STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365867	A. Building B. Wing	05/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
River Run Healthcare of Portsmouth	1319 Spring Street Portsmouth, OH 45662

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0627 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, review of hospital records, policy review, review of local police reports, staff interview, resident interview and interview with the Long-Term Care Ombudsman, the facility failed to provide a safe and proper discharge to an appropriate location for Resident #25. This resulted in Immediate Jeopardy and the potential for serious life-threatening harm, injuries, and/or death on [DATE] when Resident #25, who had diagnoses including type two diabetes mellitus with two chronic ulcers, adult failure to thrive, functional quadriplegia, nicotine dependence, deep vein thrombosis, personality disorder, psychoactive substance abuse, anxiety, depression, and viral Hepatitis C, was discharged to an unknown location without housing, medications, or arrangements for ongoing care. Resident #25 was discharged without evidence of continuity of care related to medical care and services in place to address the resident's medical and mental health diagnoses. Resident #25 required 24-hour care for medication and behavior monitoring. This affected one (Resident #25) of three residents reviewed for discharge. The facility census was 22. On [DATE] at 1:45 P.M., the Administrator, Chief Clinical Officer (CCO) #500 and Director of Nursing (DON) were notified Immediate Jeopardy began on [DATE] when Resident #25, who resided in the facility for 12 days, was discharged to an unknown location without evidence he had a safe location in which to discharge to and without evidence of coordination of care to ensure the resident's medical and psychosocial needs were met resulting in the resident being hospitalized two days later. The Immediate Jeopardy was removed on [DATE], when the facility implemented the following corrective actions: - On [DATE] at 2:30 P.M., CCO #500 reviewed and revised the facility policy for transfer and discharge. The revisions included collaborating with the Ombudsman and community resources as indicated, ensuring discharge location meets the resident's needs, medications are given along with instructions and follow up for medical care. - On [DATE] at 2:45 P.M., CCO #500 educated the Administrator and the DON on the revised transfer and discharge policy. Education included the following components of the policy: during the appeal process of any 30-day discharge issued, the resident will not be discharged ; If an emergency occurs, the facility will confer with the Ombudsman, Medical Director #800 and company leadership to establish a safe discharge location to ensure the resident needs will be met; and the facility will notify the Ombudsman prior to discharge and after-hours voicemail will be left. 1. The Ombudsman will be notified by the Administrator immediately of any 30-day or emergency discharge as required. The Administrator or designee will confer with the Ombudsman to assist as necessary in resolving resident care concerns or facility barriers to meeting resident needs.2. Medical Director #800 will be notified by the DON of any 30 day or emergency discharge immediately upon the residents receiving documents, including rationale for discharge, location of discharge, ongoing needs and plan for medical follow up. - On [DATE], Corporate Minimum Data Set (MDS) Coordinator #700 audited all 22 in-house residents discharge care plans. All 22 care plans were reviewed and revised as indicated. - On [DATE] at 3:00 P.M., CCO #500 educated Social Services Designee #410 via the telephone on the facility's revised transfer and discharge policy and procedure.- On [DATE], the Director of Nursing reviewed the three residents (#27, #28, and #29) who were discharged in the past (continued on next page)

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.

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

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F 0627 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	was given his belongings which he took with him. He left on his motorized wheelchair at 3:15 P.M.During an interview on [DATE] at 11:20 A.M., the DON verified Resident #25 was given an emergency discharge from the facility on [DATE]. She stated the resident left with his belongings and was not provided with any type of discharge instructions, wound care instructions, or medications.During a telephone interview on [DATE] at 1:20 P.M., Resident #25 stated the facility kicked him out for something he did not do (in reference to setting fire to his bed). He verified he was living on the streets after he was kicked out on [DATE] and his motorized wheelchair battery was dead two days later ([DATE]) and he was stuck in a grocery store parking lot. The facility did not give him anything but his belongings and he denied receiving instructions or medications. He stated he does not want to return to this facility.During a telephone interview on [DATE] at 10:50 A.M., the Administrator stated the facility notified the local police for assistance with giving the resident an immediate removal from the facility. Resident #25 was escorted off the facility's property by a police officer. He left the property in his motorized wheelchair. The Administrator stated they were attempting to find placement in a homeless shelter when Resident #25 left the facility.Review of the facility policy titled Transfer and Discharge Policy dated [DATE] revealed the facility's transfer/discharge notice will be provided to the resident in a language and way they can understand. The notice will include all the following at the time it is provided: this includes the specific location (such as the name of the new provider or description and/or address if the location is a residence) to which the resident is to be transferred or discharged .The revised version of the Transfer and Discharge Policy dated [DATE] revealed prior to any facility-initiated discharge, the facility will review as an interdisciplinary team (IDT) and confer with senior leadership. Facility will collaborate with the Ombudsman to facilitate resolution to care concerns, barriers to care. Ombudsman will be contacted prior to emergency discharge. The facility will collaborate with the area Ombudsman and other community resources to assist with discharge as indicated.This deficiency represents non-compliance investigated under Complaint Number 2992143.