STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345164	A. BUILDING _____ B. WING _____	C 08/22/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHOWAN RIVER NURSING AND REHABILITATION CENTER	1341 PARADISE ROAD P O BOX 566 EDENTON, NC 27932

(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 622 SS=D	Transfer and Discharge Requirements CFR(s): 483.15(c)(1)(i)(ii)(2)(i)-(iii) §483.15(c) Transfer and discharge- §483.15(c)(1) Facility requirements- (i) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless- (A) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility; (B) The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility; (C) The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident; (D) The health of individuals in the facility would otherwise be endangered; (E) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or (F) The facility ceases to operate. (ii) The facility may not transfer or discharge the resident while the appeal is pending, pursuant to § 431.230 of this chapter, when a resident exercises his or her right to appeal a transfer or discharge notice from the facility pursuant to § 431.220(a)(3) of this chapter, unless the failure to discharge or transfer would endanger the health	F 622		9/17/18

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		09/05/2018

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.

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F 622	Continued From page 1	F 622		

or safety of the resident or other individuals in the facility. The facility must document the danger that failure to transfer or discharge would pose.

§483.15(c)(2) Documentation.
When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider.
(i) Documentation in the resident's medical record must include:
(A) The basis for the transfer per paragraph (c)(1)(i) of this section.
(B) In the case of paragraph (c)(1)(i)(A) of this section, the specific resident need(s) that cannot be met, facility attempts to meet the resident needs, and the service available at the receiving facility to meet the need(s).
(ii) The documentation required by paragraph (c)(2)(i) of this section must be made by-
(A) The resident's physician when transfer or discharge is necessary under paragraph (c) (1) (A) or (B) of this section; and
(B) A physician when transfer or discharge is necessary under paragraph (c)(1)(i)(C) or (D) of this section.
(iii) Information provided to the receiving provider must include a minimum of the following:
(A) Contact information of the practitioner responsible for the care of the resident.
(B) Resident representative information including contact information
(C) Advance Directive information
(D) All special instructions or precautions for

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F 622	Continued From page 2 ongoing care, as appropriate. (E) Comprehensive care plan goals; (F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff and family interviews, the facility failed provide Physician documentation of criteria for facility-initiated discharge necessary for the resident's welfare, and documentation the facility could not meet the needs of the resident for 1 of 3 residents (Resident #2) reviewed for admission, transfer and discharge. The findings included: Resident #2 was admitted to the facility on 2/28/2018 with diagnoses to include a history of falls, altered mental status, and dementia. She was discharged to another facility on 5/11/2018. A wandering risk assessment dated 2/28/2018 was scored as 10, with 5 or below being not at risk for wandering. Her admission Minimum Data Set (MDS) assessment dated 3/7/2018 revealed her cognition was moderately impaired and she exhibited wandering behaviors for 1 to 3 days of the look back period. She was independent with her activities of daily living. Her care plan, initiated on 3/7/2017 included a problem of ineffective coping: wandering related to cognitive impairment. Interventions included	F 622	Chowan River Nursing and Rehabilitation 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 Corrections is submitted as a written allegation of compliance. Chowan River Nursing and Rehabilitation 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, Chowan River Nursing and Rehabilitation reserves the right to refute any of the deficiencies on this Statement of Deficiencies through Informal Dispute Resolution, formal appeal procedure and/or any other administrative or legal proceeding. The process that led to this deficiency (F622) was the facility failed to give reasonable and appropriate notice for discharge for a discharge from the facility to another facility related to inability to meet the needs of the resident. The	

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F 622	Continued From page 3 redirect resident, allow resident to wander on unit, check daily to ensure resident has an alarm bracelet on and that it is functioning properly. Document episodes of wandering. A wandering risk assessment dated 3/9/2018 was scored as 10, a high risk of wandering. Nurse's notes were reviewed and documented wandering on the following days: 2/28/18, 3/1, 3/2, 3/4, 3/5, 3/12/18. 4/7, 4/23, 4/24, 4/26, 4/27/2018. 5/5, 5/6/2018. The Nurse's notes did not include any documentation of notifying the Physician of Resident #2's wandering. Nurse's notes were reviewed and documented the following days Resident #2 removed her alarm bracelet: 3/2/2018, 4/4/2018, 4/24/2018, and 5/10/2018. The Nurse's notes did not include any documentation of notifying the Physician of Resident #2's removing her alarm bracelet. A Physician progress note dated 5/1/2018 revealed there was no new acute issues with Resident #2 per staff, her behavior was stable, and she was assessed with senile dementia, Alzheimer's type, at least moderate. There was no documentation by the Physician of specific resident needs the facility could not meet, facility efforts to meet those needs, and specific services the receiving facility would provide to meet the needs of the resident. A nurse's note dated 5/10/2018 at 5:10 PM, was written by the Director of Nursing (DON), and revealed the resident had increased wandering and felt it was exit seeking. The resident wore an alarm bracelet and her whereabouts were monitored. Her Legal Guardian (LG) was made	F 622	facility failed to show that a transfer was necessary for the resident□s welfare and that the facility could not meet the needs of the resident by not providing Physician documentation that it was necessary for the resident□s welfare to discharge, and physician documentation to show that the facility could not meet the needs of the resident. On 02/28/18 resident #2 was admitted to the facility with diagnoses to include a history of falls, altered mental status, and dementia. Resident #2 had a wandering risk assessment dated 2/28/18 and was scored as 19, with 5 or below being not at risk for wandering. Her MDS assessment on 3/7/18 revealed her cognition was moderately impaired and she exhibited wandering behaviors for 1-3 days in the lookback period and interventions were put into place. She was independent with her activities of daily living. She was discharged from the facility to another facility on 5/11/18 without documentation of the appropriate notice for discharge without showing the transfer was necessary for the resident□s welfare and that the facility could not meet the needs of the resident. On 9/14/18 100% Audit of all residents being discharged to another facility will be completed by the Administrator to ensure that all discharges to other facilities have been given proper notice of transfer with properly documented physician orders to show that the transfer is necessary for the resident□s welfare and that the facility is	

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F 622	Continued From page 4 aware of her increased wandering and exit seeking behaviors and he desired her to be safe. The DON and LG had discussed that a facility with a locked unit may be a better option at this time. LG was agreeable to transfer the resident to that facility tomorrow. A notice of transfer/discharge dated 6/1/2018 documented the date of discharge as 5/11/2018. Reasons for discharge were listed as: 1. It is necessary for your welfare and your needs cannot be met in this facility; 2. The safety of individuals in this facility is endangered due to the clinical or behavioral status of the resident. The discharge notice included an Appeal Rights as follows: "You have the right to appeal this transfer/discharge to the DHHS Hearing Office within 11 calendar days of the date of this notice if you want to continue to stay at this facility. . .." On 8/15/2018 at 2:52 PM, an interview was conducted with Resident #2's LG who stated he was Resident #2's legal guardian. The LG stated Resident #2 was admitted to the facility for long term, as she was not safe to be at home unsupervised by herself. The LG stated he visited Resident #2 very often and spoke with the DON and Administrator about Resident #2's behaviors of wandering and exit seeking. The LG stated he was unaware that the resident's behaviors had gotten so bad that she had to be discharged until he was called on 5/10/2018 and was told she was to be discharged the next day. The LG stated he begged the DON if there wasn't anything that could be done to keep her at the facility. He stated he was told he could take her home or find another facility of his choice. The LG stated it was very late in the afternoon when	F 622	unable to meet the resident□s needs. All identified areas of concern will be immediately addressed by the Administrator during the audit. On 8/30/18 100% in-service with persons involved with the discharge process, to include the Administrator, DON, finance, medical records, and social work was initiated by the Administrator to include: 1. Any resident discharged from the facility will have: a. Reasonable and appropriate notice for discharge b. A physician□s documentation of criteria identifying why discharge is necessary for the resident□s welfare c. Documentation to show that the facility cannot meet the needs of the resident 100% of residents discharging to other facilities will be reviewed by the Administrator weekly for 8 weeks, then monthly for 1 month, utilizing the Discharge to Other Facility Audit Tool to ensure that all discharges are given proper notice and have a physician order supporting that the transfer was necessary for the resident□s welfare and that the facility could not meet the needs of the resident. Any areas of concern identified during the review will be immediately addressed by the Administrator to include obtaining an order clarification by the physician and/or providing additional staff training.	

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F 622	Continued From page 5 the DON called him, and he did not have time to find another facility. The LG stated he did not argue with the DON and it was presented to him as if he had no choice. The LG stated he should have received a 30-day notice to find another placement for Resident #2. On 8/15/2018 at 3:15 PM, a phone interview was conducted with the previous DON who was employed at the facility when Resident #2 was discharged on 5/11/2018. The DON stated she remembered Resident #2 wore an alarm bracelet and made attempts to exit the facility. The DON stated they were concerned the resident would exit the facility. The DON stated the resident was transferred to another skilled nursing facility with a locked unit because she was a danger to herself and she had documented that in her note when she called the LG. The Administrator who was employed at the facility when Resident #2 was discharged on 5/11/2018 was no longer employed at the facility and was unavailable for interview. On 8/20/2018 at 4:13 PM, an interview was conducted with the present DON who stated she expected staff to follow the guidelines when discharging a resident to another facility. Multiple attempts to interview the Physician were unsuccessful.	F 622	The Administrator will present the Findings of the Discharge Audit Tool to the Executive QI committee monthly for 3 months. The Executive QI committee will meet monthly for 3 months and review the Discharge to Other Facility Audit Tool to determine trends and/or issues that may need further interventions put into place and to determine the need for further frequency of monitoring. The administrator will be responsible for the implementation of corrective actions to include all 100% of audits, in-services, and monitoring related to the	
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on	F 690		9/17/18

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F 690	Continued From page 6 admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, staff and resident interviews, the facility failed to have a diagnosis for an indwelling urinary catheter, Physician orders for the use of the catheter, how often to change the catheter, or an assessment for removal of the catheter for 1 of 3	F 690	Chowan River Nursing and Rehabilitation 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	

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F 690	Continued From page 7 residents (Resident #3) observed for indwelling catheters. The findings included: Resident #3 was admitted to the facility on 7/10/2017 with diagnoses to include hip fracture, muscle weakness, congestive heart failure, hypertension, cardiomyopathy, and pacemaker. There was no diagnosis for the indwelling catheter. Hospital discharge orders dated 7/10/2018 included a diagnosis of retention of urine, but discharge orders, and discharge summary did not include any mention of an indwelling urinary catheter. Resident #3's Care plan, initiated 7/10/2018, included an altered pattern of bladder elimination with indwelling catheter. Interventions included change catheter per physician orders. A Physician Progress note dated 7/11/2018 for Resident's #3's history and physical revealed her indwelling catheter was present and draining yellow urine. Review of Resident #3's admission Minimum Data Set (MDS) assessment dated 7/17/2018 revealed her cognition was intact, she required extensive to total assistance from staff for activities of daily living, and she had an indwelling urinary catheter for bladder elimination. No diagnosis was listed for the indwelling catheter. Physician orders for July 2018 and August 2018 did not included orders to change the indwelling catheter, a diagnosis for the catheter, or a plan	F 690	rules and provisions of quality of care of residents. The Plan of Corrections is submitted as a written allegation of compliance. Chowan River Nursing and Rehabilitation 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, Chowan River Nursing and Rehabilitation reserves the right to refute any of the deficiencies on this Statement of Deficiencies through Informal Dispute Resolution, formal appeal procedure and/or any other administrative or legal proceeding. The process that led to this deficiency (F690) was the facility failed to have a diagnosis for an indwelling urinary catheter, Physician orders for the use of the catheter, how often to change the catheter, or an assessment for removal of the catheter for 1 of 3 residents (resident #3) observed for indwelling catheters. On 8/16/18 resident #3 was assessed by the physician to review the continued need for an indwelling catheter with new order to attempt voiding trail. Resident #3 indwelling catheter was removed by the assigned hall nurse with no further urinary retention noted. On 8/16/18 100% Audit of all residents with Foley catheters was completed by the Minimum Data Set Nurse (MDS) to include resident #3 to ensure all orders for	

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F 690	Continued From page 8 for removal of the catheter. On 8/15/2018 at 12:39 PM an interview was conducted with Resident #3, who stated she had the catheter because she couldn't stand or bear weight on her legs because of her fractured hip. The resident stated staff currently got her up with a lift to her chair. The Resident did not say she had a history of urinary retention. On 8/16/2018 at 12:11 PM, an interview was conducted with nursing assistant (NA) #1. The NA stated Resident #3 was alert and oriented. The NA stated she gave Resident #3 peri care/ catheter care daily and emptied her catheter bag at the end of her shift. On 8/16/2018 at 10:16 AM, an interview was conducted with Nurse #1. The Nurse stated she knew Resident #3 had a catheter, but there was no documentation on the Medication Administration Record (MAR) that the catheter was checked every shift, because no orders had been written for the catheter. The Nurse stated normally orders for the catheter are written and then transcribed to the MAR to check the catheter every shift and document. The nurse did not know who was responsible for obtaining orders for the urinary catheter. On 8/20/2018 at 4:13 PM, an interview was conducted with Director of Nursing (DON). The DON stated it was her expectation that on admission, the admitting nurse would get the diagnosis for the indwelling catheter, as well as an order to continue or discontinue the indwelling catheter from the Physician. The DON stated she was researching the incident to see where the breakdown occurred.	F 690	indwelling urinary catheters were complete to include appropriate diagnosis, size of catheter and parameters for changing the urinary catheters present in chart and MAR. All identified areas of concern were immediately addressed by the MDS nurse and the Assistant Director of Nursing (ADON) during the audit with notification of physician for order clarifications and correction of MAR/TAR. On 8/16/18 100% audit of all care plan/care guides for resident with indwelling catheters to include resident #3 was completed by the MDS to ensure residents with indwelling catheters were care planned for use of catheter to include supporting diagnosis, size of catheter, and how often to change catheter. All areas of concern were immediately addressed by the MDS nurse to include updating care plan/care guide. On 8/16/18 100% Audit of Medication Administration Record (MAR) x30 days of residents with indwelling catheters to include resident #3 was completed by the MDS to ensure documentation was complete and indwelling urinary catheters had been changed per physician orders. Any areas of concern identified during the audit were immediately addressed by the DON by conducting an assessment of the resident to include the indwelling urinary catheter for any abnormalities, signs/symptoms of UTI, changing of urinary catheter per physician, notification of the physician, and/or providing additional staff training.	

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F 690	Continued From page 9 On 8/22/2018 at 1:06 PM, a phone interview was conducted with the Physician. The Physician stated he did not recall the specifics of her indwelling catheter on her arrival, but that information would be in his history and physical. The Physician stated he was unaware there were no orders for when to change the resident's catheter. The Physician stated he generally tried to do a trial of removing the catheter after therapy had worked with a resident too get them stable enough to be on a bed pan. The Physician stated most of the time the hospital would send orders for the catheter, but that was overlooked for this resident.	F 690	On 09/14/18 100% in-service with all nurses will be completed by the Director of Nursing (DON) in regards to Physician Orders for Indwelling Urinary Catheter to include: 1. Any resident admitted with indwelling urinary catheter must have a physician□s order for use of catheter to include: a. Supporting medical diagnosis for use of catheter such as urinary retention related to BPH, bladder cancer, neurogenic bladder, retractable pain, stage 3-4 sacral wound b. Size of catheter to include size of balloon c. Parameters for when to change catheter d. Block the date for the next catheter change per physician order on the MAR e. Notifying the physician to clarify any orders that do not contain appropriate diagnosis, size and instructions on when to change indwelling urinary catheters 2. Care Plan/Care guide must be updated for Indwelling Catheter use to include diagnosis for use, size of catheter, and parameters for changing catheter. In-service will be completed on 09/14/18. All newly hired nurses will be in-serviced by the Staff Facilitator/DON/ADON during orientation to ensure all orders for indwelling urinary catheters are complete to include: 1. Any resident admitted with indwelling urinary catheter must have a physician□s	

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F 690	Continued From page 10	F 690	order for use of catheter to include: a. Supporting medical diagnosis for use of catheter such as urinary retention related to BPH, bladder cancer, neurogenic bladder, retractable pain, stage 3-4 sacral wound b. Size of catheter to include size of balloon c. Parameters for when to change catheter d. Block the date for the next catheter change per physician order on the MAR e. Notifying the physician to clarify any orders that do not contain appropriate diagnosis, size and instruction s on when to change indwelling urinary catheters 2. Care Plan/Care guide must be updated for Indwelling Catheter use to include diagnosis for use, size of catheter, and parameters for changing catheters. 10% of residents with indwelling catheters will be reviewed by the MDS nurse weekly for 8 weeks, then monthly for 1 month, utilizing a Foley Audit Tool to ensure that all orders for indwelling urinary catheters have supporting diagnosis for use, size of catheter, parameters for changing the catheters, orders are transcribed correctly to the MAR, and documentation is completed on the MAR when the indwelling urinary catheter is changed per the physician orders. Any areas of concern identified during the review will be immediately addressed by the DON to include obtaining an ode clarification, notification of attending physician assessment of the resident and /or providing additional staff training.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345164	A. BUILDING _____ B. WING _____	C 08/22/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 690	Continued From page 11	F 690	The DON will present the Findings of the Foley Audit Tool to the Executive QI committee monthly for 3 months. The Executive QI committee will meet monthly for 3 months and review the Foley Audit Tool to determine trends and/or issues that may need further interventions put into place and to determine the need for further frequency of monitoring. The administrator and the DON will be responsible for the implementation of corrective actions to include all 100% of audits, in-services, and monitoring related to the plan of correction.	