STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	325033	A. BUILDING _____ B. WING _____	**05/27/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
RIO RANCHO CENTER	**4210 SABANA GRANDE SE RIO RANCHO, NM 87124**

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 0692 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Provide enough food/fluids to maintain a resident's health.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure that acceptable parameters of nutritional status were kept for 1 (R #1) of 1 (R #1) residents reviewed by not addressing significant weight loss. This deficient practice is likely to result in malnutrition, dehydration and decline in resident's well-being. A. Record review of R #1's face sheet dated 05/26/20 revealed R #1 was discharged on [DATE] to the Funeral Home: Mortuary. B. Record review of the Monthly weight report dated 05/26/20, reveals R #1's weight on 03/02/20- 150.6 lbs (pounds), 03/09/20-147.8 lbs, 03/16/20-144.4 lbs, 04/01/20- 127.4 lbs, and 05/04/20-109.4 lbs resulting in a 41.2 pound weight loss in two months. C. Record review of R #1's Nutrition progress note dated 04/21/20 revealed, (Name of R #1) has a stage II pressure ulcer (Injury to skin and underlying tissue resulting from prolonged pressure on the skin) on his (sic) coccyx (also known as the tailbone, is a small, triangular bone resembling a shortened tail located at the bottom of the spine). Her (R #1) current weight is 127.# (pounds), she (R #1) has lost weight over the past month. She (R #1) continues to be followed by hospice. She (R #1) receives liquid protein BID (twice a day). Diet is dysphagia (difficulty or discomfort in swallowing, as a symptom of disease) puree. Per chart, she (R #1) often asks for additional drinks. Current receives additional juice and ice tea at meals. Intervention: Will add house supplement TID (three times a day) and continue liquid protein BID. Continue to encourage intake of meals and fluid. Dietician available as needed. Care plan reviewed and updated. D. Record review of R #1's Activities of Daily Living (ADL) Record dated April 2020 revealed the Meal % (percent)/ Fluids section with most days not being completed by staff. Only the dates of 04/01/20, 04/02/20, 04/03/20, 04/14/20, 04/15/20, 04/18/20, 04/19/20, 04/20/20, 04/27/20, and 04/28/20 had one meal documented per day. On 04/22/20 there were two meals documented, but all other days and meals were left blank. E. Record review of R #1's care plan dated 03/03/20 revealed, Monitor for changes in nutritional status (changes in intake, ability to feed self, unplanned weight loss/ gain, abnormal labs) and report to food and nutrition/physician as indicated. F. Record review of R #1's Nutritional assessment dated [DATE] revealed, Evaluation/ Nutrition Plan- Goals: 1. Stable wt (weight) 2. PO (oral administration) intakes 50-75% (percent) for all meals 3. Promote wound healing 5. Prioritize quality of life. G. On 05/26/20 at 1:37 pm during an interview with the Registered Dietician (RD) #1, she stated, (Name of RD #2) is our dietician at (Name of another nursing facility) and she helps out a few days a week and I help out a few days a week. When asked about R #1's weight summary and weight loss, RD #1 stated, I would have wanted to get documentation of what her (R #1) usual weight is. As a clinician, I would have asked for a re-weigh (weigh something again) on April 1st (2020). I would have recommended and asked hospice to continue to re-weigh her after the April 8th (2020). We would have to feed her (R #1) and my assumption is they (staff) would feed her (R #1). H. On 05/26/20 at 2:10 pm during an interview with RD #2, when asked about R #1's nutrition progress note written by RD #2, she stated, That was the first time I had charted on her (R #1). It (R #1's weight loss) should trigger in there (electronic health record) when they (staff) put it in, if there's significant weight loss. It (R #1's weight loss) should have been triggered. To be honest with you, I'm not sure why it (R #1's weight loss) didn't trigger anything for me to see. RD #2 confirmed she was not aware of the significant weight loss that R #1 experienced. I. On 05/26/20 at 2:49 pm during an interview with the Director of Nursing (DON), when asked about R #1's April 2020 ADL Record showing incomplete meal%/ fluids data, DON stated, It looks like it's not filled out. You're taught in nursing school that if it's not documented, it didn't happen. J. On 05/26/20 at 3:31 pm during an interview with Registered Nurse (RN) #1, when shown R #1's April 2020 ADL Record showing incomplete meal %/ fluids data, RN #1 stated, It should not be blank at all. I train my staff not to do that. RN #1 confirmed R #1's ADL meal %/ fluids were not being properly tracked by staff.

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.