

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # 345145	MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	DATE SURVEY COMPLETE: 11/22/2019
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NAME OF PROVIDER OR SUPPLIER ROANOKE RIVER NURSING AND REHABILITATION CEN	STREET ADDRESS, CITY, STATE, ZIP CODE 119 GATLING STREET WILLIAMSTON, NC
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ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
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F 661	<p>Discharge Summary CFR(s): 483.21(c)(2)(i)-(iv)</p> <p>§483.21(c)(2) Discharge Summary When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following:</p> <ul style="list-style-type: none"> (i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results. (ii) A final summary of the resident's status to include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident's representative. (iii) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter). (iv) A post-discharge plan of care that is developed with the participation of the resident and, with the resident's consent, the resident representative(s), which will assist the resident to adjust to his or her new living environment. The post-discharge plan of care must indicate where the individual plans to reside, any arrangements that have been made for the resident's follow up care and any post-discharge medical and non-medical services. <p>This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to complete a recapitulation of stay for 1 of 1 resident reviewed for a planned discharge from the facility to the community (Resident #112).</p> <p>Findings included:</p> <p>Resident #112 was admitted to the facility on 8/22/19 with diagnoses which included hypertension and anxiety.</p> <p>Review of Resident #112's admission Minimum Data Set (MDS) dated 8/29/19 revealed he was coded as cognitively intact and had the expectation to be discharged to the community.</p> <p>Record review revealed Resident #112 was discharged home on 9/20/19 and the facility failed to complete a recapitulation of Resident #112's stay in the facility.</p> <p>The Director of Nursing (DON) stated during an interview on 11/21/19 at 11:35 AM, the nurse discharging a resident was responsible for completing the discharge recapitulation section of the discharge summary. She stated the discharge recapitulation was not completed on Resident #112's discharge summary. She also stated the nurse who discharged Resident #112 was no longer employed with the facility. The DON stated it was her expectation all departments complete the discharge summary prior to a resident's discharge.</p> <p>The Administrator stated during an interview on 11/21/19 at 11:44 AM that the nurse should have completed the discharge summary for Resident #112 and she didn't know why it had not been done.</p>
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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

The above isolated deficiencies pose no actual harm to the residents