STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345145	A. BUILDING _____ B. WING _____	C 01/11/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROANOKE RIVER NURSING AND REHABILITATION CENTER	119 GATLING STREET WILLIAMSTON, NC 27892

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F 000	INITIAL COMMENTS No deficiency was sited as a result of the complaint investigation Evnet ID HCB011.	F 000		
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	F 656		2/12/18

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

Electronically Signed | 02/02/2018

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F 656	Continued From page 1 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 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 observations, staff interviews, and record review the facility failed to implement a resident's care plan by not providing assistance to attend activities for 1 of 3 residents reviewed for activities (Resident #36). Findings included: Resident #36 was admitted to the facility on 6/27/14. His active diagnoses included anemia, hypertension, diabetes mellitus, and Alzheimer's disease. Review of Resident #36's most recent comprehensive minimum data set assessment dated 4/24/17 coded as an admission assessment revealed he was assessed as severely cognitively impaired in his ability to make decisions regarding tasks of daily life. Resident #36's preferences for activities was listening to music, doing things with groups of people, and participating in religious activities or practices. Review of Resident #36's most recent quarterly minimum data set assessment dated 10/16/17 revealed the resident was severely cognitively impaired. Resident #36 required extensive assistance with bed mobility, transfers, and locomotion on and off unit.	F 656	Roanoke River Nursing and Rehabilitation Center acknowledges receipt of the Statement of Deficiencies and proposes this Plan of Correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and provisions of quality of care of residents. The Plan of Correction is submitted as a written allegation of compliance. Roanoke River Nursing and Rehabilitation Center response to this Statement of Deficiencies does not denote agreement with the Statement of Deficiencies nor does it constitute an admission that any deficiency is accurate. Further, Roanoke River Nursing and Rehabilitation Center reserves the right to refute any of the deficiencies on this Statement of Deficiencies through Informal Dispute Resolution, formal appeal procedure and/or any other administrative or legal proceeding. F656 Develop/Implement Comprehensive Care Plan CFR(s): 483.21 (b)(1)	

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F 656	Continued From page 2 Review of Resident #36's care plan, last updated 10/17/17, revealed the resident had a care plan for activities. Interventions included to offer activity programs directed towards Resident #36's specific interests, and transport Resident #36 to activities. During observation on 1/9/18 at 10:18 AM Resident #36 was observed to be in bed in his room during the game time activity in the activities room. During observation on 1/9/18 at 1:53 PM Resident #36 was observed to be in bed in his room during an art class activity in the activities room. During observation on 1/9/18 at 3:08 PM Resident #36 was observed to be in bed in his room during the story time activity in the activities room. During an interview on 01/10/18 9:36 AM Nurse Aide #1 stated activities staff would announce the activities and then offer activities to the residents by coming down the halls and asking them if they would like to attend. She stated she was not sure what activities Resident #36 would like to attend but believed he received one on one activities. She further stated the activities staff were the ones who would ask residents if they wished to attend and then let the nurse aides know who to help take to the activity. During observation on 1/10/18 at 9:46 AM Resident #36 was observed to be in bed in his room during the devotional activity in the activities room.	F 656	The process that lead the deficiency was based on observations, staff interviews and record review that the facility failed to implement a resident□s care plan by not providing assistance to activities for resident #36. Resident #36 was assisted out of bed on 1/10/18 by the floor Certified Nursing Assistant (CNA). Resident #36 was provided assistance to activities by the floor CNA and attended a church activity. Documentation of attending the activity was documented in Point of Care (POC) for resident #36. Resident #36 expired on 1/19/18. 100% of all current resident□s care plans were reviewed on 1/31/18 by the Minimum Data Set (MDS) nurse for providing assistance to activities, to ensure all resident□s that are care planned for providing assistance to activities are being assisted to activities per the care plan choices and that documentation of the attendance is documented in Point of Care (POC). The audit was completed utilizing a current resident census and was completed on 1/31/18. A list of those individuals requiring assistance was formulated and given to Activity staff and nursing staff and will be located at each nursing station and in the Activity Office. 100% in-service of all Nursing Staff was initiated by the Staff Facilitator on 1/25/18 on ensuring that residents care plans are followed in regards to providing	

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F 656	Continued From page 3 During observation on 1/10/18 at 10:10 AM Resident #36 was observed to be in his room sitting in his chair during the church activity in the activities room. During an interview on 1/10/18 at 10:14 AM the Activities Director stated staff provided an overhead announcement for activities and also activities staff go to the rooms of residents in the building to ask if residents who are cognitively impaired would like to go to the activities. She further stated Resident #36 received one on one activities three times a week. The Activities Director stated Resident #36 enjoyed religious activities and would sometimes sing or recite scripture when he attended such activities. She stated he was currently in his room during the church activity at that time, had not been offered to attend the church activity, and gave no reason why he was not in attendance. She further stated she would go to his room after the interview and offer further church activities. The Activities Director stated it was her expectation the care plan would be followed and Resident #36 would be offered activities and he was not. During an interview on 1/10/18 at 10:33 AM the Director of Nursing stated an activities assessment is performed on admission by the Activities Director to identify what activities the residents would like to attend. When the activity is about to begin an overhead announcement is made and activities staff let nursing staff know who wished to attend. Then nursing staff assisted residents to the activity. The Director of Nursing stated Resident #36 was not able to provide reliable answers when offered choices. She concluded her expectation was activities staff	F 656	assistance to activities with a list provided to nursing staff of these residents that will be located at each nursing station and in the Activity Office and will be completed by 2/5/18. The Administrator in-serviced the Activity Department on 2/01/18 to ensure resident care plans are followed in regards to providing assistance to activities with a list provided that will be located at each nursing station and in the Activity Office. 10% of residents that are care planned for providing assistance to activities will be observed for being provided assistance to activities by the Quality Improvement (QI) Nurse 3 times a week for 4 weeks, then weekly times 4 weeks and then monthly times 1 month utilizing an Activities QI tool. All identified areas of concern will be addressed immediately by the QI Nurse by retraining appropriate staff not providing the resident assistance to activities. The Administrator will review and initial the Activities QI tool weekly times 8 weeks and then monthly for 1 to ensure any areas of concerns have been addressed. The Administrator is responsible for forwarding the results of the Activity QI Audit Tool to the Executive QI Committee monthly times 3 month. The Executive QI committee will meet monthly and review the Activity QI Audit Tool and address any issues, concerns and\or trends and to make changes as needed, to include continued frequency of monitoring times 3 months.	

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F 656	Continued From page 4 would let her staff know to assist Resident #36 to activities and monitor his response to those activities according to his care plan.	F 656		
F 809 SS=E	Frequency of Meals/Snacks at Bedtime CFR(s): 483.60(f)(1)-(3) §483.60(f) Frequency of Meals §483.60(f)(1) Each resident must receive and the facility must provide at least three meals daily, at regular times comparable to normal mealtimes in the community or in accordance with resident needs, preferences, requests, and plan of care. §483.60(f)(2)There must be no more than 14 hours between a substantial evening meal and breakfast the following day, except when a nourishing snack is served at bedtime, up to 16 hours may elapse between a substantial evening meal and breakfast the following day if a resident group agrees to this meal span. §483.60(f)(3) Suitable, nourishing alternative meals and snacks must be provided to residents who want to eat at non-traditional times or outside of scheduled meal service times, consistent with the resident plan of care. This REQUIREMENT is not met as evidenced by: Based on record review, 5 of 5 residents present in the Resident Council Group Meeting (Resident #15, #50, #56, #46 and #12) and staff interviews, the facility failed to offer all residents in the facility a bedtime snack. The findings included: Review of the scheduled meal times for the facility revealed the time between dinner (evening	F 809	F809 Frequency of Meals/Snacks at Bedtime CFR(s): 483.60(f)(1)-(3) The process that lead to the deficiency based on record review, 5 of 5 residents present in the Resident Council Group Meeting (Resident #15, #50, #46 and #12) and staff interviews, the facility failed to offer all resident in the facility a bedtime	2/8/18

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F 809	Continued From page 5 meal) and breakfast was 14 hours and 30 minutes to 14 hours and 40 minutes. On 1/9/18 at 10:08 AM a Resident Council Meeting was held with 5 alert and oriented residents. All 5 of the residents in the meeting stated they were not offered a bedtime snack but they could get one if they asked for it. On 1/10/18 at 3:00 PM the Dietary Manager stated in an interview that snacks labeled with the resident's name were sent to the nurse's station at 8:00 PM for the residents who were diabetic and residents who had ordered snacks and supplements by the physician and the nursing assistants (NAs) pass them out. The Dietary Manager stated they usually sent extra sandwiches and they there were always graham crackers, cereal, peanut butter nabs, milk and juice at the nurse's station for residents who wanted a snack. On 1/10/18 at 3:50 PM an interview was conducted with NA #2 and NA #3. Both NAs stated the kitchen staff brought snacks to the nurse's station at 8:00 PM for residents who were diabetics or received supplements. The NAs stated that other residents on the unit could get a snack if they asked for one. On 1/10/18 at 4:05 PM, NA #4 stated in an interview the kitchen staff delivered snacks to the nurse ' s station around 8:00 PM for residents who were diabetic and those who were on supplements. The NA stated these snacks were passed out by the NAs on the unit. NA #4 stated she knew some of her residents like tea at night and she would ask them if they wanted their tea and would get it for them. The NA stated she	F 809	snack due to the time from the evening meal to breakfast the following day was greater than the required 14 hours, 14 hours and 30 minutes to 14 hours and 40 minutes. Resident #15, #50, #56, #46 and #12 are now being offered a bedtime snack. Resident #15, #50, #56, #46 and #12 were all offered bedtime snacks. All Nursing and Dietary staff was in-serviced on offering and providing a bedtime snack to all residents by the Staff Facilitator on 1/25/18. All residents will be offered a bedtime snack based on dietary restrictions. Snacks will be available at the nursing station for any resident who may request an additional snack. Staff will document all snack offers and refusal on a snack audit tool. DON and/or Administrative Nurses will review the snack audit tool 5x/week for 4 weeks, then 3x/week for 4 weeks, then weekly 4 weeks. Any identified areas of concern will be addressed and corrected by the DON and/or Dietary Manager. The Administrator is responsible for forwarding the results of the snack audit tool to the QI Committee monthly x 3 months. The Executive QI committee will meet quarterly and review the snack audit tool and address any issues, concerns and/or trends and make changes as needed to include continued frequency of monitoring x 3 months.	

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F 809	Continued From page 6 knew which residents usually asked for a snack and she would ask them if they wanted a snack but did not go around and ask all her residents if they wanted a bedtime snack. On 1/11/18 at 9:49 AM the Director of Nursing (DON) stated in an interview they have cereal, juice, milk and snacks available in the medication room and the residents that do not get snacks from the kitchen can get a snack if they wanted one. The DON stated she was not aware the NAs were not offering all residents a bedtime snack. On 1/10/18 an observation of the room with ice machine. Refrigerator has cartons of milk and juice. In top cabinet observed graham crackers, cereal and peanut butter nabs.	F 809		