STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345106	A. BUILDING _____ B. WING _____	C 05/24/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRINITY RIDGE	2140 MEDICAL PARK DRIVE HICKORY, NC 28602

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 367 SS=D	483.60(e)(1)(2) THERAPEUTIC DIET PRESCRIBED BY PHYSICIAN (e) Therapeutic Diets (e)(1) Therapeutic diets must be prescribed by the attending physician. (e)(2) The attending physician may delegate to a registered or licensed dietitian the task of prescribing a resident's diet, including a therapeutic diet, to the extent allowed by State law. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews, the facility failed to follow and serve the prescribed therapeutic diet of no added salt to 2 of 4 sampled residents residing in the facility (Residents 2 and #7). The findings included: 1. Resident #7 was admitted to the facility on 01/28/17 with diagnoses including diabetes, hypertension and unspecified dementia. Review of the May 2017 recapitulation physician orders, the original order of 01/29/17 was included for a limited concentrated sweet, no added salt diet. His most recent Minimum Data Set, a quarterly dated 03/09/17, coded him with moderately impaired cognition, requiring set up and supervision for eating, and receiving a therapeutic diet. The most recent dietary notes dated 05/15/17 stated he was on a limited concentrated sweet,	F 367	A. For the residents found to be affected the following actions were taken: 1. Residents #7 and #2 did not use the extra salt packets on the table. Both residents verbalized understanding that the physician has ordered for them not to add salt to their meals on 5/24/17. Dietician reviewed orders for therapeutic diets for residents #7 and #2 on 6/7/17. The CNA for resident #7 was in serviced by the SDC on 5/24/17 regarding the importance of following therapeutic diets as written on the tray card. The CNA for resident #2 was in serviced on 5/24/17 by the nurse manager regarding the importance of following therapeutic diets as written on the tray card. B. To address the potential for residents to be affected, the following actins have been taken: 1. Tray cards were audited to ensure that all therapeutic diets are communicated accurately and that tray cards match the order. The audit was done by Assistant	6/9/17

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

Electronically Signed | 06/06/2017

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F 367	Continued From page 1 no added salt diet. A care plan last updated 05/15/17 identified the problem of needing set up and if not eating provide encouragement. Interventions included to provide the ordered diet. On 05/24/17 at 12:33 PM Resident #7 was observed to have been served his meal by Nurse Aide #2 in the dining room. He was left with an unopened salt packet by his plate. The tray card indicated he was to receive a limited concentrated sweet, no added salt diet. He was observed able to cut up his roll and ham independently. At 12:36 PM, NA #2 was interviewed and she stated she gave him a salt packet by mistake. Upon follow up interview on 05/24/17 at 2:27 PM, NA #2 stated she was supposed to read the tray cards but was side tracked orienting a new staff member. Resident #7 stated during interview on 05/24/17 at 12:42 PM that he usually does not need salt as the food is fine without it. On 05/24/17 at 3:51 PM the Director of Nursing (DON) was interviewed. The DON stated the kitchen staff serve up the entree on the plates and the nurse aides were responsible for placing the condiments on the tray before service. The DON stated she expected the nurse aides to read and follow the tray card information. She further stated that they just had an all staff meeting specific to following the tray cards. On 05/24/17 at 4:03 PM the Administrator stated she expected staff to read and follow the tray	F 367	Food Service Director on 5/30/17. All staff who assist in tray set up were in serviced by the SDC on reading the tray card and following the instructions regarding therapeutic diets; training was completed by 6/6/17. Dietician completed therapeutic diet order audit of all residents on 6/6/17 and 6/7/17. C. The following systematic changes have been made to ensure deficient practices do not occur: 1. Therapeutic diets are written in large font on the tray cards to make them more visible for staff. Dietary staff will read therapeutic diets aloud to the CNA when serving from the tray line. Food Service Director in serviced dietary staff on changes by 6/8/17. D. The facility will monitor to ensure that solutions are maintained as follows: 1. DON or nursing supervisors will audit 2 trays on each neighborhood for each meal on each neighborhood daily for 30 days to ensure residents are receiving therapeutic diet as ordered. DON or nursing supervisor will then audit 2 trays for each meal on each neighborhood weekly for 3 months. Results will be reported to the QAPI committee quarterly to ensure compliance. Corrective action completed by June 9, 2017.	

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cards.

2. Resident #2 was admitted to the facility on 05/09/17. Her diagnoses included diabetes, hypertension, congestive heart failure, and chronic kidney disease.

Review of the admission physician orders dated 05/09/17 revealed the physician ordered her a regular texture, no added salt, limited concentrated sweets diet and to have her weighed daily before breakfast.

Her admission Minimum Data Set dated 05/16/17 coded her with having intact cognition, being independent with set up only for eating, and receiving a therapeutic diet.

The initial dietary assessment dated 05/11/17 revealed she was on a no added salt limited concentrated sweets diet. The note stated the resident was on daily weights due to fluid retention.

A care plan was developed 05/11/17 due to her risk for dehydration and weight fluctuations. Interventions included providing the diet as ordered.

Resident #2 stated during interview on 05/24/17 at 10:59 AM that her weights varied due to her fluid volume.

On 05/24/17 at 1:05 PM she was observed eating in her room her noon meal tray. The tray card listed her diet as no added salt and limited concentrated sweet. She received the planned menu of ham, sweet potato and received a fruit cup per her personal choice. She also had a salt

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packet which was not opened. At this time she stated she usually received a salt packet but usually the food did not need additional salt.

An interview with Nurse Aide (NA) #1 on 05/24/17 at 1:09 PM revealed NA #1 delivered Resident #2 her meal tray at noon. She stated she did not realize that she should not have received a salt packet. During follow up interview with NA #1 on 05/24/17 at 2:34 PM, NA #1 stated she was supposed to check the tray card and was rushing and failed to check the tray card indicating no added salt.

On 05/24/17 at 3:51 PM the Director of Nursing (DON) was interviewed. The DON stated the kitchen staff serve up the entree on the plates and the nurse aides were responsible for placing the condiments on the tray before service. The DON stated she expected the nurse aides to read and follow the tray card information. She further stated that they just had an all staff meeting specific to following the tray cards.

On 05/24/17 at 4:03 PM the Administrator stated she expected staff to read and follow the tray cards.