Findings include: According to the admission Minimum Data Set (MDS) assessment, dated 5/23/16, Resident #2 scored 8 on the Brief Interview for Mental Status (BIMS) indicating cognitive impairment. Resident #2 required extensive assistance with activities of daily living (ADL's) including bed mobility, transfer, dressing, toilet use, and personal hygiene. Resident #2's diagnoses included Alzheimer's disease and diabetes. Resident #2 had a risk for developing pressure ulcers, but had no pressure ulcers. A Care Area Assessment (CAA) with an assessment reference date of 5/23/16 documented Resident #2 triggered for pressure ulcers related to ADL assistance with bed mobility, frequent urinary incontinence, and was at risk for developing pressure ulcers. The CAA documented pressure ulcers would be addressed on the care plan to avoid complications and minimize risks. The Care Plan dated 5/26/16 lacked identification of Resident #2's risk for developing pressure ulcers or interventions to prevent pressure ulcer development. The Progress Notes dated 10/6/16 at 7:07 p.m. documented Resident #2 had a reddened area on his/her left heel. Resident #2 had a sheered area on the left heel measuring 0.7 by 0.8 cm. Resident #2 denied discomfort, and the heel had no drainage or warmth. The heels were elevated on a pillow. A facsimile (fax) dated 10/6/16 notified the	F 279		

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F 279	Continued From page 3	F 279		

primary care provider Resident #2 had area 0.7 by 0.8 cm on the back of the left heel, looked sheared. Both heels elevated on pillow, with no odor, drainage or redness noted. On 10/10/16, the provider responded to continue to monitor [the heels].

A Podiatry note dated 10/17/16 documented Resident #2's diagnoses included a pressure ulcer of the left heel. The note documented Resident #2 had eschar with minimal serous drainage to area measuring 2.5 by 2.2 cm, and the nursing facility offloaded when supine (laying face up). The Podiatrist ordered a Prevalon (pressure reduction) boot left, and an ET consult.

A wound Progress Record dated 10/19/16 documented Resident #2 had a 2.5 by 2.2 cm dry, black eschar to left medial heel with no increased redness, warmth, or foul smell noted. The nurse stated staff floated Resident #2's heels at bedtime (HS). Resident #2 had an unstageable pressure ulcer of the left medial heel. New orders to paint the ulcer with Betadine and allow to air dry daily, wear the Prevalon boot to the left lower extremity at all times, float heels when in bed, assist in repositioning in bed at least every 2 hours and as needed (PRN) through the night and day, and get a dietary consult related to the pressure ulcer.

The Care Plan identified Resident #2 had an unstageable pressure ulcer of the left heel with eschar initiated 10/17/16 and revised 11/1/16 with a goal target date of 11/2/16. The interventions included:

a. Educate resident/family of the causes of skin breakdown including: transfer/positioning requirements, the importance of taking care

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F 279	Continued From page 4 during ambulation/mobility, good nutrition and frequent repositioning, b. Prevalon boot to left foot and ET nurse evaluation and treat left heel until resolved, c. Notify the nurse immediately of any new areas of skin breakdown, redness, blisters, bruises, discoloration, etc... noted during bath or daily care. The Care Plan with a goal target date of 11/23/16 identified by the Director of Nursing as the current care plan, showed no changes in interventions regarding the pressure ulcer. The Care plan lacked identification of at least every 2 hour repositioning, floating heels, and no whirlpools per the ET nurse direction. During an interview on 1/4/17 at 9:00 a.m. the Director of Nursing (DON) stated she did rounds with the podiatrist and he brought the area on Resident #2's heel to her attention (10/17/16). She said interventions were added to the care plan on 10/17/16. At 3:30 p.m. the DON stated staff routinely repositioned residents on rounds, but she could not say they repositioned at least every 2 hours, or floated his/her heels per the direction of the ET nurse. She said she applied the boot as soon as she was aware of the area. The facility policy, Pressure Ulcer Practice Guidelines, dated September 2012 (page 7) documented once a resident had been assessed and determined at risk for development of a pressure ulcer, the interdisciplinary team should evaluate interventions and actions that could be taken to assist in the prevention of pressure ulcer development.	F 279		
F 282	483.21(b)(3)(ii) SERVICES BY QUALIFIED	F 282		

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F 282 SS=D	Continued From page 5 PERSONS/PER CARE PLAN (b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (ii) Be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to follow care plan interventions in regards to feeding assistance at meals for 1 of 9 active residents reviewed. (Resident #4). The facility reported a census of 29 residents. Findings included: According to a Diagnosis Report form dated 1/4/2017, Resident #4's diagnoses included Alzheimer's disease, anorexia, and abnormal weight loss. A Minimum Data Set (MDS) assessment with a reference date of 11/8/2016, identified Resident #4 with severely impaired cognitive skills and short and long term memory problems. The MDS revealed the resident required extensive assistance from 1 staff member with eating, documented a weight loss of 5% or more in the last month or a loss of 10% or more in the last 6 months and had not been on a physician prescribed weight loss program. A Physician's Order Report form dated 11/22/2016, included orders for a regular diet with pureed texture, liquefy the pureed texture if needed and a House Supplement, 240 cc (cubic centimeter, measurement of volume) three times	F 282		

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F 282	Continued From page 6 a day. Resident #4's care plan, with a print date of 1/4/17, included a focus area for a self care deficit related to Alzheimer's disease and an intervention for eating with the assistance of 1 staff member. A Bath and Weight Check List form dated 2016 included the following weight trends for Resident #4: 2/28/16 - 117 lbs (pounds) 9/1/16 - 111 lbs 10/11/16 - 103 lbs 11/23/16 - 97 lbs 12/29/16 - 95 lbs Review of facility Dietitian Progress Notes revealed the following: 10/17/16 at 10:51 A.M.- The resident's food was liquefied at the table by staff at times. The resident is more willing to drink than eat at most meals. 10/31/16 at 12:08 P.M. - The resident's condition has declined. Intake is very poor at meals. Weight 100 lbs, with a significant weight loss noted. 11/7/16 at 1:31 P.M. - Overall decline with admission to Hospice services. Weight 100 lbs with a significant weight loss in 30 and 90 days. Average intake at meals is 21%. Continue with assistance at all meals. 12/12/16 at 1:22 P.M. - Meal intake very poor. Observation on 1/4/17 at 7:58 A.M., revealed Resident #4 sat in a wheelchair at a round table in the dining room and no staff present at the table. 2 plastic cups (contained 120 cc each) of house supplement drink, a 240 cc glass of orange juice, a 240 cc glass of water sat on the dining room table in front of the resident. Observation on 1/4/17 at 8:40 A.M., (approximately 40 minutes later) revealed dietary	F 282		

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F 282	Continued From page 7 staff placed separate bowls of pureed sausage, pureed toast with jelly, pureed fruit, a bowl of oatmeal and a 240 cc glass of milk down on the table in front of the resident. Further observation revealed the resident unable to attempt to feed his/herself. Observation revealed 2 other residents sat across the table from Resident #4 while Staff A, Registered Nurse (RN)/ MDS Coordinator, sat between the 2 other resident's and assisted the other 2 residents with eating. At 8:42 A.M., Staff A stood up from her chair, walked around to the other side of the table, sat next to Resident #4 and assisted the resident with a drink of House Supplement and 1 bite of pureed fruit. Staff A attempted to give the resident another bite of pureed fruit and the resident refused to open his/her mouth. Staff A then assisted the resident with another drink of supplement. At 8:45 A.M., Staff A got up from her chair, walked around the other side of the table, sat down between the other 2 residents at the same table and assisted those 2 residents with eating. Observation of the entire dining room, revealed 2 nursing staff members assisting 8 residents at 3 different tables with eating assistance. Staff A at the same table as Resident #4, Staff B, Certified Nurse Aid (CNA) sat at a table across from Resident #4's table with 3 residents present and assisted 1 resident with eating and 2 residents sat a table behind Resident #4 with no staff present at the table. [Note: During interview on 1/4/17 at 9:16 A.M., Staff B, Licensed Practical Nurse (LPN) confirmed the 2 resident's at the table behind Resident #4, all 3 resident's at Resident #4's table required eating assistance from staff and the 3 resident's at the table across form Resident #4's table required prompts and cues with eating] (even though Staff B assisted 1 of the residents who required prompts and cues, with eating	F 282		

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F 282	Continued From page 8 assistance). Ongoing observation on 1/4/17 at 8:48 A.M., revealed Staff A sat down next to Resident #4 and assisted the resident with a drink of supplement ,2 bites of pureed fruit another drink of supplement and Staff A moved back to the other side of the table at 8:51 A.M. At 8:55 A.M., Staff A sat down next to Resident #4 and assisted the resident with eating as follows: the resident refused a bite of fruit offered, took a drink of supplement, took 2 bites of fruit, took a drink of supplement and took 2 bites of fruit. Ongoing observation revealed the resident ate 100% of the pureed fruit and completed 1 glass of supplement. Staff A failed to offer the resident a bite of pureed sausage, toast or a bite of oatmeal nor did she offer a drink of orange juice, water or milk. At 9:00 A.M., Staff A moved back to the other side of the table to assist the other 2 residents at the table. At 9:05 A.M., Staff A sat down next to Resident #4 and the resident refused a drink of supplement, orange juice and a bite of pureed toast. Staff A attempted again to give the resident a drink of supplement, orange juice and a bite of toast and the resident refused. At 9:06 A.M., Staff A moved back to the other side of the table to assist the other 2 residents. At 9:08 A.M., Staff C, relieved Staff A at Resident #4's table and sat between the other 2 residents at the table. During interview on 1/4/17 at 9:10 A.M., Staff A confirmed not normally helping out with assisting residents with feeding, but helps out when she can. Staff A stated normally 3 staff members assisted residents with eating, but felt the staff who typically assisted residents with eating had been slow getting to the dining room. Staff A state she had not offered Resident #4 sausage, toast or cereal prior to 9:05 A.M., because she	F 282		

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knew the resident liked fruit.
Ongoing observation on 1/4/17 at 9:20 A.M., revealed Staff B sat down next to Resident #4 and assisted the resident with 2 drinks of orange juice. Staff B attempted to give the resident 2 bites of pureed toast and the resident refused. At 9:23 A.M., (approximately 40 minutes after the resident's food had been served) Staff B mixed the milk at the table and sugar in a glass with oatmeal, liquefied the oatmeal, attempted to give the resident a drink of the liquefied oatmeal and the resident refused. At 9:25 A.M., Staff D, Dietary Cook, took the temperature of the resident's liquefied oatmeal and revealed a temperature of 83.6 degrees Fahrenheit (F). Staff D took the temperature of the resident's pureed sausage at the table and revealed a temperature of 73.4 degrees F. (Note: During interview on 1/4/17 at 9:25 A.M., and review of a Food Temperature Log, Staff D reported the temperature of the resident's pureed sausage prior to serving at 169 degrees F and the resident's cereal at 177 degrees F).
Ongoing observation revealed Staff B left the resident's table at 9:25 A.M., and went to the kitchen service window. At 9:40 A.M.,Resident #4 remained at the dining room table with his/her eyes closed and no assistance from staff with eating. At 9:50 A.M., Staff B returned to the resident's table with fresh, warm oatmeal and a 240 cc glass of milk. Staff C placed a fresh 120 cc glass of supplement at the table. Staff B liquefied the cereal with milk, fed the resident the freshly liquefied oatmeal with dinks of supplement in between. At 10:19 A.M., (greater than 2 hours after the resident had been first noted at the dining room table and with consistent help in eating), the resident finished eating approximately 75 % of the oatmeal, 100 % of the supplement

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F 282	Continued From page 10 and 100% of the fresh milk. During interview on 1/4/17 at 10:40 A.M., Staff C (licensed practical nurse)stated on a typical day, the facility provided 2-4 nursing staff to assist with feeding residents at meals. Staff C confirmed if her own parent sat at dining room table for greater than 2 hours without consistent staff assistance with eating, she would feel upset. During interview on 1/4/17 at 10:45 A.M., the facility Director of Nursing Services (DNS), confirmed 3 CNAs with the help of a nurse, needed to be in the dining room to assist residents with eating. During interview on 1/4/17 at 12:55 P.M., Staff B (certified nursing assistant) confirmed the residents who required assistance with eating, probably had not received the help they needed on 1/4/17 at breakfast.	F 282		
F 314 SS=G	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 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.	F 314		

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F 314	Continued From page 11 This REQUIREMENT is not met as evidenced by: Based on observation, record review, staff interviews and review of the facility policy and procedures, the facility failed to assure a resident received care to prevent pressure sore development and failed to immediately initiate measures to promote healing after the development of a pressure sore (Resident #2). The sample consisted of 2 residents with pressure sores and the facility identified a census of 29 residents. Findings include: 1. Resident #2 had an admission MDS (Minimum Data Set) assessment with a reference date of 5/23/16. Resident #2 scored 8 on the Brief Interview for Mental Status (BIMS) indicating a cognitive impairment. Resident #2 required extensive assistance with activities of daily living (ADL) skills including bed mobility, transfer, dressing, toilet use, and personal hygiene. The MDS identified the resident ' s diagnoses included Alzheimer's disease and diabetes. Resident #2 had a risk for the development of pressure ulcers, but had no pressure ulcers at the time of the MDS assessment. A Care Area Assessment (CAA) with an assessment reference date of 5/23/16 documented Resident #2 triggered for pressure ulcers related to ADL assistance with bed mobility, frequent urinary incontinence, and risk for developing pressure ulcers. The CAA documented pressure ulcers would be addressed on the care plan to avoid complications and minimize risks.	F 314		

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F 314	Continued From page 12 The Care Plan dated 5/26/16 lacked identification of Resident #2's risk for developing pressure ulcers or interventions to prevent pressure ulcer development. According to the quarterly MDS assessment with a reference date of 08/16/16, Resident #2 scored 6 on the BIMS. A score of 6 identified a severe cognitive impairment. Resident #2 required extensive assistance with ADL's including bed mobility, transfer, dressing, toilet use, and personal hygiene. Resident #2 had a risk for developing pressure ulcers, but had no pressure ulcers. The MDS defined an unstageable pressure ulcer as a known pressure ulcer, but unstageable due to the coverage of the wound bed with slough or eschar (dead, necrotic tissue). A Braden Scale for Predicting Pressure Sore Risk dated 8/23/16 scored Resident #2 at 16, with a score 18 or below indicated at risk. The intervention guide for mild risk (score of 15-18) included frequent turning, protecting heels, and managing friction and shear. The Progress Notes dated 10/6/16 at 7:07 p.m. (late entry) documented Resident #2 had a reddened area on his/her left heel. Resident #2 had a sheered area on the left heel measuring 0.7 by 0.8 cm. Resident #2 denied discomfort, and the heel had no drainage or warmth. The heels were elevated on a pillow. A Skin Observation dated 10/9/16 at 1:30 a.m. documented Resident #2 with an open sheer left heel with no drainage. The report lacked any measurements or other description of the area (as directed by the form).	F 314		

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F 314	Continued From page 13 A facsimile (fax) dated 10/6/16 notified the primary care provider Resident #2 had an area 0.7 by 0.8 cm on the back of the left heel, that looked sheared. Both heels elevated on pillow, with no odor, drainage or redness noted. The provider responded to continue to monitor on 10/10/16. The Progress Notes dated 10/10/16 at 9:50 a.m. documented the fax returned regarding the left heel, and to continue to monitor. The clinical record lacked documentation of any additional monitoring of the left heel. A Nursing Home visit form showed Resident #2 seen by the nurse practitioner on 10/11/16. The form documented skin negative with no mention of the area to the left heel. The Progress Notes dated 10/17/16 at 2:20 p.m. documented the podiatrist did rounds. The sheered area to the left heel scabbed over. Received new orders for Enterostomal Therapy (ET/wound) Nurse evaluation and treatment, and Prevalon (pressure reduction) boot to left heel until healed. A Podiatry note dated 10/17/16 documented Resident #2's diagnoses included a pressure ulcer of the right heel. The note documented Resident #2 had eschar with minimal serous drainage to area measuring 2.5 by 2.2 cm, and the nursing facility offloaded when supine (laying on back). The Podiatrist ordered a Prevalon boot to left foot, and an ET consult. The Progress Notes dated 10/19/16 at 10:39 a.m. documented a visit by the ET Nurse with new orders for Betadine daily and a dietary consult.	F 314		

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F 314	Continued From page 14 A wound Progress Record dated 10/19/16 documented Resident #2 had 2.5 by 2.2 cm dry, black eschar to left medial heel with no increased redness, warmth, or foul smell noted. The nurse stated staff floated Resident #2's heels at bedtime (HS). Resident #2 had an unstageable pressure ulcer of the left medial heel. New orders written to paint the ulcer with Betadine and allow to air dry daily, wear the Prevalon boot to the left lower extremity at all times, float heels when in bed, assist in repositioning in bed at least every 2 hours and as needed (PRN) through the night and day, and get a dietary consult related to the pressure ulcer The Braden Scale for predicting Pressure Sore Risk (quarterly) identified a score of 16 (mild risk for pressure ulcers). The Care Plan identified Resident #2 had an unstageable pressure ulcer of the left heel with eschar initiated 10/17/16 and revised 11/1/16 with a goal target date of 11/2/16. The interventions included: a. Educate resident/family of the causes of skin breakdown including: transfer/positioning requirements, the importance of taking care during ambulation/mobility, good nutrition and frequent repositioning, b. Prevalon boot to left foot and ET nurse eval and treat left heel until resolved, c. Notify the nurse immediately of any new areas of skin breakdown, redness, blisters, bruises, discoloration, etc... noted during bath or daily care. The wound Progress Record dated 11/1/16 documented Resident #2 just out of whirlpool.	F 314		

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F 314	Continued From page 15 The left heel unstageable ulcer measured 2.9 by 2.8 cm. an increase in size. The wound nurse directed no whirlpools until ulcer resolved, and continue efforts of pressure redistribution. The wound Progress Record dated 11/22/16 documented the left heel unstageable pressure ulcer eschar measured 2.7 by 1.7 cm. The right posterior heel had a pink hyperpigmented area 0.5 by 0.2 cm. The wound nurse directed to elevate right foot on pillows also. The wound Progress Record dated 12/6/16 documented the left heel had a brown crust measuring 2 by 1 cm. The right heel intact without erythema. The wound nurse directed to continue all pressure redistribution measures. The Care Plan with a goal target date of 11/23/16 identified by the Director of Nursing as the current care plan showed no changes in interventions regarding the pressure ulcer. The Care plan lacked identification of at least every 2 hour repositioning, floating the heels, and no whirlpools until pressure ulcer resolved per the ET nurse direction. During an observation on 1/3/16 at 11:57 a.m. Resident #2 sat in the dining room with a blue boot on his/her left foot. At 2:08 p.m. Staff E Certified Nursing Assistant (CNA) and Staff F CNA assisted Resident #2 with toileting, transferred via the sit to stand lift to the recliner, and elevated his/her legs with the footrest. Resident #2 had the boot on the left foot, but staff did not float Resident #2's heels. During an observation on 1/4/17 at 6:45 a.m. with the MDS Coordinator, Resident #2 had a dark	F 314		

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F 314	Continued From page 16	F 314		

area to the posterior left heel with circumferential skin peeling from the dark area. At 3:25 p.m. Resident #2 sat in the recliner with his/her legs up on the footrest. Resident #2 wore the blue boot on the left foot, but his/her heels were not floating.

During an interview on 1/4/17 at 9:00 a.m. the Director of Nursing (DON) stated she did rounds with the podiatrist and he brought the area on Resident #2's heel to her attention (10/17/16, 11 days after an impairment was noted). The DON checked the care plan and interventions were added 10/17/16 regarding the skin impairment. She found some documentation where they elevated the heels with pillows, but could not say what they did to protect the heels and decrease the pressure other than that. At 3:30 p.m. the DON stated staff routinely repositioned residents on rounds, but she could not say they repositioned at least every 2 hours, or floated his/her heels per the direction of the ET nurse. She said she applied the boot as soon as she was aware of the area.

During an interview on 1/4/17 at 11:20 a.m. the MDS Coordinator stated the day the podiatrist alerted the DON about the pressure ulcer was the first she knew of Resident #2 having it.

The facility policy and procedures titled Pressure Ulcers, dated September 2012, defined the purpose is to provide appropriate assessment and prevention of pressure ulcers as well as treatment when necessary.

The facility policy and procedures titled, Pressure Ulcer Practice Guidelines, dated September 2012 (page 7) documented once a resident had been

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F 314	Continued From page 17 assessed and determined at risk for development of a pressure ulcer, the interdisciplinary team should evaluate interventions and actions that could be taken to assist in the prevention of pressure ulcer development. Movement or management of tissue load (page 8) documented employees should implement resident-specific turning and positioning programs based upon an individualized assessment. This included a consistent program for changing the resident's position and realigning the body. Employees should use support surfaces (mattresses, wheelchair cushions, etc.) to decreases ischemia (lack of blood flow) of bony prominence's. Once a resident experienced a pressure ulcer, an assessment should take place immediately to determine the severity of the injury and treatment interventions necessary. Heel ulcers that were intact and free of infection should have skin protected (i.e., skin prep) pressure removed and monitored for any changes.	F 314		
F 325 SS=G	483.25(g)(1)(3) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE (g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- (1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise;	F 325		

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F 325	Continued From page 18 (3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview, the facility failed to direct nursing care services to provide adequate feeding assistance for a resident with a significant weight loss (Resident #4). The sample consisted of 3 residents identified by the facility with significant weight loss and identified a census of 29 residents. Findings included: According to a Diagnosis Report form dated 1/4/2017, Resident #4's diagnoses included Alzheimer's disease, anorexia, and abnormal weight loss. A Minimum Data Set (MDS) assessment with a reference date of 11/8/2016 identified Resident #4 with severely impaired cognitive skills and short and long term memory problems. The MDS indicated the resident required extensive assistance from 1 staff member with eating, documented a weight loss of 5% or more in the last month or a loss of 10% or more in the last 6 months and had not been on a physician prescribed weight loss program. A Physician's Order Report form dated 11/22/2016, included orders for a regular diet with pureed texture, liquefy the pureed texture if needed and a House Supplement, 240 cc (cubic centimeter, measurement of volume) three times a day. Resident #4's care plan, with a print date of 1/4/17, included a focus area for a self-care deficit related to Alzheimer's disease and an intervention for eating with the assistance of 1	F 325		

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F 325	Continued From page 19	F 325		

staff member.
A Bath and Weight Check List form dated 2016 included the following weight trends for Resident #4:
On 2/28/16 - 117 lbs. (pounds)
On 9/1/16 - 111 lbs.
On 10/11/16 - 103 lbs. [weight loss of 7.20 % in 41 days)
On 11/23/16 - 97 lbs. [weight loss of 5.82 % in 43 days.
On 12/29/16 - 95 lbs. [weight loss of 14.4 % in 3 months).
Review of the facility Dietitian Progress Notes identified the following:
On 10/17/16 at 10:51 A.M. the resident's food was liquefied at the table by staff at times. The resident is more willing to drink than eat at most meals.
On 10/31/16 at 12:08 P.M. the resident's condition has declined. Intake is very poor at meals. Weight 100 lbs., with a significant weight loss noted.
On 11/7/16 at 1:31 P.M. overall decline with admission to Hospice services. Weight 100 lbs. with a significant weight loss in 30 and 90 days. Average intake at meals is 21%. Continue with assistance at all meals.
On 12/12/16 at 1:22 P.M. - Meal intake very poor.
Observation on 1/4/17 at 7:58 A.M. identified Resident #4 sitting in a wheelchair at a round table in the dining room and no staff present at the table. Two plastic cups (contained 120 cc each) of house supplement drink, a 240 cc glass of orange juice, a 240 cc glass of water sat on the dining room table in front of the resident.
Observation on 1/4/17 at 8:40 A.M., (approximately 40 minutes later) identified dietary staff placed separate bowls of pureed sausage, pureed toast with jelly, pureed fruit, a bowl of

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F 325	Continued From page 20 oatmeal and a 240 cc glass of milk down on the table in front of the resident. Further observation revealed the resident unable to attempt to feed him/her. Observation identified 2 other residents sat across the table from Resident #4 while Staff A, Registered Nurse (RN)/ MDS Coordinator, sat between the 2 other resident's and assisted the other 2 residents with eating. At 8:42 A.M., Staff A stood up from her chair, walked around to the other side of the table, sat next to Resident #4 and assisted the resident with a drink of House Supplement and 1 bite of pureed fruit. Staff A attempted to give the resident another bite of pureed fruit and the resident refused to open his/her mouth. Staff A then assisted the resident with another drink of supplement. At 8:45 A.M., Staff A got up from her chair, walked around the other side of the table, sat down between the other 2 residents at the same table and assisted those 2 residents with eating. Observation of the entire dining room, revealed 2 nursing staff members assisting 8 residents at 3 different tables with eating assistance. Staff A at the same table as Resident #4, Staff B, Certified Nurse Aid (CNA) sat at a table across from Resident #4's table with 3 residents present and assisted 1 resident with eating and 2 residents sat a table behind Resident #4 with no staff present at the table. [Note: During interview on 1/4/17 at 9:16 A.M., Staff B, Licensed Practical Nurse (LPN) confirmed the 2 residents at the table behind Resident #4, all 3 residents at Resident #4's table required eating assistance from staff and the 3 residents at the table across form Resident #4's table required prompts and cues with eating] (even though Staff B assisted 1 of the residents who required prompts and cues, with eating assistance). Ongoing observation on 1/4/17 at 8:48 A.M.,	F 325		

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F 325	Continued From page 21 revealed Staff A sat down next to Resident #4 and assisted the resident with a drink of supplement. Two bites of pureed fruit another drink of supplement and Staff A moved back to the other side of the table at 8:51 A.M. At 8:55 A.M., Staff A sat down next to Resident #4 and assisted the resident with eating as follows: the resident refused a bite of fruit offered, took a drink of supplement, took 2 bites of fruit, took a drink of supplement and took 2 bites of fruit. Ongoing observation revealed the resident ate 100% of the pureed fruit and completed 1 glass of supplement. Neither staff A failed to offer the resident a bite of pureed sausage, toast or a bite of oatmeal nor did she offer a drink of orange juice, water or milk. At 9:00 A.M., Staff A moved back to the other side of the table to assist the other 2 residents at the table. At 9:05 A.M., Staff A sat down next to Resident #4 and the resident refused a drink of supplement, orange juice and a bite of pureed toast. Staff A attempted again to give the resident a drink of supplement, orange juice and a bite of toast and the resident refused. At 9:06 A.M., Staff A moved back to the other side of the table to assist the other 2 residents. At 9:08 A.M., Staff C, relieved Staff A at Resident #4's table and sat between the other 2 residents at the table. During an interview on 1/4/17 at 9:10 A.M., Staff A confirmed not normally helping out with assisting residents with feeding, but helps out when she can. Staff A stated normally 3 staff members assisted residents with eating, but felt the staff that typically assisted residents with eating had been slow getting to the dining room. Staff A stated she had not offered Resident #4 sausage, toast or cereal prior to 9:05 A.M., because she knew the resident liked fruit. An ongoing observation on 1/4/17 at 9:20 A.M.,	F 325		

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F 325	Continued From page 22 identified Staff B sat down next to Resident #4 and assisted the resident with 2 drinks of orange juice. Staff B attempted to give the resident 2 bites of pureed toast and the resident refused. At 9:23 A.M., (approximately 40 minutes after the resident's food had been served) Staff B mixed the milk at the table and sugar in a glass with oatmeal, liquefied the oatmeal, attempted to give the resident a drink of the liquefied oatmeal and the resident refused. At 9:25 A.M., Staff D, Dietary Cook, took the temperature of the resident's liquefied oatmeal and revealed a temperature of 83.6 degrees Fahrenheit (F). Staff D took the temperature of the resident's pureed sausage at the table and revealed a temperature of 73.4 degrees F. (Note: During interview on 1/4/17 at 9:25 A.M., and review of a Food Temperature Log, Staff D reported the temperature of the resident's pureed sausage prior to serving at 169 degrees F and the resident's cereal at 177 degrees F). Ongoing observation identified Staff B left the resident's table at 9:25 A.M., and went to the kitchen service window. At 9:40 A.M., Resident #4 remained at the dining room table with his/her eyes closed and no assistance from staff with eating. At 9:50 A.M., Staff B returned to the resident's table with fresh, warm oatmeal and a 240 cc glass of milk. Staff C placed a fresh 120 cc glass of supplement at the table. Staff B liquefied the cereal with milk, fed the resident the freshly liquefied oatmeal with drinks of supplement in between. At 10:19 A.M., (greater than 2 hours after the resident had been first noted at the dining room table and with consistent help in eating), the resident finished eating approximately 75 % of the oatmeal, 100 % of the supplement and 100% of the fresh milk. During an interview on 1/4/17 at 10:40 A.M., Staff	F 325		

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F 325	Continued From page 23 C (licensed practical nurse) stated on a typical day, the facility provided 2-4 nursing staff to assist with feeding residents at meals. Staff C confirmed if her own parent sat at dining room table for greater than 2 hours without consistent staff assistance with eating, she would feel upset. During an interview on 1/4/17 at 10:45 A.M., the facility Director of Nursing Services (DNS), confirmed 3 CNAs with the help of a nurse, needed to be in the dining room to assist residents with eating. During an interview on 1/4/17 at 12:55 P.M., Staff B (certified nursing assistant) confirmed the residents who required assistance with eating, probably had not received the help they needed on 1/4/17 at breakfast.	F 325		

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Preparation and execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. For the purposes of any allegation, that the center is now in substantial compliance with federal requirements of participation, this response and plan of correction constitutes the center's allegation of compliance in accordance with section 7305 of the State Operations Manual.

F 279

1. Resident #2 care plan was updated with interventions to prevent skin breakdown/pressure ulcers on 10/17/2016 and again on 01/23/2017 by the Director of Nursing.
2. All residents at risk for skin breakdown/pressure ulcers could be affected. Residents identified by the Charge Nurse on 01/23/2017.
3. All nursing staff were reeducated regarding the need to care plan residents who are at risk for skin breakdown/pressure ulcers and add interventions for prevention to those care plans per the Good Samaritan Society's, "Pressure Ulcer Practice Guidelines" on 01/27/2017 by the Staff Development Educator/Charge Nurse.
4. Audits monitoring care plans for prevention interventions on those residents at risk for skin breakdown/pressure ulcers will be done by the Director of Nurses/designee weekly x4, bi weekly x2, monthly x3 then brought to the Quality Assurance and Performance Improvement committee for further recommendations.
5. Completion date: 01/27/2017.

F 282

1. All nursing staff were reeducated regarding the need to call for help with feeding of residents in the dining room when not enough staff present and specifically regarding resident #4 on 01/04/2017 by the Staff Development Educator/Charge Nurse.
2. All residents needing feeding assistance could be affected. Residents identified on 01/23/2017 by the Charge Nurse.

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3. All nursing staff reeducated regarding the need to have ample staff to feed residents according to their care plans and according to the Good Samaritan Society's, "Dining Room Service" procedure and if there are not enough staff at the time of service, they are to call using their 2 way radios/overhead system to alert more staff on 01/27/2017 by the Staff Development Educator/Charge Nurse.
4. Audits by the Director of Nurses/designee monitoring 5 random mealtimes for adequate feeding assistants will be done weekly x4, bi weekly x2, monthly x3 then brought to the Quality Assurance and Performance Improvement committee for further recommendations.
5. Completion date: 01/27/2017

F 314

1. On 10/17/2016 the Minimum Data Set Coordinator was reeducated by the Director of Nursing regarding the need to put skin breakdown/pressure ulcer prevention interventions on resident #2 care plan immediately when she was identified at risk.
2. All residents at risk for skin breakdown/pressure ulcers could be affected. Residents identified on 01/23/2017 by the Charge Nurse.
3. All nursing staff were reeducated regarding the need to care plan residents who are at risk for skin breakdown/pressure ulcers and add interventions for prevention to those care plans and also add any podiatrist and/or wound nurse orders/recommendations to the care plan per the Good Samaritan Society's, "Pressure Ulcer Practice Guidelines" and "Pressure Ulcers" policy on 01/27/2017 by the Staff Development Educator/Charge Nurse.
4. Audits monitoring compliance of care planned interventions and follow through of orders for residents with pressure ulcers/skin break down will be done on 3 random residents weekly x4, bi weekly x2, monthly x3 then brought to the Quality Assurance and Performance Improvement committee for further recommendations.
5. Completion date : 1/18/17

F 325

1. All nursing staff were reeducated on 01/04/2017 regarding the need to call for help with feeding of residents in the dining room when not enough staff present and specifically regarding resident #4 by Charge Nurse.
2. All residents needing feeding assistance could be affected. Residents identified on 01/23/2017 by Charge Nurse.

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3. All nursing staff were reeducated regarding the need to have ample staff to feed residents according to their care plans and according to the Good Samaritan Society's, "Dining Room Service" procedure and if there are not enough staff at the time of service, they are to call using their 2 way radios/overhead system to alert more staff on 01/27/2017 by the Staff Development Educator/Charge Nurse.
4. Audits by the Director of Nurses/designee monitoring 5 random mealtimes for adequate feeding assistants will be done weekly x4, bi weekly x2, monthly x3 then brought to the Quality Assurance and Performance Improvement committee for further recommendations.
5. Completion date: 1/18/17