STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056158	A. BUILDING _____ B. WING _____	08/04/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COLLEGE OAK NURSING & REHABILITATION CENTER	4635 COLLEGE OAK DRIVE SACRAMENTO, CA 95841

(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 The following reflects the findings of the California Department of Public Health during a recertification survey from 8/2/11 to 8/4/11. Representing the Department of Public Health: HFEN 2171/26663 HFEN 2141/26367 HFEN 2377/28392 HFEN 1949/29824 HFEN 2426/28991 The facility census was 85 and the sample size was 17. The following abbreviations were used in this report: AD- Activity Director ADL- Activity of Daily Living (grooming, eating, dressing, walking) Admin- Administrator cm- centimeters, 1 cm equals less than 1/2 inch CNA- Certified Nursing Assistant DC- Discharge DON- Director of Nurses IDT - Interdisciplinary Team LN- Licensed Nurse OT - Occupational Therapy/therapist MAR- Medication Administration Record MD- Medical Doctor MDS- Minimum Data Set, an assessment tool for care planning MDSC- Minimum Data Set Coordinator RP - Responsible Party	F 000	Preparation and/ or execution of this Plan of Correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth on the Statement of Deficiencies. This Plan of Correction is prepared and/ or executed solely because required by the provisions of Health and Safety Code Section 1280 and 42 CFR 405.1907.	
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES	F 226		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Tina Kaplan — TITLE: Administrator — (X6) DATE: 8/24/11

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 226	Continued From page 1 The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to implement its abuse prevention policy for 2 of 17 sampled residents (11 & 14) when their injuries of unknown origin were not investigated for possible abuse and the injuries were not reported to the State agency. Findings: 1. Resident 11 was admitted to the facility on 7/14/09 with diagnoses which included dementia with behavioral disturbances. During the Abuse Prohibition record review an occurrence of an injury of unknown origin, dated 8/14/10 for Resident 11, was reviewed. The report revealed the resident was found walking in the hall at 9:15 p.m. with blood on her hands and blouse and was found to have bled from her ear. The resident was not able to describe how she was injured. Review of the clinical record for Resident 11 included: -Nurse's Notes dated 8/14/10 described finding the resident with blood and "noted a small bump 0.4 x 0.5 cm scrape on the back of her head with scanty bleeding noted. Right ear noted draining a small amount of bright red blood...[complained of]	F 226	F226 (1.) **Corrected Action for Affected Residents**: The facility policy was modified to include language identical to the federal interpretive guidelines defining "Injuries of Unknown Source". The Incident Reports reviewed by surveyors were not considered allegations of abuse, so the Abuse Investigation Form was not implemented. The Incident Reports reviewed were regarding unwitnessed injuries and these situations did not meet the Federal definition of "Injuries of unknown source" where both of the conditions set forth in the Interpretive Guidelines were present. Resident 11 had a falls care plan in place because she was known to be falling multiple times per day. All staff interviewed throughout the survey clearly remembered this resident's falling behaviors. **Identification of Other Potential Residents:** All unwitnessed injuries will be investigated. **Systemic Measures in Place to Ensure Deficient Practice Does Not Recur:** The facility policy has been revised to include an investigation of any unwitnessed injury to determine whether it meets the federal interpretive guidelines for "injuries of unknown source". Reasoning for	8/22/2011 8/22/2011 and ongoing 8/22/2011 And ongoing

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F 226	Continued From page 2 mild pain on the back of her head." -Emergency room instructions, dated 8/15/10, which indicated the resident had a perforated eardrum. -An X-Ray report, dated 8/15/10, from the emergency room which described a "prominent" bruise on the back of the resident's head. -A Non-Pressure Sore Skin Problem Report, dated 8/15/10, described a bruise on the back of her head measuring "13 x 13 cm...with scrapes in the center and scant bleeding." -IDT Post Bruise/Skin Tear Assessment, dated 8/17/10, which was a team review of the injury on 8/14/11. This report did not describe how the injury occurred or an investigation. Review of the facility investigative file for Resident 11's injuries of 8/14/10 indicated the event was not witnessed and the source of the injury was "unknown." The investigation form did not include any interviews of staff or residents in the area that night and did not document an investigation into the source of her injuries. In an interview with LN 1 on 8/3/11 at 2:30 p.m. she stated, "If I don't know where a resident injury came from I need to notify the Ombudsman and complete an incident report." Review of facility policy titled Abuse, Prevention of, undated, revealed: -"Complaints, observations, suspicions, or reporting of incidents, falls, bruised and skin tears (of suspicious or unknown origin) will be investigated to rule out abuse." -"Falls and bruises and skin tears of unknown origin will be investigated to rule out abuse." -"The investigation and report shall	F 226	whether an injury is of unknown source will be documented and submitted to the administrator for review and signature. **Monitoring Plan:** The Accident and Incident logs are summarized and reviewed for trends on a monthly basis by the DON and quarterly by the QA Committee.	8/22/2011 And ongoing

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F 226	Continued From page 3 include:...circumstances surrounding the incident; names of witnesses and their account when applicable....outcome of investigation..." -"Administrator shall report all incidents of alleged abuse or suspected abuse to DPH [Department of Public Health, the State agency] within 24 hours...and the results of the investigation to DHS [Department of Health Services, the former name of DPH] within 5 working days of the incident..." In an interview with the Administrator on 8/4/11 at 11:40 a.m. she confirmed the facility had not followed it's policy to conduct a thorough investigation and notify the Department of an injury of unknown origin. She stated, "We all assumed it was just another fall for [Resident 11]." 2. Resident 14 was most recently readmitted to the facility on 5/25/11 with diagnoses that included dementia. The admission MDS assessment for Resident 14, dated 6/14/11, noted significant cognitive impairment. The clinical record for Resident 14 included a nursing note, dated 7/25/11, which noted a bruise had been discovered on her left arm above the crease of the elbow. The note indicated the resident was taking aspirin and had a habit of banging her arms on the table. The note further documented the RP had been contacted and the RP had reported the resident had a habit of positioning her arms in a manner that could have led to bruising. The note contained no information if staff or witnesses had been interviewed to determine other possible sources of the bruises. Review of facility policy titled Abuse, Prevention	F 226	F226 (2.) **Corrected Action for Affected Residents**: The facility policy was modified to include language identical to the federal interpretive guidelines defining "Injuries of Unknown Source". The Incident Reports reviewed by surveyors were not considered allegations of abuse, so the Abuse Investigation Form was not implemented. While the Incident Reports were regarding unwitnessed injuries, these situations did not meet the Federal definition of "Injuries of unknown source" where both of the conditions set forth are present. Resident 14 has a care plan for bruising easily due to her medications (she takes aspirin) and she has Parkinson's. Resident 14 is often in her wheelchair and chronically shakes her arms in space within her wheelchair arms and under table tops	8/22/2011

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F 226	Continued From page 4 of, undated, revealed: -"Complaints, observations, suspicions, or reporting of incidents, falls, bruised and skin tears (of suspicious or unknown origin) will be investigated to rule out abuse." -"Falls and bruises and skin tears of unknown origin will be investigated to rule out abuse." -"The investigation and report shall include:...circumstances surrounding the incident; names of witnesses and their account when applicable....outcome of investigation..." -"Administrator shall report all incidents of alleged abuse or suspected abuse to DPH [Department of Public Health, the State agency] within 24 hours...and the results of the investigation to DHS [Department of Health Services, the former name of DPH] within 5 working days of the incident..." In an interview with LN 2 and LN 3 on 8/4/11 at 8:45 a.m. , LN 2 reported she had noticed the bruise on 7/25/11 and had written the nursing note. She reported she had informally interviewed the nursing staff on all shifts, but nobody had any information to specifically identify the source of the bruise. She verified she had not documented any of the interviews with the staff. She reported she had completed an incident report and had submitted it to the DON. She verified she had no specific information as to how the bruise occurred either at the time of discovery, or after conducting an investigation to determine the source, and it was an injury of unknown origin. In the interview with LN 2 and LN 3 on 8/4/11 at approximately 8:45 a.m. LN 3 reported that injuries of unknown origin were supposed to be reported to the Ombudsman. She was unaware	F 226	and desk tops. This repetitive motion causes bruising on her arms. Resident 14 is monitored weekly and more often as needed by the Treatment Nurse for her chronic bruising. The incident reports are generated for all new bruises noted with Resident 14, however, the bruising does not meet the federal interpretive guidelines definition for "Injury of Unknown Source". The bruising is not suspicious because the location of injury is in a place where she chronically has bruising and the resident likely bruises easily due to her aspirin medication. **Identification of Other Potential Residents:** All unwitnessed injuries will be investigated. **Systemic Measures in Place to Ensure Deficient Practice Does Not Recur:** The facility policy has been revised to include an assessment of the federal guidelines for "injuries of unknown source". Reasoning for whether an injury is of unknown source will be documented and submitted to the administrator for review and signature. **Monitoring Plan:** The Accident and Incident logs were summarized and reviewed for trends on a monthly basis by the DON and quarterly by the QA Committee.	8/22/2011 and ongoing 8/22/2011 And ongoing 8/22/2011 And ongoing

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F 226	Continued From page 5 of any requirement to report injuries of unknown origin to the Department. In an interview with the DON on 8/4/11 at 11:45 a.m. she reported she had misplaced the incident report LN 2 had submitted. She verified the Department had not been notified of the injury of unknown origin.	F 226		
F 246 SS=D	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to accommodate the needs of 1 of 17 sampled residents (8) when: Resident 8 could not use her water cup due to severe arthritis in her hands, was unable to reach her call bell when in a wheelchair, and was not woken up before a podiatrist trimmed her nails. Findings: Resident 8 was admitted to the facility on 6/17/10 with diagnoses including severe rheumatoid arthritis with multiple deformities (inflammation of the joints causing stiffness, swelling, and pain). Resident 8's annual MDS, dated 6/3/11, revealed she had minimal cognitive impairment, and was	F 246	F246 **Corrected Action for Affected Residents:** Resident 8 has been given an adaptive drinking cup to be used for her daily bedside water. Resident 8 has been given an adaptive call light. **Identification of Other Potential Residents** Staff have been inserviced on ensuring the call light is within reach. The Administrator discussed with the Podiatrist the need to ensure that residents are awaken prior to treatments. **Systemic Measures in Place to Ensure Deficient Practice Does Not Recur:** A facility staff person familiar to the resident will accompany the podiatrist when treating residents. **Monitoring Plan:** Residents will discuss satisfaction/ dissatisfaction regarding physician/ specialists quarterly during care conferences.	8/5/2011 8/24/2011 8/5/2011 And ongoin 8/22/2011 And ongoin

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F 246	Continued From page 6 totally dependent on others for her care, could not stand up, or move herself when in a wheelchair. During an observation on 8/4/11 at 8:30 a.m., Resident 8 was in her wheel chair by the side of her bed watching television. Her call light was lying across her bed, four feet away from the resident. Resident 8's fingers were observed to be curved inward and her legs did not reach the ground. A 16 ounce styrofoam cup with no handles was on the bedside table. She was observed unsuccessfully trying to hold the 16 ounce styrofoam container filled with water with her arthritic hands. In a concurrent interview on 8/4/11 at 8:30 a.m. Resident 8 stated she was incapable of propelling her wheelchair to get closer to her call light. Resident 8 also stated she was unable to hold her water glass in or out of the bed. She stated the only cup she could use by herself was a coffee cup that had a handle. Resident 8 stated if she became thirsty she had to use her call light but could not reach it when she was in the wheelchair, and the staff did not come in and offer her fluids on a routine basis. During an observation on 8/4/11 at 11:45 a.m., Resident 8 was in the dining room drinking hot chocolate by herself, using a coffee cup with a handle. When asked if she was doing okay with the cup she replied, "Oh yes, I can do this very well." Review of the clinical record for Resident 8 revealed: -A Dehydration Care Plan, dated 6/20/10, which indicated a risk for dehydration because of	F 246		

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F 246	Continued From page 7 needed assistance with fluids and she was receiving a water pill. Approach plans included encouraging Resident 8 to drink liberal amounts of fluids and to keep water available at the bedside within reach. -A Self Care Deficit Care Plan, dated 6/17/10, which indicated the facility was to encourage independence with ADLs and mobility to the extent she was able. -A Nutritional Plan of Care, dated 6/17/10, which indicated the facility was to provide adaptive equipment/assistive dining devices as needed and to frequently offer and encourage fluids as tolerated. -An Occupational Therapy Initial Plan of Treatment Evaluation, dated 6/17/10, indicated a recommended goal for self-feeding with adaptive devices. The facility's policy and procedures on assistive feeding devices (undated) indicated that assistive feeding devices were essential for residents who had difficulty feeding themselves secondary to medical diagnosis or physical impairment. In an interview with CNA 1 on 8/4/11 at 8:40 a.m., she stated Resident 8 liked to watch TV. She confirmed Resident 8 could not reach her call light when she was out of bed. When asked how Resident 8 made her needs known to the staff, CNA 1 stated Resident 8 would call out into the hall, or depended upon her roommate to get her help. CNA 1 also stated that she usually offered water to Resident 8 2-3 times in a 8 hour shift. She confirmed Resident 8 could not hold her water glass but could hold a smaller juice glass or coffee cup.	F 246		

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F 246	Continued From page 8 In an interview with the OT 1 on 8/4/11 at 11:05 a.m. she stated they had coffee cups or sippy cups (cups with covers on top with handles) for residents who had a hard time handling a regular glass by themselves, to promote more independence. She stated that these special containers were only offered at meal time and the facility did not offer special cups at the bedside for water. In an interview with Resident 8 on 8/3/11 at 8:45 a.m., she stated a couple of months ago she was awoken in the middle of the night, with a man at the end of her bed trimming her toenails. She stated, "It scared me to death" and further reported the man did not bother to wake her up before he started cutting her toe nails. In an interview with LN 4 on 8/3/11 at 2:30 p.m., she stated that the podiatrist usually came in between 5-6 a.m. She stated they came early because all the residents were in bed so it was easier to treat them. LN 4 also stated the podiatrist was supposed to make sure the residents were fully awake before cutting their toe nails.	F 246		
F 248 SS=E	483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by:	F 248		

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F 248	Continued From page 9 Based on observation, interview and document review, the facility failed to provide activities to meet the needs of 3 of 17 sampled residents (9, 8, and 12). Findings: 1. Resident 9 was admitted to the facility on 9/1/10 with diagnoses including a stroke with left-sided weakness, the inability to talk, difficulty swallowing and a feeding tube. An MDS assessment, dated 5/11/11, indicated Resident 9 could sometimes make himself understood, and could sometimes understand what was said to him. This MDS assessment also indicated Resident 9 had moderately impaired ability to make daily decisions. It also indicated he was totally dependent on others for his activities of daily living. During the initial tour of the facility on 8/2/11 at 8:30 a.m., Resident 9 was observed sitting in his wheelchair in his darkened room, facing the hallway, with the TV on. -On 8/3/11 at 12:30 p.m., Resident 9 was observed sitting up in bed in his darkened room with the TV on. -On 8/3/11 at 3 p.m., Resident 9 was observed sitting in his wheelchair watching TV in his darkened room. In a telephone interview with RP 1 on 8/3/11 at 3 p.m., he stated Resident 9 liked to read, listen to music, watch soccer, and be outside. Resident 9's clinical record review revealed: - A quarterly Activity Progress Note, dated 11/22/10, indicated his "Response to Activities"	F 248	F248 **Corrected Action for Affected Residents** Resident 9 was interviewed and provided books on tape. The spouse of Resident 9 was trained as to how to obtain additional tapes as necessary. Resident 8 was interviewed and provided books on tape. The Activity staff will conduct room visits three times per week to provide different books upon request. Resident 12 is receiving three room visits per week. **Identification of Other Potential Residents:** All residents who prefer to remain primarily in their rooms were interviewed by the Activity Director to ensure that preferred activities are provided. **Systemic Measures in Place to Ensure Deficient Practice Does Not Recur:** The residents identified are all residents who prefer to primarily remain in their rooms. The Activity Director has implemented a board in the AD office to designate which residents are to receive room visits and also identify the frequency and specific staff assigned to conduct the room visit. A new form has been implemented to document the room visits as well as the resident's response to the room visits.	8/22/2011 8/22/2011 8/22/2011 And ongoing

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F 248	Continued From page 10 was "extensive assist, dependent, and passive." Under the heading of Socialization Pattern, a note indicated, "Socialization received from in room visits by activity staff." The document also indicated that room visits would continue. - A quarterly Activity Progress Note, dated 5/10/11, indicated Resident 9 received socialization from his wife and son. - An "Activity Care Plan" dated 2/11/11 under the heading "Goal/Outcome" indicated, "Res will receive visits 2 x per week for direct 1-on-1 attention." Review of a document entitled, "Record of One-to-One Activities" for 5/17/11 through 8/1/11 indicated the following: -5/17/11: An invitation to make "Bumble Bee Pots". -6/15/11: "hand him the newspaper" -6/19/11: Greeted resident and "gave him the newspaper" -6/21/11: "gave him the newspaper" -7/4/11: "Greated[sic] happy 4th of July, and handed him the newspaper." -7/19/11: "Gave him the newspaper" -8/1/11: Visited the resident and brought calendar to "discuss the month's events" The facility provided 7 in room visits of 17 opportunities per the care plan. During an interview with AD on 8/3/11, she stated Resident 9 was not a "joiner". He does not like to attend group activities. She noted that activities staff goes in "sometimes to talk about sports, and engage him in conversation." No other in room activities were noted for this resident. During an interview with RP 1 and RP 2 on 8/4/11	F 248	**Monitoring Plan:** AD to provide service satisfaction surveys to residents on a quarterly basis. Administrator to review satisfaction surveys with QA Committee.	8/22/2011 And ongoing

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F 248	Continued From page 11 at 9:30 a.m., RP 2 expressed concern that her husband was depressed and needed emotional support. She stated Resident 9 was a very active man prior to his strokes. She stated that he liked to read and she was not aware of anyone reading to him or providing books on tape. She also stated that he enjoyed Brazilian music, and he had a music player that is always available to use. RP 1 explained Resident 9 also liked to be outside. RP 1 and RP 2 were not aware the facility could assist the resident with these kinds of in room activities. During an interview with AD and AA on 8/4/11 at 3:30 p.m., they described the one -to-one activity program as for people who cannot or will not leave their room. AA stated they made personalized room visit kits with things each resident enjoyed, for instance, cards, music, books, talking books or reading material tailored to the resident's interests. AA then produced a bin of packets for the current room activity residents. All were examined and there was not one present for Resident 9. 2. Resident 8 was admitted to the facility on 6/17/10 with diagnoses that included severe rheumatoid arthritis with multiple deformities. Resident 8's annual MDS dated 6/3/11, revealed minimal cognitive impairment, and that she was totally dependent on others for her care, could not stand up, or move herself when in a wheelchair. Review of the clinical record for Resident 8 revealed: -An Activity Assessment, dated 6/21/10, which indicated Resident 8 liked crossword puzzles and	F 248		

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	056158	A. BUILDING _____ B. WING _____	08/04/2011

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F 248	Continued From page 12 reading. -An Activity Care Plan dated 6/21/10, which indicated the facility was to explore Resident 8's interests, and encourage her to vent her needs and interests. During an observation and interview with Resident 8 on 8/3/11 at 8:45 a.m., she was sitting alone in her wheel chair facing the patio. She stated she liked to sit by the patio window where it was warm. She said she waited to be offered activities because she felt it was not her place to ask. Resident 8 stated she had no family or friends who visited her. When asked what kind of activities she liked she mentioned reading, but could not read because of her eye sight. She mentioned she would be interested in books on tape but no one had ever offered or suggested them to her. In an interview on 8/4/11 at 8:40 a.m. with CNA 1, she stated that Resident 8 " likes going to the group activities if you offer to take her." She stated that most of the time Resident 8 just watched TV in her room. In an interview with the AD on 8/3/11 at 9:30 a.m., she stated the facility tries to bring residents who were isolating themselves to participate in the group activities. The AD stated the facility had a large supply of books on tape that were available to the residents. When asked about Resident 8 voicing an interest in the tapes but had never been offered them, she stated "I am not a mind reader", and that the residents had to advocate for themselves. The AD also stated Resident 8 had never asked for the tapes and that she usually just watched TV all day.	F 248		

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F 248	Continued From page 13 3. Resident 12 was readmitted to the facility on 1/21/11 with diagnoses including chronic pain syndrome, major depression, and advanced dementia. Resident 12's quarterly MDS, dated 7/18/11, described her cognitive level as severely impaired and she was totally dependent on others for her care, and remained mostly in bed. During an observation on 8/4/11 at 8:10 a.m., Resident 12 was lying in bed in a darkened room, alone. During an observation on 8/4/11 at 9:50 a.m., Resident 12 was lying in bed in a darkened room, alone. During an observation on 8/4/11 at 12:00 noon, Resident 12 was lying in bed in a darkened room, alone. Review of the clinical record for Resident 12 revealed: -An Activity Care Plan, dated 1/26/11, indicated the facility was to provide music, use hand massage for tactile stimulation and visit resident at least two times a week. -A Care Plan Conference/Interdisciplinary Review, dated 7/21/11, revealed Resident 12 was to have activity visits two times per week in her room. A review of Resident 12's Record of One-to-One Activities log revealed: - 6/19/11: Resident 12 talked to AA and had hands massaged. - 6/28/11: Resident 12 was able to do some Trivia, with AA.	F 248		

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F 248	Continued From page 14 - 7/13/11: Resident 12 was offered but refused to have her nails done. - 7/21/11: Resident 12 was offered to have her make-up done but she refused. AA talked to the resident about an entertainer. - 8/2/11 Resident 12 was visited for a chat session, which she enjoyed, and thanked AA for visiting. There was no documentation in the log to indicate twice a week in-room visits were conducted 6/19/11 through 8/2/11 per the care planned measures. A review of the facility's Individual Activities and Room Visit Program, dated 2001, revealed residents on a full room visit program were to receive, at a minimum, three room visits per week. The policy indicated a room visit was ten to fifteen minutes in length. In an interview with the AD on 8/3/11 at 4:00 p.m., she stated the facility practice was to visit bedbound residents for 1:1 activities two times a week. She also stated the activity staff was required to chart each time they did or attempted activities with the residents. In an interview with AA on 8/3/11 at 4:15 p.m., she stated sometimes residents were asleep when she went in to see them, but she always went back when they were awake. She stated she saw Resident 12 yesterday, and the resident was so " happy" to see her she, "talked up a storm."	F 248		
F 366 SS=D	483.35(d)(4) SUBSTITUTES OF SIMILAR NUTRITIVE VALUE	F 366		

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F 366	Continued From page 15 Each resident receives and the facility provides substitutes offered of similar nutritive value to residents who refuse food served. This REQUIREMENT is not met as evidenced by: Based on observation, interviews, and record review, the facility failed to provide a substitute food for 1 of 17 sampled residents (8) when Resident 8 requested a fried egg instead of the scrambled egg that had been given to her. Findings: Resident 8 was admitted to the facility on 6/17/2010 with diagnoses including severe rheumatoid arthritis. Resident 8's annual MDS, dated 6/3/11, revealed minimal cognitive impairment, and that she was totally dependent on others for her care. During an observation on 8/3/11 at 8: a.m., Resident 8 was in the dining room sitting with her breakfast in front of her. Her breakfast included scrambled eggs. She was observed telling CNA 3 that she did not like the scrambled eggs and would rather have a fried egg. CNA 3 listened to Resident 8's request and then continued to assist the other residents with their meals. CNA 3 did not inform dietary staff about Resident 8's request for a fried egg. At 8:20 a.m., Resident 8 was observed being taken out of the dining room, having drank some milk but had not eaten any of the food. In an interview with Resident 8 on 8/3/11 at 8:45 a.m., she stated she did not like the scrambled	F 366	F366 **Corrected Action for Affected Residents:** Opportunity to correct this situation is gone, facility was not informed of this situation until survey exit. Resident's diet tray card has been modified to include scrambled eggs to dislike list. **Identification of Other Potential Residents:** All residents diet likes and dislikes have been reviewed and updated by the Dietary Manager with each resident. **Systemic Measures in Place to Ensure Deficient Practice Does Not Recur:** Staff inserviced regarding informing Dietary Department immediately for resident requests for alternate food item(s). **Monitoring Plan:** Dietary Manager to confirm food likes and dislikes quarterly at resident care conferences. Dieatary Manager to periodically make rounds in dining rooms to interview residents regarding food satisfaction. QAs to also include residents who prefer to remain in their rooms.	8/5/2011 8/22/2011 8/24/2011 And ongoing 8/22/2011 And ongoing

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F 366	Continued From page 16 eggs because they added things to it. She preferred a simple fried egg. Resident 8 stated she had complained before and the facility knew she did not like the scrambled eggs. Resident 8 stated she had never received a fried egg instead. In an interview with the DS on 8/4/11 at 11:50 a.m., she was asked about substituting scrambled eggs for fried eggs. She stated "oh yes, we can do that." She also stated when residents complained about the food, she would talk to the residents and ensured they received the food that they preferred from then on. A review of Resident 8's Nutritional Plan of Care, dated 6/17/10, revealed the facility was to offer substitutes for foods refused if intake was less than 75% and the facility was to identify and provide preferred foods. A review of the facility's undated policy and procedure titled, "Dining Program" indicated all CNAs were to offer substitute food per resident requests or in the event they had eaten less than 75% of their meal. In an interview with CNA 3 on 8/3/11 at 8:40 a.m., she stated Resident 8 had complained about the scrambled eggs having no taste and did not like them. She confirmed Resident 8 had asked for a fried egg. She confirmed that she did not follow the facility policy by not requesting a fried egg from the kitchen.	F 366		