STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345336	A. BUILDING _____ B. WING _____	C 06/17/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROANOKE RAPIDS HEALTHCARE AND REHABILITATION CENTE	305 FOURTEENTH STREET ROANOKE RAPIDS, NC 27870

(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 242 SS=D	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. This REQUIREMENT is not met as evidenced by: Based on record review and staff and family interviews, the facility failed to inform the responsible party (RP) of all hospice service options available to her so that she could make an informed decision resulting in services not being provided for 1 of 2 residents (Resident #1). Findings included: Resident #1 was initially admitted to the facility on 3/18/13 with diagnoses that included cerebral vascular accident, chronic obstructive pulmonary disease, and metastatic brain neoplasm resulting in the requirement for total dependent care. As per the Minimum Data Set dated 2/19/2014, the cognitive assessment was unable to be completed due to the inability of the resident to complete the interview, rarely/never understood by others but at times does understand others by responding adequately to simple direct communication, and severly impaired in her decision making abilities. The Nurses Notes reviewed from April to June 2014 indicated a rapid decline in health. A grievance report dated 4/23/14 indicated that Resident #1 ' s RP made a request to the Director	F 242		7/9/14

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

Electronically Signed | 07/09/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345336	A. BUILDING _____ B. WING _____	C 06/17/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROANOKE RAPIDS HEALTHCARE AND REHABILITATION CENTE	305 FOURTEENTH STREET ROANOKE RAPIDS, NC 27870

(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 242	Continued From page 1	F 242		

of Nursing and Social Worker (SW) to have Resident #1 enrolled in hospice care in April 2014.

Resident #1 was hospitalized from 6/5/14 until 6/13/14 for pneumonia, after which she returned to the facility with hospice care issued by the hospital. Date of death was determined to be 6/14/14.

The discharge summary dated 6/13/14 from Hospital #1 stated that " Patient is being discharged to the nusing home today, she is to get hospice evaluation and treatment at the nusing home per (RP ' s) request. "

An interview was conducted with the SW at 3:40 PM on 6/17/14. She recalled that a few months ago the RP requested hospice services by an agency with whom the facility did not have a contract. The SW instructed the RP to discuss matters with the Administrator because it was the Administrator ' s responsibility to oversee the establishment and renewal of contracts with hospice agencies.

An interview was conducted with the Administrator at 3:52 PM on 6/17/14. She indicated that she was not employed by the facility until May 2014. She said that she understood that the former administrator explained to the RP that the only current contract was with Agency #1 and a pending contract with Agency #2. She said that the RP refused Agency #1 at that time because she wanted to have a contract established with the agency of her choice, Agency #3. She indicated that during April 2014 Agency #3 refused to provide services at the facility and so she, after becoming

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345336	A. BUILDING _____ B. WING _____	C 06/17/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROANOKE RAPIDS HEALTHCARE AND REHABILITATION CENTE	305 FOURTEENTH STREET ROANOKE RAPIDS, NC 27870

(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 242	Continued From page 2	F 242		

employed by the facility in May 2014, pursued to establish a contract with Agency #2, as a result of her interpretation that the RP did not want hospice care offered by Agency #1. She indicated that she worked with " corporate " to get this contract established but says that the legal department at Agency #2 delayed the process. The contract was still not established to date (6/17/14).

The Administrator further acknowledged that she did not keep the RP informed about the pending issues nor did she revisit the option of having hospice care provided by Agency #1 since May 2014. She acknowledged that the resident did in fact return to the facility on 6/13/14 from the hospital with a hospital-appointed hospice care provided which happened to be provided by Agency #1 on 6/13/14. She also indicated that the RP did not appear dissatisfied with the services offered by Agency #1. Moreover, the administrator acknowledged that the facility entirely failed to initiate the hospice protocol which included contacting the physician and evaluating Resident #1 for eligibility, since the initial request was made (April 2014).

An interview with the RP was conducted on 6/17/14 at 6:24 PM. She indicated that she was not kept informed of the delays with Agency #2. She stated that she would have prefered that hospice care begun in April 2014 when the initial request was made and that she was not satisfied that Resident #1 only begun to receive hospice care one day prior to the date of her death by a hopsital-issued arrangement. The RP also clarified that she never refused services by Agency #1, but requested services by the agency familiar to her (Agency #3). She continued to say

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345336	A. BUILDING _____ B. WING _____	C 06/17/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROANOKE RAPIDS HEALTHCARE AND REHABILITATION CENTE	305 FOURTEENTH STREET ROANOKE RAPIDS, NC 27870

(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 242	Continued From page 3 that had she been informed of the delays then she would have accepted hospice care by Agency #1 given Resident #1 ' s rapid decline.	F 242		