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ROANOKE RIVER NURSING AND REHABILITATION CENTER	119 GATLING STREET WILLIAMSTON, NC 27892

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F 000	INITIAL COMMENTS A complaint survey was conducted from 10/30/20 through 11/2/20. Event ID#: 2X5V11 Immediate Jeopardy was identified at: CFR 483._15__ at tag F626 at a scope and severity (J) Immediate Jeopardy began on 10/28/20 and was removed on 10/31/20. 2 of the 2 complaint allegations were substantiated resulting in deficiencies.	F 000		
F 626 SS=J	Permitting Residents to Return to Facility CFR(s): 483.15(e)(1)(2) §483.15(e)(1) Permitting residents to return to facility. A facility must establish and follow a written policy on permitting residents to return to the facility after they are hospitalized or placed on therapeutic leave. The policy must provide for the following. (i) A resident, whose hospitalization or therapeutic leave exceeds the bed-hold period under the State plan, returns to the facility to their previous room if available or immediately upon the first availability of a bed in a semi-private room if the resident- (A) Requires the services provided by the facility; and (B) Is eligible for Medicare skilled nursing facility services or Medicaid nursing facility services. (ii) If the facility that determines that a resident	F 626		11/30/20

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

Electronically Signed | 11/19/2020

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F 626	Continued From page 1 who was transferred with an expectation of returning to the facility, cannot return to the facility, the facility must comply with the requirements of paragraph (c) as they apply to discharges. §483.15(e)(2) Readmission to a composite distinct part. When the facility to which a resident returns is a composite distinct part (as defined in § 483.5), the resident must be permitted to return to an available bed in the particular location of the composite distinct part in which he or she resided previously. If a bed is not available in that location at the time of return, the resident must be given the option to return to that location upon the first availability of a bed there. This REQUIREMENT is not met as evidenced by: Based on record review, hospital staff, law enforcement, resident, and staff interviews, the facility failed to allow a resident to return to the facility after being sent to the hospital for an evaluation using the resident's behaviors prior to transfer as a basis for the decision for 1 of 3 residents reviewed for transfer and discharge (Resident #1). This resulted in Resident #1 being found in a ditch approximately six miles from the facility the day after the hospital discharge. Immediate Jeopardy began on 10/28/20 when the facility, after Resident #1 was medically and psychiatrically cleared by the hospital physicians to return to the facility, refused to allow Resident #1 into the facility which resulted in Resident #1 being discovered in a ditch on 10/29/20 approximately six miles from the facility. Immediate Jeopardy was removed on 10/31/20 when the facility implemented a credible allegation of Immediate Jeopardy removal. The	F 626	1. Resident returned to facility assessed for signs and symptoms of injury and harm none presented. A private sister was placed with the resident and is on-going. 2. All residents that have left the facility for hospital care and/or therapeutic leave and who have requested to return from a hospital stay or therapeutic leave during the last 31 days have been reviewed to ensure that any resident who was ready to return to the facility, and still needed the level care offered by the facility, was not denied readmission consistent with federal law. No inappropriate denials of readmission to the facility or other issues were identified from review. Completed October 31, 2020. All D/C and re-admits are being reviewed by the facility IDT and corporate compliance teams for 90 days	

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F 626	Continued From page 2 facility remains out of compliance at a lower scope and severity level of D (no actual harm with the potential for more than minimal harm that is not immediate jeopardy) to complete employee education and ensure monitoring systems in place are effective. Findings included: Resident #1 was admitted to the facility on 6/25/20 with a history traumatic brain injury and mood disorder. His diagnoses included paranoid schizophrenia, anxiety disorder, and dementia. Resident #1 transferred to the facility from the hospital after a hospital admission from 5/26/20-6/25/20 due being struck by a car going approximately 50 miles an hour. His injuries included multiple rib fractures, a fracture to his right lower extremity and a fracture to his right upper extremity. The latest Minimum Data Set (MDS) a quarterly MDS dated 10/02/20 revealed Resident #1 was severely cognitively impaired. His speech was clear, he made himself understood and he understands others. He had verbal behaviors directed towards others but no physical behavioral symptoms. Resident #1 had rejection of care 1-3 days. He was independent with eating, bed mobility, transfers, walking and locomotion on the unit. He required supervision for toileting, needed limited assistance for dressing and required extensive assistance for personal hygiene. He was frequently incontinent of bowel and bladder. He received antipsychotic and antianxiety medications daily. He had a wander/elopement guard in place daily. The care plan for Resident #1 updated on 7/2/20	F 626	according to re-admission to facility policy 4.8 and D/C planning review version 1.1 a PPC assessment. 3. Training on appropriate discharges and readmit policy and procedure to ensure full compliance with resident rights consistent with applicable state and federal law, comply specifically including a resident's rights to return from a hospital visit or therapeutic leave if the facility remain able to provide care needed by the resident, once the facility is notified that the resident is ready to return to the facility. If the facility is no longer able to provide the level of care the resident needs based upon a documented assessment, then appropriate discharge notice and planning will be initiated consistent with federal law governing resident discharges. Retraining of facility management and admission staff to ensure they are aware of: Residents' right to return to the facility following a hospitalization therapeutic leave, if they still need the services offered by the facility, consistent with federal law; That request for resident readmissions for the next 30 days will be routed to the facility's corporate compliance. That all communications from any hospital regarding a resident's readiness to retrun will also be routed to the facility's corporate Compliance team ffor evaluation and further direction., and follow up. If, following telephone contact by a discharging hospital, the facility qadmission staff will follow up to determine if the resident still plans to	

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F 626	Continued From page 3 indicated Resident #1 had chronic/progressive decline in Intellectual functioning characterized by deficits in memory, judgement, decision making and thought process related to brain deterioration, mental illness, long term memory loss and short term memory loss. On 7/08/20 a focus area of ineffective coping with verbal and physical aggression or agitation and combativeness related to anger, loss of control, unpredictable situations (outbursts due to not being able to go outside when he wants to smoke, laying in the floor in the hallway to sleep was updated. The interventions included allow resident to respond to directions or request (due to dementia more time is required to absorb instructions); document summary of each episode; and monitor and document behavior. A focus area updated on 8/03/20 indicated Resident #1 was resistive to treatment due to cognitive impairment, laying in the floor in the hallway to sleep and refuses to go in the room. A progress note dated 10/21/20 revealed Resident #1 was discharged to the hospital on 10/21/20 due to agitated and aggressive behavior. Resident #1 hit a staff member and resident #1 was involuntarily committed to the hospital. During an interview with the facility social worker on 10/30/20 at 1:06 PM, she stated when Resident #1 struck a staff member she went to the magistrate's office and filed for an involuntary commitment. She reported that Resident #1 had behaviors since his admission in June, but no efforts had been made to discharge him elsewhere. Review of a hospital note dated 10/28/20	F 626	return to the facility and, if so, to ensure timely receipt of the hospital discharge paperwork. For the foreseeable future all returns for readmissions form hospital visits or therapeutic visit will be routed for analysis to the Compliance team. Decision regarding readmission will be made by the Compliance team to ensure compliance with all applicable federal and state law. Follow up by the Compliance team will also occur to ensure that all readmission decisions are fully and properly implemented in accordance with applicable law. This process will continue until the Compliance Team is satified that all readmission requests are being properly received, responded to and implemented. Date completed: action initiated effective October 31,2020 and ongoing. the Compliance Team monitoring will continue for a period of 90 days and will continue thereafter on a stepped-down basis, assuming no further incidents are involved, for a period of 90 days therafter. 4. All audits will be presented to QAPI committee to monitor for compliance each month x 3 months and every 6 months thereafter.	

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revealed Resident#1 was released from involuntary commitment by a psychiatrist and the physician ordered the resident be sent back to the facility.

An interview with law enforcement officer #1(LEO #1) on 10/30/20 at 11:57AM revealed he had been contacted that Resident #1 was at a local hospital and been released from involuntary commitment. LEO #1 stated he took Resident #1 to the magistrate's office to deal with some old warrants. He reported Resident #1 was released with a written promise to appear in court. LEO #1 stated he transported Resident #1 to the facility. He continued that he was advised by someone who identified themselves as the Administrator that Resident #1 was not welcome and had been discharged from the facility. LEO #1 stated when he spoke with Resident #1 the resident informed him he was going to walk to his mother's home. LEO #1 stated he left the resident at the facility.

LEO #1 stated approximately ten minutes later he was called to return to the facility. He reported upon arrival to the facility the Administrator stated Resident #1 was still on the premises. He stated he spoke to Resident #1 and agreed to take him to his mother's home. LEO #1 stated when he and Resident #1 were driving by a car wash Resident #1 stated he saw his brother. Resident #1 requested the officer stop the car. LEO #1 stated Resident #1 requested to be left with an individual he identified as his brother. LEO #1 stated he complied.

During an interview with law enforcement officer #2 (LEO #2) on 10/30/20 at 11:47 AM he stated he was the responding officer to an emergency call on 10/29/20 at approximately 9:00 AM. He

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reported Resident #1 was found lying in a ditch approximately 6 miles from Williamston. He reported that Resident #1 appeared fine and was assessed by Emergency Medical Services. LEO #2 stated he contacted the facility and spoke with the Administrator. He reported he was told that Resident #1 had assaulted one of their patients and would not be allowed back at the facility. He stated Resident #1 was transported to a local hospital.

An interview was conducted with the Director of Outpatient Nursing Services at the hospital on 10/30/20 at 1:35 PM, who reported when Resident #1 was ready to be discharged the assigned nurse attempted to contact the facility to give report with no success. She further stated the hospital was never told that Resident #1 could not return to the facility prior to discharge on the 10/28/20.

During an interview with the hospital case manager assigned to Resident #1 on 10/30/20 at 1:52 PM, she stated the hospital psychiatrist rescinded the involuntary commitment on Resident #1. She reported she attempted to fax clinical information needed for Resident #1's readmission. The case manager stated the fax never went through. She indicated prior to refaxing the information she was advised by the Emergency Department Director that Resident #1 had been transported to the facility by the local police department.

The hospital case manager stated she had spoken with the facility Admissions Director on 10/26/20 about discharge preparations. She stated they had attempted to place him with no success and he appeared to have stabilized. The

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hospital case manager stated she was advised by the facility Admissions Director that she would need to contact the Administrator and the Director of Nursing to determine if Resident #1 would be allowed to return. The hospital case manager stated she never received any follow-up information from the facility Admissions Director.

An interview was conducted with the Admissions Director on 10/30/20 at 2:15 PM who stated she was not aware Resident #1 was being transferred back to the facility. She reported that the Administrator and the Director of Nursing went outside when Resident #1 and the police officer arrived and spoke with the police officer. The Admissions Director stated she contacted the hospital case manager who stated Resident #1 had some outstanding warrants and needed to be transported to the magistrate.

The Admissions Director stated she had spoken with the Emergency Room case manager on 10/26/20 who stated the physician felt Resident #1 had stabilized. The Admissions Director stated she told the Emergency Room case manager that she did not think the facility would be taking him back but she needed to check with the Administrator and the Director of Nursing. She stated she sent a text message to both the Administrator and Director of Nursing. She reported she spoke with the Director of Nursing first who stated it was her understanding that Resident #1 would not be accepted back to into the facility, but she would need to speak to the Administrator. The Admissions Director stated she spoke with the Administrator who stated Resident #1 would not be returning to facility as they couldn't meet his needs.

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During an interview with a nurse at the hospital on 10/30/20 at 2:30 PM he revealed he was Resident #1's assigned nurse the day he was discharged from the hospital. The nurse stated the psychiatrist voided the involuntary commitment paperwork and he arranged for the police department to take Resident #1 to the facility. The hospital nurse stated he attempted to contact the facility multiple times and the one time he got an answer he was placed on hold for thirty minutes The nurse stated hospital staff frequently ask the police department to transport residents who are discharged from the hospital emergency room. He further stated that Resident #1 did not meet the criteria for ambulance transportation.

During an interview conducted with the Administrator on 10/30/20 at 2:48 PM she stated she and other staff members were in the dining room having a clinical meeting. They noticed a police car outside with Resident #1 in the back. The Administrator stated she spoke with the Admissions Director to ascertain Resident #1's status. The Admissions Director was on the phone with the assigned hospital case manager and was told Resident #1 was to go to the magistrate to deal with outstanding warrants. She stated she spoke with the officer and explained that the facility was not aware that Resident #1 was returning to the facility. She continued that the police officer told her the hospital had attempted to contact the facility and had faxed the discharge paperwork. The Administrator further stated that the police officer asked for Resident #1's belongings. She reported the police officer was gone when staff returned with Resident #1's belongings. The Administrator reported contact was made with the

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officer who returned to building to transport Resident #1 away from the building.

During an interview on 10/30/20 at 4:20 PM the facility Staff Development Coordinator stated she saw a man dressed in a paper gown in the ditch while she was driving to work at approximately 8:00 AM on 10/29/20. She stated she stopped her vehicle and called 911. The Staff Development Coordinator stated she contacted the facility and advised them she had found Resident #1.

The temperatures 10/28-10/29/20 ranged from 67 degrees to 78 degrees with no rainfall according to the Weather Channel website (https://weather.com) referenced 10/30/20 at 4:00 PM

A hospital physician progress note dated 10/29/20 revealed Resident #1 was brought to the emergency department by emergency medical services for safety and well-being. Resident #1 was in the emergency department for 7 days on involuntary commitment paper from 10/21/20-10/28/20. Patient had a telepsychiatry evaluation and was awaiting placement to a psychiatric facility. In the emergency department he exhibited increased confusion and delirium at times but was easily redirected. Patient was never noted to be dangerous or a threat to staff. Patient had a telepsychiatry evaluation and the involuntary commitment was discontinued. He was discharged back to the nursing home. Law enforcement came to pick him up and advised he had outstanding warrants. Patient was taken to jail in handcuffs and presented to the magistrate. The magistrate released him. The patient was taken by the law enforcement officer to the

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nursing home. The nursing home staff refused to accept patient and stated he does not belong here and that he has been discharged. Patient was given his belongings. The law enforcement officer dropped him at an unknown address. Patient walked away from that address and was found sitting in a ditch. He spent all night in the elements sitting out in the ditch. This morning Emergency Medical Service brought him to the emergency department for his well-being and safety. On arrival he voiced no complaints. He has not taken his medications since before discharge from the emergency department.

A hospital progress note dated 10/29/20 revealed Resident #1 had not had any food or personal hygiene since his discharge on 10/28/20. Patient was provided food and clean clothes upon admission.

An interview with Resident #1 was conducted on 10/30/20 at 6:30 PM. He reported that he went to visit his mother and was resting in the ditch when he was found. He stated he did not remember the events leading up to the decision to visit his mother.

An interview with the Admission Director on 10/30/20 at 6:43 PM revealed the facility had beds available on 10/28/20 and 10/29/30.

On 10/30/20 at 7:55 PM the Administrator and Director of Nursing were notified of Immediate Jeopardy.

On 11/2/20 the facility provided an acceptable credible allegation of Immediate Jeopardy removal that included:

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1. Identify those recipients who have suffered, or are likely to suffer, a serious adverse outcome as a result of the noncompliance.
Background facts: Resident # 1 was not permitted to timely return to the facility after the local hospital notified and/or attempted to notify the facility that resident was ready to return to the facility. Resident # 1 had not been officially discharged from the facility. The facility's admissions staff did not follow up with the local hospital after she was initially contacted by the hospital about the resident's return to the facility.
In addition to Resident #1, other residents who could have potentially suffered an adverse outcome include any other residents with recent hospital stays or therapeutic leave absences.
Both Resident #1 and those other potential residents have been addressed in the steps outlined in item 2, below.

2. Specify the Action the Entity Will Take to Alter the Process or System Failure to Prevent a Serious Adverse Outcome From Occurring or Recurring, and When the Action Will be Complete

On October 30, 2020, Resident #1 was safe and sleeping soundly in his hospital bed at the local hospital. Communication was provided to the Hospital that a bed would be made available to Resident #1 as soon as he was prepared for discharge.
He returned to the facility that same evening and was assessed for signs and symptoms of injury and harm. None presented.
The resident had no recall of the incident.

A private sitter was placed with him for the night and will continue through the weekend. Date completed: October 30, 2020.

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All residents that have left the facility for hospital care and/or therapeutic leave and who have requested to return from a hospital stay or therapeutic leave during the last 31 days have been reviewed as of October 31, 2020 to ensure that any resident who was ready to return to the facility, and still needed the level of care offered by the facility, was not denied readmission consistent with federal law. No inappropriate denials of readmission to the facility or other problems or issues were identified from this review. Date completed: October 31, 2020.

On October 31, 2020 at 3:00 pm a full staff, mandatory meeting for all direct care staff, management staff and admissions staff was conducted the dining room at the facility. Any staff who could not be present for this training will not be allowed to provide care to residents or otherwise resume their normal job roles until they completed the training. Date completed: All staff were trained as of October 31, 2020 with the exception of one nurse who was not scheduled for duty until the week of November 2 and one housekeeper. Training for both of these employees, as noted, will occur before they are allowed to return to work, with the nurse's training scheduled for Monday, November 2, 2020.

Training topics includes the following:

1. Status of survey and update on Resident #1

2.Training on appropriate discharge and readmit policy and procedure to ensure full compliance with resident rights consistent with applicable state and federal law, specifically including a resident's right to return from a hospital visit or

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therapeutic leave if the facility remains able to provide care needed by the resident, once the facility is notified that the resident is ready to return to the facility.

3. If the facility is no longer able to provide the level of care the resident needs based upon a documented assessment, then appropriate discharge notice and planning will be initiated consistent with federal law governing resident discharges.

4. Retraining of facility management and admission staff to ensure they are aware of:

a. .Residents' rights to return to the facility following a hospitalization or therapeutic leave, if they still need the services offered by the facility, consistent with federal law;

b. That all requests for resident readmissions for the next 30 days will be routed to the facility's corporate Compliance Team for review, evaluation, a decision and follow up to ensure compliance.

c. That all communications from any hospital regarding a resident's readiness to return will also be routed to the facility's corporate Compliance Team for evaluation and further direction and follow up.

d. If, following telephone contact by a discharging hospital, the facility receives no discharge paperwork from the hospital, the facility admission staff will follow up to determine if the resident still plans to return to the facility and, if so, to ensure timely receipt of the hospital discharge paperwork.

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 11/02/2020

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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For the foreseeable future, all returns for readmissions from hospital visits or therapeutic visits will be routed for analysis to the Compliance Team. Decisions regarding readmission will be made by the corporate compliance team to ensure compliance with all applicable federal and state law. Follow up by the Compliance Team will also occur to ensure that all readmission decisions are fully and properly implemented in accordance with applicable law. This process will continue until the Compliance Team is satisfied that all readmission requests are being properly received, responded to and implemented. Date completed: action initiated effective October 31, 2020 and ongoing. The Compliance Team monitoring will continue for a period of 30 days and will continue thereafter on a stepped-down basis, assuming no further incidents are involved, for a period of 60 days thereafter.

Immediate Jeopardy was removed on 10/31/20. The credible allegation was verified 11/2/20 at 11:00 AM. Staff were interviewed and confirmed they received training from the Managing Director on regulatory requirements pertaining to resident rights pertaining to discharge and transfers. An observation on 11/2/20 at 9:30 AM revealed Resident #1 in a room watching television with a sitter. Staff stated there had been no behavior problems since his readmission.