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DEPARTMENT OF HEALTH AND HUM. SERVICES
HEALTH CARE FINANCING ADMINISTRATION

PRINTED: 8/14/02
FORM APPROVED
2567-L

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465088	A. BUILDING _____ B. WING _____	8/8/02

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALPINE VALLEY CARE CENTER	25 EAST ALPINE DRIVE PLEASANT GROVE, UT 84062

POC with addendum approved 9/18/02 ETJ

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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
F 281 SS=E	483.20(k)(3)(i) RESIDENT ASSESSMENT	F 281	281	

The services provided or arranged by the facility must meet professional standards of quality.

This REQUIREMENT is not met as evidenced by:

Based on observations, interviews, review of medical records, review of facility policies and review of the American Dietetic Association's Manual of Clinical Dietetics, Sixth Edition, it was determined that the services provided by the facility did not meet professional standards of quality. Specifically, 3 of the 10 sample residents had one or more pressure sores. None of these 3 residents received appropriate dietary intervention, as recommended by the American Dietetic Association, to promote the healing of the pressure sores. Resident identifiers: 4, 14, and CR1.

Findings include:

The American Dietetic Association (ADA), Manual of Clinical Dietetics, Sixth Edition, pg. 3, reads:

"Nutritional disequilibrium occurs with changes in dietary intake, nutrition needs, and nutrient metabolism. It occurs with varying degrees and can go unnoticed, even in the absence of active disease, unless a thorough nutrition assessment is completed. Unnecessary morbidity and mortality, along with increase health costs, have been associated with nutritional disequilibrium and reinforce the need for nutrition assessment...Nutrition assessment is usually preceded by nutrition screening to identify clients or groups who are at risk for nutritional disequilibrium and who may require nutrition intervention...The nutrition assessment is the basis for the nutrition care plan and formulation of goals...The client's nutritional status must be evaluated before intervention is initiated, and should be revisited throughout the course of care...Components of a complete nutrition

Lynette Perkins, RD, CD of Crandall And Associates was hired on August 19,2002. Every resident was assessed on August 10-16, 2002, using correct calorie, protein and fluid factors per ADA standards. A copy of the forms used is attached. Residents 4,14,and CR1 were assessed on August 10,2002. 10-7-02

Crandall and Associates Clinical Charting Handbook follows ADA Guidelines and will be used as the Clinical resource. The Food Service Supervisor will be trained on September 3, 2002 in nutritional protocol and in the use of the nutritional assessment forms per Crandall and Associates policy and procedures. The RD will review, cosign and add an RD notes to all initial, annual, change of condition and high risk assessments.

Until the Food Service Supervisor is Completely trained in clinical systems, The RD will frequently monitor Charting to ensure compliance with Clinical protocol. Fax consults will be Implemented between RD visits. A copy Of the fax consult is included.

The monthly report will monitor clinical Compliance and findings will be Reviewed with the administrator, director Of nursing and food service supervisor. The Plan of correction from these monthly Reports will be implemented by the facility With the food service supervisor having The primary responsibility.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATUR	TITLE	(X6) DATE
Bruce Allen	Administrator	9/6/02

y deficiency statement ending with an asterisk (*) denotes a deficiency which may be excused from correction providing it is determined that other safeguards provide fficient protection to the patients. The findings stated above are disclosable whether or not a plan of correction is provided. For nursing homes, the findings are disclosable within 14 days after h information is made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

Utah Dept. of Health
SEP 06 2002
#50744
Bur. of Medicare/Medicaid Prog.
Certification and Res. Assessment

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F 281	Continued From page 1 assessment include: medical and social history, dietary history, physical examination, anthropometry and body composition, biochemical data, and estimation of energy, protein and fluid requirements." The American Dietetic Association, Manual of Clinical Dietetics, Sixth Edition, pg. 154, reads: "Nutrition intervention is an integral component in the treatment of pressure ulcers along with wound care, pressure relief, and treatments to enhance perfusion." The American Dietetic Association, Manual of Clinical Dietetics, Sixth Edition, pg. 151, reads: "Selected physiological problems associated with aging and suggested nutrition interventions": "Pressure ulcers" - "Ensure minimum protein intake of 1.2 - 1.5 g/kg (grams per kilogram) or up to 2 g/kg with multiple or highly exudative ulcers. Recommend energy intake of 30 - 35 kcal/kg (kilocalories per kilogram); fluid intake of 20 - 30 mL/kg (milliliters per kilogram)." 1. Resident 4 was a 66 year old female who was admitted to the facility on 7/19/02 with the diagnoses of multiple sclerosis, congestive heart failure, hypothyroidism, pressure sores, urinary tract infection, colostomy, and atrial fibrillation. Resident 4 was alert and oriented. The medical record of resident 4 was reviewed from 8/6/02 - 8/8/02. The admission nursing assessment, dated 7/19/02, documented that resident 4 was admitted with five pressure sores. Four of these pressure sores were at a stage 4 and the fifth pressure sore was a stage 2.	F 281		

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The Nutritional Assessment, signed by the food service supervisor (FSS) on 7/22/02 and by the registered dietitian (RD) on 7/24/02, recorded the admission weight of resident 4 to be 152 pounds (which is equal to 69 kg).

The nutrition assessment documented that resident 4 was to receive a no added salt, soft diet. The assessment also documented that resident 4 "does not like milk, resident with multiple pressure sores - Monitor intake of meals. Assess for supplement with increased pro (protein), zinc, etc."

The protein needs of resident 4 were figured to be "69 - 83gm". Below this, the dietitian wrote in "1.0 - 1.2 gm/kgm".

Considering that resident 4 was admitted with five pressure sores, one of which was producing moderate drainage, the dietitian did not calculate the protein requirements to adequately meet the needs of this resident to promote healing of the sores. Based on the recommendations of the ADA, the minimal protein calculations for resident 4 should have been from 1.2 - 1.5 g/kg. This would have set her protein needs between 82.8 - 103.5. The dietitian could have calculated up to 2g/kg based on the multiple pressure sores and the moderate drainage.

During an interview with the FSS on 8/8/02, she confirmed that resident 4 was receiving a regular diet. Based on the menus and nutritional statistics provided by the facility's food supplier, the regular diet served in the facility provided an average of 87 to 89 grams of protein a day, if the resident ate 100% of the meals served.

On 8/7/02, the Director of Nurses (DON) and the FSS provided to the survey team a list of individuals who

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received a liquid protein supplement from the nurses during medication pass and a list of individuals who received "special nourishment" from the kitchen. Resident 4 was not on either list.

During an interview with resident 4 on 8/8/02, she was asked if she received any special supplements with her meals or between meals. (Special supplements were explained as anything with extra protein like a sweet liquid drink or cheese or boiled eggs, etc.) Resident 4 stated that she received her meals three times a day and hot chocolate in the mornings after breakfast and did not receive any additional protein-type supplements. She also stated that she did not like milk. During further interview with resident 4, she stated that she would eat anything with chocolate and would be willing to try a chocolate protein shake, chocolate ice cream or boiled eggs. She also stated that she would not mind her hot chocolate being made with milk.

During an interview with the FSS and a dietary staff member on 8/8/02, they were asked if the hot chocolate for resident 4 was prepared with milk or water. The dietary staff member stated that they make it with water and add "a little milk". Making an 8 ounce cup of hot chocolate with milk, instead of water, would add approximately 8 grams of protein to this resident's diet.

During an interview with the facility's dietitian and the FSS on 8/8/02 at 11:30 AM, they were asked if the facility provided high protein diets or things like "super cereal". The registered dietitian stated that they did not and that she found "those types of things to be too labor intensive". She continued to say that she liked the residents to eat what was served to them and then if they needed more, the resident would be provided with a protein supplement.

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In addition to the above, it was also determined that the facility's nurses, the facility's dietitian and FSS were not following the facility's policies regarding resident's with pressure sores. The policy titled "Residents with weight loss, and / or pressure sores" called for residents with pressure sores to be placed on the "special nutrition program with 2 Cal/cc med pass qid (liquid protein drink four times a day)." Page 249 of the facility's policy documents that the Special Nutrition Program provided 1403 additional calories / 43 grams of additional protein daily.

The special nutrition program was not implemented for resident 4.

During review of the medical record for resident 4, there was no documentation to evidence that staff had initiated a care plan to address the nutritional needs of resident 4. On 8/8/02, the nurse in charge was asked if she could find a nutritional care plan for resident 4. The facility nurse looked through the record and replied, "I can't find one either."

2. Resident 14 was a 78 year old female who was re-admitted to the facility on 7/9/02 after suffering a hip fracture and then a surgical hip repair. The admission nursing assessment, dated 7/9/02, documented that resident 14 had a "pressure area on heel".

The nutritional assessment was completed by the FSS on 7/14/02 and was not co-signed by the registered dietitian. The FSS documented that upon admit, 7/9/02, resident 14 weighed 156 pounds (equal to 70 kg). The FSS documented that resident 14 was to receive a low concentrated sweet diet and that her daily protein needs were 66 grams.

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F 281	Continued From page 5 The calculation of 66 grams of protein for resident 14 would not even equal 1.0 gram per kilogram which would still be below the minimum recommendation for repletion of an individual trying to heal tissues both at the surgical site and the pressure sore area. If resident 14's protein needs had been calculated based on ADA recommendations, the minimum protein necessary to promote healing for resident 14 would have been 85 to 105 grams. The facility had established a care plan for resident 14 regarding "potential for altered nutritional status r/t (related to) diabetes, anemia". The care plan did not address nutritional concerns related to her recent hip fracture, surgery or pressure area to her heel. The care plan directed staff to provide a nutritional supplement if resident 14 ate less than 50% of most meals. Neither the nutritional assessment nor the nutritional care plan discussed adding additional protein to meet the needs of resident 14. During review of the supplement list and the "special nourishment list" on 8/8/02, it was noted that resident 14 was not on either list. During an interview with the registered dietitian on 8/8/02, she stated that the protein requirements for resident 14 had been "figured wrong". Also, the facility did not implement the special nutrition program for resident 14 as required by their own policy. 3. Resident CR1, a 73 year old female, was admitted to the facility on 2/14/02 with diagnoses of right hip fracture, osteoporosis, history of bowel obstruction, hypoglycemia, hypothyroidism, history of seizures, and a hysterectomy.	F 281		

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F 281	Continued From page 6 A review of resident CR1's medical record revealed an initial nursing assessment which identified a stage II pressure ulcer on the coccyx measuring 3 X 3 cm, a stage II pressure ulcer on the bottom measuring 2.2 cm and red spots on both heels. The initial nursing assessment identified that resident CR1 was on a regular diet and did not need any nutritional supplements. The yearly Nutritional Assessment was completed by the FSS on 2/19/02. There was no documentation of the stage II pressure ulcers identified by the facility's nursing staff. The protein needs were not calculated for resident CR1. There was no documentation to provide evidence that the RD assessed or calculated resident CR1's nutritional needs or protein requirements. There were no lab values to assess if resident CR1 had a low albumin level due to the identified pressure sores. During an interview on 8/8/02, at approximately 11:00 AM, the RD stated that the FSS usually sees all residents as close to admission as possible to determine what they like or dislike. She further stated that unless she gets a call from the FSS she won't be in to see a resident, even with pressure sores. When the surveyor asked the RD about resident CR1 she stated, she usually remembers residents with pressure ulcers, but she doesn't remember resident CR1. According to the facility's policies and procedures (pg 261), "Residents identified with weight loss and/or pressure sores will be provided with additional calories, proteins and other nutrients if appropriate." There was no documentation to provide evidence resident CR1 received additional protein to help heal	F 281		

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F 281	Continued From page 7 her pressure sores. Resident CR1 was discharged from the facility on 3/1/02 without ever being seen by the RD. Resident CR1 went home with her family and was followed by home health.	F 281	On August 10,2002, Lynette Perkins RD, CD of Crandall and Associates Completed nutritional assessments On Residents 5,24,31,15,3,10. All Other residents were also assessed During this time using Crandall and Associates Clinical Charting Handbook, which follows ADA Guidelines and Crandall Clinical Policies and procedures Systems have been implemented To calculate significant weight Variance on a weekly, 1 month 3month, and 6 month intervals. Those which fall into the significant Weight variance categories have Been and will be charted on monthly By the RD. The Food Service Supervisor was trained on September 3,2002 to complete these interventions with the RD cosigning and adding a process notes to each interventions with the RD cosigning and adding a progress notes to each intervention on a monthly basis. An inservice was held on September 3. 2002 to review the "Best Practice Guidelines" regarding significant Weight variance, low albumin and Pressure ulcers. These guidelines Specify what steps are to be Implemented in each clinical situation. They may be altered if the RD Determines that the resident may Benefit from an alternative plan of Action.	
F 325 SS=G	483.25(i)(1) QUALITY OF CARE Based on a resident's comprehensive assessment, the facility must ensure that a resident 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. This REQUIREMENT is not met as evidenced by: The facility's "Resident at Nutritional Risk" policy and procedure (pg 241) documented, "Residents at nutritional risk will be identified and evaluated by the Dietary Manager/Diet Technician and/or Consultant Dietitian monthly. All residents who have any of the conditions below will be evaluated for a nutritional risk...1-2% weight loss in one week, five percent weight loss in one month, 7.5% weight loss in 3 months, 10% weight loss in 6 months. Tube feedings, TPN's...Pressure Ulcers. Abnormal lab values of blood glucose, albumin, hemoglobin, hematocrit and/or potassium, sodium, magnesium... Eats less than 50 percent of food served for one week period or refusal to eat...Difficulty swallowing/chewing, mouth pain. Therapeutic diet. Mechanically altered diet... Difficulty feeding... The Dietary Manager, Diet Technician and/or Consultant Dietitian will evaluate the resident's condition with input from nursing to determine the plan of action if needed and monitor the residents's problem until the problem is resolved. This action will be noted on a Nutrition Intervention Form.	F 325		10-7-02

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F 325	Continued From page 8 The nutritional intervention list shall be kept in the Nutritional Intervention Notebook. All nutritional risk residents will have a care plan and a Nutrition Intervention within 72 hours of identification..." The facility's "Monthly Weight and Pressure Ulcer List" policy and procedures (pg 242) documented, "The Nursing Department will provide the Dietary Department with the monthly weights of each resident and also a list of residents with pressure ulcers... A Nutritional Intervention note will be written in the event of a significant loss in weight in one month, three months, or six months. This will be done by the Dietary manager and reviewed by the Registered Dietitian. Nursing will notify the physician of significant or severe weight loss... All weight loss and pressure ulcers will be care planned and have nutritional goals and approaches." The facility's "Weekly Weight Intervention" policy and procedure (pg 243) documented, "Those residents at risk for significant weight loss shall be put on weekly weights...A nutritional intervention note is written by the Dietary Manager or RD with appropriate interventions noted. Care plan significant weight loss." The facility's "Criteria for Intervention with Abnormal Labs" (pg 245) documented, "Abnormal labs which fall into the intervention area will be reviewed by the RD monthly. When the following labs appear they will be put on the nutrition intervention list for RD:...Albumin < [less than] 3.5 g/dl- > [greater than] 60 years: < [less than] 3.4g.dl..." The facility's "Nutritional Risk (NAR) Weekly Meeting" policy and procedure (pg 246) documented, "Residents at nutritional risk will be reviewed weekly by Dietary and Nursing. Nutritional intervention must	F 325	The MAR and nourishment list have Been reviewed by the RD and will be Reviewed on a monthly basis to Ensure accuracy. A procedure has Been established for the Food Service Supervisor to receive labs. The lab book Is available at the nurses station and the Labs that are drawn are recorded. The RD/FSS will review the labs that have been Drawn since the previous visit. Abnormal Labs will be referred to the RD for Intervention. As part of the Food Service Supervisor's training, she will also be Trained using the "Best Practice Guidelines" to address abnormal albumin Levels. Nutrition At Risk meetings are held Weekly and all high risk residents Are reviewed throughout the month (weight loss, low albumin, pressure ulcers, poor intake, dialysis and tube feeders). Forms are attached. The monthly RD report will monitor Clinical compliance and findings will Be reviewed with the administrator, Director of nursing and food service Supervisor. The plan of correction From these monthly reports will be Implemented by the facility with the Food service supervisor having the Primary responsibility.	

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be done on significant weight variances, abnormal labs, pressure ulcers, tube feeding, dialysis and residents < [less than] 90% of IWR (ideal body weight).

1. Dietary and Nursing will designate a time each week to discuss high risk residents. The meeting can be held after weekly care plan. NAR attendance sheet must be completed each week.
2. Residents will be reviewed as follows:
   Week 1: all pressure ulcers, all tube feeders and first week weekly wts, any abnormal labs, and residents eating < [less than] 50% or refusing to eat.
   Week 2: 1 month, 3 months, 6 months, second week weekly wts, new or changes in pressure ulcers/tube feeding, any abnormal labs, and residents eating < [less than] 50% or refusing to eat.
   Week 3 & 4: weekly wts, changed or new pressure ulcers/tube feeding, dialysis residents, residents < [less than] 90%IWR, abnormal labs, and residents eating < [less than] 50% or refusing to eat.
3. Nutrition Intervention Notebook should accompany Dietary Manager/Technician as all necessary information is enclosed.
4. Both disciplines will discuss residents and jointly make recommendations.
5. Monthly nutrition intervention notes will be made. (The *NAR Tracking Form should be completed as nutrition interventions are done.)"

On 8/8/02 from 10:30 AM to 12:30 PM, the facility FSS and RD were interviewed. When asked if the facility held routine weight meetings the FSS said they did and that they were held weekly usually after care plan meeting. The FSS said that the weight meeting information was kept by the DON (director of nursing). When the weight meeting information was reviewed by the survey team it was documented that

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meetings were held once in January 2002, once in April 2002, once in June 2002 and once in July 2002.

A review of the weight meeting which had been held by the facility was done. There was no documented evidence that the residents identified by the survey team as being at nutritional risk related to weight loss, low albumin and/or pressure sores or wounds were addressed by the facility during these meetings. Based on clinical record review and staff interviews it was determined that the facility did not ensure that each resident maintained an acceptable parameter of nutritional status as evidenced by 2 of 10 sampled residents plus an additional 2 residents experienced significant weight loss with no dietary interventions implemented to prevent further weight decline. Resident identifiers: 5, 10, 24,31. Additionally, 2 of 10 sampled residents plus an additional 4 residents experienced low albumin (a protein and indicator of nutritional status) levels with no dietary interventions implemented to help increase the albumin levels and prevent further protein depletion. Resident identifiers: 3, 5, 10, 15, 24 and 31.

Calculating weight loss percentages is done by subtracting the current weight from the previous weight, dividing the difference by the previous weight and multiplying by 100. Significant weight losses are as follows: 5% in one month, 7.5% in 3 months and 10% in 6 months. (Reference guidance: Manual of Clinical Dietetics, American Dietetic Association, 6th edition, 2000).

Findings include:

1. Resident 5, a 91 year old male, was admitted to the facility on 9/7/01 with diagnoses of fever, altered level of consciousness, mood disorder due to cerebral vascular disease, hypothyroidism, CVA and

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hypertension.

A review of resident 5's weights revealed the following:

January 2002	144 pounds
February 2002	149 pounds
March 2002	144 pounds
April 2002	141 pounds
May 2002	139 pounds
June 2002	132 pounds
July 2002	126.5 pounds

Between the months of January 2002 and July 2002 resident 5 lost 17.5 pounds (12%) which is significant.

Between the months of April 2002 and July 2002 resident 5 lost 14.5 pounds (10%) which is significant.

A lab value taken at the facility and dated 5/17/02 showed an albumin (a protein and indicator of nutritional status) level of 3.0 g/dl (gram per deciliter). The lab reference range for an acceptable level was 3.3 g/dl to 4.8 g/dl.

An albumin level of less than 2.4 g/dl is considered a severe visceral protein deficit, an albumin level of 2.4 g/dl- 2.9 g/dl is considered a moderate visceral protein deficit and an albumin level of 3.0 g/dl-3.5 g/dl is considered a mild visceral protein deficit. (Reference guidance: Manual of Clinical Dietetics, American Dietetic Association, 6th edition, 2000, page 22).

The albumin of 3.0 g/dl dated 5/17/02 was the most current in resident 5's medical record and was acknowledged by the food service supervisor (FSS) on the quarterly assessment dated 6/4/02.

A review of resident 5's medical record dietary notes

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revealed that no registered dietitian (RD) assessment addressing the weight loss or low albumin had been completed for resident 5.

The yearly nutritional assessment was completed by the FSS on 9/12/01 and co-signed by the RD on 10/1/01. The protein needs were calculated at 80 (IBW in kg x 1.2).

A quarterly nutritional assessment completed by the FSS and dated 6/4/02, documented the following, " % loss- 17 lbs [pounds]...Albumin- 3.0 g/dl...Resident is not eating well from meals. Will send Great Shake for snack." A review of the facility's snack list revealed no documentation that resident 5 was receiving a Great Shake as a snack.

Review of resident 5's medical record revealed no documentation that the physician had been notified of the weight loss or low albumin level.

Review of resident 5's medical record revealed a nutritional care plan addressing the weight loss. There was no date of origination on the care plan but it did document a target date of 9/6/02. The care plan goals included: "1. Resident will be assisted with meals and encouraged to eat at least 50% of most meals. 2. Resident will not have a weight loss of more than 5% in one month."

Review of resident 5's medical record revealed no nutritional care plan addressing the low albumin level.

On 8/8/02 at approximately 11:00AM, during an interview with the FSS and dietitian, the FSS stated, resident 5 "doesn't eat well, don't remember documenting any nutritional interventions." The FSS further stated that for awhile the Great Shakes were being offered but they were coming back, "there was

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no order for the Great Shakes." The FSS also stated she "did not call" the RD. The RD stated that resident 5's weight loss "happened so rapidly he is one who just fell through the cracks."

Observation of resident 5 during breakfast on 8/7/02 revealed him to eat 100% of everything offered. Resident 5 was not assisted by staff.

On 8/8/02 resident 5's lunch was observed. Resident 5 was served 180 cc of milk, 180 cc of water, green beans, noodles with gravy, ground meat with gravy and cake with cherry topping. He was observed to feed himself, with no encouragement from the staff. Resident 5 ate 75% of his green beans, 90% of his ground meat with gravy, 75% of his noodles with gravy, 100% of his cake with cherry topping, 90 cc of milk and 90 cc of water. Overall, resident 5 was observed to consume approximately 80% of his meal, on his own, with no staff interventions.

There was no documentation or observation to evidence that staff changed his diet to add increased calories and protein to this resident who was experiencing significant weight loss.

2. Resident 24 was admitted to the facility on 1/23/02, with the diagnoses of rib fracture, hypertension, and dementia.

A review of resident 24's weights revealed the following:

January 2002	139 pounds
February 2002	135 pounds
March 2002	130 pounds
April 2002	125 pounds
May 2002	124 pounds
June 2002	115 pounds

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F 325	Continued From page 14 July 2002 110 pounds August 2002 110 pounds Between the months of January 2002 and April 2002, resident 24 lost 14 pounds (10.1%) which is significant. Between the months of January 2002 and July 2002, resident 24 lost 29 pounds (21%) which is significant. A review of resident 24's medical record monthly nursing summary dated 5/02, documented under progress towards care plan goals, "...see dietary notes." For the month of May 2002, there were no dietary notes in resident 24's medical record. A monthly nursing summary dated 6/26/02, documented under progress towards care plan goals,"... meal consumption varies from 0-100%." A monthly nursing summary dated 7/15/02, documented under progress towards care plan goals, "...eats 50-75% of meals." A lab value taken at the facility and dated 5/17/02, showed an albumin level of 2.9 g/dl and the most current lab value dated 6/3/02, showed an albumin level of 3.0 g/dl. The quarterly nutritional assessment was completed by the FSS on 8/1/02. Resident 24's weight loss and low albumin level of 3.0 g/dl, dated 6/3/02, were not addressed by the FSS or RD on this quarterly nutritional assessment. A review of resident 24's medical record revealed a nutritional care plan addressing the weight loss, dated 1/28/02, with a target date of 7/26/02. The care plan documented "potential for weight loss d/t [due to] leaves 25% or more of food uneaten." The goals	F 325		

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F 325	Continued From page 15 documented that "resident will consume 75% of meals TNR [through next review]." The approaches documented to "monitor and record intake of meals TID [three times a day], monitor and record monthly weight, visit 1:1 and ask resident of food likes and dislikes, and offer snack of choice BID [twice a day]." On 8/7/02, the Director of Nurses (DON) and the FSS provided to the survey team a list of individuals who received "special nourishment" from the kitchen. Resident 24 was not on this list. A review of resident 24's medical record revealed an additional nutritional care plan addressing her recent weight loss dated 6/10/02 with a target date of 10/26/02. The care plan documented that "resident has had a recent weight loss due to decline in cognitive status and increased paranoia." The goals documented that "resident will be assisted with meals and encouraged to eat at least 50% of most meals, and resident will not have a weight loss of more than 5% in one month." The approaches documented were to "encourage oral intake, provide alternatives if doesn't want to eat her meal, encourage resident to come to dining room to eat, and if she eats in her room, to check frequently to make sure she is not having any difficulty with her meal, help provide a calm, relaxing atmosphere to eat, and monitor weight Q [every] month and PRN [as needed]." A review of resident 24's medical record revealed no nutritional care plan addressing the low albumin levels. A review of resident 24's medical record nursing notes dated 5/20/02, documented, "c/o [complains of] tooth ache." Nursing notes dated 7/5/02, documented, "c/o [complains of] being hungry, snacks given, resident c/o [complains of] mouth "teeth" pain when chewing."	F 325		

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There was no documentation to provide evidence that the facility made a dental appointment concerning her mouth pain.

A review of resident 24's medical record dietary notes revealed that no FSS or RD assessments addressing her weight loss or the low albumin level had been completed for resident 24.

A review of resident 24's medical record revealed that the physician was aware of her weight loss and low albumin, but no interventions were put in place.

An observation was done on 8/8/02 at 11:55AM in the dining room. Resident 24 was eating her lunch with no assistance. She was served pasta with gravy, meatballs with gravy, beans, 180cc of buttermilk, 360cc of water, and cherry cobbler. Resident 24 ate 60% of her meatballs with gravy, 75% of her pasta with gravy, 75% of her beans, 270cc of her buttermilk, 20cc of her water, and 90% of her cherry cobbler. Overall, resident 24 was observed to eat approximately 80-85% of her meal, on her own.

3. Resident 31 was admitted to the facility on 6/16/99, with the diagnoses of Rt. (right) leg spasms, arthritis, anemia, FX (fractured) Rt. fibula, Parkinson's with depressive features, constipation and degenerative joint disease.

A review of resident 31's weight's revealed the following:

December 2001	139 pounds
January 2002	138 pounds
February 2002	131 pounds
March 2002	131 pounds
April 2002	123 pounds
May 2002	125 pounds

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June 2002 118 pounds
July 2002 122 pounds
August 2002 120 pounds

Between the months of December 2001. and June 2002, resident 31 lost 21 pounds (15.1%), which is significant.

Between the months of March 2002 and June 2002, resident 31 lost 13 pounds (9.9%), which is significant.

Between the months of March 2002 and April 2002, resident 31 lost 8 pounds (6.1%), which is significant.

Between the months of May 2002 and June 2002, resident 31 lost 7 pounds (5.5%), which is significant.

A lab value taken at the facility and dated 4/12/02 showed an albumin level of 2.7 g/dl. The albumin of 2.7 g/dl dated 4/12/02 was the most current in resident 31's medical record and was acknowledged by the FSS on the quarterly assessment dated 7/9/02.

The yearly nutritional assessment was completed by the FSS on 4/16/02 and co-signed by the RD on 4/26/02. They documented the following, "resident not eating as well- eats in her room- feeds her self." They did not make any dietary recommendations concerning the weight loss or low albumin.

A quarterly assessment was completed by the FSS on 7/9/02 documenting, "...% loss- 7 lbs [pounds], ...food acceptance- 20-60%...Albumin- 2.7g/dl...Resident not eating well. Does like sweet foods. Will try [increase] caloric med pass..." There was no documentation to provide evidence that the calorie supplement was added as recommended.

A review of resident 31's medical record dietary

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F 325	Continued From page 18 progress notes revealed no RD assessment addressing the weight loss or low albumin had been completed for resident 31. Review of resident 31's medical record revealed a nutritional care plan addressing the weight loss, there was no date of origination on the care plan but it did document a target date of 10/7/02. The care plan documented that she "leaves 25% of food uneaten at most meals." The goal documented that "resident will be nutritionally stable as evidenced by not having a weight loss of greater than 5% in one month or 10% in 3 months." Approaches documented were the "staff needs to consult with resident and ask about food likes and dislikes, monitor and record weights, and report to the physician weight loss of more than 5 lbs [pounds], monitor and record intake of meals, and offer high calorie of choice BID [twice a day]." Review of resident 31's medical record revealed no nutritional care plan addressing the low albumin levels. Review of resident 31's medical record revealed no documentation that the physician had been notified of resident 31's weight loss and low albumin. The Monthly Nursing Summary's dated 7/1/02, documented that resident 31 "eats poorly", 6/12/02 documented that resident 31 "has lost weight", 5/1/02 documented that resident 31 "eats poorly at meals, and loves candy." Resident 31's Interdisciplinary Team Meeting (IDT meeting) on 4/16/02 document under dietary, "...loosing weight over past few months-doesn't eat very well-enjoys candy..." An IDT meeting on 7/9/02 documented under dietary "...may look at adding 2cal [calorie] supplement..." There is no documentation	F 325		

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that 2cal supplement was ordered.

In an interview with a facility aide on 8/8/02 at approximately 9:30AM, she stated that resident 31 "receives milk and juice at breakfast, but I have not seen a Health Shake. She also gets juice at lunch, but I have not seen a Health Shake then either."

In an interview with the food service supervisor on 8/8/02 at approximately 10:45AM, she stated that "I did not notify the dietitian of her [resident 31's] weight loss."

In an interview with the facility nurse on 8/8/02 at approximately 12:20PM, she stated "we have to fight to keep her [resident 31] up for dinner. If we are not in her room by 5:00PM she will already be in her pajamas. She is also up in the morning between 5-6:00AM." There were no documented interventions done to give resident 31 her meals at different times of the day.

During an observation of resident 31 on 8/8/02 at 12:05PM, she was in her room eating lunch. She had pasta with gravy, meatballs with gravy, beans, 180cc of milk and cherry cobbler on her tray. Resident 31 ate 100% of her cobbler, two bites of beans, pasta with gravy, meatballs with gravy, and 70cc of her milk. Overall, resident 31 was observed to consume approximately 5-10% of her meal on her own, with no staff interventions.

4. Resident 15 was admitted to the facility on 7/29/85, with the diagnoses of MR (mental retardation), seizure disorder, dysphasia, hypomenorrhea, G-tube (gastrostomy tube), quadriplegia, CP (cerebral palsy), and constipation.

The RD documented in a dietary note dated 1/20/02,

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that resident 15's albumin was 2.9 g/dl. On 1/28/02 the RD then documented that her albumin was 3.0 g/dl. There is no documentation to provide evidence that any interventions were implemented.

The yearly nutritional assessment was completed by the FSS on 2/9/02 and co-signed by the RD on 2/28/02. The low albumin of 3.0 g/dl dated 1/28/02 in an RD progress note was not addressed. The protein needs for resident 15 were not calculated.

In an interview with the dietitian on 8/6/02, she stated that "the last protein and calorie calculations for resident 15, were done on 4/3/97."

Review of resident 15's medical record revealed no documentation that the physician had been notified of the low albumin levels.

Review of resident 15's medical record revealed no nutritional care plan addressing the low albumin levels.

Review of resident 15's medical record revealed no current lab values to provide evidence that the dietary intervention of Fiber Source HN was providing enough protein to increase the albumin levels.

A lab value taken at the facility for resident 15, dated 8/7/02 showed an albumin level of 2.8 g/dl.

5. Resident 3, a 87 year old female, was admitted to the facility on 3/16/98 with diagnoses of diabetes mellitus, dementia, pernicious anemia and Alzheimer's Disease.

A lab value taken at the facility and dated 4/12/02 showed an albumin level of 2.6 g/dl and the most current lab value dated 7/15/02 showed an albumin

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F 325	Continued From page 21 level of 2.7 g/dl. The yearly nutritional assessment was completed by the FSS on 6/18/02 and co-signed by the RD on 6/27/02. The low albumin level of 2.6 g/dl dated 4/12/02 was not addressed by the FSS or RD on this yearly nutritional assessment. The protein needs were calculated at 62 gm (IBW in kg x 1.2). They calculated resident 3's IBW at 125 pounds, the protein requirement should have been calculated at 68 gm. Review of resident 3's medical record dietary notes revealed that no RD assessments addressing the low albumin had been completed for resident 3. Review of resident 3's medical record revealed no documentation that the physician had been notified of the low albumin levels. Review of resident 3's medical record revealed no nutritional care plan addressing the low albumin levels. Review of resident 3's medical record revealed no dietary interventions addressing the low albumin levels. On 8/8/02 at approximately 11:00 AM, the RD stated, "I can't remember if I was notified of the low albumin, but that doesn't mean I wasn't." 6. Resident 10, an 88 year old female, was admitted to the facility on 10/5/99 with diagnoses of spinal lumbar stenosis with depressive features, vertigo, urinary incontinence, constipation, glaucoma, osteoarthritis, chronic pain and decompression laminectomy. A review of resident 10's weights revealed the following:	F 325		

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February 2002 157 pounds
March 2002 146 pounds

Between the month of February 2002 to March 200 resident 10 lost 11 lbs (7%) which is significant.

June 2002 148 pounds
July 2002 138 pounds

Between the month of June 2002 and July 2002 resident 10 lost 10 lbs (6.8%) which is significant.

A lab value taken at the facility and dated 7/19/02 showed an albumin level of 3.2 g/dl.

The yearly nutritional assessment was completed by the FSS on 9/11/01 and co-signed by the RD on 11/20/01. The protein needs were calculated at 51gm (IBW in kg x 1.2). They calculated resident 10's IBW at 104 pounds, the protein requirement should have been calculated at 57 gm.

Review of resident 10's medical record dietary notes revealed that no RD assessments addressing the weight loss or low albumin had been completed for resident 10.

Review of resident 10's medical record revealed no documentation that the physician had been notified of the weight loss or low albumin level.

Review of resident 10's medical record revealed a nutritional care plan addressing the weight loss. There was no date of origination on the care plan but it did document a target date of 8/28/02. The care plan goals included: "1. Resident will be assisted with meals and encouraged to eat at least 50% of most meals. 2. Resident will not have a weight loss of

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more than 5% in one month."

Review of resident 10's medical record revealed no nutritional care plan addressing the low albumin level.

On 3/3/02, the FSS documented the following, "Continues to gain weight, may be d/t [due to] some edema. Weight not done d/t [due to] scales have been broken..." Resident 10 had a significant weight loss (7%) in the month of February to March, she did not have a weight gain.

Review of resident 10's medical record revealed dietary interventions by the FSS to offer a bedtime snack and continue with NAS (no added salt) diet dated 6/4/02. No other dietary interventions were documented in resident 10's medical record.

On 8/8/02 at 9:40 AM, resident 10 stated, "I'm happy I've lost weight." She further stated she wanted to loose it, doesn't take snacks and doesn't want them.

On 8/8/02 at approximately 11:00 AM, the FSS stated resident 10 is not on a planned weight loss. She further stated that resident 10 won't eat the snack provided to her but she does have a refrigerator in her room and provides her own snacks. The FSS also stated that she did not notify the RD of the weight loss or low albumin level.

On 8/8/02 resident 10's lunch was observed. Resident 10 was served 180 cc of milk, 180 cc of water, green beans, noodles with gravy, meatballs with gravy and cake with cherry topping. Resident 10 was observed to feed herself, with no encouragement or assistance from the staff. Resident 10 ate 50% of her green beans, 25% of her meatballs with gravy, 25% of her noodles with gravy, 25% of her cake with cherry topping, 50 cc of milk and 0 cc of water. Overall,

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F 325	Continued From page 24 resident 10 was observed to consume approximately 25% of her meal, on her own, with no staff interventions. On 8/8/02, resident 10's care plan was reviewed a second time and there was no care plan addressing a planned or resident desired weight loss program.	F 325		
F 361 SS=G	483.35(a)(1)-(2) DIETARY SERVICES The facility must employ a qualified dietitian either full-time, part-time, or on a consultant basis. If a qualified dietitian is not employed full-time, the facility must designate a person to serve as the director of food service who receives frequently scheduled consultation from a qualified dietitian. A qualified dietitian is one who is qualified based upon either registration by the Commission on Dietetic Registration of the American Dietetic Association, or on the basis of education, training, or experience in identification of dietary needs, planning, and implementation of dietary programs. This REQUIREMENT is not met as evidenced by: Based on staff interview and observations, it was determined that the facility did not utilize their part-time consultant dietitian in a manner which provided adequate supervision to the dietary manager or dietary staff regarding 1. accurately monitoring and assessing residents at risk for weight loss, healing of pressure sores or wounds and/or low protein status (Resident identifiers 3, 4, 5, 10, 14, 15, 24, 31, and CR1) and 2. monitoring the sanitation of the kitchen, ensuring proper storage, distribution and serving of foods.	F 361	Crandall and Associates was hired As the new consulting firm with Lynette Perkins, RD, CD as the dietitian For this facility Monthly RD reports are Completed and include the following Areas: Sanitation, Meal Service, Nutritional Assessment, Budget Control, Staff Development. This report is reviewed In an exit meeting with the Administrator, Director of Nursing, Food Service Supervisor and RD. A sample copy is Enclosed. Crandall and Associates Management And Clinical Manuals have been purchased And the staff have been given an overview Training on September 16,2002. The clinical Portion of these manuals also includes" Best Practice Guidelines" for weight lose, pressure Ulcers, low albumin, dialysis and tube Feeding. The food service supervisor was inserviced On August 10,2002 and again on September 3,2002 regarding the Special Nutrition Program to provide additional calories and protein to residents with altered milk tid, super cereal 8 oz q am, super pudding 4 oz at lunch. This program was implemented on August 15,2002.	10-7-02

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F 361	Continued From page 25 Findings include: 1. Based on clinical record review it was determined that the facility did not ensure that each resident maintained an acceptable parameter of nutritional status as evidenced by 2 of 10 sampled residents plus an additional 2 residents experienced significant weight loss with no dietary interventions implemented to prevent further weight decline. 2 of 10 sampled residents plus and additional 4 residents experienced low albumin (a protein) levels with no dietary interventions implemented to help increase the albumin levels and prevent further protein depletion. 3 of 10 sampled residents with pressure sores or wounds did not have dietary interventions implemented to help promote healing. Further, the dietitian did not provide services and supports, through assessment, monitoring and recommendations, to meet each resident's nutritional needs. The facility failed to provide dietetic supports and services which maintained the body weights for residents 5, 24, 31 and 10 as evidenced by: a. Resident 5 was admitted to the facility on 9/7/01 with diagnoses including mood disorder due to cerebrovascular disease, hypothyroidism and hypertension. A review of resident 5's weight history revealed the following: January 2002 144 pounds February 2002 149 pounds March 2002 144 pounds April 2002 141 pounds May 2002 139 pounds June 2002 132 pounds July 2002 126.5 pounds	F 361	The food service staff was inserviced on September 3,2002 regarding the following Proper labeling and dating of food items, Storage (see attached leftover policy), Interpreting the spreadsheet, portion control And distribution. At least1 meal service is Monitored each month via the RD monthly Report.	

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Between the months of January 2002 and July 2002 resident 5 lost 17.5 pounds (12%) which is significant.

Between the months of April 2002 and July 2002 resident 5 lost 14.5 pounds (10%) which is significant.

A review of dietary notes completed since resident 5's admission did not evidence that the dietitian re-assessed his nutritional needs based on his significant weight loss. There was no documented evidence that dietary interventions were attempted to increase calories in resident 5's diet. Resident 5's weight had been on a downward trend since March 2002.

b. Resident 24 was admitted to the facility on 1/23/02 with diagnoses including rib fracture, hypertension and dementia.

A review of resident 24's weight history revealed the following:

January 2002 139 pounds
February 2002 135 pounds
March 2002 130 pounds
April 2002 125 pounds
May 2002 124 pounds
June 2002 115 pounds
July 2002 110 pounds
August 2002 110 pounds

Between the months of January 2002 and April 2002, resident 24 lost 14 pounds (10.1%) which is significant.

Between the months of January 2002 and July 2002, resident 24 lost 29 pounds (21%) which is significant.

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A review of dietary notes completed since resident 24's admission did not evidence that the dietitian re-assessed her nutritional needs based on her significant weight loss. There was no documented evidence that dietary interventions were attempted to increase calories in resident 24's diet. Resident 24's weight had been on a downward trend since February 2002.

c. Resident 31 was admitted to the facility on 6/16/99 with diagnoses including anemia, Parkinson's with depressive features and arthritis.

A review of resident 31's weight history revealed the following:

December 2001 139 pounds
January 2002 138 pounds
February 2002 131 pounds
March 2002 131 pounds
April 2002 123 pounds
May 2002 125 pounds
June 2002 118 pounds
July 2002 122 pounds
August 2002 120 pounds

Between the months of December 2001 and June 2002 resident 31 lost 21 pounds (15.1%) which is significant.

Between the months of March 2002 and June 2002 resident 31 lost 8 pounds (6.1%) which is significant.

Between the months of May 2002 and June 2002 resident 31 lost 7 pounds (5.5%) which is significant.

A quarterly dietary assessment, dated 7/9/02 and completed by the FSS was reviewed. The recommendation was made to increase the high calorie

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supplement at medication pass due to resident 31 not eating well. There was no documented evidence that the high calorie supplement was added as recommended.

A review of all dietary notes completed since resident 31's admission did not evidence that the dietitian re-assessed her nutritional needs based on her significant weight loss. There was no documented evidence that dietary interventions were attempted to increase calories in resident 31's diet. Resident 31's weight had been on a downward trend since February 2002.

d. Resident 10 was admitted to the facility on 10/5/99 with diagnoses which included spinal stenosis with depressive features, osteoarthritis and chronic pain and decompression laminectomy.

A review of resident 10's weight history revealed the following:

February 2002 157 pounds
March 2002 146 pounds

Between the months of February 2002 and March 2002 resident 10 lost 11 pounds (7%) which is significant.

June 2002 148 pounds
July 2002 138 pounds

Between the months of June 2002 and July 2002 resident 10 lost 10 pounds (6.8%) which is significant.

On 8/8/02 at 9:40 AM resident 10 was interviewed. She stated that she was happy to have lost the weight and wanted to lose it. She further stated that she did not want snacks.

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On 8/8/02 at approximately 11:00 AM, the FSS was interviewed. She stated that resident 10 was not on a weight loss plan. She further stated that she had not informed the dietitian of resident 10's weight loss.

A review of resident 10's nutrition care plan documented as a goal "resident will not have weight loss of more than 5% in one month". The care plan did not document a planned or resident desired weight loss program.

A review of all dietary notes completed since resident 10's admission did not evidence that the dietitian assessed her significant weight loss or the fact that resident 10 wished to lose weight.

The facility failed to provide dietetic supports and services to maintain or improve the protein status for residents 3, 5, 10, 15, 24, and 31 as evidenced by:

a. Resident 3 was admitted to the facility on 3/16/98 with diagnoses including Alzheimer's disease, diabetes mellitus and dementia.

A laboratory (lab) value taken and the facility and dated 4/12/02 showed an albumin (a laboratory test used to determine nutritional status) level of 2.6 g/dl (grams per deciliter). A more current lab value, dated 7/15/02, showed an albumin level of 2.7 g/dl.

An albumin level of less than 2.4 g/dl is considered a severe visceral protein deficit, an albumin level of 2.4 g/dl- 2.9 g/dl is considered a moderate visceral protein deficit and an albumin level of 3.0 g/dl-3.5 g/dl is considered a mild visceral protein deficit. . (Reference guidance: Manual of Clinical Dietetics, American Dietetic Association, 6th edition, 2000, page 22).

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F 361	Continued From page 30 A review of all dietary notes completed since resident 3's admission did not evidence that the dietitian re-assessed her nutritional needs based on her low albumin levels which indicated a moderate protein depletion. There was no documented evidence that dietary interventions were attempted to increase the protein provided in resident 3's diet. b. Resident 5 was admitted to the facility on 9/7/01 with diagnoses including mood disorder due to cerebrovascular disease, hypothyroidism and hypertension. A lab value taken at the facility and dated 5/17/02 showed an albumin level of 3.0 g/dl. A review of all dietary notes completed since resident 5's admission did not evidence that the dietitian re-assessed his nutritional needs based on his low albumin levels which indicated a mild protein depletion. There was no documented evidence that dietary interventions were attempted to increase the protein provided in resident 5's diet. c. Resident 10 was admitted to the facility on 10/5/99 with diagnoses which included spinal stenosis with depressive features, osteoarthritis and chronic pain and decompression laminectomy. A lab value taken at the facility and dated 7/19/02 showed an albumin level of 3.2 g/dl. A review of all dietary notes completed since resident 10's admission did not evidence that the dietitian re-assessed her nutritional needs based on her low albumin levels which indicated a mild protein depletion. There was no documented evidence that dietary interventions were attempted to increase the protein provided in resident 10's diet.	F 361		

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d. Resident 15 was admitted to the facility on 7/29/85 with diagnoses which included mental retardation, cerebral palsy, dysphagia and G-tube (gastrostomy tube) placement for feeding.

Resident 15's albumin levels were documented as 2.9 g/dl in a dietary note dated 1/20/02 and 3.0 g/dl in a dietary note dated 1/28/02. A lab value taken at the facility and dated 8/7/02 showed an albumin level of 2.8 g/dl.

A review of all dietary notes completed since resident 15's admission did not evidence that the dietitian re-assessed her nutritional needs based on her low albumin levels which indicated a moderate protein depletion. There was no documented evidence that dietary interventions were attempted to increase the protein provided in resident 15's tube feeding.

In an interview with the dietitian on 8/6/02 she stated, "the last protein and calorie calculations for resident 15 were done on 4/3/97".

e. Resident 24 was admitted to the facility on 1/23/02 with diagnoses including rib fracture, hypertension and dementia.

A lab value taken at the facility and dated 5/17/02 showed an albumin level of 2.9 g/dl. A more current lab value, dated 6/3/02, showed an albumin level of 3.0 g/dl.

A review of all dietary notes completed since resident 24's admission did not evidence that the dietitian re-assessed her nutritional needs based on her low albumin levels which indicated a moderate protein depletion. There was no documented evidence that dietary interventions were attempted to increase the

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protein provided in resident 24's diet.

f. Resident 31 was admitted to the facility on 6/16/99 with diagnoses including anemia, Parkinson's with depressive features and arthritis.

A lab value taken at the facility and dated 4/12/02 showed an albumin level of 2.7 g/dl.

A review of all dietary notes completed since resident 31's admission did not evidence that the dietitian re-assessed her nutritional needs based on her low albumin levels which indicated a moderate protein depletion. There was no documented evidence that dietary interventions were attempted to increase the protein provided in resident 31's diet.
(Refer to Tag F-325)

The facility failed to provide dietetic support and services to help promote pressure sore or wound healing for residents 4, 14 and CR1 as evidenced by:

a. Resident 4 was a 66 year old female who was admitted to the facility on 7/19/02 with the diagnoses of multiple sclerosis, congestive heart failure, hypothyroidism, pressure sores, urinary tract infection, colostomy, and atrial fibrillation. Resident 4 was alert and oriented.

The medical record of resident 4 was reviewed from 8/6/02 - 8/8/02. The admission nursing assessment, dated 7/19/02, documented that resident 4 was admitted with five pressure sores. Four of these pressure sores were at a stage 4 and the fifth pressure sore was a stage 2.

The Nutritional Assessment, signed by the food service supervisor (FSS) on 7/22/02 and by the registered dietitian (RD) on 7/24/02, recorded the

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F 361	Continued From page 33 admission weight of resident 4 to be 152 pounds (which is equal to 69 kg). The nutrition assessment documented that resident 4 was to receive a no added salt, soft diet. The assessment also documented that resident 4 "does not like milk, resident with multiple pressure sores - Monitor intake of meals. Assess for supplement with increased pro (protein), zinc, etc." The protein needs of resident 4 were figured to be "69 - 83gm". Below this, the dietitian wrote in "1.0 - 1.2 gm/kgm". Considering that resident 4 was admitted with five pressure sores, one of which was producing moderate drainage, the dietitian did not calculate the protein requirements to adequately meet the needs of this resident to promote healing of the sores. Based on the recommendations of the American Dietetic Association (ADA), the minimal protein calculations for resident 4 should have been from 1.2 - 1.5 g/kg. This would have set her protein needs between 82.8 - 103.5. The dietitian could have calculated up to 2g/kg based on the multiple pressure sores and the moderate drainage. During an interview with the FSS on 8/8/02, she confirmed that resident 4 was receiving a regular diet. Based on the menus and nutritional statistics provided by the facility's food supplier, the regular diet served in the facility provided an average of 87 to 89 grams of protein a day, if the resident ate 100% of the meals served. On 8/7/02, the Director of Nurses (DON) and the FSS provided to the survey team a list of individuals who received a liquid protein supplement from the nurses during medication pass and a list of individuals who	F 361		

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received "special nourishment" from the kitchen. Resident 4 was not on either list.

During an interview with resident 4 on 8/8/02, she was asked if she received any special supplements with her meals or between meals. (Special supplements were explained as anything with extra protein like a sweet liquid drink or cheese or boiled eggs, etc.) Resident 4 stated that she received her meals three times a day and hot chocolate in the mornings after breakfast and did not receive any additional protein-type supplements. She also stated that she did not like milk. During further interview with resident 4, she stated that she would eat anything with chocolate and would be willing to try a chocolate protein shake, chocolate ice cream or boiled eggs. She also stated that she would not mind her hot chocolate being made with milk.

During an interview with the FSS and a dietary staff member on 8/8/02, they were asked if the hot chocolate for resident 4 was prepared with milk or water. The dietary staff member stated that they make it with water and add "a little milk". Making an 8 ounce cup of hot chocolate with milk, instead of water, would add approximately 8 grams of protein to this resident's diet.

During an interview with the facility's dietitian and the FSS on 8/8/02 at 11:30 AM, they were asked if the facility provided high protein diets or things like "super cereal". The registered dietitian stated that they did not and that she found "those types of things to be too labor intensive". She continued to say that she liked the residents to eat what was served to them and then if they needed more, the resident would be provided with a protein supplement.

In addition to the above, it was also determined that

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F 361	Continued From page 35 the facility's nurses, the facility's dietitian and FSS were not following the facility's policies regarding resident's with pressure sores. The policy titled "Residents with weight loss, and / or pressure sores" called for residents with pressure sores to be placed on the "special nutrition program with 2 Cal/cc med pass qid (liquid protein drink four times a day)." Page 249 of the facility's policy documents that the Special Nutrition Program provided 1403 additional calories / 43 grams of additional protein daily. The special nutrition program was not implemented for resident 4. b. Resident 14 was a 78 year old female who was re-admitted to the facility on 7/9/02 after suffering a hip fracture and then a surgical hip repair. The admission nursing assessment, dated 7/9/02, documented that resident 14 had a "pressure area on heel". The nutritional assessment was completed by the FSS on 7/14/02 and was not co-signed by the registered dietitian. The FSS documented that upon admit, 7/9/02, resident 14 weighed 156 pounds (equal to 70 kg). The FSS documented that resident 14 was to receive a low concentrated sweet diet and that her daily protein needs were 66 grams. The calculation of 66 grams of protein for resident 14 would not even equal 1.0 gram per kilogram which would still be below the minimum recommendation for repletion of an individual trying to heal tissues both at the surgical site and the pressure sore area. If resident 14's protein needs had been calculated based on ADA recommendations, the minimum protein necessary to promote healing for resident 14 would have been 85 to 105 grams.	F 361		

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The facility had established a care plan for resident 14 regarding "potential for altered nutritional status r/t (related to) diabetes, anemia". The care plan did not address nutritional concerns related to her recent hip fracture, surgery or pressure area to her heel. The care plan directed staff to provide a nutritional supplement if resident 14 ate less than 50% of most meals. Neither the nutritional assessment nor the nutritional care plan discussed adding additional protein to meet the needs of resident 14.

During review of the supplement list and the "special nourishment list" on 8/8/02, it was noted that resident 14 was not on either list.

During an interview with the registered dietitian on 8/8/02, she stated that the protein requirements for resident 14 had been "figured wrong".

Also, the facility did not implement the special nutrition program for resident 14 as required by their own policy.

c. Resident CR1, a 73 year old female, was admitted to the facility on 2/14/02 with diagnoses of right hip fracture, osteoporosis, history of bowel obstruction, hypoglycemia, hypothyroidism, history of seizures, and a hysterectomy.

A review of resident CR1's medical record revealed an initial nursing assessment which identified a stage II pressure ulcer on the coccyx measuring 3 X 3 cm, a stage II pressure ulcer on the bottom measuring 2.2 cm and red spots on both heels. The initial nursing assessment identified that resident CR1 was on a regular diet and did not need any nutritional supplements.

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F 361	Continued From page 37 The yearly Nutritional Assessment was completed by the FSS on 2/19/02. There was no documentation of the stage II pressure ulcers identified by the facility's nursing staff. The protein needs were not calculated for resident CR1. There was no documentation to provide evidence that the RD assessed or calculated resident CR1's nutritional needs or protein requirements. There were no lab values to assess if resident CR1 had a low albumin level due to the identified pressure sores. During an interview on 8/8/02, at approximately 11:00 AM, the RD stated that the FSS usually sees all residents as close to admission as possible to determine what they like or dislike. She further stated that unless she gets a call from the FSS she won't be in to see a resident, even with pressure sores. When the surveyor asked the RD about resident CR1 she stated, she usually remembers residents with pressure ulcers, but she doesn't remember resident CR1. According to the facility's policies and procedures (pg 261), "Residents identified with weight loss and/or pressure sores will be provided with additional calories, proteins and other nutrients if appropriate." There was no documentation to provide evidence resident CR1 received additional protein to help heal her pressure sores. (Refer to Tag F-281) 2. Based on observations it was determined that the facility did not store and serve food under sanitary conditions as evidenced by multiple food and beverage items not being labeled and/or dated. (Refer to Tag F-371)	F 361		

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F 361	Continued From page 38 3. Based on observations it was determined that the facility did not follow the approved menus as the dietary staff was unaware of the proper amounts of foods to serve residents, which resulted in inconsistent meal servings and variances in the amount of calories, protein and other nutrients provided to each resident. When the food distribution errors were brought to the attention of the food service supervisor (FSS), she examined the scoops and spoons the dietary staff were using and confirmed that the staff member had been serving the wrong amount. The FSS was observed to instruct the dietary staff member to continue to use the same utensils but to serve larger amounts. This method would not ensure the accuracy of the amount dispensed. (Refer to Tag F-363) On 8/8/02 at from 10:30 AM to 12:30 PM, the consultant dietitian was interviewed. She stated that she visited the facility 5-10 hours for one day each month. When asked if, for example, a resident was admitted to the facility on a day after she'd already made her monthly visit if the resident would not been seen until her next visit which could be weeks, she stated yes unless someone at the facility calls me. She stated that she did not attend any of the weight or care plan meetings held by the facility. Based on observations in the kitchen on 8/5/02 and 8/7/02 it was determined that the dietary staff lacked supervision to direct them in proper dietary procedures including the storage and serving of foods. There was no documented evidence that the consultant dietitian had identified and/or attempted to correct any of the deficient practices found during the re-certification survey.	F 361		

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F 363	Continued From page 39	F 363		
F 363 SS=E	483.35(c)(1)-(3) DIETARY SERVICES 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 observation and interview, it was determined that for the noon meal of 8/7/02, the facility's dietary staff were not following the approved menu. Specifically, food portions were inadequate. Findings include: 1. A member of the facility's dietary staff was observed to dish up the lunch meal on 8/7/02 between 11:10 AM and 11:30 AM. For the puree diets, the facility's menu required staff to provide one cup of the entree (Turkey A LA King), 1/2 cup of puree rice and 1/3 cup of puree broccoli. For 8 of the 8 puree diets, staff provided 1/2 cup of the entree and 1/3 cup of the puree rice. The menu was not followed for these two items. The surveyor then observed approximately 8 additional regular textured diets being prepared. For the regular diets, the facility's menu required staff to provide one cup of the entree (Turkey A LA King), 1/2 cup of rice and 1/2 cup of broccoli. For 8 of the 8 regular textured diets prepared, the dietary staff did not use a measured scoop, but rather a large spoon. The staff was observed to place 2 scoops of the rice on the plate and then cover it with 2 scoops of the entree and sometimes 2 and 1/2 scoops. Staff	F 363	An inservice was held on September 3,2002 with the Dietary staff which included The following: portion control, Reading/following spreadsheets Scoop sizes, with specific focus On portions for the mechanically Altered diets. The monthly RD report includes The monitoring of a least 1 meal Per month to ensure compliance With the menu via the spreadsheet And portion control. This report is Reviewed in the exit interview with The Administrator, Director of Nursing , Director of Food Service Supervisor.	10/7/02

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F 363	Continued From page 40 was also not observed to measure the amount of broccoli provided. When this method of food distribution was brought to the attention of the food service supervisor (FSS), she examined the scoops used for the puree and confirmed that the staff member had been serving the wrong amount. The FSS then went to a drawer and pulled out a metal measuring cup equal to one cup. The FSS then had the staff member use the large spoon and dish up the amount she had been giving to the residents and place it in the measuring cup. The amount was equal to a little over one half cup. The FSS then told the staff member that she could use the large spoon but just give larger scoops. This method would not ensure the accuracy of the amount dispensed.	F 363		
F 371 SS=E	483.35(h)(2) DIETARY SERVICES The facility must store, prepare, distribute, and serve food under sanitary conditions. This REQUIREMENT is not met as evidenced by: Based on observations within the ~~kit~~chen and further observations within the facility ha~~ll~~ways, it was determined that the facility did not store and serve food under sanitary conditions. Findings include: 1. A brief initial tour of the kitchen was conducted on 8/5/02 at 2:30 PM with the food service supervisor (FSS). The facility's freezer was observed to contain 3 different bags of breaded meats which did not have labels and were not dated. There was an additional bag of meat patties (reported by the FSS to be pepper	F 371	An inservice was given by Kay Painter, DON on August 23,2002 regarding the Proper storage of the ice scoop during The distribution of ice. A plastic labeled Container is available on the ice cart for The scoop storage when not is use. Staff Were instructed not to leave the ice scoop In the ice when not in use. An inservice was given by Lynette Perkins, RD, CD on September 3,2002 with the dietary Staff on the following items: proper storage Of items- sealing, labeling , and dating. The Staff have been instructed to check all areas Daily to ensure that all items are appropriately Labeled, dated and sealed. The RD will monitor all areas of the kitchen For compliance to this issue as part of the Regular monthly sanitation check and report.	10/7/02

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F 371	Continued From page 41 steak) with no label and no date. The refrigerator was observed to contain 4 one gallon pitchers of juice which were not dated. An additional smaller pitcher was observed to contain amber colored liquid. This smaller pitcher had no label, no date and no lid or cover. The refrigerator was also observed to contain a mostly empty gallon container of mayonnaise and half empty container of buttermilk ranch dressing. Neither container was dated as to when the original seal was broken. On 8/8/02, between 9:50 AM and 9:55 AM, two facility staff members were observed to pass ice to 14 facility residents. The ice was located in a large clear container and was sitting on a wheeled cart. The staff members would take a metal scoop by the handle, scoop ice into a resident's container and then leave the scoop sitting within the ice so that the handle touched the other ice. This technique contaminated the ice within the large container.	F 371		
F 387 SS=B	483.40(c)(1)&(2) PHYSICIAN SERVICES The resident must be seen by a physician at least once every 30 days for the first 90 days after admission, and at least once every 60 days thereafter. A physician visit is considered timely if it occurs not later than 10 days after the date the visit was required. This REQUIREMENT is not met as evidenced by: Based on record review and interviews, it was determined that 3 of 10 sample residents were not seen by a physician at least every 60 days as required. Resident Identifiers: 5, 20 and 15.	F 387	If dictations from MD visits not Received 1 week after visit Medical Recorders will call MD and request Dictations be sent to the facility within 1 week. Medical Records will provide charge nurse with a weekly list of residents due to be seen by MD. Charge nurse will notify MD of Required visit and make appointment For resident to be given either at the Facility or at MD's office, or if MD Is unable to come to facility house Physician will resume care.	10/7/02

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Findings include:

1. Resident 5, a 91 year old male, was admitted to the facility on 9/7/01 with diagnoses of fever, altered level of consciousness, mood disorder due to cerebral vascular disease, hypothyroidism, CVA and hypertension.

A review of resident's 5 clinical record revealed that the resident was seen by a physician on 1/29/02, 3/29/02 and 5/15/02. Resident 5 should have been seen by a physician on or around 7/15/02. There was no documentation in the clinical record to provide evidence that resident 5 had been seen by a physician.

The facility administration was asked by the survey team to provide documentation that resident 5 had been seen by a physician on or around 7/15/02. They were unable to locate any documentation to evidence that resident 5 had been seen by a physician in July 2002 for a 60 day review.

2. Resident 20 was a 24 year old female who was admitted to the facility on 11/13/00 with the diagnoses of coma, traumatic brain injury, obstructive hydrocephalus, other quadriplegia, dysphagia, incontinence, constipation, anemia, and venous thrombosis.

The medical record for resident 20 was reviewed on 8/7/02. During review of this record, it was noted that physician progress notes were present and documented visits for 9/13/01, 1/17/02, and 6/27/02. A nurse's note in May 2002 mentioned that the physician had been in to see resident 20, but there was no correlating physician's progress note. There was also no documentation to evidence that the physician performed visits every 60 days as required. Physician's progress notes were missing for November

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F 387	Continued From page 43 2001 and March 2002. On 3/8/02, facility staff were asked if they could show that resident 20 had been seen by a physician as required. Facility staff stated that nursing progress notes document that the physician saw resident 20 in May 2002, but "as of now we can not show she was actually seen." 3. Resident 15 was admitted to the facility on 7/29/85, with the diagnoses of mental retardation, seizure disorder, dysphasia, hypomenorrhea, G-tube, quadriplegia, cerebral palsy, and constipation. A review of resident 15's clinical record revealed that the resident was seen by a physician on 1/24/02 and 6/13/02. Resident 15 should have been seen by a physician on or around 3/24/02 and 5/24/02. There was no documentation in the clinical record to provide evidence that resident 15 had been seen by a physician. The facility administration was asked by the survey team to provide documentation that resident 15 had been seen by a physician on or around 3/24/02 and 5/24/02. They were unable to locate any documentation to evidence that resident 15 had been seen by a physician in March and May 2002 for a 60 day review.	F 387		
F 426 SS=D	483.60(a) PHARMACY SERVICES A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. This REQUIREMENT is not met as evidenced by:	F 426	Insulin sliding scale was developed By DON based on physicians formula. All licensed nursing staff was Inserviced by DON on August 16,2002 On how to use scale which was placed In the MAR. Weekly audits to be conducted By DON or designee x 1 month, then Monthly x 2. Audits to be reviewed In QA meeting.	10/7/02

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Based on interview and medical record review, it was determined that the facility was not providing pharmaceutical services (including procedures to assure the accurate administering of all drugs) to meet the needs of 1 of 10 sample residents. Specifically, one of the ten sample residents was an insulin dependent diabetic and did not receive sliding scale insulin as ordered by the physician. Resident identifier: 14.

Findings include:

Resident 14 was a 78 year old female who was admitted to the facility on 7/9/02 with insulin dependent diabetes mellitus and several other diagnoses.

The medical record of resident 14 was reviewed on 8/7/02. During this review, it was noted that physician's orders, dated 7/10/02, required facility staff to obtain pre-meal blood sugars and provide sliding scale insulin based on the results of the blood sugars. The physician provided a formula to follow to figure the amount of insulin that resident 14 would require. The formula was as follows: If blood glucose greater than 150, then (blood glucose - 100)/25. Based on this formula, facility nurses were not always providing insulin as ordered by the physician.

From July 10 through 31, 2002, a total of 22 days, facility nurses gave the wrong amount of insulin to resident 14 nineteen times.

On 7/10/02, at 4:00 PM, the blood sugar for resident 14 was 161. Facility nurses should have given 2 units of insulin, but instead gave none.

On 7/11/02, at 7:00 AM, the blood sugar for resident 14 was 219. Facility nurses should have given 4 units

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of insulin, but instead gave 2 units.

On 7/11/02, at 4:00 PM, the blood sugar for resident 14 was 224. Facility nurses should have given 4 units of insulin, but instead gave 5 units.

On 7/12/02, at 11:00 AM, the blood sugar for resident 14 was 293. Facility nurses should have given 7 units of insulin, but instead gave 8 units.

On 7/12/02, at 4:00 PM, the blood sugar for resident 14 was 222. Facility nurses should have given 4 units of insulin, but instead gave 5 units.

On 7/14/02, at 11:00 AM, the blood sugar for resident 14 was 273. Facility nurses should have given 6 units of insulin, but instead gave 7 units.

On 7/14/02, at 4:00 PM, the blood sugar for resident 14 was 136. Facility nurses should have given no insulin, but instead gave 1 unit.

On 7/17/02, at 4:00 PM, the blood sugar for resident 14 was 291. Facility nurses should have given 7 units of insulin, but instead gave 4 units.

On 7/18/02, at 7:00 AM, the blood sugar for resident 14 was 197. Facility nurses should have given 3 units of insulin, but instead gave 4 units.

On 7/19/02, at 11:00 AM, the blood sugar for resident 14 was 170. Facility nurses should have given 2 units of insulin, but instead gave 1 unit.

On 7/20/02, at 4:00 PM, the blood sugar for resident 14 was 240. Facility nurses should have given 5 units of insulin, but instead gave 6 units.

On 7/22/02, at 7:00 AM, the blood sugar for resident

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14 was 205. Facility nurses should have given 4 units of insulin, but instead gave 2 units.

On 7/25/02, at 7:00 AM, the blood sugar for resident 14 was 293. Facility nurses should have given 7 units of insulin, but instead gave 5 units.

On 7/25/02, at 4:00 PM, the blood sugar for resident 14 was 158. Facility nurses should have given 2 units of insulin, but instead gave none.

On 7/26/02, at 7:00 AM, the blood sugar for resident 14 was 213. Facility nurses should have given 4 units of insulin, but instead gave 2 units.

On 7/27/02, at 7:00 AM, the blood sugar for resident 14 was 136. Facility nurses should have given no insulin, but instead gave 1 unit.

On 7/28/02, at 7:00 AM, the blood sugar for resident 14 was 147. Facility nurses should have given no insulin, but instead gave 1 unit.

On 7/29/02, at 7:00 AM, the blood sugar for resident 14 was 146. Facility nurses should have given no insulin, but instead gave 1 unit.

On 7/30/02, at 7:00 AM, the blood sugar for resident 14 was 129. Facility nurses should have given no insulin, but instead gave 1 unit.

August 2002

From August 1 through the 7th, 2002, facility nurses provided the wrong amount of insulin to resident 14 five times.

On 8/2/02, at 7:00 AM, the blood sugar for resident 14

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F 426	Continued From page 47 was 150. Facility nurses should have given no insulin, but instead gave 2 units. On 8/3/02, at 11:00 AM, the blood sugar for resident 14 was 153. Facility nurses should have given 2 units of insulin, but instead gave none. On 8/4/02, at 7:00 AM, the blood sugar for resident 14 was 177. Facility nurses should have given 3 units of insulin, but instead gave none. On 8/4/02, at 11:00 AM, the blood sugar for resident 14 was 229. Facility nurses should have given 5 units of insulin, but instead gave 3 units. On 8/4/02, at 4:00 PM, the blood sugar for resident 14 was 162. Facility nurses should have given 2 units of insulin, but instead gave none. During interview with the Director of Nurses (DON) right after the mini-exit on 8/7/02, she agreed that errors had been made in the administration of insulin to resident 14. During further interview with the DON on 8/13/02, she stated that they did not have a policy of when to round up or down when calculating the formula given by the physician. She stated that the nurses should not round up when calculating this formula.	F 426		
F 495 SS=D	483.75(e)(4) ADMINISTRATION A facility must not use any individual who has worked less than 4 months as a nurse aide in that facility unless the individual is a full-time employee in a State-approved training and competency evaluation program; has demonstrated competence through satisfactory participation in a State-approved nurse aide training and competency evaluation program or	F 495	Nursing assistant's who have not Obtained a CNA certificate within 4 months of employment will be taken off the schedule until a certificate is in his/her personal file. Monthly audits will be conducted to ensure compliance. The audit will be conducted by The staff developer.	10/7/02

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F 495	Continued From page 48 competency evaluation program; or has been deemed or determined competent as provided in s483.150(a) and (b). This REQUIREMENT is not met as evidenced by: Based on review of employee personnel files and interviews with the Director of Nurses (DON) and the Nursing Assistants (NA) Coordinator, it was determined that 1 of 3 facility NA's, hired in the last 8 months, was not certified and had been working in the facility for more than 4 months. Employee identifier: 3. Findings include: NA 3 was employed at the facility on 3/25/02. She finished her nursing aide class on 7/9/02. She was listed as working as an aide on the current facility schedule for the dates of August 5, 6 and 7, 2002. In an interview with the DON and NA Coordinator, they stated, "she has not taken her nursing aide test yet. She has finished her class, and is waiting for vouchers to test. Yes, she is still on the schedule."	F 495		
F 516 SS=B	483.75(l)(3) ADMINISTRATION The facility must safeguard clinical record information against loss, destruction, or unauthorized use. This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined that the facility did not keep clinical records in a place that would protect against loss, destruction or unauthorized use.	F 516		10/7/02

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F 516	Continued From page 49 Findings include: On 8/5/02 at approximately 2:45 PM, several boxes of clinical records were observed in a lower basement tunnel within the facility. The records appeared to have gotten wet and appeared to have a great amount of mildew on them. The physical plant supervisor was interviewed by the life safety surveyor on 8/8/02. The physical plant supervisor confirmed that the files were resident clinical records and were as current as 1996.	F 516	On September 4,2002 all medical Records that were stored in the tunnel Were removed. All old records 7 years And older were taken to West Jordan to Be destroyed. All records now are stored In a central location safe from water. The Medical records storage room will be Organized quarterly by administrator and The medical records director. In January The Administrator and Director of Medical Records will destroy all old medical records That are 7 years old, by doing this and monitoring The medical records room there will always be Enough storage space in a area were the medical Records can be stored safely. In the future there Will be no storage of medical records in the Tunnel.	

Sep 18 02 07:56a -- ALPINE VALLEY CARE CENTER -- 801 785 5908 -- p.4
Sep 17 02 03:29p doc warners 8012988140 p.1

Attn Bruce Allison
4 pgs. total

Hi Bruce,

Hope your day goes well. Let me know if you have any questions.

F-281

The RD will visit monthly to review all high risk charting. A diet technician (DT) has been hired who has 2 years experience charting with Crandall & Associates systems. The DT will chart on all high risk residents (monthly and weekly significant weight changes, pressure ulcers, abnormal labs) and the RD will review, add a progress note and cosign. The DT will follow the Best Practice Guidelines – attached to the original POC. This will be the procedure until the dietary manager has received sufficient training that the RD determines that she can begin the high risk charting. The RD will continue to review, add a progress note and cosign as part of the monthly visit.

The RD meets monthly with the Administrator, DON or other nursing designee, FSS to review the monthly report compiled by the RD. The FSS has responsibility for the following areas from the RD's report: Sanitation, Meal Service, Staff Development, Dietary Budget, Nutritional Assessment. Nursing also has responsibilities in the areas of Meal Service and Nutritional Assessment. The RD makes recommendations to Nursing and Dietary based on the monthly report. The DON and FSS are responsible for addressing and implementing the policies and procedures specific to their areas of responsibilities.

The Administrator has the overall responsibility to ensure that the RD makes monthly visits and addresses all of the areas of the monthly report. The FSS will review the RD's report as part of the QA meeting. The RD will attend the QA meeting quarterly . HOW OFTEN DO YOU HAVE QA MEETINGS? DO WE WANT TO COMMIT ME TO A QUARTERLY RD VISIT AT THE QA MEETING?

F-325

Initially, the NAR meeting will be attended by the DT, FSS and a designee from nursing. When the FSS is fully trained, the meeting will be attended by the FSS and the designee from nursing. The RD will review the minutes from these minutes to ensure that they are being conducted appropriately as part of the monthly report. The RD will report on the compliance with the NAR meeting to the Administrator as part of the monthly exit meeting.

The QA committee will receive the monthly RD report which addresses that the meetings are being held on a weekly basis. The minutes are available for review as needed.

F-361

The Administrator has the responsibility to employ a qualified dietitian on a consultant basis. The RD will notify him each month when she will be planning to be in his building to compile the monthly report.

The QA committee will receive the monthly RD report as part of the QA meeting.

F-363

Food Portions will be monitored by the dietary manager or cook on a daily basis using the Trayline Checklist (see attached form 520). This form will be dated and filed for RD review each month. This will be done for 30 days and if the RD determines that it is acceptable, it will decrease to 3x/wk. The documentation will be kept in the dietary QA manual. The dietary manager has the responsibility to monitor and ensure the accuracy of scoop/portion sizes. The RD reviews at least 1 meal during her monthly visit.

The QA committee will receive the monthly RD report as part of the QA meeting.

F-371

As part of the daily recording of refrigerated temperatures, Form 403 (attached) has a column for checking the label, date and proper sealing of food items. This will be initialed daily by either the FSS, cook or aide to demonstrate that all food in the refrigerated units have been checked for proper labeling, dating and sealing.

The FSS will monitor the kitchen on a daily (5d/wk) basis to ensure that the labeling, dating and sealing is actually being accomplished as indicated by the form. The RD will check this form as part of her monthly visit. The completed forms will be kept in the Temperature Manual.

The QA committee will receive the monthly RD report as part of the QA meeting.

I HOPE THIS HELPS, I ALSO SENT THE 2 COPIES OF THE FORMS. PLEASE HAVE LYDIA BEGIN USING THEM ASAP. I WILL CALL YOU WHEN I KNOW WHEN I AM COMING. THE NEW DIET TECHNICIAN WILL COME IN WITH ME. THANKS FOR ALL OF YOUR HELP. PLEASE CALL IF YOU HAVE ANY QUESTIONS. LYNETTE

Lynette