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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                           |  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>435068</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br><br>B. WING _____  | (X3) DATE SURVEY COMPLETED<br><br><b>05/07/2014</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>GOLDEN LIVINGCENTER - WATERTOWN</b> |  |   | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>415 FOURTH AVE NE<br/>WATERTOWN, SD 57201</b>   |   |
| (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<br><br>Surveyor: 12218<br>A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for long term care facilities, was conducted from 5/5/14 through 5/7/14. Golden LivingCenter - Watertown was found not in compliance with the following requirements: F315 and F514.   | F 000   | Preparation, submission and implementation of this Plan of Correction does not constitute an admission of or agreement with the facts and conclusions set forth on the survey report. Our Plan of Correction is prepared and executed as a means to continuously improve the quality of care and to comply with all applicable state and federal regulatory requirements. This covers F315 & F514.  |   |
| F 315<br>SS=D  | 483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER<br><br>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.<br><br>This REQUIREMENT is not met as evidenced by:<br>Surveyor: 32335<br>Based on record review, interview, and incontinence management/bladder function guideline review, the provider failed to properly complete the bladder assessment and follow the toileting schedule for one of eight residents (5) on a toileting program. Findings include:<br><br>1. Review of resident 5's 1/29/14 Minimum Data Set (MDS) assessment revealed she had been occasionally incontinent (loss of bladder control).<br><br>Review of resident 5's care plan dated 2/3/14 | F 315   | F315<br><br>1. Verbal education done by DNS (Director of Nursing Services) and MDS Coordinator with nursing staff reviewing the policy and procedure for Incontinence Management/Bladder Function Guideline on 5/9/14. The bowel and bladder recording tool was completed for Resident #5 on May 31, June 1 and June 2. Upon completion of this tracking tool and the bowel and bladder evaluation form, the appropriate toileting/bladder program was determined. The bladder management program effectiveness for this resident will be reviewed at a minimum with the Quarterly MDS. | 6-23-14   |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Maria Phillips TITLE: Administrator (X6) DATE: 6-2-14

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

PRINTED: 05/20/2014  
FORM APPROVED  
OMB NO. 0938-0391

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                           |  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>435068</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br><br>B. WING _____   | (X3) DATE SURVEY COMPLETED<br><br><b>05/07/2014</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>GOLDEN LIVINGCENTER - WATERTOWN</b> |  |   | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>415 FOURTH AVE NE<br/>WATERTOWN, SD 57201</b>  |   |
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| F 315  | Continued From page 1<br>revealed she:<br>*Had started a toileting program on 4/22/14.<br>*Was to have been toileted at 7:00 a.m., 9:15 a.m., 11:30 a.m., 1:30 p.m., 3:30 p.m., and 5:15 p.m.<br><br>Interview and review of resident 5's Bowel and Bladder Record Data Collection Tool on 5/7/14 at 1:45 p.m. with the director of nursing and the MDS coordinator regarding resident 5 revealed:<br>*The Bowel and Bladder Record Data Collection Tool was used to determined the toileting schedule.<br>*The certified nursing assistants (CNA) completed that form.<br>*They had provided training to the CNAs regarding how to complete the form.<br>*The columns on the assessment form were:<br>-Urine continent or incontinent.<br>-Resident aware of urge.<br>-If incontinent saturation of pad.<br>-Prompt to void: small amount, medium amount, large amount, refused, did not void.<br>-Activity when incontinence occurred.<br>-BM (bowel movement).<br>*On 4/5/14 she had been toileted eight times.<br>-The prompt to void column had been completed four times out of the eight.<br>-On 4/6/14 she had been toileted eight times.<br>-The prompt to void column had been completed seven times out of the eight.<br>*On 4/7/14 she had been toileted five times.<br>*The prompt to void column had been completed zero times out of the five.<br>*When asked multiple times how they determined if a resident had voided they stated by looking at the resident aware of urge to void column.<br>*When asked if the prompt to void: small amount, medium amount, large amount, refused, didn't | F 315   | 2. All residents have the potential to be affected by this process.<br><br>3. Directed in-service for all nursing staff done by the DNS and MDS Coordinator on 5/29/14 regarding the bladder and bowel toileting programs. Education on the identified issue including instruction on completion of bowel and bladder tracking tool in addition to documentation of the daily toileting schedule and monitoring for effectiveness of toileting program.<br><br>4. The DNS or designee to conduct an audit of completion of the bowel and bladder tracking tool including daily bladder documentation by nursing per scheduled toileting plan for 2 randomly selected residents twice weekly x4 weeks, weekly x4 weeks and biweekly x4 weeks. Audit results will be taken to Quality Assurance Process <del>improvement</del> <del>committee</del> Improvement committee by Director of Nursing or designee for further review and recommendation.<br><br><i>*5. All residents on bladder and bowel training programs were reviewed by the mds coordinator. A new incontinence summary form has been started for all residents and is reviewed quarterly.</i><br><i>MJH/SDD/DMF</i> |   |

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                           |  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>435068</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br><br>B. WING _____  | (X3) DATE SURVEY COMPLETED<br><br><b>05/07/2014</b> |
|--|--|---|---|---|
| NAME OF PROVIDER OR SUPPLIER<br><br><b>GOLDEN LIVINGCENTER - WATERTOWN</b> |  |   | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>415 FOURTH AVE NE<br/>WATERTOWN, SD 57201</b>   |   |
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| F 315  | Continued From page 2<br>void column should have been how they determined if the resident had voided they both said "probably."<br>*They agreed they would have to re-train staff on how to properly complete the bowel and bladder records as the assessments were not complete.<br>*The CNAs daily bladder documentation had not reflected they had taken resident 5 to the bathroom according to the toileting schedule of 7:00 a.m., 9:15 a.m., 11:30 a.m., 1:30 p.m., 3:30 p.m., and 5:15 p.m.<br><br>Instructions for completing the Bowel and Bladder Record Data Collection Tool were requested, but they did not have instructions for the tool.<br><br>Review of the provider's 2013 Incontinence Management/Bladder Function Guideline revealed the completion of the Bowel and Bladder Tracking Tool and the Bladder Evaluation Form and the Bowel Evaluation Form should have been used to determine the toileting program. | F 315   |   |   |
| F 514<br>SS=D  | 483.75(l)(1) RES<br>RECORDS-COMPLETE/ACCURATE/ACCESSIBLE<br><br>The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.<br><br>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.   | F 514   | F514<br><br>1. Verbal education done by DNS and MDS Coordinator on 5/19/2014 with nursing staff reviewing the policy and procedure of complete and accurate documentation specific to the restorative program.<br><br>2. All residents have the potential to be affected by this process. | 6-23-14   |

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| F 514 | <p>Continued From page 3</p> <p>This REQUIREMENT is not met as evidenced by:<br/>Surveyor: 32335<br/>Based on record review, interview, and restorative nursing program guidelines review, the provider failed to maintain complete and accurate documentation for 8 of 12 sampled residents (1, 3, 4, 5, 6, 10, 11, and 12) receiving a restorative program. Findings include:</p> <p>1. Review of resident 1's monthly restorative record revealed she had orders for restorative therapy to assist with the following:<br/>*Active range of motion (AROM) exercises to have been done six to seven days per week.<br/>*Ambulation exercises to have been done up to seven days per week.</p> <p>Review of her April 2014 restorative record revealed there had been nothing documented for:<br/>*AROM exercises 22 out of 30 days.<br/>*Ambulation exercises 24 out of 30 days.</p> <p>2. Review of resident 5's monthly restorative records revealed she had orders for restorative therapy to assist with the following:<br/>*Transfer exercises to have been done up to six to seven days per week.<br/>*Ambulation exercises to have been done two times per day as tolerated.</p> <p>Review of her March 2014 through April 2014 restorative records revealed there had been nothing documented for:<br/>*Transfer exercises 42 out of 61 days.<br/>*Ambulation exercises 48 out of 122 possibilities.</p> | F 514 | <p>3. Directed in-service for all nursing staff done by the Director of Nursing (DON) on 5/29/14 regarding the necessity of complete and accurate documentation in all aspects of care to include the specific findings cited in the deficiency.</p> <p>4. The DNS or designee to conduct an audit of completion of the restorative records for 4 randomly selected residents twice weekly x4 weeks, weekly x4 weeks and biweekly x4 weeks. Audit results will be taken to Quality Assurance Process <i>*monthly</i> <i>05/04/14</i> Improvement committee by Director of Nursing or designee for further review and recommendation.</p> <p><i>*5. The MDS coordinator reviewed all residents' restorative programs including residents 1, 3, 4, 5, 6, 10, 11 and 12. 05/13/2014</i></p> |  |
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| NAME OF PROVIDER OR SUPPLIER<br><br><b>GOLDEN LIVINGCENTER - WATERTOWN</b> |  |   | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>415 FOURTH AVE NE<br/>WATERTOWN, SD 57201</b>                       |   |
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| F 514  | <p>Continued From page 4</p> <p>3. Review of resident 10's monthly restorative record revealed she had orders for restorative therapy to assist with the following:<br/>*AROM exercises to have been done up to six to seven days per week.<br/>*Transfer exercises to have been done six to seven days a week.</p> <p>Review of her April 2014 restorative record revealed there had been nothing documented for:<br/>*AROM exercises 23 out of 30 days.<br/>*Transfer exercises 21 out of 30 days.</p> <p>4. Review of resident 11's monthly restorative record revealed she had orders for restorative therapy to assist with transfer exercises. They should have been done six to seven days a week.</p> <p>Review of her April 2014 restorative record revealed there had been nothing documented for 21 out of 30 days.</p> <p>Surveyor: 32332</p> <p>5. Review of resident 3's monthly restorative records revealed she had orders for restorative therapy to assist with:<br/>*AROM exercises to have been done up to seven days per week.<br/>*Transfer exercises to have been done up to seven days per week.</p> <p>Review of her January 2014 through April 2014 restorative records revealed there had been nothing documented for:<br/>*AROM exercises 28 of 96 days.<br/>*Transfer exercises 39 of 96 days.</p> <p>6. Review of resident 4's monthly restorative</p> | F 514   |   |   |

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| F 514  | <p>Continued From page 5</p> <p>records revealed she had orders for restorative therapy to assist with AROM exercises up to seven days per week.</p> <p>Review of her February 2014 through April 2014 restorative records revealed there had been nothing documented for 24 of 55 days of AROM exercises.</p> <p>7. Review of resident 6's monthly restorative records revealed she had orders for restorative therapy to assist with:<br/>*AROM exercises to have been done up to seven days per week.<br/>*Transfer exercises to have been done up to seven days per week.</p> <p>Review of her December 2013 and January 2013 restorative records revealed there had been nothing documented for:<br/>*AROM exercises 38 of 62 days.<br/>*Transfer exercises 40 of 62 days of transfer exercises.</p> <p>8. Review of resident 12's monthly restorative records revealed she had orders for restorative therapy to assist with passive range of motion exercises up to seven days per week.</p> <p>Review of her January 2014 through April 2014 restorative records revealed there had been nothing documented for 30 of 99 days of exercises.</p> <p>9. Interview on 5/7/14 at 8:30 a.m. with the restorative nurse revealed the restorative records documentation had not been complete. The restorative aides were to have documented if the residents had attended or why they had not</p> | F 514   |   |                      |   |

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| F 514  | Continued From page 6 attended.<br><br>Interview on 5/7/14 at 3:15 p.m. with the director of nursing revealed the restorative documentation had been incomplete.<br><br>Review of the provider's revised 2013 Restorative Guidelines for Documentation revealed:<br>*The restorative record was to have been initialed daily as the programs had been completed.<br>*The documentation of treatment was to have matched the frequency and content of the program. | F 514   |   |                      |   |

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| K 000 | <p><b>INITIAL COMMENTS</b></p> <p>Surveyor: 14180<br/>A recertification survey for compliance with the Life Safety Code (LSC) (2000 existing health care occupancy) was conducted on 5/7/14. Golden LivingCenter - Watertown was found in compliance with 42 CFR 483.70 (a) requirements for Long Term Care Facilities.</p> <p>The building will meet the requirements of the 2000 LSC for Existing Health Care Occupancies in conjunction with the provider's commitment to continued compliance with the fire safety standards.</p> | K 000 |  |  |
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| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE<br><i>Marie Phillips</i> | TITLE<br><b>Administrator</b> | (X6) DATE<br><b>6-2-14</b> |
|--|-------------------------------|----------------------------|

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**DISCLOSED**  
**JUN 04 2014**  
If continuation sheet Page 1 of 1  
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SOUTH DAKOTA DEPARTMENT OF HEALTH

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>10704</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br>B. WING _____ | (X3) DATE SURVEY COMPLETED<br><br><b>05/07/2014</b> |
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| NAME OF PROVIDER OR SUPPLIER<br><b>GOLDEN LIVINGCENTER - WATERTOWN</b> | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>415 4TH AVENUE NE P.O BOX 1210<br/>WATERTOWN, SD 57201</b> |
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| S 000 | Initial Comments<br><br>Surveyor: 12218<br>A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:04, Medical Facilities, requirements for nursing facilities, was conducted from 5/05/14 through 5/07/14. Golden LivingCenter - Watertown was found not in compliance with the following requirements: S236 and S290.  | S 000 | Preparation, submission and implementation of this Plan of Correction does not constitute an admission of or agreement with the facts and conclusions set forth on the survey report. Our Plan of Correction is prepared and executed as a means to continuously improve the quality of care and to comply with all applicable state and federal regulatory requirements. This covers S236 & S290.  |         |
| S 236 | 44:04:04:08.01 TUBERCULIN SCREENING REQUIREMENTS<br><br>Tuberculin screening requirements for healthcare workers or residents are as follows:<br><br>(1) Each new healthcare worker or resident shall receive the two-step method of Mantoux skin test to establish a baseline within 14 days of employment or admission to a facility. Any two documented Mantoux skin tests completed within a 12 month period prior to the date of admission or employment shall be considered a two-step. Skin testing is not necessary if documentation is provided of a previous positive reaction of ten mm induration or greater. Any new healthcare worker or resident who has a newly recognized positive reaction to the skin test shall have a medical evaluation and a chest X-ray to determine the presence or absence of the active disease;<br><br>This Rule is not met as evidenced by:<br>Surveyor: 32335<br>Based on record review, interview, and policy review, the provider failed to ensure one of five sampled employees (A) received a two-step tuberculin (TB) screening in the fourteen day | S 236 | <del>S236</del><br><br>1. Verbal education done with Department Heads by Executive Director (ED) reviewing the policy and procedure regarding Tuberculin screening on 5/12/14.<br><br>2. All residents and employees have the potential to be affected by this process.<br><br>3. Directed in-service for all Department Heads done by the Executive Director regarding the necessity of timely Tuberculin screening on all new employees on 5/30/14. Reviewed and explained that Department Heads will be expected to ensure the timely completion of Tb | 6-23-14 |

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| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE<br><i>Maui Phillips</i> | TITLE<br><b>Administrator</b> | (X6) DATE<br><b>6-23-14</b> |
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STATE FORM

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SOUTH DAKOTA DEPARTMENT OF HEALTH

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                       |  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>10704</b>                                 | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br>B. WING _____   | (X3) DATE SURVEY COMPLETED<br><br><b>05/07/2014</b> |
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| NAME OF PROVIDER OR SUPPLIER<br><b>GOLDEN LIVINGCENTER - WATERTOWN</b> |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>415 4TH AVENUE NE P.O BOX 1210<br/>WATERTOWN, SD 57201</b> |  |   |
| (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) COMPLETE DATE                                  |
| S 236  | Continued From Page 1<br><br>timeframe. Findings include:<br><br>1. Review of activity assistant A's employee file revealed she had been hired on 3/18/14. She had received her second step of the two-step TB screening on 4/7/14. That had exceeded the fourteen day timeframe.<br><br>Interview on 5/7/14 at 11:30 a.m. with the administrator confirmed a two- step TB screening had not been completed in the two-week timeframe for employee A.<br><br>Review of the provider's December 1998 Tuberculosis Exposure Control Plan policy revealed step two should have been administered seven to ten days after step one.  | S 236  | injections with new employees within their department starting on 5/30/14.<br><br>4. Audit to be completed by ED or Designee of all new employees timely completion of the Tuberculin screening. Audit to be completed on all new employees x3 months. Audit results will be taken to monthly Quality Assurance Process Improvement committee by ED or designee for further review and recommendation.   |   |
| S 290  | 44:04:07:02.04 FOOD SUPPLY<br><br>An on-site supply of nonperishable foods adequate to meet the requirements of planned menus for three days must be maintained.<br><br>This Rule is not met as evidenced by:<br>Surveyor: 12218<br>Based on menu review, observation, and interview, the provider failed to ensure:<br>*A variety and an adequate supply of protein type nonperishable meat and meat substitute foods were available to meet the needs and requirements of a three day food supply for forty-eight residents on oral diets.<br>*The three days of planned emergency menus and menu extensions for texture modified diets coordinated with the requirements of the non-perishable food supply. | S 290  | S290<br><br>1. Verbal education done by ED with Dietary Manager and Registered Dietician on 5/12/14 regarding deficiencies. All required nonperishable items were ordered and delivered 6/2/14.<br><br>2. All residents have the potential to be affected by this process.<br><br>3. Dietary Manager created a separate shelving area for three day menu items on 5/9/14. Directed in-service done with all dietary staff by the Dietary Manager | 6-23-14   |

SOUTH DAKOTA DEPARTMENT OF HEALTH

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                           |  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>10704</b>                                 | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br>B. WING _____   | (X3) DATE SURVEY COMPLETED<br><br><b>05/07/2014</b> |
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| S 290  | Continued From Page 2<br><br>Findings include:<br><br>1. Observation on 5/7/14 at 1:45 p.m. of the dry food storage area and the food supply with the registered dietitian (RD) and the dietary manager (DM) revealed:<br>*There was not enough variety and supply of protein type nonperishable meat or meat substitute foods to meet the protein requirement of five ounces per day for three days for forty-eight residents on oral diets.<br>*The provider had canned ravioli, canned pork and beans, dry northern beans, and peanut butter on hand for protein choices.<br>-A usual pattern for protein was one ounce at breakfast, two ounces at dinner, and two ounces at supper to equal five ounces of protein for the day to meet the minimum portion requirement.<br>-A one ounce serving of meat or meat substitute equaled seven grams (gm) of protein.<br>-A usual main course (entree) of a two ounce serving of meat or meat substitute at lunch or supper equaled fourteen gm of protein.<br>*There were enough one cup servings of canned ravioli for only thirty-six servings and not for forty-eight residents. The one cup serving only had six grams of protein.<br>*There were enough one cup servings of canned pork and beans (meat substitute) for seventy-two servings or one and one half meals for the forty-eight residents on oral diets. A one cup serving provided fourteen grams of protein but a half cup provided only seven gm of protein.<br><br>Review of the three day menus and menu diet extensions revealed there was no tuna, canned chicken, canned beef stew, or canned corned beef hash non-perishable food supply items on hand to meet the planned menus as evidenced by:<br>*Day one lunch menu had a tuna casserole | S 290  | on 5/29/14 regarding the policy and procedure for the maintenance of the on-site supply of nonperishable foods that is adequate to meet the requirements of planned menus for three days. Also covered the need for the three days of planned emergency menus and menu extensions for texture modified diets to coordinate with the requirements of the non-perishable food supply.<br><br>4. Audit to be completed by ED or Designee of the supply of three day menu items to ensure the adequacy of on-site nonperishable food items needed to meet the menu requirements. Audit to be completed randomly 2x per month for 4 months. Audit results will be taken to monthly Quality Assurance Process Improvement committee by ED or designee for further review and recommendation. |   |

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| S 290  | Continued From Page 3<br><br>planned, and there was no supply of tuna.<br>*Day two lunch menu had beef stew planned, and there was no supply of canned beef stew.<br>*Day two supper menu had chicken sandwiches planned, and there was no canned chicken on hand.<br>*Day three lunch menu had a chicken noodle hotdish planned, and there was no canned chicken on hand.<br>*Day three supper had corned beef hash planned as the main meal and protein source, and there was no canned corned beef hash on hand.<br><br>Interview at the above time with the RD and the DM revealed:<br>*The DM had just started and was new to the operation.<br>*They had been rotating their supply of food and had used the tuna.<br>*They had a food delivery coming on Friday but had not ordered canned chicken, beef stew, or corned beef hash.<br>*They were not aware the supply of ravioli would not meet the number of servings needed or the protein requirement for one meal.<br>*They agreed they needed a variety and could not serve beans twice a day for three days.<br>*They confirmed they did not have the food supply on hand to meet the planned menus. | S 290  |   |   |