STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345215	A. BUILDING _____ B. WING _____	C 08/04/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVER TRACE NURSING AND REHABILITATION CENTER	250 LOVERS LANE WASHINGTON, NC 27889

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F 000	INITIAL COMMENTS A complaint investigation was conducted from 8/3/2023 to 8/4/2023. Event ID # X0CC11. The following intakes were investigated NC00204778 and NC00204399. Six of the six allegations did not result in deficiency.	F 000		
F 660 SS=D	Discharge Planning Process CFR(s): 483.21(c)(1)(i)-(ix) §483.21(c)(1) Discharge Planning Process The facility must develop and implement an effective discharge planning process that focuses on the resident's discharge goals, the preparation of residents to be active partners and effectively transition them to post-discharge care, and the reduction of factors leading to preventable readmissions. The facility's discharge planning process must be consistent with the discharge rights set forth at 483.15(b) as applicable and- (i) Ensure that the discharge needs of each resident are identified and result in the development of a discharge plan for each resident. (ii) Include regular re-evaluation of residents to identify changes that require modification of the discharge plan. The discharge plan must be updated, as needed, to reflect these changes. (iii) Involve the interdisciplinary team, as defined by §483.21(b)(2)(ii), in the ongoing process of developing the discharge plan. (iv) Consider caregiver/support person availability and the resident's or caregiver's/support person(s) capacity and capability to perform required care, as part of the identification of discharge needs. (v) Involve the resident and resident representative in the development of the discharge plan and inform the resident and	F 660		8/25/23

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

Electronically Signed | 08/19/2023

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resident representative of the final plan.
(vi) Address the resident's goals of care and treatment preferences.
(vii) Document that a resident has been asked about their interest in receiving information regarding returning to the community.
(A) If the resident indicates an interest in returning to the community, the facility must document any referrals to local contact agencies or other appropriate entities made for this purpose.
(B) Facilities must update a resident's comprehensive care plan and discharge plan, as appropriate, in response to information received from referrals to local contact agencies or other appropriate entities.
(C) If discharge to the community is determined to not be feasible, the facility must document who made the determination and why.
(viii) For residents who are transferred to another SNF or who are discharged to a HHA, IRF, or LTCH, assist residents and their resident representatives in selecting a post-acute care provider by using data that includes, but is not limited to SNF, HHA, IRF, or LTCH standardized patient assessment data, data on quality measures, and data on resource use to the extent the data is available. The facility must ensure that the post-acute care standardized patient assessment data, data on quality measures, and data on resource use is relevant and applicable to the resident's goals of care and treatment preferences.
(ix) Document, complete on a timely basis based on the resident's needs, and include in the clinical record, the evaluation of the resident's discharge needs and discharge plan. The results of the evaluation must be discussed with the resident or resident's representative. All relevant resident

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F 660	Continued From page 2 information must be incorporated into the discharge plan to facilitate its implementation and to avoid unnecessary delays in the resident's discharge or transfer. This REQUIREMENT is not met as evidenced by: Based on record review, family interview, and staff interviews, the facility failed to have an effective discharge planning process in place that included ensuring a resident who required home health services was referred and accepted for services prior to discharge and durable medical equipment was ordered and available upon discharge for one (Resident #1) of three residents reviewed for discharge planning. Findings included: Resident #1 was admitted to the facility from the hospital on 6/20/2023 with cumulative diagnoses, some of which included diabetes mellitus, diabetic retinopathy, chronic respiratory failure, macular degeneration, and hypokalemia. There was no documentation on the care plan initiated on 6/20/2023 for discharge planning prior to the discharge of Resident #1. The admission Minimum Data Set assessment dated 6/26/2023 revealed Resident #1 was coded as cognitively intact. Documentation in a Social Narrative progress note dated 6/28/2023 revealed a care plan meeting was scheduled with the resident representative of Resident #1. An interview was conducted with the facility Social Worker on 8/3/2023 at 12:30 PM. The Social Worker revealed a care plan meeting was held	F 660	River Trace 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. River Trace 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, River Trace Nursing and Rehabilitation Center reserves the right to refute any of the deficiencies in this Statement of Deficiencies through Informal Dispute Resolution, formal appeal procedure and/or any other administrative or legal proceeding. Resident #1 no longer resides at the facility. Facility Social Work had contacted home health provider and services were set to be initiated on 07/11/2023, upon further collaboration with resident and family. An audit was initiated by the Minimum	

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with the family of Resident #1 on 6/29/2023. She stated on 7/7/2023, during a telephone conversation, the family of Resident #1 indicated there was a possibility they were going to take Resident #1 to their home.

Documentation on medical equipment supplier order forms revealed on 7/7/2023 at 3:18 PM a prescription for a three in one commode and a wheelchair package was sent to the supplier from the facility for Resident #1.

Documentation on the discharge summary, completed by Nurse #1, dated 7/10/2023 effective 1:51 PM revealed the diagnosis upon admission was "Hypokalemia" and "copy of lab results provided" for recent lab work and pertinent clinical findings relevant to discharge. The documentation on the same form stated Resident #1 was discharging, "Home with son."

Documentation on the discharge instructions, completed by Nurse #1, for Resident #1 dated 7/10/2023 effective 1:51 PM revealed appointment information with a physician, medications were released, vaccination information, and diet information. The documentation on the discharge instructions did not indicate if any community services or equipment were needed.

Documentation in a health status note written by Nurse #1 dated 7/10/2023 at 5:52 PM indicated Resident #1 was discharged from the facility at 5:40 PM with her family. Discharge papers were reviewed and signed. Resident was escorted to the car via wheelchair by staff. All medications were sent home with the resident.

Data Set Nurse (MDS) to ensure all residents had a discharge plan of care in place. The MDS nurse will address all concerns identified during the audit to include updating plan of care for resident's desired discharge. The audit will be completed by 8/25/23.

On 08/16/2023 the interdisciplinary team to include Administrator, Director of Nursing, MDS nurse, Dietary Manager, Activities Director, Social Worker and therapy was educated by the nurse consultant on the requirements of ensuring each resident has a discharge plan of care, that home health services referral is completed/accepted prior to discharge and that durable medical equipment is ordered and available upon discharge when indicated. The facility will utilize a Discharge Checklist to ensure thorough completion of recommendations of services required prior to/upon discharge.

The Administrator and/or Director of Nursing will audit the Discharge Checklists weekly x 4 weeks then monthly x 1 month to ensure home health services referral is completed and accepted prior to resident discharge and to ensure durable medical equipment is ordered and available upon discharge for resident safety when indicated. The Administrator and/or Director of Nursing will address all concerns identified during the audit to include but not limited to the completion of home health referral, ordering of durable medical equipment

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An interview was conducted with Nurse #1 on 8/3/2023 at 2:02 PM. Nurse #1 revealed she was an agency nurse and on the day of discharge (7/10/2023) for Resident #1 she had been working at the facility for approximately three weeks. Nurse #1 also revealed she had never handled the discharge of a resident from a facility before. Nurse #1 stated she was alerted in the electronic medical record that Resident #1 was discharging home at 5:30 PM that day. Nurse #1 stated that at the time of discharge she printed off the discharge summary and the discharge instructions, went over the resident's medications with the family, gave the family the resident's medications, and assisted Resident #1 into the family's vehicle. Nurse #1 stated Resident #1 was able to stand and pivot into the seat of the vehicle under her supervision. Nurse #1 stated she took the wheelchair back into the facility after Resident #1 left because it was the facility's wheelchair. Nurse #1 stated she assumed someone else in the facility had set up services and equipment for the resident.

Resident #1 was unavailable for interview.

A phone interview was conducted with the family of Resident #1 on 8/3/2023 at 2:39 PM. The family explained a decision was made to take Resident #1 home on 7/10/2023. The family stated they thought all the services and needed equipment was set up by the facility, but the resident had not received her medical equipment as of 7/10/23 when discharged from the facility.

The medical equipment supplier order form (initially sent to the medical equipment supplier on 7/7/2023) revealed on 7/10/2023 at 10:11 AM, 7/10/2023 at 6:25 PM, and 7/11/2023 at 8:31 AM

when indicated and/or re-training of staff.

The Administrator will report the results of these audits to the Quality Performance Improvement Committee (QAPI) monthly x 2 months or until a period of sustained compliance.

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the supplier requested the facility provide signed orders for the requested equipment. The documentation revealed the physician approved the order for the equipment on 7/11/2023 at 10:36 AM and the equipment order was accepted on 7/11/2023 at 12:51 PM.

Documentation in email communication sent from the facility Social Worker to the Home Health agency dated 7/11/2023 at 10:32 AM stated, "Our resident [Resident #1] [discharged] home yesterday 07/10 and will need [Physical Therapy/Occupational Therapy/Skilled Nursing."

A follow up interview was conducted with the Social Worker on 8/3/2023 at 4:18 PM. The Social Worker revealed she started to set up delivery of needed equipment for the home of Resident #1 on 7/7/2023 but did not set up home health services until 7/11/2023, after the discharge of Resident #1. The Social Worker explained she did not go to work on 7/10/2023, the day of discharge for Resident #1. The Social Worker stated the Director of Admissions was her back up person to handle discharges in her absence. The Social Worker stated she did not know for certain Resident #1 was going to discharge on 7/10/2023 so she did not set up the home health services on 7/7/2023.

An interview was conducted with the Director of Admissions on 8/3/2023 at 4:29 PM. The Director of Admissions confirmed she was the back up person when someone was discharging, and the Social Worker was not going to be in the facility. The Director of Admissions also confirmed she put an alert in the electronic medical record on 7/10/2023 stating that Resident #1 was going to be discharged home with home health at 5:30

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PM. The Director of Admissions stated that the Social Worker sets up the home health and orders for equipment for residents as specified by the therapy department. The Director of Admissions stated she assumed the Social Worker set up home health for Resident #1.

An interview was conducted with the facility Administrator on 8/4/2023 at 9:15 AM. The Administrator stated that although she was not the Administrator at the time of the discharge of Resident #1, the facility had a process for discharging residents that was effective. The Administrator stated an initial care plan meeting was set up to begin planning for discharge or extended services. The Administrator stated that usually the Social Worker sets up home health services and medical equipment prior to discharge but in the case of Resident #1 it appeared discharge planning was not started until 7/7/2023 because the family indicated she would be a long-term resident of the facility in an initial care plan meeting.