STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265363	A. BUILDING _____ B. WING _____	09/25/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
RIVERWAYS MANOR	**403 WATERCRESS ROAD, BOX 969 VAN BUREN, MO 63965**

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0624 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Prepare residents for a safe transfer or discharge from the nursing home.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to document preparation and orientation for transfer to the hospital for one closed record resident (Resident #42) out of three residents selected for review. The facility's census was 42. Record review of Resident #42's Nurse's Notes showed: - The resident transferred to the hospital on [DATE] and readmitted to the facility on [DATE]; - The resident transferred to the hospital on [DATE] and returned to the facility the same day. Record review of the resident's medical record did not contain documentation which showed the resident was prepped and oriented for transfer out of the facility on 8/3/20 or 8/22/20. During an interview on 9/25/20 at 12:30 P.M., the Director of Nursing (DON) said she understood staff should document that a resident was prepped and oriented for transfer to the hospital. She said they go through the steps to tell them, but some of the residents do not understand. Record review of the facility's policy titled, Transfer or Discharge, Emergency, dated August 2018, showed should it become necessary to make an emergency transfer or discharge to a hospital, our facility will prepare the resident for transfer.
F 0641 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure each resident receives an accurate assessment.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to document a complete and accurate Minimum Data Set (MDS; a federally mandated assessment to be completed by the facility), and failed to accurately identify the type of assessment for one resident (Resident #20) out of 12 sampled residents. The facility's census was 42. Record review of Resident #20's physician's orders [REDACTED]. Observation on 9/24/20 at 9:07 A.M. showed the resident to have a [DEVICE] in place. Record review of the resident's quarterly MDS, dated [DATE], showed: - Section K0510 for presence of [DEVICE] not marked; - The MDS did not show an accurate assessment of tube feeding. Record review of the resident's annual MDS, dated [DATE], showed: - Assessment marked as a quarterly assessment in section V (care area assessment summary); - Section K0510 for presence of [DEVICE] not marked; - The MDS did not show the accurate type of assessment; - The MDS did not show an accurate assessment of tube feeding. During an interview on 9/25/20 at 12:30 P.M., the Administrator said she would expect: - The presence of tube feeding ([DEVICE]) to be indicated in section K on each MDS; - The correct assessment type to be listed in section V. The facility did not provide a policy for MDS completion.
F 0657 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to revise and update the comprehensive care plan with specific interventions to meet the individual needs of one resident (Resident #31) out of 12 sampled residents. The facility's census was 42. Record review of the Resident #31's Physician's Order Sheet (POS), dated 9/1/20, showed an order dated 4/22/20 for wound care to medial frontal head. Record review of the resident's Nurse's Notes, dated 6/14/20, showed: - Resident found in floor; - Skin tear to right forearm; - Physician and family notified. Record review of the resident's comprehensive care plan, last updated on 8/25/20, showed: - No interventions for wound care to medial frontal head; - No new interventions for fall on 6/14/20. During an interview on 9/24/20 at 12:25 P.M., the Director of Nurses (DON) said the resident has a history of [MEDICAL CONDITION] of the medial frontal head, the wound opens and heals frequently. During an interview on 9/25/20 at 12:30 P.M., the DON and Administrator said: - They would expect the comprehensive care plan to be updated for care of a chronic wound; - They would expect the comprehensive care plan to be updated with new interventions when there is a fall. Record review of the facility policy titled, Care Plans, Comprehensive Person-Centered, dated December 2016, showed: - A comprehensive, person-centered care plan that includes measurable objective and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident; - Assessment of residents are ongoing and care plans are revised as information about the residents and the residents' condition change.
F 0732 **Level of harm** - Potential for minimal harm **Residents Affected** - Many	**Post nurse staffing information every day.** Based on observation, interview, and record review, the facility failed to post nurse updated and accurate staffing data accessible to residents and visitors on a daily basis. This deficient practice had the potential to affect all residents. The facility's census was 42. Observation on 9/24/20 at 3:30 P.M., showed a blank nurse staffing sheet posted at the nurse's station. Record review of staffing sheets, dated 9/1/20 through 9/24/20, posted at the nurse's station showed: - On 9/1/20 the sheet not completed for each shift and no census; - On 9/2/20 the staff sheet blank; - On 9/7/20 not completed for each shift; - On 9/8/20 not completed for each shift; - On 9/9/20 not completed for each shift; - On 9/15/20 not completed for each shift; - On 9/16/20 not completed for each shift; - On 9/20/20 not completed for each shift; - On 9/21/20 no staffing sheet; - On 9/22/20 not completed for each shift. During an interview on 9/25/20 at 12:30 P.M., the Administrator said the staffing sheets should be completed accurately and posted each day. Record review of the facility's policy titled, Posting Direct Care Daily Staffing Numbers, dated July 2016, showed: - Our facility will post, on a daily basis for each shift, the number of nursing personnel responsible for providing direct care to residents; - Within two hours of the beginning of each shift, the number of Licensed Nurses and the number of unlicensed nursing personnel directly responsible for resident care will be posted in a prominent location (accessible to residents and visitors) and in a clear and readable format.

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.