STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245421	A. BUILDING _____ B. WING _____	06/30/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
NEW BRIGHTON CARE CENTER	805 SIXTH AVENUE NORTHWEST NEW BRIGHTON, MN 55112

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F 0689 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	**Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review, the facility failed to provide the appropriate modified texture diet for 2 of 8 residents (R1 and R2) whom had swallowing difficulties, and were at risk for choking. This placed R1 and R2 in immediate jeopardy for not receiving the correct modified diets as prescribed to prevent choking. In addition, 6 other residents (R4, R5, R6, R8, R9 and R10) who had a prescribed modified textured diets due to swallowing difficulties were at potential risk of receiving the wrong diet. In addition, there was 1 of 3 residents (R3) whom had an identified food allergy, received a food items which she was allergic to. The immediate jeopardy began on 6/25/20, when R1 received a NDD3 (bite-sized pieces of moist foods with near-normal texture that requires more chewing ability) diet instead of the NDD2 diet (moist/soft textured foods that are easy to chew and swallow), choked, required the [MEDICATION NAME] maneuver, oxygen and was hospitalized , and when R2 received grapes when on an altered diet. The administrator, director of nursing and associate director of nursing (ADON) were notified of the immediate jeopardy on 6/29/20, at 6:01 p.m. The immediate jeopardy was removed on 6/30/20, at 4:09 p.m. but noncompliance remained at the lower scope and severity level of G isolated, scope and severity level, which indicated actual harm that is not immediate jeopardy. Findings include: R1's admission MDS dated [DATE], indicated moderate cognitive impairment with [DIAGNOSES REDACTED]. R1 ate independently and was seeing speech therapist and complained of difficultly or pain when swallowing. R1's tray ticket indicated Diet: DYS2 Nectar Thk Liq, (dysphagia (difficulty swallowing) level 2, mechanically altered diet- moist and soft textured foods that are easy to chew- with nectar thickened liquids) small portions. R1's Initial Nutritional Evaluation dated 6/7/20, indicated R1 had, difficulty swallowing. R1's ST (speech therapist) - Therapist Progress and Discharge Summary dated 6/25/20, indicated R1's current swallowing level was nectar thick liquid, NDD2: Dysphagia-mechanical altered. R1's OT assessment dated [DATE], indicated R1 required NND2 mechanically altered diet with nectar-thick liquids and had difficulty swallowing liquids and foods. R1's incident report dated 6/25/20, included, 6/25/20 1740 (5:40 p.m.) NAR reported to RN (registered nurse) that resident was unresponsive. Resident was pale and gasping. RN initiated [MEDICATION NAME] Maneuver. CNA (certified nursing assistant) summoned nurse from adjacent station. Resident placed on floor. Staff continued chest thrusts. CNA instructed by nurse to visually check patient's mouth to see if any food could be removed. CNA was able to remove food which appeared to be bread and pork. Sats (oxygen saturation level, normal is 95-100%) increased to 95% after intervention. Prior, sats were ranging from 20-40%. Oxygen was applied by RN which resulted in regular breathing. RN called 911. Nurse called family to inform them about situation and that patient was being sent to the hospital. Upon arrival of EMS - resident was stable. Staff placed him in bed for comfort via Hoyer with head of the bed raised. Resident had emesis after being transferred the stretcher. At 1820 (6:30 p.m.) resident was taken to Regions Hospital. MD (medical doctor) and DON updated. DON placed call to Regions hospital to check on condition. Investigation initiated immediately. Administrator and ADON notified. RN informed DON that the diet resident received was incorrect. This was confirmed by the dietary aid. The patient received an NDD 3 (bite-sized pieces of moist foods with near-normal texture) diet when ordered to receive an NDD 2 diet (moist/soft textured foods that are easy to swallow). Administrator directed all staff involved in incident to document details of incident as to gather information for continued investigation. DON in constant conversation with staff regarding incident throughout evening. DON gathering information and continuing investigation. Immediate reeducation of nursing and dietary staff related to modified diets. Resident hospital speech notes reviewed. Resident was being seen by speech therapy in facility. DON followed up 6/26 Nursing and dietary policies/procedures reviewed. Education and training also reviewed for staff involved and was noted to be required. Training for registered dietary and nursing staff to be completed on 6/30/20. Registered Dietitian to provide training on diet texture, diet modifications and reading tray card. Statements reviewed with interdisciplinary team. Dietary aid interviewed. DON placed call again to Regions Hospital as well as son to check on condition. Cognition at baseline. X-ray shows infiltrate is present in left lower lobe. Incident will be reviewed at July's nursing meeting as well as at July's QAPI (quality assurance and performance improvement) meeting. When interviewed on 6/29/20, at 2:57 p.m. RN-A stated they had not receiving additional training on modified diets in the last week. RN-A further stated if the NA discovered a discrepancy, the NA should tell the nurse and the nurse could verify the order. RN-A further verified and stated, (R1) had a pulled pork sandwich and fries. It was not what (R1) was supposed to have. NDD2 was what he was supposed to get, but (R1) got the NDD3 diet. When interviewed on 6/29/20, at 3:02 p.m. the DON stated they had immediately started to train staff as they arrived to work about ensuring diets provided matched the directions on the dietary card and a high level overview of the different diet types provided in the facility. However, no monitoring was completed to ensure residents received the correct diet after the training was provided. When interviewed on 6/29/20, at 4:39 p.m. family member (FM)-A stated the facility informed (FM-A) that (R1) had been served bread and that (R1) should not have had it. The tray was handed to (R1) and then (R1) was left alone so staff could deliver the rest of the trays. Then staff returned to find (R1) not breathing quite right and the staff took food out of (R1's) mouth. FM-A stated that prior to this event, (R1) had been rehabilitating, and the family was planning for (R1) to return home. FM-A further stated the palliative care doctor told (FM-A) that the choking event was very traumatic for (R1) and (R1) was not going to improve. FM-A further stated (R1) had moved on to hospice care now. When interviewed on 6/30/20, at 11:45 a.m. dietitian (D) stated, NDD3 would be ground meat - moistened with gravy or sauce, certain vegetable would be avoided or pureed, certain fruits would be avoided or substituted - would need to be soft, can have bread, cake, vegetable should be soft mashable. When interviewed on 6/30/20, at 3:51 p.m. DON verified and stated discovering through staff interviews the night of R1's choking incident, that R1 was served the wrong diet tray. (R1) received an NDD3 instead of a 2. When interviewed on 6/30/20, at 3:58 p.m. cook (C)-C verified being the one who prepared R1's tray for dinner on 6/25/20. C-C stated, I looked at the tray ticket and thought it was a 3 but it was a 2. I was looking at it when it was still in the transport cart. R2's admission Minimum Data Set ((MDS) dated [DATE], indicated cognitively intact with [DIAGNOSES REDACTED]. R2 required extensive one person physical assistance to eat. The MDS identified R2 had a swallowing disorder and complained of difficulty or pain with swallowing. R2's Initial Nutritional Evaluation dated 6/15/20 indicated R2 had, difficulty swallowing and required a special diet of, Pureed, NDD1 along with honey thick liquids. R2's tray ticket indicated Diet: DYS1 Pur, Honey Thk Liq (pureed food with honey thickened liquid). R2's care plan initiated on 6/12/20, failed to include nutrition risks or how to manage her difficulty with swallowing. Even though R2's nutritional evaluation and admission MDS identified a swallowing disorder, her care plan failed to identify this. R2's progress note by the registered dietician dated 6/16/20, identified, Dx (diagnoses) dysphagia and s/sx (signs and symptoms) swallowing problems: c/o (complains of) difficulty and pain with swallowing which necessitates the pureed, honey thick textures. R2's progress note by registered nurse (RN)-B dated 6/23/20, at 3:03 p.m. indicated, Resident had great difficulty with medication this

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 0689 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 1) shift. Writer asked if she preferred applesauce or pudding. Resident chose pudding. Medications were crushed and administered with honey thick liquid to follow pudding. Resident coughed, choked, sneezed, gagged, and mouth, nose, and eyes watered for approximately 15 minutes. Resident turned red and struggled to maintain baseline breathing before administration. R2's nurse practitioner's progress note dated 6/25/20, identified, Per nursing, pt (patient) on hospice but is struggling with swallowing. Tried nectar and honey thickened per Speech therapy. However, pt is unable to swallow causing her to choke. R2's progress note by RN-C dated 6/26/20, at 12:26 a.m. indicated, Pt. (patient) continues to have complications swallowing; staff is currently attempting to find things that pt. can consume safely. During observation on 6/29/20, at 11:14 a.m. the lunch trays were prepped in the kitchen while stacked in the transport cart. There was a tray ticket on each tray with a picture of the resident. The tray tickets listed the specific information for each resident including diet type and required modifications, food allergies and special instructions. The director of dietary services stated that this was the tray preparation process the facility had been following since the COVID-19 outbreak and elimination of communal dining. During observation on 6/29/20, at 12:13 p.m. R2 was in the north common area and had a meal tray in front of her that consisted of pureed spaghetti, pureed carrots, ice cream, thickened milk, thickened juice and whole grapes. R2's tray ticket identified, DYS 1 Pur, Honey Thk Liq. R2 pointed to the dish of grapes to LPN-A whom was at the table assisting with the lunch meal and LPN-A removed the grapes from R2's tray. When interviewed on 6/29/20, at 12:32 p.m. R2 stated, I cannot eat grapes. LPN-A stated, I don't know why they gave (R2) grapes. LPN-A stated R2 was on a puree diet with honey thickened liquids as indicated on the tray ticket. LPN-A further stated R2 was at risk for choking and whole grapes were not appropriate for R2's diet. When interviewed on 6/29/20, at 12:40 p.m. dietary aide (DA)-B stated R2 required a NDD 1 (level 1 dysphagia (difficulty swallowing) diet including only pureed foods with the same texture as pudding) pureed diet with honey thickened liquids and should not have been served whole grapes. When interviewed on 6/29/20, at 12:43 p.m. director of dietary services (DDS) stated the fresh fruit indicated on the lunch menu should have been pureed and thickened grapes for anyone on an NDD1 pureed diet with thickened liquids. When interviewed on 6/29/20, at 12:52 p.m. nursing assistant (NA)-A stated the person who delivered the tray should have verified that the meal matched the diet on the tray ticket. When interviewed on 6/29/20, at 12:53 p.m. NA-B stated, I delivered (R2's) lunch tray today. NA-B further stated (NA-B) read the tray ticket and lifted the lid to the main dish, and confirmed R2 was getting a pureed meal. NA-B further stated R2 should not have been served whole grapes and did not notice them when the tray was checked. When interviewed on 6/29/20, at 12:58 p.m. LPN-A stated, Fortunately (R2) knows not to eat grapes, but if this was someone that ate alone and did not know, they could have eaten the grapes. When interviewed on 6/29/20, at 1:03 p.m. NA-A verified the point of care iPad charting system showed R2's header indicated, Diet: NDD1 (puree), texture: puree, fluid consistency: honey, special instructions: none. When interviewed on 6/29/20, at 1:09 p.m. the director of nursing (DON) stated resident's diets were indicated by orders placed upon admission or after a change in condition requiring a change in diet. The assistant director of nursing (ADON) stated point of care iPad chart was directly linked to point click care (PCC- the system that contains the electronic medical record). DON further stated the NA delivering the tray should check the tray for accuracy and if a discrepancy is discovered, they should remove the tray and notify the nurse immediately. When interviewed on 6/29/20, at 2:09 p.m. DDS stated the cooks were trained by experienced cooks upon hire, and that in-services were provided every time a new cook was hired. The dysphagia diet would have been taught to the new cook by the experience cook as well. The new cook works with an experienced cook for several weeks. The last in-service was 7/9/18, and there have been no new cooks since then. When interviewed on 6/29/20, at 2:54 p.m. NA-C stated the food on the resident's tray was supposed to be checked against the tray ticket. Upon hire, I was trained on the modified diet. NA-C further stated receiving re-education on 6/26/20, and there was an additional mandatory training scheduled for 6/30/20. R4's annual MDS dated [DATE], indicated moderate cognitive impairment with [DIAGNOSES REDACTED]. R4 required supervision and set up help for eating. R4's dietary tickets for breakfast, lunch and supper indicated, Diet: DYS 3 Adv, diabetic, ground meat. Per R4's speech therapy plan of care, dated 6/30/19, STG: Swallowing 1: In order to decrease the risk of aspirating/choking, patient will apply recommended safe feeding/swallow strategies (including bolus size/pacing control, through mastication, oral clearance between bites, cyclic ingestion of solids/liquids, and single sips of thin liquids across 90% of opps x3/3 observations. R4's care plan, last revised 6/30/20, indicated, (R4) has a nutritional problem: Inconsistent CHO (carbohydrate) intake r/t dx DM AEB elevated blood sugars >200; requires tx diet. (R4) has a dx dysphagia; requires mechanically altered diet. (R4) will tolerate diet textures without coughing, choking, s/sx aspiration. (R4) will comply with prescribed therapeutic diet. Diet: NDD3, 2gm na+, THIN LIQUIDS. Monitor intake and record q meal. Observe/document/report to Nurse, MD s/sx of dysphagia: Pocketing, Choking, Coughing, liquid spilling from mouth, Holding food in mouth, Several attempts at swallowing, Refusing to eat, Appears concerned during meals. Serve meals in the dining room and provide tray set up. ST (speech therapist) recommendations: small/single bites; slow rate of intake; cyclic ingestion liquids/solids. R5's quarterly MDS dated [DATE], indicated severe cognitive impairment with [DIAGNOSES REDACTED]. R5's dietary tickets for breakfast, lunch and supper indicated, Diet: small portions, NDD3. R5's care plan, last revised 7/6/20, indicated, (R5) has a potential nutritional problem r/t dx dementia. Loose teeth, does not want DDS appointment, necessitating a mechanically altered diet. Diet: Small portions, NDD3 d/t dental status. Monitor intake and record q meal. Serve meals in the dining room. R6's admission MDS dated [DATE], indicated cognitively intact with [DIAGNOSES REDACTED]. R6 required limited one person physical assistance to eat and complained of difficulty or pain when swallowing. R6's dietary tickets for breakfast, lunch and supper indicated, Diet: DYS 3 Adv. Per R6's speech pathology initial evaluation, dated 4/21/20, Swallowing: The patient demonstrates mild oropharyngeal dysphagia; likely consistent with baseline, but swallowing appears functional for a modified diet. R6's care plan, last revised 7/6/20, indicated, Altered nutrition: Inadequate oral food intake r/t (related to) decreased appetite and hx difficulty chewing/swallowing AEB requires mechanically altered diet and supplements. Diet: NDD3, thin liquids. Monitor and record intake at all meals. Provide tray set-up. R8's significant change MDS dated [DATE], indicated cognitively intact with [DIAGNOSES REDACTED]. R8 required extensive assistance to eat and complained of difficulty or pain when swallowing. R8's dietary tickets for breakfast, lunch and supper indicated, Diet: Regular. R8's care plan, last revised 6/30/20, indicated, Nutrition: (R8) has a potential for inadequate oral intake r/t dx malignant neoplasm of the brain, [MEDICAL CONDITION], edentulism AEB weight loss PTA and hospice status. (R8) will consume food and fluid as desired for comfort and pleasure. (R8) prefers to eat meals in her room. Staff will offer to go to dining room. Resident request to eat meal in bed will be honored. (R8) eats her meal over one to two hours. Provide eating assist prn (as needed). Provide, serve diet as ordered: Regular, Regular Textures, Thin Liquids. Monitor intake and record q meal. R8's Comprehensive Nutritional Evaluation, dated 4/10/2020, indicated difficulty swallowing and included She is receiving eating assist at meals; eats in her room and is being served on disposables. Her diet has changed since readmit from hospital-switched to puree NTL (nectar thick liquids) d/t difficulty swallowing likely r/t congestion. R9's quarterly MDS dated [DATE], indicated severe cognitive impairment with [DIAGNOSES REDACTED]. R9's dietary tickets for breakfast, lunch and supper indicated, Diet: DYS 3 Adv, PUREED MEAT. R9's care plan, last revised 6/30/20, indicated, (R9) has a potential for altered nutrition status r/t dx dementia. (R9) eats in the dining room. Provide, serve diet as ordered: NDD3, pureed meat, thin liquids. Monitor intake and record q (every) meal. R10's quarterly MDS dated [DATE], indicated severe cognitive impairment with [DIAGNOSES REDACTED]. R10 required supervision and one person physical assistance to eat. R10's dietary tickets for breakfast, lunch and supper indicated Diet: DYS 3 Adv. R10's care plan, last revised 6/2/20, indicated, Potential for altered nutrition r/t DX: DM and dysphagia requiring mechanically altered diet. Diet: NDD3, thin liquids. Monitor and record intake for all meals. The facility policy Dysphagia revised 3/2018, identified how to recognize and treat dysphagia. The policy indicated the resident would be assessed by a speech-language pathologist and recommend appropriate consistency diets. The policy further indicated staff would assure proper consistencies are prepared and served. The facility policy Therapeutic Diets reviewed 4/2020, indicated attending physicians would prescribe therapeutic diets for resident's that support the resident's treatment and plan of care. An altered texture for a diet would be considered a therapeutic diet. Standard mechanically altered diets available at the facility include NDD1 (pureed), NDD2, NDD3, honey thickened liquids, nectar thickened liquids, and pudding thickened liquids. The facility policy Dining Room Audits reviewed 4/2020, indicated the food and nutrition services department would audit regularly to ensure that resident needs are met and that dining is safe. The policy instructed, the dietician, food and nutrition services manager and/or dietary supervisor will make scheduled daily meal rounds to every dining room at all meal times to audit the dining room and food service to the residents. The auditor will assess whether correct therapeutic diets and consistencies are served. A copy of these audits was requested, but not provided by the facility. When interviewed on 6/30/20, at 2:30 p.m. DDS stated, they used to do the audits twice a week. However, this had not been done

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F 0689 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 2) in the past few months because of COVID-19 and need to change dining practices to mainly cart services rather than communal dining. The audits were not documented. The facility provided an undated National Dysphagia Diet Levels that indicated the following: NDD1 - puree, NDD2 - mechanical soft, NDD3 - dysphagia advanced, NDD4 - regular textures. The immediate jeopardy that began on 6/25/20, was removed on 6/30/20, when the facility modified the tray preparation and tray identification process to ensure all trays were checked prior to being placed on the transport cart and double checked for accuracy prior to reaching the resident. All staff who prepared food, delivered trays or assisted with feedings were educated on altered diets and when and how to review trays for accuracy. All meal tickets for residents with altered diets were changed to print on colored paper to stand out from regular diet tray cards. Audits were completed by nursing leadership to ensure tray accuracy. Staff were interviewed and could identify the tray identification process and differences in altered diets. The noncompliance remained at the lower scope and severity level of G, isolated, scope and severity level, which indicated actual harm that is not immediate jeopardy. R3's quarterly MDS dated [DATE], indicated moderate cognitive impairment with [DIAGNOSES REDACTED]. R3 also had a swallowing disorder with coughing or choking during meals or with medications. R3's care plan, last updated 6/30/20, indicated, The resident has a potential nutritional problem r/t (related to) dysphagia (difficulty swallowing) AEB (as evidenced by) requires NDD3 diet. Waiver for regular meat. Intolerance to rice starch, tomato (ok for tomato soup per her son), lettuce, popcorn, and nuts. R3's care plan did not reflect food allergies or Intolerances prior to 6/30/20. Per R3's speech therapy initial assessment, dated 9/6/17, Pt has a history of dysphasia upon her last stay at this TCU and was downgraded to an NDD3 diet with thin liquids. Referral to SLP now due to nursing and dietary staff noticing episodes of coughing, throat clearing, and emesis of phlegm during meals for the last 2 days. Swallowing difficulties are likely caused by weakness, fatigue, and lack of awareness while eating. SLP is required now to evaluate and treat in order to prevent malnutrition, respiratory compromise, and dehydration. R3's Initial Nutritional Evaluation, dated 8/22/17, included, no popcorn, hard nuts, small seeds, lettuce, and tomato. Per progress note dated 9/19/2018, Kitchen's staff notified writer that resident was coughing during breakfast. Writer came to assess resident in the DR. Resident was able to communicate verbally and stated: I am ok. Resident was removed to room for further assessment. Lung sounds were diminishes all lobes. TPR: 97.1, 76, 16, 121/67, 94%RA. Resident stated: I told you I didn't choke. I was trying to clear my throat. I had phlegm. Bethany, NP was updated in regards to the incident. Resident still wishes to have regular diet and refuses to follow the diet order which is NDD3. The Diet refusal form was signed. Writer provided the risks/benefits in regards to resident current condition and having regular diet would put resident at risk for aspiration. Resident is aware all the risks and benefits. R3's electronic medical record, allergy entry last revised on 5/18/18, indicated an active allergy to tomatoes, Reaction Note: Per son, responsible party, resident can eat tomato soup, but NOT tomatoes as she is allergic to the seeds. R3's electronic medical record, progress note dated 9/5/17 indicated, Resident admitted on NDD3 diet, multiple food intolerances Rice starch, popcorn, nuts, small seeds, tomato, and lettuce. No current orders for SLP (speech/language pathologist) but has been observed to be coughing during meals therefore therapy department will obtain orders for SLP eval and treat. R3's dietary tickets for breakfast, lunch and supper included, Observe for coughing or choking/no straw, and listed an allergy to lettuce, rice and tomatoes. When observed on 6/29/20, at 12:25 p.m. R3 sat alone at a table in the dining room. R3 was served spaghetti and whole meatballs topped with spaghetti sauce, a large slice of bread, sliced carrots, apple juice, whole milk, and applesauce for lunch. R3's tray ticked indicated, Diet: regular, allergy lettuce, allergy rice, allergy tomatoes. When interviewed on 6/29/20, at 1:00 p.m. C-A stated, (R3) She is on a regular diet, but no seeds. It says no seeds on her ticket, so we always check the tickets when we serve, usually we give her only shredded lettuce, and she doesn't like skins - like potato skins. NDD3 means the food has moisture, it should be soft and bite size, regular diet we can give every food, NDD3 we need to chop or dice them, and grind the meat, it needs to be soft. When interviewed on 6/29/20, at 1:15 p.m. R3 stated, Yeah it is hard for me to eat, the food has to be cut up, it's on my ticket to help me, I have choked before when eating, my lettuce has to be shredded up, things that gets caught in my throat. There is certain stuff I can't eat, the doctor said I can't have anything with seeds in it, and no tomatoes. They do feed me tomatoes and cucumbers once in a while - I just pick them out and throw them aside. When interviewed on 6/29/20, at 2:30 p.m. director of dietary services stated, The allergies are listed under dislikes on the meal cards- she can't have cucumber seeds, cucumber you have to do that delicately for her, no tomato seeds, when we interviewed her she said she doesn't like tomato seeds or cucumber seeds, because it gets stuck in her throat, it is a preference not an allergy. At 2:35 pm DDS stated here let me double check then went into R3's electronic Health Record through Point Click Care (PCC), reviewed the allergies listed for R3 and stated, well that is interesting . she is allergic to rice, lettuce, and tomato . I wonder if we are caught up on Optima (dietary software) let me look. It says allergy to lettuce in Optima already, but no tomato, I don't understand why I didn't get that information, I am supposed to be getting that information. At 2:45 p.m. when asked why R3 received spaghetti with tomato sauce for lunch if allergic to tomatoes, DDS stated She had it with the sauce? I thought that she had it with the tomato off, if she is truly allergic to tomatoes I just think that the nursing staff and dietary need to go through all these charts and make sure that if there is any allergies or anything that needs to be communicated with us. If I would have known that she had an allergy I would not have given it to her, we do have plain meatballs for those who cannot have tomato products. When interviewed on 6/29/20, at 2:52 p.m. dietary aid (DA)-A stated, On the meal ticket, the 'likes' means she likes to eat that, the 'dislikes' mean she doesn't like it, she don't like seeds to tomatoes it is not an allergy, she likes shredded lettuce, but she don't like the leaves, it's not an allergy, it is a dislike - she don't like the leaves and she don't like the seeds. When interviewed on 6/29/20, at 6:00 p.m. administrator stated, Like for Betty, she gets diverticulitis from the tomato seeds, so where should we be listing this on the care plan? When interviewed on 6/30/20, at 11:45 a.m. dietitian stated, I don't think that tomato was listed as an allergy in the care plan, if it were truly an allergy and she received a tomato sauce it would be the incorrect thing that should be omitted from her meals. Per the facilities policy titled, Food Allergies and Intolerances, last revised 08/17: a) Residents are assessed for a history of food allergies and intolerances upon admission and as part of the comprehensive assessment. b) All resident reported food allergies and intolerances are documented in the assessment notes and incorporated into the resident's care plan. c) Residents with food intolerances and allergies are offered appropriate substitutions for foods that they cannot eat.