

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

PRINTED: 08/09/2012
FORM APPROVED
OMB NO. 0938-0391

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345406 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | (X3) DATE SURVEY COMPLETED C 07/28/2012 |
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| NAME OF PROVIDER OR SUPPLIER CHARLOTTE HEALTH CARE CENTER | STREET ADDRESS, CITY, STATE, ZIP CODE 1736 TODDVILLE RD CHARLOTTE, NC 28214 |
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| F 309 SS=D | <p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING</p> <p>Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews the facility failed to implement physician orders for one (1) of three (3) sampled residents reviewed for well-being. Resident #53 was not taken to the dining room for meals as specified by physician orders.</p> <p>The findings are:</p> <p>Resident #53 was originally admitted to the facility on 4/30/12 with diagnoses which included Chronic Obstructive Pulmonary Disease (COPD) and dementia.</p> <p>Review of the Minimum Data Set (MDS) dated 5/7/12 revealed Resident #53 was severely impaired in cognition and needed extensive assistance in all Activities of Daily Living (ADLs) with one person physical assistance.</p> <p>Review of the Nutrition Care Area Assessment Summary (CAAS) dated 5/7/12 revealed the resident was on a mechanical soft diet and being followed by speech language pathologists due to pocketing food.</p> | F 309 | <p>The statements made in this plan of correction are not an admission and do not constitute agreement with the alleged deficiencies herein.</p> <p>To remain in compliance with all state and federal regulations, the center has taken or will take the actions set forth in this Plan of Correction. In addition, the following plan constitutes the center's allegation of compliance. All alleged deficiencies have been or will be corrected by the dates indicated.</p> <p>F309</p> <p>This facility does understand that each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> | 8/25/12 |
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| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Laura P. [Signature]</i> , MSNS, LANA | TITLE ADMINISTRATOR | (X8) DATE 8/16/12 |
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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 309 | Continued From page 1 Record review revealed Resident #53 was readmitted on 5/23/12 with diagnoses which included altered mental status, hypoxia, Alzheimer's dementia and COPD exacerbation. Review of a physician order dated 5/24/12 revealed Resident #53 was to eat all meals on second dining in order to increase his arousal, safety, and to provide physical assistance as needed for increased oral intake. Review of the MDS dated 5/30/12 documented Resident #53 was severely impaired in cognition and needed extensive assistance in all ADLs including eating, with one person assist due to holding food in mouth/cheeks or residual food in mouth after meals. Review of a Speech Therapy (ST) note dated 5/25/12 documented Resident #53 was seen for therapy. The note specified the resident became attentive once awakened and the position in bed was adjusted to sit in a more upright position for safety and efficiency during an oral trial. The Resident required maximum assistance through out the meal, required moderate verbal cues to attend to the meal and continue to eat until meal completed. The ST plan of care short term goal was for the resident to sit upright in chair while eating. Review of a ST note dated 5/30/12 documented the Resident should remain upright at all times for meals. Review of a nursing Progress Notes (PN) dated 7/12/12 documented the resident continued to | F 309 | How the corrective action will be accomplished for the resident(s) affected. Resident #53 is taken to the dining room for all meals unless resident refuses. If resident refuses, assistance will be provided in the room. How corrective action will be accomplished for those residents with the potential to be affected by the same practice. An audit of current residents was conducted on 8/7/12 to identify other residents with the potential to be affected by the alleged deficient practice and immediate corrections were made to the patient care guide as indicated. Measures in place to ensure practices will not occur. Licensed nursing staff and therapy staff received education on the processing and communication of dining orders; completed by 8/24/12. The Director of Rehabilitation (DOR) and the Director of Nursing (DON) will check physician orders for appropriateness and interventions | 8/25/12 | |

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| F 309 | Continued From page 2 need verbal cuing at meal times. Review of a PN dated 7/21/12 documented the Resident needed verbal cuing daily at meal times and tolerated his meals in the dining room during the day. Observation revealed Resident #53 in bed with a meal tray sitting on the over bed table on 7/24/12 at 12:30 PM, 7/25/12 at 8:30 AM, 7/26/12 at 12:30 PM, and 7/27/12 at 12:30 PM. The head of the bed was approximately 30 degrees and the resident was leaning slightly on one elbow while eating with the other hand. No observations were noted of staff assisting or encouraging the resident. During an interview on 7/28/12 at 9:40 a.m., Nurse Aide (NA) #1 stated Resident #53 needed encouragement and reminders but could feed himself most days. NA #1 was not aware of the Resident's need to be out of bed and in the dining room for meals. During an interview on 7/28/12 at 11:00 AM, the Unit Manager stated it appeared no one knew about the order to have Resident #53 in the dining room for meals and at the time of that order there was no system in place to check and verify orders. During an interview on 7/28/12 at 2 PM, the Director of Nursing (DON) stated it appeared the order to have the resident up in the dining room may not have gotten onto the resident's care guide. The DON further stated there appeared to be a breakdown in the communication of the staff that need to know. | F 309 | to be placed on the patient care guide for 5 times a week for 2 weeks, 3 times a week for 2 weeks, and 1 time a week for 2 weeks. Any staff found to be deficient in practice will be disciplined using the progressive discipline process. How the facility plans to monitor and ensure correction is achieved and sustained. The DOR and DON will monitor the orders for six weeks as indicated above and report any patterns or trends to the quality assurance committee. The quality assurance committee will determine if further education or systemic changes are needed. | 8/25/12 |
| F 315 SS=D | 483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER | F 315 | F315 This facility does understand that based on the resident comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was | 8/25/12 |

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| F 315 | <p>Continued From page 3</p> <p>Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews the facility failed to provide incontinence care to prevent possible infections for one (1) of three (3) sampled residents. (Resident #78).</p> <p>The findings are:</p> <p>Resident #78 was admitted to the facility with diagnoses including dementia and Parkinson's disease. A quarterly Minimum Data Set (MDS) dated 6/20/12 indicated Resident #78 had short and long-term memory problems and had moderately impaired cognitive skills for daily decision making. The resident was totally dependent for most activities of daily living (ADLs) which included toileting. Resident #78 was incontinent of bowel and bladder.</p> <p>A review of the Care Area Assessment Summary (CAAS) dated 1/20/12 documented that all toileting/hygiene was performed by staff for Resident #78. A review of the resident's care</p> | F 315 | <p>necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.</p> <p>How the corrective action will be accomplished for the resident(s) affected. For resident #78 the staff member who provided the incontinence care was counseled and educated on the proper procedure.</p> <p>How corrective action will be accomplished for those residents with the potential to be affected by the same practice. To identify other residents with the potential to be affected by the same alleged deficient practice, facility licensed nursing staff did a peri-care observation of facility certified nursing assistants (CNA) with immediate corrections and instruction as indicated; will be completed by 8/24/12.</p> <p>Measures in place to ensure practices will not occur. Facility certified nursing assistants</p> | 8/28/12 |
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| F 315 | <p>Continued From page 4</p> <p>plan updated on 5/17/12 noted a history of urinary tract infections (UTIs) and that staff would cleanse the perineal area after each episode of incontinence and maintain good hygiene and peri-care.</p> <p>A review of physician orders for Resident #78 revealed antibiotic therapy was started on 5/18/12 and 7/08/12 for a diagnosis of UTI.</p> <p>A review of the facility's policy for perineal care, which is the Mosby's Textbook for Long-Term Care Nursing Assistants, Sixth Edition, noted that the procedure for female residents included "clean the rectal area, clean from the vagina to the anus with one stroke and repeat until the area is clean".</p> <p>An observation on 7/26/12 at 9:40 AM revealed Nurse Aide (NA) #3 and NA #4 assisted Resident #78 onto the toilet. The resident had a bowel movement and stood with assistance in front of the toilet to be cleaned. NA #3 sprayed no-rinse cleaner onto the resident's bottom and took a clean wipe, using a downward motion, from the anus toward the vagina (back to front). NA #3 repeated the process with a clean wipe, using a downward motion, back to front. NA #3 again applied the spray cleaner, and NA #4 stated quietly, "front to back". NA #3 proceeded to clean the resident using an upward motion, from the vagina toward the anus, front to back, from that moment forward.</p> <p>During an interview on 7/26/12 at 9:55 AM, NA #4 stated that she observed NA #3 wipe back to front, twice, when cleaning the resident, and then I told her, "front to back".</p> | F 315 | <p>received education on perineal care as outlined in the Mosby Textbook for Long-Term Care Nursing Assistants; completed by 8/24/12. Facility licensed nurses will monitor CNA pericare on various shifts using the Perineal Care Skills Checklist for 5 times a week for 2 weeks, 3 times a week for 2 weeks, and 1 time a week for 2 weeks. Any staff found to be deficient in practice will be disciplined using the progressive discipline process.</p> <p>How the facility plans to monitor and ensure correction is achieved and sustained. The DON will monitor the checklist forms completed by the licensed nursing staff for six weeks as indicated above and report any patterns or trends to the quality assurance committee. The quality assurance committee will determine if further education or systemic changes are needed.</p> | 8/25/12 |

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| F 315 | Continued From page 5 During an interview on 7/26/12 at 9:58 AM, NA #3 stated that she did wipe resident from back to front twice when cleaning stool. NA #3 stated that she was just trying to get the stool off the resident and when NA #4 stated "front to back", I corrected my wiping motion to front to back. NA #3 also stated that she had been instructed to clean residents "front to back". During an interview on 7/28/12 at 2:46 PM, the Director of Nursing (DON) stated that it was her expectation that staff follow facility policy in regards to incontinence care and toileting. The DON also stated that staff members should wipe front to back when providing peri-care. | F 315 | | 8/25/12 |
| 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 observations, interviews and medical record review, the facility failed to provide staff assistance during meals as indicated by the residents assessment, care plan and orders for | F 325 | F325 The facility understands that based on a resident's comprehensive assessment, the facility must ensure that a resident receives a therapeutic diet when there is a nutritional problem. How the corrective action will be accomplished for the resident(s) affected. Resident #64 is taken to the dining room and receives assistance at all meals unless resident refuses. If resident refuses, assistance will be provided in the room. | 8/25/12 |

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| F 325 | <p>Continued From page 6</p> <p>one (1) of four (4) sampled residents (Resident #64).</p> <p>The findings are:</p> <p>Resident #64 was admitted to the facility in July 2011 with diagnoses including dementia and Parkinson's disease. The most recent significant change Minimum Data Set dated 7/04/12 revealed that Resident #64 had moderately impaired cognition and required supervision and set up assistance with eating. Review of his care plan dated 5/17/12 revealed Resident #64 was not at his optimal level of function due to his decreased ability to feed himself, poor intake, fluctuating weight, and was currently underweight. Care plan goals included avoiding significant weight loss with no specified target weight. Interventions included providing the Resident encouragement and assistance to complete his meals/fluids and seating him during the second seating in the dining room</p> <p>Review of his medical record revealed a nutrition assessment dated 4/8/12; his weight was assessed at 137 pounds with an ideal body weight of 166 pounds plus or minus 10 percent (%). He was assessed as underweight. The assessment documented that Resident #64 ate 75% of most meals/supplements and that his current diet order was sufficient to meet his nutritional needs.</p> <p>His medical record showed that as of 6/04/12 his weight was 128 pounds (6.57% weight loss from 4/08/12). On 7/23/12 Resident #64's weight was documented as 118 pounds (13.84% weight loss from 4/08/12).</p> | F 325 | <p>How corrective action will be accomplished for those residents with the potential to be affected by the same practice. An audit of current residents with weight loss will be conducted by 8/22/12 to identify other residents with the potential to be affected by the alleged deficient practice with immediate corrections as indicated.</p> <p>Measures in place to ensure practices will not occur. Licensed nursing staff, Certified Nursing Assistants, Dietary, Speech and Occupational therapy staff received education on Ensuring a Dining Experience including how diets are not just for weight loss, maintaining nutrition in the elderly, and preventing malnutrition; completed 8/24/12. The Certified Dietary Manager (CDM) and the Director of Nursing (DON) will monitor meals and document findings using the meal rounds evaluation, which includes adequate resident assistance, for 5 times a week for</p> | 8/25/12 | |

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| F 325 | Continued From page 7 A nurse practitioner's (NP) note dated 6/06/12 documented that Resident #64 had lost 16 pounds. An NP's order was written to seat the Resident in the second dining so staff could feed him. On 7/27/12 at 12:00 PM Resident #64 was observed seated in the main dining room during the first seating for lunch. He ate alone and received no staff assistance. On 7/27/12 at 2:03 PM a nursing assistant (NA) #1 was interviewed. NA #1 stated that Resident #64 was taken to the first seating for all three meals. She stated that he was a "picky eater" with most food ending up on the floor and that the staff needed to help him sometimes due to increased shaking. NA #1 stated that Resident #64 preferred having someone eat with him and with assistance and encouragement he tended to eat more. On 7/27/12 at 2:30 PM NA #1 was observed weighing Resident #64 on an electronic scale and obtained a weight of 117 pounds (14.60% weight loss from 4/08/12). On 7/27/12 at 4:30 PM the NP was interviewed. During the interview the NP stated that she evaluated Resident #64 on 6/06/12 and wrote the order for him to sit in the second dining and to increase the frequency of his nutritional supplement to TID. The NP stated that the resident tolerated the supplement well and that if staff sat with him and assisted him during meals he ate better. | F 325 | 2 weeks, 3 times a week for 2 weeks, and 1 time a week for 2 weeks. Any staff found to be deficient in practice will be disciplined using the progressive discipline process. How the facility plans to monitor and ensure correction is achieved and sustained. The CDM and DON will monitor as indicated above and report any patterns or trends to the quality assurance committee. The quality assurance committee will determine if further education or systemic changes are needed. | 8/25/12 | |

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| F 325 | <p>Continued From page 8</p> <p>During an interview with the certified dietary manager (CDM) on 7/27/12 at 4:50 PM, she reviewed an electronic note by the weight team dated 7/06/12 that stated Resident #64 was encouraged to sit at the second seating for dining. The CDM stated that residents assigned to the second seating received increased feeding assistance. The CDM reviewed the tray card for Resident #64 and confirmed he was assigned to the first seating in the dining room, not the second.</p> <p>On 7/27/12 at 6:30 PM Resident #64 was observed seated in the main dining room during the first seating for dinner. He ate alone and received no staff assistance.</p> <p>On 7/28/12 at 8:00 AM Resident #64 was observed seated in the main dining room during the first seating for breakfast. He ate alone and received no staff assistance.</p> <p>On 7/28/12 at 9:47 AM NA #2 was interviewed. NA #2 stated that Resident #64 ate during the first dining for all meals, required supervision, encouragement to open his mouth and that there were times when he was fed. NA #2 stated that with supervision and encouragement Resident #64 would eat approximately 75% of his meal.</p> <p>On 7/28/12 at 12:10 PM Resident #64 was observed seated in the main dining room during the first seating for lunch. He ate alone and received no staff assistance.</p> <p>On 7/28/12 at 2:40 PM the Director of Nursing (DON), Nursing Consultant and Quality Improvement (QI) Representative were</p> | F 325 | F325 (see pages 6 – 8) | 8/25/12 | |

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| F 325 | Continued From page 9 interviewed. The DON stated that she expected a dietary order for a resident to eat during second dining to be documented in the nursing unit's Dietary Communication Log Book for dietary and nursing staff awareness. The DON, Nurse Consultant and QI representative all agreed that the dietary order as written by the nurse practitioner should have been carried out. | F 325 | | 8/25/12 | |
| 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, staff interviews, review of menus and facility policy, the facility failed to provide sausage gravy and biscuits according to the approved menu. Sausage gravy was not provided during a breakfast meal in portion sizes according to the menu. Biscuits were not provided to Resident #67 according to the menu. The findings are: 1. A facility policy, undated, titled "Dietary Services Policies and Procedures, Meal Service, Portion Control" recorded in part, "Standard portion control utensils shall be used to serve patients all foods on the menus. The dietary staff responsible for serving a meal shall assemble all portion control utensils prior to the start of the | F 363 | F363 The facility understands that 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. The staff member who did not provide the correct portion of the sausage gravy to the residents was counseled. How the corrective action will be accomplished for the resident(s) affected. The staff members who did not provide the biscuits for Resident #67 were counseled. How corrective action will be accomplished for those residents with the potential to be affected by the same practice. Residents who | 8/25/12 | |

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| F 363 | <p>Continued From page 10</p> <p>meal service, checking all diets on the spreadsheet menu for that particular meal."</p> <p>A continuous breakfast meal observation of the tray line occurred on 7/26/12 at 7:50 - 8:28 AM. Review of the breakfast menu, the diet spreadsheet and the list of residents' diets based on census, revealed 75 residents on a regular or mechanical soft diet and 12 residents on a pureed diet would receive a four ounce portion (regular/mechanical soft) or six ounce portion (pureed) of sausage gravy served over a biscuit. On 7/26/12 dietary staff #1 was observed to serve a two ounce portion of sausage gravy to residents receiving regular, mechanical soft and pureed diets.</p> <p>An interview with dietary staff #1 on 7/26/12 at 8:20 AM revealed that she thought the serving size for meat was a two ounce portion. Dietary staff #1 stated that she knew to use the menu when setting up the tray line, but she just thought the portion size for all meats was two ounces.</p> <p>An interview with the Certified Dietary Manager (CDM) on 7/26/12 at 8:21 AM revealed that she was responsible for monitoring the portion sizes served at meals, but she did not check the utensils used for breakfast that morning. The CDM confirmed that staff were trained to reference the menu when setting up the tray line and to make sure the correct portion size of foods was served.</p> <p>An interview with the corporate registered dietitian (RD) on 7/28/12 at 11:30 AM revealed that staff should monitor the tray line for portions and provide portions per the diet spreadsheet.</p> | F 363 | <p>did not receive the correct portion of sausage gravy at breakfast on 7/26/12 were provided an additional serving of protein at the dinner meal service to ensure the protein amount for the day was received, as presented during survey.</p> <p>No other residents were affected by the alleged deficient practice of not receiving menu items as observed during survey.</p> <p>Measures in place to ensure practices will not occur. Facility dietary staff received education regarding the facility policy on portion control and food preparation and quality control; completed by 8/24/12. The production sheet will be hung in the kitchen in front of the cook during meal service instead of placed in a binder; effective 8/22/12. The Certified Dietary Manager (CDM) will conduct tray accuracy evaluations for 5 times a week for 2 weeks, 3 times a week for 2 weeks, and 1 time a week for 2 weeks. Any staff found to</p> | 8/25/12 | |

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| F 363 | Continued From page 11 2. A continuous breakfast meal observation of the tray line occurred on 7/26/12 at 7:50 - 8:28 AM. Review of the breakfast menu, the diet spreadsheet and the list of residents' diets revealed residents served a mechanical soft diet would receive sausage gravy and biscuits. During the tray line observation a mechanical soft breakfast was plated for Resident #67. Dietary staff #1 was observed to inform the CDM that no more biscuits were available on the tray line. On 7/26/12 at 8:25 AM, during an interview with the CDM she stated "We ran out of biscuits, so we will serve toast points to this Resident." A mechanical soft breakfast with toast points and sausage gravy was plated for Resident #67 and placed on the delivery cart for service. The breakfast tray line ended on 7/26/12 at 8:26 AM. Interview with dietary staff #1 and the CDM on 7/26/12 at 8:28 AM revealed that in the past when this meal was served, a lot of biscuits were left over, but today fewer biscuits were prepared to decrease waste. The CDM confirmed that more biscuits were available in the freezer and only took ten minutes to prepare. On 7/26/12 at 8:48 AM Resident #67 was observed in the main dining room receiving feeding assistance from staff. The Resident received sausage gravy over toast. When asked, the Resident stated she would have preferred to receive a biscuit with the sausage gravy instead of toast. During an interview with the corporate RD on | F 363 | be deficient in practice will be disciplined using the progressive discipline process. How the facility plans to monitor and ensure correction is achieved and sustained. The CDM will monitor as indicated above and report any patterns or trends to the quality assurance committee. The quality assurance committee will determine if further education or systemic changes are needed. | 8/25/12 | |

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| F 363 | Continued From page 12 7/28/12 at 11:30 AM the corporate RD confirmed that if staff run out of a food item on the tray line, the resident should be asked their preference and should receive the food item per their request. | F 363 | | 8/25/12 | |
| F 367 SS=D | 483.35(e) THERAPEUTIC DIET PRESCRIBED BY PHYSICIAN Therapeutic diets must be prescribed by the attending physician. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interviews and review of the medical record the facility failed to provide a therapeutic diet as ordered for one of two sampled residents. (Resident #44) The findings are: Resident #44 was admitted to the facility with diagnoses that included end stage renal disease with hemodialysis three times weekly, congestive heart failure, hypercholesterolemia and atrial fibrillation. Medical record review revealed lab results dated 5/24/12, which recorded that Resident #44 had a potassium level of 4.8. Continued review of the medical record for Resident #44 revealed a physician's order from the dialysis center dated 6/7/12 that recorded a request to provide the Resident with a 2 gram potassium restricted diet due to an elevated potassium level of 6.0 on 5/29/12. | F 367 | F367 The facility understands that therapeutic diets must be prescribed by the attending physician. How the corrective action will be accomplished for the resident(s) affected. Resident #44 diet order was changed to a regular diet per physician order after discussion with the dialysis center on 7/27/12, as presented during survey. How corrective action will be accomplished for those residents with the potential to be affected by the same practice. To identify residents with the potential to be affected by the same deficient practice, the CDM did an audit of current dialysis resident's tray cards to physician orders by 8/22/12; with immediate corrections as indicated. Measures in place to ensure practices will not occur. Facility licensed nursing staff and dietary staff received education on the | 8/25/12 | |

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| F 367 | <p>Continued From page 13</p> <p>Lab results dated 6/11/12 revealed Resident #44 had a potassium level of 5.1.</p> <p>Further review revealed a second physician's order dated 6/14/12 for a 2 gram potassium restricted diet and recorded that the potassium level drawn on 6/12/12 at the dialysis center was high at 5.6. The order also recorded that Resident #44 reported to the dialysis center that he had received tomatoes and potatoes at the facility.</p> <p>A dietary communication form dated 6/17/12 recorded that Resident #44 would receive a 2 gram potassium restricted diet.</p> <p>On 7/26/12 at 9:04 AM and 7/27/12 at 9:04 AM, Resident #44 was observed with his breakfast meal. Review of his tray card recorded that he received a 2 gram sodium restricted diet with no bacon or sausage. There were no restrictions recorded for potassium rich foods.</p> <p>During an interview with the certified dietary manager (CDM) and the consulting registered dietitian (RD) on 7/27/12 at 9:52 AM, they both confirmed that Resident #44 currently received a 2 gram sodium restricted diet. They stated they were not aware that the Resident was to receive a 2 gram potassium restricted diet. The consulting RD stated that the effects of not receiving a potassium restricted diet could present some heart problems for a dialysis resident. The consulting RD further stated that ideally a resident receiving dialysis should have a potassium level of 4 to 4.7 and we would not want the potassium to rise to a level of 6. The consulting RD also stated that a potassium restricted diet should eliminate several things</p> | F 367 | <p>facility's regular diet being a healthful, consistent carbohydrate, low fat, low sodium diet as well as the more restrictive diets we offer if a physician requests more a restrictive diet; completed by 8/24/12. Facility dietary staff also received education on the processing of diet orders; completed by 8/24/12. The Certified Dietary Manager (CDM) will verify dietary communication slips to physician orders and to tray cards for 5 times a week for 2 weeks, 3 times a week for 2 weeks, and 1 time a week for 2 weeks. Any staff found to be deficient in practice will be disciplined using the progressive discipline process.</p> <p>How the facility plans to monitor and ensure correction is achieved and sustained. The CDM will monitor as indicated above and report any patterns or trends to the quality assurance committee. The quality assurance committee will determine if further education or systemic changes are needed.</p> | 8/25/12 |

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| F 367 | Continued From page 14 including potatoes and tomato products. On 7/27/12 at 12:00 PM, Resident #44 stated that he had routinely received tomatoes and potatoes since he was admitted to the facility. He stated he did not remember who, but knew someone told him these foods were not good for him. The director of nursing (DON) was interviewed on 7/27/12 at 3:22 PM and stated that if a new order for a diet change was received, the nurse would remove the order from the fax machine and implement the order by writing a dietary communication form for the new diet order and give the diet order to dietary. The DON stated Resident #44 should have received the 2 gram potassium restricted diet as ordered. An interview with the CDM on 7/27/12 at 5:28 PM revealed that the CDM and the cooks were responsible for inputting diets from the dietary communication form into the computer. The CDM stated she could not locate the dietary communication slip which recorded a 2 gram potassium restricted diet for Resident #44 and could not explain why he was receiving a 2 gram sodium restricted diet instead. The CDM stated that routine diet audits were completed and the last diet audit was done on 6/24/12 by the previous RD. She stated this error was missed. An interview with the corporate RD occurred on 7/28/12 at 11:30 AM and revealed that Resident #44 should have been placed on a renal diet until staff contacted the dialysis center and received clarification on his diet. | F 367 | | 8/25/12 | |
| F 371 SS=D | 483.35(j) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY | F 371 | F371 The facility understands that it is required to procure food from sources approved or considered satisfactory by Federal, State, or local authorities; and store, prepare, distribute and serve food under sanitary conditions. | 8/25/12 | |

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| F 371 | <p>Continued From page 15</p> <p>The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and interviews with staff, the facility failed to discard six quart sized containers of a dairy product that was stored beyond the manufacturer's use by date. The containers of half and half were observed stored with a bulging/inflated appearance.</p> <p>The findings are: Six quart sized containers of half and half (a dairy product) were observed on 7/24/12 at 9:00 AM stored in the reachin refrigerator available for use. Four containers revealed a manufacturer's date stamp of 7/14/12 and two containers revealed a manufacturer's date stamp of 7/16/12. Each container was observed with a bulging/inflated appearance. The certified dietary manager (CDM) was interviewed during the observation and stated that a team effort was made to monitor the refrigeration units for expired items. She stated that the half and half was available for staff to use when baking cakes. She further stated, "I will just throw the containers away to be safe." The CDM was observed to discard the six containers of half</p> | F 371 | <p>How the corrective action will be accomplished for the resident(s) affected. The six quart sized containers of half and half were discarded immediately, as observed during survey.</p> <p>How corrective action will be accomplished for those residents with the potential to be affected by the same practice. No residents were affected by the alleged deficient practice; the six quart sized containers of half and half were never opened, as observed during survey.</p> <p>Measures in place to ensure practices will not occur. Facility dietary staff received education on use by dates, storage of refrigerated items, and rotating stock; completed by 8/24/12. The Certified Dietary Manager will conduct a sanitation audit of the kitchen, including refrigerated items twice a week for six weeks. Any staff found to be deficient in practice will be disciplined using the progressive discipline process.</p> | 8/25/12 |

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| F 371 | Continued From page 16 and half. On 7/26/12 at 11:45 AM a follow-up interview with the CDM occurred and revealed that the date stamped on the six containers of half and half was the manufacturer's recommended use by date. She further stated that dairy products should be discarded per manufacturer's recommendations with an additional seven day window if the item was unopened and showed no signs of expiration. The CDM stated she was not sure why the six containers of half and half were not discarded. | F 371 | How the facility plans to monitor and ensure correction is achieved and sustained. The CDM will monitor as indicated above and report any patterns or trends to the quality assurance committee. The quality assurance committee will determine if further education or systemic changes are needed. | 8/25/12 | |