STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345528	A. BUILDING ______ B. WING ______	12/14/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVER LANDING AT SANDY RIDGE	**1575 JOHN KNOX DRIVE** **COLFAX, NC 27235**

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F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care	F 656		12/14/17

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE
(X6) DATE: 01/04/2018

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 656	Continued From page 1 plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on staff interviews, resident observation, resident representative interview and record review the facility failed to develop a care plan to address significant weight loss in 1 of 8 residents (Resident #44). Findings included: Resident #44 was admitted to the facility on 3-7-17 with multiple diagnoses which included atrial fibulation, peripheral vascular disease, end stage renal disease, diabetes, dysphagia, and muscle weakness. The Minimum Data Set (MDS) dated 11-13-17 revealed that resident #44 was severely cognitively impaired. The MDS revealed that resident #44 needed extensive assistance with one person for bed mobility, transfers, dressing, toileting, and personal hygiene, limited assistance with one person for eating. Resident #44 was coded for dehydration and having a 5% weight loss in one month without being on a weight loss program. The resident did have speech therapy till 10-25-17 to assist with her dysphagia. The MDS indicated that resident #44 triggered for nutritional status and was to be care planned for her nutrition and weight loss. The Care plan dated 12-5-17 had no plan for resident #44's weight loss, nutrition, or eating needs. A review of resident #44's weights from June	F 656	Corrective action for the specific deficiency, F656, related to resident #44, has been corrected 12/14/2017 by initiating a care plan to address weight loss. The process that lead to the deficiency resulted in a breakdown of the "double check" system that was already in place. The system was as follows: The MDS Nurse Mentor provided the care plan decision page print out to the Nurse Mentor on the household. The Nurse Mentor was to complete the care plan with the team, check off each area, and return the care plan decision page to the MDS Nurse Mentor. The MDS Nurse Mentor was to verify the completion of the care plan and sign and close the MDS. The page for resident #44 was not completed, returned, or verified. All appropriate care related to this area was provided to the resident, at the resident's wishes, despite the written care plan not being active. The procedure for implementing the plan of correction is as follows: The care plan to address weight loss for resident #44 was completed 12/14/2017, an audit of all care plans was completed by the Clinical Mentor (DON) 12/18/2017 to assure all care plans were in place as indicated from the MDS, and all care plans were noted to be in place and accurate. The procedure to assure accurate completion of care plans will remain as stated above: The	

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F 656	Continued From page 2	F 656		

2017 to December 2017 revealed that the resident had a 13.9% weight loss. The weights were: June=115Lbs, July=113, August=114, September=115, October=108, November=101, December=99.

An interview with resident #44's daughter occurred on 12-13-17 at 4:30pm. The daughter stated that she did not feel the resident had a choice in what she was given to eat and that the food was not cooked appropriately. She went on to state that resident #44 needed supervision when she was eating because the resident would have "choking" episodes but that she was told by staff that unless the resident sat at the supervised table the resident could not be supervised. The daughter stated she requested her mother be placed at the supervised table.

An interview with the nursing assistant (NA) occurred on 12-14-17 at 12:20pm. The NA stated she did help in the dining room during meal times and that resident #44 had been sitting at the supervised table for 2-3 weeks. She went on to state that prior to that resident #44 was sitting at another table but was closely supervised because the resident would often fall asleep while eating. She stated that some days the resident did not sleep well and would be tired when she came to eat. The NA stated when the resident was offered help by the dining staff the resident would refuse stating "I can eat on my own". The NA stated she had not seen the resident "choke" or have trouble swallowing her food.

An interview with the nurse occurred on 12-14-17 at 12:30pm. The nurse stated she was not in the dining room all the time but that she had not seen or heard of resident #44 "chocking" or having

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The monitoring procedure to ensure the plan of correction is effective and the community remains in compliance is as follows: The MDS Nurse Mentor will monitor daily and the Clinical Mentor will monitor weekly as stated. The MDS Nurse Mentor will report on completed and accurate care plans monthly at the QAPI meeting. If any discrepancies are noted they will be addressed through the QAPI program as indicated.

The person responsible for implementing and overseeing the plan of correction is the Clinical Mentor.

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F 656	Continued From page 3	F 656		

trouble swallowing her food for "quite a while". She also denied ever hearing complaints from resident #44's daughter about the food or the resident not receiving help during meal times.

An interview with the Minimum Data Set (MDS) coordinator occurred on 12-14-17 at 3:45pm. The MDs coordinator stated she had coded resident #44 to have a care plan for nutrition and weight loss. She looked at the residents care plan and stated resident #44 was not care planned for nutrition or weight loss. The coordinator stated she did not know why this occurred as she was not the one to develop the care plan. She stated she did send the coordination sheet to the care planners to have this completed and did not know why this was not done.

An interview with the care plan coordinators (staff #1 and staff #2) occurred on 12-14-17 at 4:00pm. Both coordinators stated that they work together to develop care plans for the residents. They checked the care plan and the MDS for resident #44 and stated that the resident was not care planned for nutrition or weight loss but should have been. Staff #1 stated she missed putting nutrition and weight loss on resident #44's care plan because "I was focused on keeping the resident safe and from falling". She went on to state she was aware of the resident's weight loss but again was focused on the resident's safety. Both coordinators also stated that they had met with the resident's daughter to discuss hospice but that the daughter was refusing hospice services at that time.

An interview with the Director of Nursing (DON) occurred on 12-14-17 at 4:45pm. The DON stated he had not heard any complaints from

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F 656	Continued From page 4	F 656		

resident #44 or the resident's daughter regarding the resident not receiving food choices or the resident not receiving assistance during meal times. The DON also stated that he knew that the resident's daughter was approached regarding hospice services but that the daughter did not want hospice services at that time.

An observation of resident #44 occurred on 12-14-17 at 5:05pm. The resident was observed eating supper at the supervised table in the dining room. Resident #44 was offered assistance when it was noted she was having difficulty getting food onto her fork. The resident refused the help stating "I don't need help". The observation revealed the resident was able to adapt and ate over half of her meal. No "chocking" or difficulty swallowing was noted. The resident was noted to be able to finish her meal prior to the other residents at the table.

An interview with the Administer occurred on 12-14-17 at 5:30pm. The administrator stated she expected that the care plans be completed correctly and follow what MDS had triggered.