	-	ID HUMAN SERVICES					FORM	APPROVED
								0.0938-0391
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	PLE CONSTRUC		1		LETED
		345566	B. WING					C 16/2024
NAME OF PF	ROVIDER OR SUPPLIER			STREET ADDF	RESS, CITY, STATE, ZIP COD)E		
PRUITTHE	ALTH-UNION POINTE			3510 WEST H				
				MONROE, N				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION ROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE		(X5) COMPLETION DATE
E 000	Initial Comments		E 00	00				
F 000	through 2/8/24. An exconducted on 2/16/24 was changed to 2/16/ in compliance with the	vere conducted from 2/5/24 tended survey was 4. Therefore, the exit date 2024. The facility was found e requirement CFR 483.73, ness. Event ID #9U2E11.	F 00	00				
	through 2/8/24. An exconducted on 2/16/24 was changed to 2/16/24 The following intakes NC00213083, NC002 NC00196947, NC001 NC00200273, NC002 NC00201445, NC002 NC00210749, NC002 NC00210749, NC002 NC00212734, NC001 NC00212632, NC001 complaint allegations Substandard Quality CFR483.10 at tag F5	vere conducted from 2/5/24 tended survey was 4. Therefore, the exit date 2024. Event ID# 9U2E11. were investigated: 212793, NC00212734, 98776, NC00198838, 201279, NC00201351, 202645, NC00205850, 210182, NC00210380, 211555, NC00211928, 98116, NC00201089,						
	(H). The tag F550 constitu Care.	ited Substandard Quality of						
F 550 SS=H	0	cise of Rights	F 55	50				3/11/24
LABORATORY I	DIRECTOR'S OR PROVIDER/S	SUPPLIER REPRESENTATIVE'S SIGNATUR	RE	1	TITLE			(X6) DATE
Electroni	cally Signed							03/05/2024

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.

PRINTED: 03/22/2024

	-	D HUMAN SERVICES MEDICAID SERVICES					FORM	D: 03/22/2024 MAPPROVED D. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` <i>'</i>		CONSTRUCTION		(X3) DATE COMF	SURVEY PLETED
		345566	B. WING			_		C 16/2024
NAME OF PI	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, ST	ATE, ZIP CODE		
PRUITTHE	EALTH-UNION POINTE				10 WEST HIGHWAY 74 ONROE, NC 28110			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD BE ICED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 550	self-determination, an access to persons an outside the facility, ind this section. §483.10(a)(1) A facilit with respect and dign resident in a manner a promotes maintenance her quality of life, reco- individuality. The facil promote the rights of §483.10(a)(2) The faci access to quality care severity of condition, of must establish and map practices regarding tra- provision of services of residents regardless of §483.10(b) Exercise of The resident has the of rights as a resident of or resident of the Unit §483.10(b)(1) The fac resident can exercise interference, coercion from the facility. §483.10(b)(2) The resi free of interference, c reprisal from the facili rights and to be support	Rights. In to a dignified existence, a communication with and a services inside and cluding those specified in y must treat each resident ity and care for each and in an environment that we or enhancement of his or ognizing each resident's ity must protect and the resident. Solity must provide equal regardless of diagnosis, or payment source. A facility aintain identical policies and ansfer, discharge, and the under the State plan for all of payment source. of Rights. right to exercise his or her i the facility and as a citizen	F 5	50				

Facility ID: 080171

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TATEMENT C	S FOR MEDICARE & F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í			(X3) DATE	D. 0938-039 SURVEY PLETED	
		345566	B. WING _			C 02/16/2024		
NAME OF PF	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE	02/	10/2024	
				351	10 WEST HIGHWAY 74			
PRUITTHE	ALTH-UNION POINTE			мс	DNROE, NC 28110			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 550	Continued From page	e 2	F f	550				
	subpart.							
		is not met as evidenced						
	by:							
	Based on record rev	iews, resident, family			1. Address how corrective action will b			
		terviews, the facility failed to			accomplished for those residents found	l to		
		nity when residents were left			have been affected by the deficient			
		aturated in urine for 4 of 17			practice:			
	residents reviewed for dignity issues (Resident #192, Resident #34, Resident #48, and Resident					_		
					Resident #192 is no longer a resident in	n		
		ovide a dignity cover over a			the facility.			
		age bag for 1 of 4 residents catheters (Resident #390).			Resident #34 is no longer a resident in	the		
	-	dent #34, Resident #48, and			facility	uie		
		d they felt upset, angry,			lacinty			
		d not matter at all when they			Resident #48 is no longer a resident in	the		
	were not provided inc	continence care. Resident			facility.			
	urine."				Resident #390 is no longer a resident in	n		
	The reasonable personable persona	on concept was applied for			the facility			
		her inability to express her						
		hable person would feel			Resident #69 Resident #69 remains in			
		ded having to holler for			center and is provided timely incontiner	nce		
	assistance.				care.			
	The findings included	ŀ			2. Address how the facility will identify			
					other residents having the potential to b	be		
	1. Resident #192 was	s admitted to the facility on			affected by the same deficient practice			
		ses including respiratory						
	failure and hypertens				Current residents have the potential to	be		
	Minimum Data Set (M				affected. Current residents with BIMS c	of		
		192 to be cognitively intact.			12 or greater and resident #69 will be			
		MDS was in progress and			interviewed by the Director of Health			
	incomplete.				Services (DHS), Assistant Director of			
	- , ,				Health Services (ADHS), Registered			
	The admission nursir	-			Nurse Supervisors (RNS), Clinical			
	2/1/2024 documented				Competency Coordinator (CCC) Social			
	incontinent of urine a	nd feces. A care plan dated			Worker (SW), Minimal Data Set (MDS)			
	2/1/2021 addressed	Resident #192's potential for			Nurses and/or Staff Nurse(s) regarding			

Facility ID: 080171

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	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA		PLE CONSTRUCTION		<u>O. 0938-03</u> e survey
	CORRECTION	IDENTIFICATION NUMBER:	. ,			PLETED
			A. BUILDING			С
		345566	B. WING			2/16/2024
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP		
				3510 WEST HIGHWAY 74		
PRUITTHE	EALTH-UNION POINTE			MONROE, NC 28110		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TC DEFICIEI	CTION SHOULD BE D THE APPROPRIATE	(X5) COMPLETIC DATE
F 550	Continued From page	× 2				
F 330	• • • • • • • • • • • • • • • • • • •		F 55		De side ets with	
		as not completed, however,		questionnaire by 3/11/24. BIMS score less than 12		
		rom her phone, and was e badge of the surveyor.		clinical nursing managem		
		e bauge of the surveyor.		physically check the resid		
	Resident #192 was in	iterviewed on 2/5/2024 at		ensure the resident is cle		
	11:17 AM. Resident			resident is not clean and	•	
		was left saturated in urine,		care will be provided imm		
	•	re from 8:30 AM until 12:30		will be completed by 3/11	-	
	PM. Resident #192 de	escribed that her bed linens		Current residents with inc	welling catheters	
	were wet with urine, h	ner nightgown was wet with		will have catheter drainag	je bag viewed by	
		nence brief was saturated		the Director of Health Ser	· · ·	
		#192 explained that she had		Assistant Director of Hea		
		er bladder and she required		(ADHS), Registered Nurs		
		all the time. Resident #192		(RNS), Clinical Competer		
		made her feel sad and bad		(CCC) Social Worker (SV	-	
		didn't matter at all," and she ortable. When asked how		Set (MDS) Nurses and/or		
		for 4 hours for incontinence		to ensure each drainage has a privacy cover and u	÷	
		explained she pressed her		to be viewed by other res		
		and the nurse told her he		This will be completed by		
	-	er when he finished with his				
		sident #192 reported she		3. Address what measure	es will be put into	
	tracked the time on h	-		place or systematic chan		
				ensure that the deficient		
		nducted with Nurse #10 on		recur.		
		Nurse #10 reported on				
	Sunday 2/4/2024 the			The Director of Health Se		
		m working. Nurse #10		Competency Coordinator		
	· ·	to administer medications		Supervisors, and/or desig		
	before he was able to	•		education to current nurs	-	
	incontinence care on			regarding resident rights		
		92 was "very wet" when he		examples of not protectin		
		ontinence care after he had		rights/dignity including be	•	
	she was upset.	tion, but she did not mention		for an extended period ar not having a privacy cove		
	she was upset.			After 3/11/2024, any staff	-	
	NA #1 was interviewe	ed on 2/8/2024 at 10:12 AM.		worked and received the		
		as the only NA scheduled to		complete upon their next		
	work the short-term u	-		All newly hired nursing st		1

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	OF DEFICIENCIES	MEDICAID SERVICES	(X2) MULT	TIPI F	CONSTRUCTION		NO. 0938-039 ATE SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	` ´				OMPLETED
				_			С
		345566	B. WING				02/16/2024
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
PRIJITTH	EALTH-UNION POINTE			3	510 WEST HIGHWAY 74		
				Μ	IONROE, NC 28110		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIZ TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	3E	(X5) COMPLETIOI DATE
F 550	Continued From page	e 4	F	550			
		4/2024. NA reported she			the same education during general fac	cility	
	started at one side of	the short-term hall and			orientation.		
		e to residents one-by-one.					
	-	several residents were in urine, and she was not			The Director of Health Services (DHS) Assistant Director of Health Services),	
		ok to provide care to all the			(ADHS), Registered Nurse Supervisor	s	
		orted she had provided care			(RNS), Clinical Competency Coordina		
L L L	to Resident #192 on	Saturday 2/3/2024 and she			(CCC) Social Worker (SW), Minimal D	ata	
		dent #192 was incontinent of			Set (MDS) Nurses and/or Staff Nurse(s)	
		d she did not know when			will interview 10% of residents using		
		ved incontinence care on cause Nurse #10 provided			questionnaire. Additionally, 10% of residents will be audited by the clinical	1	
	that care.	ause Nuise #10 provideu			nursing management team by physica		
					checking the resident brief to ensure the		
	The Director of Nursi	ng (DON) #1 was			resident is clean and dry. If the resider		
		024 at 4:09 PM. DON #1			not, assistance will be provided		
		ot certain why staffing was so			immediately, to ensure residents are		
		she would need to review			receiving incontinence care timely. Au	dits	
	the staffing sheets.	ce care to be provided to			will occur 2 times a week x 4 weeks, weekly x 4 weeks, and then monthly x	1	
	residents in a timely	-			month. Residents with indwelling	1	
					catheters will have drainage bag viewe	ed 2	
	2. Resident #34 was	admitted to the facility on			times a week x 4 weeks, weekly x4		
		ses to include stroke and			weeks, and then monthly x1 to ensure		
		sion MDS dated 1/8/2024			privacy cover is in place.		
		34 to be cognitively intact.					
		ed Resident #192 was ent of urine and always			4. Indicate how the facility plans to monitor its performance to make sure	that	
	continent of bowels.	ent of unite and always			solutions are sustained.	lial	
		erviewed on 2/5/2024 at			The Director of Health Services will tra		
		#34 reported during the past t certain if it was 2/3/2024 or			and trend the results via the Dignity Au		
	· ·	soiled in feces and his bed			Tool weekly and report the findings to Quality Assurance Performance	ule	
	linens were wet with				Improvement Committee monthly x 3		
		call bell for assistance, but it			months or until substantial compliance	e is	
	-	ount of time before he was			achieved and then quarterly.		
	•	e care. Resident #34					
	reported he did not tr	ack the time; he only knew					

Facility ID: 080171

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l` í		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345566	B. WING				C 16/2024
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	-	
PRUITTHE	EALTH-UNION POINTE				510 WEST HIGHWAY 74		
				N	IONROE, NC 28110		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 550	he was wet and soiled reported he felt horrib and he was very upse NA #1 was interviewe NA #1 reported she w work the short-term u #10 on the hall on 2/4 that several residents in urine, and she was to provide care to all t Resident #34 was soi linens and incontinen urine. NA #1 reported angry and upset when care to him. The Director of Nursin interviewed on 2/8/20 explained she was no low on 2/4/2024 and s the staffing sheets. D expected incontinenc residents in a timely r 3. Resident #48 was 4/22/22 and readmitted diagnoses that includ (congestive) heart fail behavioral disturbanc urinary incontinence, hemiplegia with hemi infarction affecting lef erosive (osteo) arthrit Review of Resident # Date Set (MDS) dated	d and upset. Resident #34 ble to be left wet and soiled et. ad on 2/8/2024 at 10:12 AM. vas the only NA scheduled to nit and it was her and Nurse 4/2024. NA #1 explained were soiled and saturated not certain how long it took the residents. NA recounted led with feces and his bed ce brief was saturated with d Resident #34 was very in she was able to provide mg (DON) #1 was 24 at 4:09 PM. DON #1 ot certain why staffing was so she would need to review DON #1 reported she e care to be provided to manner. admitted to the facility on ed on 12/11/23 with ed chronic diastolic fure, vascular dementia with e, pulmonary hypertension, chronic pain syndrome, paresis following cerebral t non-dominant side, and is. 48's quarterly Minimum d 12/21/23 revealed	F	550	Compliance date: 3-11-24		
	Resident #48 was mo						

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	2: 03/22/2024 APPROVED 0: 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345566	B. WING		_	(02/ ⁻	C 16/2024
NAME OF P	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, ST	ATE, ZIP CODE		
PRUITTHI	EALTH-UNION POINTE			510 WEST HIGHWAY 74 IONROE, NC 28110			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD BI ICED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 550	to total dependence w living. Resident #48 w bowel and bladder. During an observation Resident #48 could be hollering for help. Up room, a urine odor wa A follow-up observatio 02/08/24 at 8:50 am of was on and she was linterview was attempt was unsuccessful. On 02/08/24 at 9:00 a leaving Resident #48' was turned off. NA #4 time and reported Res The NA stated she wa scheduler/transportation on the floor that day a indicated that she wo assigned to the Resid care. On 02/08/24 at 10:10 conducted of NA #8 p to Resident #48. Resid observed to be satura smell of urine was pression An interview with NA a am. NA #10 indicated hall to care for 26 Res Resident #48 had a b time to time when it to	quired extensive assistance with all her activities of daily vas always incontinent of n on 02/08/24 at 8:15 am e heard from the hallway on entry into Resident #48's as present. On was conducted on of Resident #48, her call light hollering for help. An ted with Resident #48 but am NA #8 was observed 's room and the call light 8 was interviewed at this sident #48's brief was wet. as the ion person but was assisting as a nurse aide. NA #8 uld get NA #10 who was lent to provide incontinence am an observation was providing incontinence care ident#48's brief was ated in urine and a strong	F 550				

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	0: 03/22/2024 APPROVED 0: 0938-0391
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	-		LETED
		345566	B. WING				C 16/2024
NAME OF P	ROVIDER OR SUPPLIER		•	STREET ADDRESS, CITY, S	TATE, ZIP CODE		
PRUITTH	EALTH-UNION POINTE			3510 WEST HIGHWAY 74 MONROE, NC 28110			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION ECTIVE ACTION SHOULD BI ENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 550	bad because staff did provide care she need she tried to treat all he respect. The Director of Nursir interviewed on 2/8/24 explained she was no low on 2/8/24 and she staffing sheets. 4. Resident #69 was a 08/14/23, diagnosis ir nephropathy, Cerebel congestive heart failu and lack of coordinati Resident #69's quarte (MDS) assessment da cognition was modera displayed no rejection coded to exhibit disor that was present and/ maximum assistance toileting hygiene, sho was frequently incont Resident #69's active 01/04/2024, included status activities of dai related to slurred spec The interventions incl Resident #69 to do as provide assistance as focus area of bladder included the intervent incontinence care after	t #48 was upset and feeling not come in sooner to ded. NA #10 indicated that er residents with dignity and ng (DON) #1 was at 4:09 PM. DON #1 to certain why staffing was so e would need to review the admitted to the facility on noluded diabetic llar stroke syndrome, re (CHF), repeated falls, on. erly Minimum Data Set ated 01/05/24 indicated his ately impaired and he nof care behaviors. He was ganized thinking behavior for fluctuated. He required with personal hygiene, wer/bath, and dressing. He inent of bowel and bladder. care plan, last revised on the focus area of functional ly living (ADL) decline ech and impaired mobility. uded for staff to encourage s much as possible and to a needed or requested. A	F 55				

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM): 03/22/2024 MAPPROVED). 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345566	B. WING		_		C 16/2024
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, ST	ATE, ZIP CODE		
	ALTH-UNION POINTE		:	3510 WEST HIGHWAY 74			
PRUITING	ALTH-UNION POINTE			MONROE, NC 28110			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD BE ICED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 550	Continued From page breakdown related to medical diagnosis. The keep skin clean and do minimizing skin expose providing incontinence An interview was come PM with Resident #69 stated she was active explained there have Resident #69 was sat his pants and his bed indicated she comes of breakfast and dinner of changed. She also sta the facility to make su stated she was very up provided. An interview was come AM with Resident #69 many times where he much that his clothes soaked. He then point stated, "look at my ma morning, they even ha indicated his sheets a was saturated with un mattress revealed a co mattress extending ou from each side of the large area was slightly the circular area were were observed on the	e 8 decline in mobility and he interventions included to dry as possible and sure to moisture and e care. ducted on 02/07/24 at 1:43 0's family member. She in Resident #69's care. She been multiple times when curated with urine through would be wet. She to the facility daily for to ensure he eats and was ated she had to come into ure he was cared for. She	F 550	C			
	was no call for it, and sores from the urine of	her commented that there he hoped that he didn't get on him like that. He then istrated and mad when staff					

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED 0. 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE	
		345566	B. WING				C 16/2024
NAME OF PF	ROVIDER OR SUPPLIER		•	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
PRUITTHE	ALTH-UNION POINTE			-	510 WEST HIGHWAY 74 MONROE, NC 28110		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	3E	(X5) COMPLETION DATE
F 550	from soaking through An interview was com AM with Nursing Assis Resident #69 was out in his wheelchair whe AM. The night shift N/ verified there were no she entered the room sheets are changed if was the residents sho circular discoloration to An interview was com AM with Nursing Assis the circular discoloration was present. She indi what was on the matt urine. She further stat prior to applying the co An interview was com AM with Director of N Resident #69 was to n needed and should be needs often. No resid should be wet with uri Multiple phone calls w Assistant (NA) #12 fro 02/08/24 with no answ Resident #69 on 02/0 5. Resident #390 was 1/29/24 with diagnose urine.	en enough to prevent him his clothes and bedding. ducted on 02/08/24 at 9:15 stant (NA) #11. She stated t of bed and dressed sitting n she came on shift at 7:00 A had gotten him up. She o sheets on the bed when . She stated normally f they were wet, soiled, or it over day. She verified to the mattress. ducted on 02/08/24 at 9:20 stant (NA) #4. She verified ion area on the mattress icated she did not know ress, but it appeared to be ted she cleaned the area clean sheets. ducted on 02/07/24 at 10:05 ursing (DON) #1. She stated receive incontinence as e checked for incontinence ents' clothing or bed linens ine. vere made to the Nursing om 02/07/24 through wer. She was assigned to 7/24 from 7:00 PM-7:00 AM.	F	550			
	A care plan, dated 1/2	29/24, was in place for a					

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FOR	M APPROVED D. 0938-0391
CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					LE CONSTRUCTION	(X3) DATE COMF	E SURVEY PLETED
		345566	B. WING				C / 16/2024
NAME OF P	ROVIDER OR SUPPLIER		1		STREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
PRUITTHE	EALTH-UNION POINTE				3510 WEST HIGHWAY 74 MONROE, NC 28110		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 550	urinary catheter relate retention. On 2/5/24 at 10:50 Al observed walking in ti Therapy (PT). He was indwelling urinary cat attached to the walke have a privacy cover which was visible to o the hallway. On 2/5/24 at 12:00 Pl observed walking in ti noted to have a urina bag attached to the w not have a privacy co the other residents ar An interview and obse Resident #390 on 2/6	ed to diagnosis of urinary M, Resident #390 was he hallway with Physical s noted to have an heter with the drainage bag r. The drainage bag did not and contained yellow urine other residents and staff in M, Resident #390 was he therapy gym. He was ry catheter with the drainage valker. The drainage bag did ver and urine was visible to nd staff in the gym. ervation occurred with i/24 at 9:18 AM. He was	F	550			
	the urinary drainage h The drainage bag did had yellow urine in th seen from the hallway commented, "I don't t my urine." An interview occurred 9:20 AM and she stat catheters should have drainage bags and in- sure one was provide On 2/6/24 at 2:18 PM observed sitting up in TV. The urinary drain	hink everyone should see d with Nurse #13 on 2/6/24 at ed all residents with urinary e a privacy cover on the dicated she would make ed for Resident #390.					

If continuation sheet Page 11 of 84

		ID HUMAN SERVICES MEDICAID SERVICES				FORM): 03/22/2024 MAPPROVED). 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · /			(X3) DATE COMP	SURVEY LETED
		345566	B. WING				C 16/2024
NAME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, S	TATE, ZIP CODE		
PRUITTHE	ALTH-UNION POINTE			3510 WEST HIGHWAY 74 MONROE, NC 28110			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID		S PLAN OF CORRECTION		(X5)
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRE CROSS-REFERE	CTIVE ACTION SHOULD BE INCED TO THE APPROPRIA DEFICIENCY)		COMPLETION DATE
F 550	Continued From page	2 11	F 55	0			
		rom the hallway. There was					
	Another interview occ	urred with Nurse #13 on					
		d she stated she spoke with					
		erk and was told there were ilable. Nurse #13 added she					
	instructed the nurse a	ides to cover the drainage					
	bag with a pillowcase						
	On 2/7/24 at 11:08 AM						
	- .	a chair in his room with a The urinary drainage bag					
	was attached to the w	alker with a pillowcase					
		und it. Yellow urine was still ay and there was no dignity					
	cover in place.						
	The Central Supply C	lerk was interviewed on					
		She explained the facility had					
	, , ,	s with a dignity cover in upply Clerk was able to					
	show that multiple uri	nary drainage bags with a					
		esent in the supply closet on sident #390 resided. She					
	added the nurses wer	re responsible for making					
	sure the residents wit urinary drainage bag	h urinary catheters had a with a dignity cover					
		I was interviewed on 2/8/24 d it was her expectation for					
	the nursing staff to us	e a privacy cover for urinary					
	drainage bags to prot was unable to state w	ect the resident's dignity and					
	drainage bag was not	•					
F 554		Meds-Clinically Approp	F 55	4			3/11/24
SS=D	CFR(s): 483.10(c)(7)						

If continuation sheet Page 12 of 84

SMTERNEY OF DEPICENCES (1) PROVIDERGUEPLERCLA (2) MULTIPLE CONSTRUCTION (x) DATE SUMPLY A BUILING (x) DATE SUMPLY A BUILING INME OF PROVIDER OR SUPPLIER 345566 B WING C 02/16/2024 INME OF PROVIDER OR SUPPLIER STREETADORESS CITY. STATE 2P CODE 3510 WEST HIGHWAY 74 MONDOE, NC 2810 C 02/16/2024 PRUITHEALTH-UNION POINTE SUMMAY STATEMENT OF DEFICIENCES (EACH OPERCIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) IP PREEX (CACH CORRECTION 4 COTON SHOULD BE (CACH CORRECTION 4 COTON SHOULD BE			D HUMAN SERVICES				FORM	M APPROVED D. 0938-0391
JAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE D2/16/2024 PRUITHEALTH-UNION POINTE STREET ADDRESS, CITY, STATE, ZIP CODE COMPACT	STATEMENT (OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA				(X3) DATE COMF	E SURVEY PLETED
NAME OF PROVIDER OR SUPPLER STREET ADDRESS, CITY, STATE, ZP CODE PRUTTHEALTH-UNION POINTE STREET ADDRESS, CITY, STATE, ZP CODE (X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL RESULATORY OR LSD IDENTIFYING INFORMATION) ID PREFIX PREFIX PROVIDER'S PLAN OF CORRECTION (EACH DEPRECIPACY MUST BE PRECEDED BY FULL RESULATORY OR LSD IDENTIFYING INFORMATION) PREFIX PREFIX PROVIDER'S PLAN OF CORRECTION (EACH DEPRECIPACY MUST BE PRECEDED BY FULL RESULATORY OR LSD IDENTIFYING INFORMATION) PREFIX PREFIX PROVIDER'S PLAN OF CORRECTION (EACH DEPRECIPACY ADD SHOULD BE DEPRETIX (CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) COMPLET DEPRETIX (CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) COMPLET DEFICIENCY COMPLET DEFICIENCY COMPLET DEFICIENCY COMPLET DEFICIENC			345566	B. WING				-
PRUTHEALTH-UNION POINTE MONROE, NC 28110 (%) ID PREFIX TAG SUMMARY STREMENT OF DEFICIENCIES (EQUIATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX REGULATORY OR LSC IDENTIFY REGULATORY OR LSC IDENTIFY REGULATO	NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
Image: Provide and the second secon					35	510 WEST HIGHWAY 74		
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR US IDENTIFYING INFORMATION) PREFIX TAG CACH CORRECTIVE ACTION SHOLD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) COMPLETION DEFICIENCY F 554 Continued From page 12 \$483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by \$483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is not met as evidenced by: Based on observations, record review, resident, and staff interview the facility failed to assess a resident's ability to self-administer medications reviewed for medications for 2 of 2 resident serviewed for medications for 2 of 2 resident serviewed for medications for 2 of 2 resident serviewed for medications at bedside (Resident #440 and Resident #194). 1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: 1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: 1. Resident #440 was admitted to the facility on 01/23/24 with diagnoses that included chronic congestive heart failure, chronic kidney disease, type 2 diabetes mellitus, anxiety disorder, and atrial fibrillation. Resident #194 is no longer a resident in the facility. 2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice. Current residents have the potential to be affected. Review of Resident #440 was cognitively intact. Review of Resident #440's medical record revealed no documentation that Resident #440 had been assessed to self-administer medications at bedside.	PRUITTHE	EALTH-UNION POINTE			м	IONROE, NC 28110		
§483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is not met as evidenced by: 1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: 2 of 2 resident's ability to self-administer medications at bedside (Resident #440 and Resident #194). 1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: 1. Resident #440 was admitted to the facility on 01/23/24 with diagnoses that included chronic congestive heart failure, chronic kidney disease, type 2 diabetes mellitus, anxiety disorder, and atrial fibrillation. Resident #194 is no longer a resident in the facility. Review of the admission Minimum Data Set (MDS) assessment dated 01/29/24 revealed that Resident #440 was cognitively intact. Current residents having the potential to be affected by the same deficient practice. Review of Resident #440's medical record revealed no documentation that Resident #440 had been assessed to self-administer medications at bedside. The Director of Health Services (DHS), Assistant Director of Health Services (DHS), Clinical Competency Coordinator	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFI	x	(EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI		COMPLETION
Further review of Resident #440's medical record and/or Staff Nurse(s) will complete an revealed no care plan for self-administration of audit of 100% of resident □s rooms to medications. ensure no medications are available at An observation and interview were conducted resident □s bedside unless the with Resident #440 on 02/06/24 at 9:13 AM. clinically appropriate for Resident #440 was sitting in his wheelchair self-administration of medications, and beside his bedside table. He was noted to have physician order obtained to self-	F 554	 §483.10(c)(7) The rig medications if the inter defined by §483.21(b) this practice is clinica This REQUIREMENT by: Based on observatio and staff interview the resident's ability to se 2 of 2 residents review bedside (Resident #4 The findings included 1. Resident #440 was 01/23/24 with diagnos congestive heart failut type 2 diabetes mellit atrial fibrillation. Review of the admisss (MDS) assessment da Resident #440 was conditions at bedside Further review of Resident # revealed no document had been assessed to medications at bedside Further review of Resident in medications. An observation and in with Resident #440 was sident # 440 was sident was sident #	ht to self-administer erdisciplinary team, as)(2)(ii), has determined that Ily appropriate. is not met as evidenced ins, record review, resident, e facility failed to assess a If-administer medications for wed for medications at 40 and Resident #194). admitted to the facility on ses that included chronic re, chronic kidney disease, us, anxiety disorder, and ion Minimum Data Set ated 01/29/24 revealed that ognitively intact. 440's medical record tation that Resident #440 o self-administer le. ident #440's medical record of or self-administration of hterview were conducted in 02/06/24 at 9:13 AM. tting in his wheelchair	F	554	 Address how corrective action will b accomplished for those residents four- have been affected by the deficient practice: Resident #440 is no longer a resident is the facility. Resident #194 is no longer a resident is the facility. Address how the facility will identify other residents having the potential to affected by the same deficient practice. Current residents have the potential to affected. The Director of Health Services (DHS) Assistant Director of Health Services (ADHS), Registered Nurse Supervisors (RNS), Clinical Competency Coordinat (CCC), Minimal Data Set (MDS) Nurse and/or Staff Nurse(s) will complete an audit of 100% of resident s rooms to ensure no medications are available at the resident had been assessed, deemed clinically appropriate for self-administration of medications, and 	d to in in be s. be s. tor es	

Facility ID: 080171

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CENTER	S FOR MEDICARE &	MEDICAID SERVICES			OMB	NO. 0938-039
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION		OATE SURVEY OMPLETED
		345566	B. WING			C 02/16/2024
NAME OF PI	ROVIDER OR SUPPLIER	I		STREET ADDRESS, CITY, STATE, ZI	P CODE	
				3510 WEST HIGHWAY 74		
PRUITTHE	EALTH-UNION POINTE			MONROE, NC 28110		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETION DATE
F 554	Continued From page	<u>_ 13</u>	E 55			
F 354	eye irritation), on his l observation revealed room that contained p included over-the-cou MiraLAX (for constipa vitamins (a suppleme Review of Resident #	esh tear eye drops (relief of bedside table. A further a table in the corner of his bersonal items which unter medications, a bottle of ation) and AREDS 2 eye	F 55	 of Health Services (ADH Nurse Supervisors (RNS Competency Coordinato Data Set (MDS) Nurses Nurse(s) will address an identified during the aud be completed by 3/11/20 3. Address what measur place or systematic char 	s), Clinical r (CCC), Minimal and/or Staff y concerns it. The audit will 024. es will be put into	
	AREDS 2, however it 01/23/24 for Flonase propionate) spray, su (mcg)/actuation: 2 sp	ve drops, MiraLAX, and was noted an order dated Allergy Relief (fluticasone spension; 50 micrograms rays; nasal once a day.		ensure that the deficient recur. The Director of Health S Competency Coordinato Supervisors, and/or desi	ervices, Clinical r, RN gnee will provide	
	on 02/06/24 at 9:20 a medications observed	ducted with Resident #440 m and he indicated the d were his medications and ications on his bedside table		education to 100% of lice noting mediations should per physician order and should be left at the bed unless they have been a be clinically appropriate	d be administered no medication side of a resident ssessed, noted to	
	Nurse #13 was interviewed on 02/06/24 at 9:32 AM. She indicated she had administered Resident #440's morning medications this morning. She stated, "he took his medicines from me, and I don't give any of these medications." Nurse #13 indicated she was not aware of the medications in Resident's room as he was sitting			self-administration of me physician order obtained will include medication b family. Education will be 3-11-2024. After 3-11-20 staff who have not worke education will receive it	I to do so. This ought in by the completed by 24, any nursing ed or received the prior to the next	
	not see the medicatio his medications. She Resident's family mer had brought medication	is wheelchair, and she did ons when she administered stated she had talked to mbers before because they ons in before. Nurse #13 140 had not been assessed		scheduled work shift. All licensed nurses will rece education during genera orientation.	ive the same I facility	
		and did not have an order		The Director of Health S Competency Coordinato Supervisors, and/or desi 100% of resident rooms	r, RN gnee will audit	
	Director of Nursing (F	OON) #1 was interviewed on		medications are not four		

Event ID:9U2E11

Facility ID: 080171

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	-					FOR	M APPROVED
			(X2) MULT	IPI F	CONSTRUCTION		O. 0938-0391 E SURVEY
	CORRECTION	IDENTIFICATION NUMBER:					IPLETED
			-				С
		Image: IDENTIFICATION NUMBER: A. BUILDING A. BUILDING A. BUILDING UPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE N POINTE STREET ADDRESS, CITY, STATE, ZIP CODE SUMMARY STATEMENT OF DEFICIENCIES D PHOEDICIENCY MUST DE PRECEDED BY FULL D ULATORY OR LSC IDENTIFYING INFORMATION) PROVIDER'S FLAN OF CORRECT From page 14 F 554 tt 4:09 PM and she indicated s family members would bring in sa and would not tell the nursing staff. ted they needed to be better at and educating residents/families. F 554 residentTips was admitted to the facility with diagnoses to include dry eye and ocular hypertension. F 554 nt 4:194 was admitted to the facility with diagnoses to include dry eye and ocular hypertension. F 10E nt dated 2/8/2024 assessed Resident e cognitively intact. The remainder of was in progress and not completed. The Director of Health Services will and trend the results via the Self Administration of Medications Audit weekly and report the findings to the Quality Assurance Performance Improvement Committee monthly x i months or until substantial complian achieved and then quarterly. Resident #194 included an order dated or brimonidine/timolol eye drops to be ed every 12 hours. Review of the n administration record indicated this ister medication record indicated this istered on 2/6/2024. Compliance date: 3-11-2024 Ital etal 2/5/2024 for dorzolamide eye e administre	02	2/16/2024			
NAME OF P	ROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
DDUUTTU				35	510 WEST HIGHWAY 74		
PRUITIN	EALTH-UNION POINTE			М	ONROE, NC 28110		
(X4) ID			ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG				<			COMPLETION DATE
iAo		,					
F 554	Continued From page	e 14	F 5	554			
	02/06/24 at 4:09 PM	and she indicated			resident⊡s beside unless the resident	has	
	sometimes family me	mbers would bring in			been assessed, deemed clinically		
	checking and educati	ng residents/families.				be	
	2 Decident #104 was	admitted to the facility					
					weekly x4 weeks, and then monthly x1	•	
					4 Indicate how the facility plans to		
		nyperteneien				that	
	The admissionMinim	um Data Set (MDS)			-		
	assessment dated 2/8	8/2024 assessed Resident					
					The Director of Health Services will tra	ck	
	the MDS was in prog	ress and not completed.					
						ol	
					-		
						is	
	There was no care pl	an developed for			•		
		-					
	self-administer medic	ations.			Compliance date: 3-11-2024		
	Orders for Posident t	104 included an order dated					
	Resident #194 receiv	ed this medication as					
	evidenced by nursing	initials.					
	An order dated 2/5/20)24 for dorzolamida ava					
		-					
	-	-					
	was administered on						
	-						
		he mentioned his wife					
1	prought in the eye dro	ops for him to administer					

If continuation sheet Page 15 of 84

						FOR	M APPROVED 0. 0938-0391
STATEMENT O	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DAT	E SURVEY IPLETED
		345566	B. WING			02	2/16/2024
NAME OF PI	PLAN OF CORRECTION IDENTIFICATION NUMBER: A BUILDING 345566 B. WING ME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, 3510 WEST HIGHWAY 74 WONROE, NC 28110 ID VECOF PROVIDER OR SUPPLIER SUMMARY STATEMENT OF DEFICIENCIES WITTHEALTH-UNION POINTE ID REFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID F 554 Continued From page 15 until the facility was able to get his prescription eye drops. F 554 Resident #194 opened his nightstand drawer to reveal the 2 bottles of eye drops, brimonidine/timolol and dorzolamide. When asked if the nursing staff knew that he had the eye drops in his room, Resident #194 reported he had told a nurse (he was uncertain who) he had his own eye drops. Resident #194 was interviewed again on 2/6/2023 and he reported the facility had obtained both of his prescription eye drops and his wife took his bottles home. Nurse #13 was interviewed on 2/6/2024 at 3:37 PM. Nurse #13 reported she was not aware Resident #194 had eye drops in his room. Nurse #13 reported she asked about home medications		STREET ADDRESS, CITY, STATE, ZIP CODE	• •			
PRUITTHE	EALTH-UNION POINTE						
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFI		PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 554	until the facility was a eye drops. Resident #194 opene reveal the 2 bottles of brimonidine/timolol ar asked if the nursing s eye drops in his room had told a nurse (he w his own eye drops. Resident #194 was in and he reported the fa his prescription eye d bottles home. Nurse #13 was interv PM. Nurse #13 repor Resident #194 had ey #13 reported she ask when she completed but did not complete assessment. Nurse #10 was interv PM. Nurse #10 repor Resident #194 had ey drawer and was self-a The facility physician at 3:03 PM. The physic drops in a closed nigh pose a danger to othe assessment for self-a should have been con The Director of Nursin	ble to get his prescription ed his nightstand drawer to f eye drops, hd dorzolamide. When taff knew that he had the h, Resident #194 reported he was uncertain who) he had hterviewed again on 2/6/2023 acility had obtained both of rops and his wife took his iewed on 2/6/2024 at 3:37 rted she was not aware ye drops in his room. Nurse ed about home medications the admission assessment Resident #194's admission iewed on 2/6/2024 at 3:45 rted that he was not aware ye drops in his nightstand administering the eye drops. was interviewed on 2/8/2024 sician reported that eye htstand drawer would not er residents, but an dministration of medications mpleted for Resident #194.	F	554			
	interviewed on 2/8/20						

Facility ID: 080171

If continuation sheet Page 16 of 84

				CONSTRUCTION	(X3) DATE SURV	38-039
		IDENTIFICATION NUMBER:			COMPLETED	
	AN OF CORRECTION IDENTIFICATION NUMBER: 345566 OF PROVIDER OR SUPPLIER TTHEALTH-UNION POINTE OF PID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 554 Continued From page 16 medications and not tell staff. DON #1 reported she would expect if a resident brought in medication from home, a medication self-administration assessment was completed. 623 Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and	D. MINO		С		
	AN OF CORRECTION IDENTIFICATION NUMBER: IDENTIFICATION NUMBER: 345566 COF PROVIDER OR SUPPLIER ITTHEALTH-UNION POINTE SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 554 Continued From page 16 medications and not tell staff. DON #1 reported she would expect if a resident brought in medication from home, a medication self-administration assessment was completed. 623 627 R(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer/Discharge CFR(s): 483.15(c)(3).(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or	B. WING		02/16/20)24	
NAME OF P	 (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 554 Continued From page 16 medications and not tell staff. DON #1 reported she would expect if a resident brought in medication from home, a medication self-administration assessment was completed. F 623 Notice Requirements Before Transfer/Discharge SS=B CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a 		TREET ADDRESS, CITY, STATE, ZIP COD	E		
PRUITTHE	EALTH-UNION POINTE			510 WEST HIGHWAY 74 IONROE, NC 28110		
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE COM	(X5) IPLETIO DATE
F 554	Continued From page	- 16	F 554			
	medications and not she would expect if a medication from hom	tell staff. DON #1 reported resident brought in e, a medication	1 304			
F 623 SS=B	Notice Requirements	Before Transfer/Discharge	F 623		3/11/	/24
	Before a facility trans resident, the facility n (i) Notify the resident representative(s) of the the reasons for the m language and manne facility must send a c representative of the Long-Term Care Oml (ii) Record the reason discharge in the resid accordance with para and (iii) Include in the not paragraph (c)(5) of the §483.15(c)(4) Timing	fers or discharges a nust- and the resident's he transfer or discharge and nove in writing and in a er they understand. The opy of the notice to a Office of the State budsman. ns for the transfer or dent's medical record in agraph (c)(2) of this section; ice the items described in nis section.				
	 (i) Except as specified (c)(8) of this section, discharge required un made by the facility a resident is transferred (ii) Notice must be ma before transfer or disc (A) The safety of indii be endangered under this section; 	d in paragraphs (c)(4)(ii) and the notice of transfer or nder this section must be it least 30 days before the d or discharged. ade as soon as practicable charge when- viduals in the facility would r paragraph (c)(1)(i)(C) of viduals in the facility would				

Facility ID: 080171

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM): 03/22/2024 MAPPROVED). 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345566	B. WING		_		C 16/2024
NAME OF P	ROVIDER OR SUPPLIER		5	STREET ADDRESS, CITY, ST	ATE, ZIP CODE		
PRUITTHI	EALTH-UNION POINTE			3510 WEST HIGHWAY 74 MONROE, NC 28110			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE) CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 623	allow a more immedia under paragraph (c)(1 (D) An immediate trar required by the reside under paragraph (c)(1 (E) A resident has not days. §483.15(c)(5) Conten notice specified in par must include the follor (i) The reason for tra- (ii) The effective date (iii) The effective date (iii) The location to wh transferred or dischar (iv) A statement of the including the name, a and telephone number receives such requess to obtain an appeal for completing the form a hearing request; (v) The name, address telephone number of Long-Term Care Omk (vi) For nursing facility and developmental di disabilities, the mailin telephone number of the protection and add developmental disabi C of the Development and Bill of Rights Act codified at 42 U.S.C. (vii) For nursing facility disorder or related dis	alth improves sufficiently to ate transfer or discharge, ()(i)(B) of this section; hefer or discharge is ent's urgent medical needs, ()(i)(A) of this section; or a resided in the facility for 30 ts of the notice. The written ragraph (c)(3) of this section wing: hefer or discharge; of transfer or discharge; of transfer or discharge; ich the resident is ged; a resident's appeal rights, ddress (mailing and email), er of the entity which ts; and information on how wrm and assistance in and submitting the appeal s (mailing and email) and the Office of the State budsman; / residents with intellectual sabilities or related g and email address and the agency responsible for vocacy of individuals with lities established under Part tal Disabilities Assistance of 2000 (Pub. L. 106-402,	F 623				

If continuation sheet Page 18 of 84

	-	D HUMAN SERVICES MEDICAID SERVICES				FORM APPROVED
STATEMENT (DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		IB NO. 0938-0391
		345566	B. WING			C 02/16/2024
NAME OF P	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STATE, ZIP	CODE	
PRUITTHE	EALTH-UNION POINTE			510 WEST HIGHWAY 74 IONROE, NC 28110		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE	(X5) COMPLETION DATE
F 623	agency responsible for advocacy of individual established under the for Mentally III Individual §483.15(c)(6) Change If the information in the effecting the transfer must update the recip as practicable once the becomes available. §483.15(c)(8) Notice if In the case of facility of the administrator of the written notification priot to the State Survey Ag State Long-Term Care the facility, and the re well as the plan for the relocation of the resid 483.70(I). This REQUIREMENT by: Based on record revi Party (RP) interviews Residents RP in writtin This was for 2 of 3 res hospitalization(Reside The findings included 1. Resident #16's quarte (MDS) dated 10/3/23 severe cognitive impa-	or the protection and ls with a mental disorder Protection and Advocacy uals Act. es to the notice. the notice changes prior to or discharge, the facility tients of the notice as soon the updated information in advance of facility closure closure, the individual who is the facility must provide or to the impending closure gency, the Office of the the Ombudsman, residents of sident representatives, as the transfer and adequate ents, as required at § is not met as evidenced ew, staff and Responsible the facility failed to notify a ang of a hospital transfer. sidents reviewed for ent #16 and Resident #19). the facility failed on 4/2/21. enty Minimum Data Set indicated Resident #16 had	F 623	1. Address how correctiv accomplished for those re have been affected by the practice: Resident #16 remains in t the resident and/or respon provided written notification transfer that occurred on Resident #19 remains in t the resident and/or respon provided written notification transfer that occurred on 3/6/24.	esidents found to e deficient the facility and nsible party was on of hospital 1/2/24 on 3/6/24. the facility and nsible party was on of hospital	

Event ID:9U2E11

Facility ID: 080171

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						/ APPROVE 0. 0938-039
TATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION	(X3) DATE	
	IN OF CORRECTION IDENTIFICATION NUMBER: Jats566 OF PROVIDER OF SUPPLIER THEALTH-UNION POINTE SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 623 Continued From page 19 was readmitted on 1/5/24. There was no documented evidence that her RP was notified in writing the reason for her hospital transfer. A telephone interview was completed on 2/8/24 at 12:08 PM with Resident #16's RP. He stated he did not receive anything in writing about Resident#16's transfer to the hospital or the reason for her hospital transfer on 1/2/24 but stated the nurse did call him to let him know. An interview was completed on 2/8/24 at 8:50 AM with the Clinical Reimbursement Coordinator. She stated the floor nurses wrote up the reason for the hospital transfer and gave it to the Business Office Manager to mail out. Another interview was completed on 2/8/24 at 9:40 AM, with the Clinical Reimbursement Coordinator. She stated the facility was not mailing out or providing a copy to the Notice Of Involuntary Transfer form to the resident if applicable or the RP. An interview was completed on 2/8/24 at 11:00 AM with the Business Office Manager. She stated she was not aware that she was supposed to mailing a copy of the Notice Of Involuntary Transfer form for hospital transfers. 2. Resident #19's quarterly Minimum Data Set dated 10/25/23 indicated she was cognativel intact.	B. WING			C 16/2024	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD		10/2024
	ENTERS FOR MEDICARE EMENT OF DEFICIENCIES PLAN OF CORRECTION ME OF PROVIDER OR SUPPLIER UITTHEALTH-UNION POINTE K4) ID REFIX TAG F 623 Continued From pa was readmitted on documented evider writing the reason f A telephone intervia 12:08 PM with Residid not receive any Resident#16's trans reason for her hosp stated the nurse did An interview was ca with the Clinical Re She stated the flood for the hospital trans Business Office Ma Another interview w 9:40 AM, with the C Coordinator. She si mailing out or provi Involuntary Transfe applicable or the Ri An interview was ca An with the Busine she was not aware mailing a copy of th Transfer form for ho 2. Resident #19's qua			3510 WEST HIGHWAY 74		
PRUITTH	EALTH-UNION POINTE			MONROE, NC 28110		
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETIO DATE
F 623	Continued From page	e 19	F 62	23		
			102			
				2. Address how the facility wil	l identifv	
				other residents having the pot	•	
		•		affected by the same deficien		
	A telephone interview	v was completed on 2/8/24 at				
				Current residents have the po	tential to be	
				affected.		
re si		•		The Director of the alth Ocrain		
				The Director of Health Service Assistant Director of Health S	· · · ·	
		call film to let film know.		(ADHS), Registered Nurse Su		
	An interview was con	npleted on 2/8/24 at 8:50 AM		(RNS), Clinical Competency (
		-		(CCC), Minimal Data Set (MD		
				and/or Staff Nurse(s) will com	,	
	for the hospital transf	er and gave it to the		audit of last 30 days of hospit	al transfers	
	Business Office Mana	ager to mail out.		to ensure written notification of	of transfer	
				was provided to the resident		
				responsible party. The Directo		
				Services (DHS), Assistant Dir		
		-		Health Services (ADHS), Reg		
				Nurse Supervisors (RNS), Cli Competency Coordinator (CC		
	-			Data Set (MDS) Nurses and/o		
				Nurse(s) will address any con		
	An interview was con	npleted on 2/8/24 at 11:00		identified during the audit. The		
	AM with the Business	Office Manager. She stated		be completed by 3/11/2024.		
				3. Address what measures wi		
	Transfer form for hos	pital transfers.		place or systematic changes		
	2. Resident #19 was	admitted 6/25/18.		ensure that the deficient pract recur.	ice will not	
	Resident #10's quart	erly Minimum Data Set dated		The Director of Health Service	es Clinical	
	-	-		Competency Coordinator, RN Supervisors, and/or designee		
	Review of her electro	nic medical record read she		education to 100% of licensed	nurses	
		e hospital on 3/21/23. She		noting the resident and/or res		
	was readmitted on 3/			party must be notified via pho		
	documented evidence	e that her RP was notified in		writing of all hospital transfers	i	

Facility ID: 080171

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DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING (X3) DATE COMP	FORM APPROVED OMB NO. 0938-0391				
STATEMENT O	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345566	B. WING		C 02/16/2024
NAME OF PI	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CODE	
				3510 WEST HIGHWAY 74	
PRUITTHE	EALTH-UNION POINTE			MONROE, NC 28110	
PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI	
F 623	writing the reason for A telephone interview 3:58 PM with Resider did not receive anythi Resident#19's transfe reason for her hospita stated the nurse did of An interview was com with the Clinical Reim She stated the floor n for the hospital transfe Business Office Mana Another interview was 9:40 AM, with the Clin Coordinator. She stat mailing out or providin Involuntary Transfer t or the RP. An interview was com AM with the Business she was not aware th a copy of the Notice O	her hospital transfer. T was completed on 2/7/24 at the #19's RP. He stated he ng in writing about ter to the hospital or the alization on 3/21/23 but call him to let him know. Appleted on 2/8/24 at 8:50 AM abursement Coordinator. Urses wrote up the reason er and gave it to the ager to mail out. as completed on 2/8/24 at hical Reimbursement ed the facility was not ng a copy to the Notice Of o the resident if applicable appleted on 2/8/24 at 11:00 c Office Manager. She stated at she was supposed to mail Of Involuntary Transfer form	F 62	 Documentation in the electronic health record should reflect the written transfer documents being provided to the resid and/or responsible party. Education will completed by 3-11-2024. After 3-11-202 any nursing staff who have not worked received the education will receive it proto the next scheduled work shift. All net hired nursing staff will receive the same education during general facility orientation. The Director of Health Services, Clinical Competency Coordinator, RN Supervisors, and/or designee will audit documentation in electronic health receive for each hospital transfer to ensure writh notification of hospital transfer were provided to the resident and/or responsible party. Audits will be conducted 3 times a week x 4 weeks, weekly x4 weeks, and then monthly x1 Indicate how the facility plans to monitor its performance to make sure the solutions are sustained. The Director of Health Services will transfer Notification Audit Tool weekly and report the findings to the Quality Assurance Performance Improvement Committee monthly x 3 months or until substantial compliance is achieved and compline complex compliance is achieved and c	er ent ll be 24, or ior wly e al al al brd tten hat ck
	Encoding/Transmittin	g Resident Assessments	F 64		3/11/24

Facility ID: 080171

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	MENT OF HEALTH AN S FOR MEDICARE & I	D HUMAN SERVICES					FORM): 03/22/2024 APPROVED). 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í		CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345566	B. WING			_	C 02/16/2024	
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, ST	ATE, ZIP CODE		
PRUITTHE	EALTH-UNION POINTE				510 WEST HIGHWAY 74 IONROE, NC 28110			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION TIVE ACTION SHOULD B ICED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 640	a facility completes a facility must encode th each resident in the fa (i) Admission assessmer (ii) Annual assessmer (iii) Significant change (iv) Quarterly review a (v) A subset of items of reentry, discharge, an (vi) Background (face is no admission asses §483.20(f)(2) Transmi after a facility complet a facility must be capa CMS System informat contained in the MDS standard record layou and that passes stand CMS and the State. §483.20(f)(3) Transmi 14 days after a facility assessment, a facility encoded, accurate, an the CMS System, incl (i) Annual assessmer (iii) Significant change	 (4) I data processing I data processing I data processing I data vithin 7 days after resident's assessment, a ne following information for acility: nent. Int updates. In status assessments. I upon a resident's transfer, id death. I sheet) information, if there assessment. I transmitting to the tion for each resident In a format that conforms to ats and data dictionaries, dardized edits defined by I ttal requirements. Within 7 days the in a format that conforms to ats and data dictionaries, dardized edits defined by I ttal requirements. Within 7 days the instatus assessment. 	F	540				

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	-						FORM	APPROVED . 0938-0391
STATEMENT C	F DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					X3) DATE S COMPL	SURVEY ETED
	NT OF DEFICIENCIES I OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING 345566 B. WING F PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 3510 WEST HIGHWAY 74 MONROE, NC 28110 MONROE, NC 28110 PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG PROVIDER'S PLAN OF CORRECTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		C 02/1	, 6/2024				
NAME OF PR		· ·	STREET ADDR	RESS, CITY, STATE, ZIP CODE				
DDUUTTUE				3510 WEST H	IIGHWAY 74			
PRUITIHE	ALTH-UNION POINTE			MONROE, N	IC 28110			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFIX		EACH CORRECTIVE ACTION S COSS-REFERENCED TO THE AF	HOULD BE	E	(X5) COMPLETION DATE
F 640	 (vii) A subset of items reentry, discharge, an (viii) Background (factinitial transmission of does not have an adm §483.20(f)(4) Data for transmit data in the for for a State which has by CMS, in the format approved by CMS. This REQUIREMENT by: Based on record revifacility failed to complete (MDS) assessme This was for 4 of 34 a MDS completion (Res #18). The findings included 1. Resident #16 was a admitted to hospice s Review of the signific: Minimum Data Set (Mit was still in progress not been completed. An interview was corr with the Clinical Reim stated the two MDS Completion and transmited to a subset of the significant stated the two MDS Completion and transmited to a subset of the significant stated the two MDS Completion and transmited to a subset of the significant stated the two MDS Completion and transmited to a subset of the significant stated the two MDS Completion and transmited to a subset of the significant completion and transmited to get completed to the state of the significant completion and transmited to a subset of the significant state of the transmited transmited to the state of the significant completion and transmited to the state of the significant completion and transmited to the state of the significant completion and transmited to the state of the significant completion and transmited to the state of the significant completion and transmited to the state of the significant completion and transmited to the state of the significant completion and transmited to the state of the significant completion and transmited to the state of the state of the significant completion and transmited to the state of the state of	upon a resident's transfer, ad death. e-sheet) information, for an MDS data on resident that hission assessment. That The facility must ormat specified by CMS or, an alternate RAI approved t specified by the State and is not met as evidenced ew and staff interviews the ete residents Minimum Data ints within the required time. ctive residents reviewed for sidents #16, #19, #8, and : admitted on 4/2/21 and was ervices on 1/8/24. ant change in status IDS) dated 1/10/24 revealed , and the mood section had inter the mood section had appleted on 2/8/24 at 1:30 PM bursement Consultant. She coordinators started six is were still learning, and ne MDS person also ed she was aware of the mission problems, and they aught up.	F 6	Correct Affected Residen Assessn 1/05/202 to Intern Evaluati date of 2 Residen Assessn 1/10/202 to Intern Evaluati date of 2 Residen Assessn 1/19/202 to Intern Evaluati date of 2 Residen Assessn 1/19/202 to Intern Evaluati date of 2 Residen Assessn 1/19/202 to Intern Evaluati date of 2 Residen Assessn	t # 8 s MDS assessme ment Reference Date (A 24 was completed and s hal Quality Improvement ion System (IQIES) with 2/9/2024. Int # 16 s MDS assessm ment Reference Date (A 24 was completed and s hal Quality Improvement ion System (IQIES) with 2/9/2024. Int # 18 s MDS assessm ment Reference Date (A 24 was completed and s hal Quality Improvement ion System (IQIES) with 2/20/2024.	ent with RD) submitted and accepte nent with RD) submitted accepte nent with RD) submitted and accepte	d d d	

Facility ID: 080171

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	OF DEFICIENCIES	MEDICAID SERVICES	(X2) MULTIPI			OMB NO. 0 (X3) DATE SUI		
	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING			COMPLET		
			A. BOILDING			с		
		345566	B. WING			02/16/2024		
NAME OF PI	ROVIDER OR SUPPLIER	L		STREET AD	DRESS, CITY, STATE, ZIP CODE	•=:••		
		3510 WEST HIGHWAY 74						
PRUITTHE	EALTH-UNION POINTE			MONROE,	, NC 28110			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		(X5) COMPLETIO DATE	
		,			DEFICIENCY)			
F 640	Continued From page		F 64	-				
	admitted to hospice s	services on 1/6/24.			24 was completed and submitted	to		
					al Quality Improvement and			
	Review of the signific				ation System (IQIES) with accepte	ed		
		IDS) dated 1/9/24 revealed		date o	of 2/9/2024.			
	it was still in progress							
	· ·	dentification information,		Action	n for the Residents Potentially			
	cognition, and prefere	ences and customary		Affect	ed			
	activities.							
w				On 2/2	28/2024, the Case Mix Director or			
	An interview was con	npleted on 2/8/24 at 1:30 PM		Desig	nee ran an assessment status			
	with the Clinical Reim	bursement Consultant. She		Repor	rt to identify any outstanding MDS			
	stated the two MDS 0	Coordinators started six		that is	in progress status or in need of			
	months ago, and they	y were still learning, and		transn	nission to the Internal Quality			
	there was one part-tir	me MDS person also		Impro	vement and Evaluation System			
		ted she was aware of the			S). Eight assessments were			
	-	mission problems, and they			fied as being in progress. No			
	were working to get o				sment identified needing to be			
	······································				nitted to the IQIES. The eight			
	3. Resident #8 was a	dmitted 6/25/18			fied outstanding MDS will be			
					ized for prompt completion and			
	Review of the quarter	rly Minimum Data Set (MDS)			nission to the IQIES. Completion			
	-	d it was still in progress and			2/29/2024			
		a not been completed.						
		The been completed.		Sveto	mic Changes			
	An interview was con	npleted on 2/8/24 at 1:30 PM		Oysici	The onaliges			
		bursement Consultant. She		00.02	0/20/2024 the two MDS purses			
		Coordinators started six			2/29/2024, the two MDS nurses ved education related to the			
		y were still learning, and			ding/transmitting Resident			
	there was one part-tir				ssments per RAI guidelines by the			
	-	ted she was aware of the		-	al Reimbursement Coordinator.			
		mission problems, and they			mission will be done at least once			
	were working to get o	aught up.			This education will be provided to			
					wly hired Case Mix Directors and/	or		
		admitted to the facility on			Mix Coordinators during general			
		mitted to hospice services		orienta				
	on 01/19/24.				case Mix Director will run the MDS			
					due report to identify assessmen	ts		
		18's most recent Minimum			re outstanding or in progress for			
		sment was dated 01/19/24	1		letion and transmission. This repo			

Facility ID: 080171

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		ID HUMAN SERVICES MEDICAID SERVICES			FORM	: 03/22/20 APPROVE . 0938-039
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	(X3) DATE S COMPL	ETED
		345566	B. WING		02/1	; 6/2024
NAME OF PI	ROVIDER OR SUPPLIER		•	STREET ADDRESS, CITY, STATE, ZI	P CODE	
PRUITTHE	EALTH-UNION POINTE			3510 WEST HIGHWAY 74 MONROE, NC 28110		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ((EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETIO DATE
F 640	and was coded as a s assessment. The ass completed and there assessment had been An interview was con PM with the Clinical F She stated the two M months ago, and they there was one part-tin assisting. She indicat	significant change in status sessment had not been was no indication the n transmitted. ducted on 02/08/24 at 1:30 Reimbursement Consultant. DS Coordinators started six y were still learning, and me MDS person also red she was aware of the mission problems, and they	F 6	 will be pulled weekly for a monthly for 4 months. The Director will maintain a loc outstanding assessments and transmission. Quality Assurance The Case Mix Director w analysis of the transmiss assessments to the Adm Quality Assurance and P Improvement Committee until three consecutive m compliance is maintained quarterly thereafter, to encompliance. 	the Case Mix bg of all identified is for completion will present the sion timing hinistrator at the Performance the meeting monthly honths of d and then	
 F 657 Care Plan Timing and Revision SS=D CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's 		F 6	Date of compliance: 3/11		3/11/24	

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		MEDICAID SERVICES			OMB NO. 0938-03
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED
		345566	B. WING		C 02/16/2024
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	ODE
PRIJITTHE	EALTH-UNION POINTE			3510 WEST HIGHWAY 74	
				MONROE, NC 28110	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC	ION SHOULD BE COMPLETION HE APPROPRIATE DATE
F 657	Continued From page	e 25	F 6	57	
		participation of the resident	10		
		presentative is determined			
	not practicable for the				
	resident's care plan.				
		e staff or professionals in			
		nined by the resident's needs			
	or as requested by th	ie resident. vised by the interdisciplinary			
		essment, including both the			
	comprehensive and c				
	assessments.				
	This REQUIREMENT	Γ is not met as evidenced			
	by:				
		on, staff interviews and		Corrective Action for the Re	esident
		cility failed to revise a care		Affected	
		le a new intervention on ers to a wheelchair. This was		On 2/08/2024, resident #16	s care plan
	for 1 of 6 residents re			was updated to reflect anti-	
	(Resident #16).			to her wheelchair by therap	
	The findings included	1 :		Action for the Residents Po Affected	tentially
	Resident #16 was ad	Imitted on 4/2/21 with			
	cumulative diagnoses			On 2/29/2024, the Case Mix	
		ipheral vascular disease with		(CMD) reviewed residents	
	a left above the knee	amputation (AKA).		related therapy intervention resident in-house, four have	
	Resident #16's quart	erly Minimum Data Set		therapy interventions. The	
		b indicated Resident #16 had		the residents care plans to	
		airment, impairment to one		they had a therapy interven	
	lower extremity and s	-		reflected in the care plan.	
		ers from sit to stand and		plans reviewed, four resider	
		wheelchair and wheelchair		related therapy intervention	is was
		ed for one fall with minor		addressed appropriately.	
	injury.				
				Suctomic Changes	
	Review of a nursing r	note dated 12/23/23 at 5:36		Systemic Changes	
	Review of a nursing r PM read Resident #1	note dated 12/23/23 at 5:36 I6 was sitting in her		Systemic Changes On 2/29/2024, the Clinical	

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		MEDICAID SERVICES			OMB NO. 0938-03
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	ECONSTRUCTION	(X3) DATE SURVEY COMPLETED
			A. BUILDING		
		345566	B. WING		C
	ROVIDER OR SUPPLIER	040000		STREET ADDRESS, CITY, STATE, ZIP CODE	02/16/2024
	NONDER OR GOI T EIER			2510 WEST HIGHWAY 74	
PRUITTH	EALTH-UNION POINTE			MONROE, NC 28110	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETIC
F 657	Continued From pag	e 26	F 657		
		parently had locked her		the in-service the Interdisciplinary	Team
		as she attempted to push her		(IDT) to include the MDS nurses,	
	wheelchair back awa			Administrator, Director of Health Se	ervices
	wheelchair tipped ba	-		(DHS), Social Worker, Activity Dire	
	-	g her head on the hearth of		Nurse Managers, Facility Educator	
		ehind where she was seated.		Therapy Director, on the timing and	
		noted with an open area to		revision of the resident care plans u	-
		. She was sent to the		the Resident Assessment Instrume	nt
	emergency room for	an evaluation.		(RAI) and company policy. The Administrator and or the DHS	will
	Review of a physical	therapy note dated 12/27/23		review three resident s care plans	
		e added to her wheelchair.		weekly times four weeks and then	
				resident s care plans monthly time	
	Review of Resident #	#16's fall risk care plan dated		months to ensure timing revision of	
		last revised on 12/29/23		care plan for, utilizing the QA Monit	
		vention dated 12/23/23 for		Tool for comprehensive care plans	•
	staff to give her verba				
		thout assistance, staff to		Quality Assurance	
		uently and to observe			
	-	ntly and place her in a		The results of these reviews will be	
		n she was out of the bed. ew intervention dated		submitted to the Quality Assurance Performance Improvement (QAPI)	
		to analyze her falls to		Committee by the Administrator and	d or
		trend and the last new		Director of Health Services for revie	
	intervention was date			the Interdisciplinary Team members	
		r a new brace due to spinal		monthly or until three months of	
		s not any documentation on		compliance is sustained then quart	erly
	the care plan regardi	ng the new intervention of		thereafter. Quality monitoring sche	dule
	anti-tippers added to	her wheelchair on 12/27/23.		modified based on findings. The Q	API
				Committee to evaluate and modify	
		npleted on 2/8/24 at 1:30 PM		monitoring as needed.	
		nbursement Consultant. She		Data of compliance: 2/11/2021	
		sight of the regional MDS		Date of compliance: 3/11/2024	
	departments. She sta Coordinators started	six months ago, and they			
		ne also said there was one			
		in also assisting. She stated			
		are plans with the previous			
		e was to write up a formal			

		MEDICAID SERVICES				NO. 0938-039		
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	PLE CONSTRUCTION G	· · · ·	ATE SURVEY OMPLETED		
		345566	B. WING		C 02/16/2024			
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE				
PRUITTHI	EALTH-UNION POINTE			3510 WEST HIGHWAY 74 MONROE, NC 28110				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE		
F 657	spread sheet of all the was revised and that was revised on 12/29 Reimbursement Coor intervention of the wh have been an oversig	ment plan but she so. She stated she had a e residents whose care plan Resident #16's fall care plan	F 6	57				
F 677 SS=E	CFR(s): 483.24(a)(2) §483.24(a)(2) A resid out activities of daily I services to maintain of personal and oral hyo This REQUIREMENT by: Based on observatio interviews of resident the facility failed to pr dependent residents #34, Resident #69, R #339), and failed to p dependent resident (F residents reviewed fo The findings included 1. Resident #192 was	ent who is unable to carry iving receives the necessary good nutrition, grooming, and giene; is not met as evidenced ns, record reviews and s, family member, and staff, ovide incontinence care for (Resident #192, Resident esident #48, and Resident rovide bathing for a Resident #339) for 5 of 16 r activities of daily living.	F 6	 Address how corrective act accomplished for those resider have been affected by the defi- practice: Resident #192 is no longer a re- the facility. Resident #34 is no longer a re- facility. Resident #48 is no longer a re- facility. 	nts found to cient esident in sident in the	3/11/24		
	The admission Minim 2/8/204 assessed Re	um Data Set (MDS) dated sident #192 to be cognitively of the MDS was in progress		Resident #339 is no longer a retter facility. Resident #69 remains in the caprovided incontinence care where the requested and as needed.	enter and is			

Event ID:9U2E11

Facility ID: 080171

If continuation sheet Page 28 of 84

		MEDICAID SERVICES				NO. 0938-03
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION	· · ·	TE SURVEY
	CONNECTION	IDENTIFICATION NOMBER.	A. BUILDIN	G		
		345566	B. WING			С
		343366	B. WING	STREET ADDRESS, CITY, STATE, ZIP C)2/16/2024
NAME OF P	ROVIDER OR SUPPLIER			3510 WEST HIGHWAY 74	ODE	
PRUITTH	EALTH-UNION POINTE			MONROE, NC 28110		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF	CORRECTION	(X5)
PREFIX TAG	1 Y	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	HE APPROPRIATE	COMPLÉTIO
F 677	Continued From page	e 28	F 6	77		
		essment was not completed,				
		192 read from her phone,		2. Address how the facility	will identifv	
		the name badge of the		other residents having the	-	
	surveyor.	5		affected by the same defici		
				Current Residents have the	e potential to be	
	The admission nursin			affected.		
	2/1/2024 documented			Current residents with BIMS		
		nd feces. A care plan dated		greater and resident # 69 w		
		Resident #192's potential for		interviewed by the Director		
	skin breakdown relate	ed to incontinence.		Services (DHS), Assistant I Health Services (ADHS), R		
	Resident #192 was in	nterviewed on 2/5/2024 at		Nurse Supervisors (RNS), N		
		#192 reported that on		Competency Coordinator (
		was left saturated in urine,		Worker (SW), Minimal Data		
	-	are from 8:30 AM until 12:30		Nurses and/or Staff Nurse(
	PM. Resident #192 d	escribed that her bed linens		incontinence care and bath	ing assistance	
		ner nightgown was wet with		is being provided when req	uested and as	
		nence brief was saturated		needed by 3-11-2024. Resi		
		#192 explained that she had		BIMS less than 12 will have		
		er bladder and she required		nursing management team		
		all the time. When asked		check the resident brief to e		
	how she knew she wa	esident #192 explained she		resident is clean and dry. If		
		at 8:30 AM and the nurse		not clean and dry, incontine and/or bathing assistance		
		in to help her when he		immediately. This will be co		
		ication pass. Resident #192		3-11-2024.	, ~ j	
		the time on her cell phone.				
		•		3. Address what measures	will be put into	
		nducted with Nurse #10 on		place or systematic change		
		Nurse #10 reported on		ensure that the deficient pra	actice will not	
	Sunday 2/4/2024 the			recur.		
		m working. Nurse #10		The Director of Leadth Care	viene and/ar	
	before he was able to	to administer medications		The Director of Health Serv Clinical Competency Coord		
	incontinence care on	-		Supervisors, and/or design		
		92 was "very wet" when he		education to current nursing		
	-	ontinence care after he had		residents should receive in		
	administered medical			bathing assistance when re		
				as needed. If residents are	•	

Event ID:9U2E11

Facility ID: 080171

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		MEDICAID SERVICES				NO. 0938-03
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	PLE CONSTRUCTION		TE SURVEY MPLETED
		345566	B. WING			C)2/16/2024
IAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO		
PRUITTHI	EALTH-UNION POINTE			3510 WEST HIGHWAY 74 MONROE, NC 28110		
0(4) 15				PROVIDER'S PLAN OF C		()(5)
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETIC DATE
F 677	Continued From page	e 29	F 67	77		
		ed on 2/8/2024 at 10:12 AM.		communicate the need for ba	athina or	
		vas the only NA scheduled to		incontinence are, the resider	•	
	-	init and it was her and Nurse		checked and changed sever		
	#10 on the hall on 2/4	4/2024. NA reported she		during the shift for incontiner		
		the short-term hall and		bathing care. Education will I	•	
		e to residents one-by-one.		by 3-11-2024. After 3-11-202	•	
		several residents were		staff that have not worked ar		
		in urine, and she was not ok to provide care to all the		the education will complete uncertain the clucation will complete uncertainty the clucation will be addressed uncertainty the clucatinty the clucation	•	
		orted she had provided care		Competency Coordinator wil		
	-	Saturday 2/3/2024 and she		same education in general o		
	was aware that Resid	dent #192 was incontinent of d she did not know when		all newly hired nursing staff.		
	Resident #192 receiv	ed incontinence care on		The Director of Health Service	ces, Clinical	
	-	ause Nurse #10 provided		Care Coordinator, RN Super		
	that care.			designee will interview 5 resi		
	The Diverter of Normal			dependent for ADL care with		
		ng (DON) was interviewed PM. The DON explained she		or higher to ensure incontine being provided when reques		
		staffing was so low on		needed. Additionally, 5 resid		
		uld need to review the		BIMS less than 12 will be au		
		DON reported she expected		clinical nursing management	•	
		be provided to residents in a		physically checking the resid		
	timely manner.			ensure the resident is clean		
				Audits will be conducted 2 tir		
		admitted to the facility on		4 weeks, weekly x 4 weeks,	and then	
		ses to include stroke and		monthly x 1 month.		
		sion MDS dated 1/8/2024 34 to be cognitively intact.		4. Indicate how the facility pla	ans to	
		ed Resident #192 was		monitor its performance to m		
		ent of urine and always		solutions are sustained.		
	Continent of DOWelS.			The Director of Health Servio	ces will track	
	Resident #34 was int	erviewed on 2/5/2024 at		and trend the results via the		
		#34 reported during the past		and Bathing Care audit tool v		
		t certain if it was 2/3 or		report the findings to the Qua		
	2/4/2024) he was left	soiled in feces and his bed		Assurance Performance Imp	rovement	
	linens were wet with			Committee monthly x 3 mont		
	reported he used the	call bell for assistance, but it		substantial compliance is acl	hieved and	

Facility ID: 080171

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		ID HUMAN SERVICES MEDICAID SERVICES			FO	ED: 03/22/2024 RM APPROVED NO. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION	(X3) DA	TE SURVEY MPLETED
		345566	B. WING			C 02/16/2024
NAME OF P	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, STATI		
			3	510 WEST HIGHWAY 74		
PRUITTHE	EALTH-UNION POINTE		N	IONROE, NC 28110		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTI CROSS-REFERENCI	LAN OF CORRECTION VE ACTION SHOULD BE ED TO THE APPROPRIATE FICIENCY)	(X5) COMPLETION DATE
F 677	Continued From page	30	F 677			
	was a significant amo provided incontinence	ount of time before he was e care. Resident #34	1 0/7	then quarterly.		
	he was wet and soiled	ack the time; he only knew d.		Compliance date: 3-1	11-2024	
	NA #1 reported she w work the short-term u #10 on the hall on 2/4 that several residents in urine, and she was to provide care to all t when she provided in #34, he was soiled wi and incontinence brie The Director of Nursir on 2/8/2024 at 4:09 P was not certain why s 2/4/2024 and she wor staffing sheets. The I incontinence care to b timely manner.	ed on 2/8/2024 at 10:12 AM. vas the only NA scheduled to nit and it was her and Nurse 2/2024. NA #1 explained were soiled and saturated not certain how long it took the residents. NA recounted continence care to Resident th feces and his bed linens f were saturated with urine. mg (DON) was interviewed M. The DON explained she staffing was so low on uld need to review the DON reported she expected be provided to residents in a				
	08/14/23, diagnosis ir nephropathy, Cerebel congestive heart failu and lack of coordinati Resident #69's quarte (MDS) assessment da cognition was modera displayed no rejection coded to exhibit disor that was present and/ maximum assistance hygiene, toileting hygi	ncluded diabetic llar stroke syndrome, re (CHF), repeated falls, on. erly Minimum Data Set ated 01/05/24 indicated his ately impaired and he n of care behaviors. He was ganized thinking behavior furtuated. He required				

Facility ID: 080171

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM): 03/22/2024 MAPPROVED). 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345566	B. WING		_		C 16/2024
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, ST	TATE, ZIP CODE		
PRUITTHE	EALTH-UNION POINTE			3510 WEST HIGHWAY 74 MONROE, NC 28110			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE) CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 677	Continued From page bowel and bladder.	31 care plan, last revised on	F 67	7			
	01/04/2024, included status activities of dai related to slurred spec The interventions incl Resident #69 to do as	the focus area of functional ly living (ADL) decline ech and impaired mobility. uded for staff to encourage much as possible and to					
	focus area of bladder included the intervent incontinence care afte He also had a focus th	needed or requested. A incontinence which ion to provide Resident #69 er each incontinent episode. nat he was at risk for skin decline in mobility and					
		e interventions included to lry as possible and sure to moisture and					
		ed from 12/31/23 through of incontinence care were					
	PM with Resident #69 stated she was active explained there have Resident #69 was sat his pants and his bed indicated she comes	to the facility daily for					
	changed. She also sta the facility to make su stated she was very u provided.						
	AM with Resident #69	ducted on 02/08/24 at 9:03 9. He stated there had been was saturated with urine so					

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM): 03/22/2024 APPROVED). 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345566	B. WING		_		C 16/2024
NAME OF P	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, ST	ATE, ZIP CODE		
PRUITTHI	EALTH-UNION POINTE		-	510 WEST HIGHWAY 74 IONROE, NC 28110			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	EPLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 677	soaked. He then poin stated, "look at my ma morning, they even ha Observation of the ma area in center of matt approximately 2 incher mattress. The center slightly damp, and the were whitish in color. on the mattress. He s shower, but the Nursi He further commenter it, and he hoped that urine on him like that. frustrated and mad wi often enough to preve through his clothes ar An interview was com AM with Nursing Assis Resident #69 was out in his wheelchair whe AM. The night shift Na verified there were no she entered the room sheets are changed if was the residents sho circular discoloration f An interview was com AM with Nursing Assis the circular discoloration f an interview was com AM with Nursing Assis the circular discoloration f an interview was com AM with Nursing Assis the circular discoloration f an interview was com AM with Nursing Assis the circular discoloration f an interview was com AM with Nursing Assis the circular discoloration f an interview was com AM with Nursing Assis the circular discoloration f an interview was com AM with Nursing Assis the circular discoloration f an interview was com AM with Nursing Assis the circular discoloration f an interview was com AM with Nursing Assis the circular discoloration f an interview was com AM with Nursing Assis the circular discoloration f an interview was com AM with Nursing Assis	and/or his bed would be ted at his mattress and attress, it happened this ad to change my sheets". attress revealed a circular ress extending out to es from each side of the of the large area was e edges of the circular area No sheets were observed tated he did not receive a ng Assistant wiped him up. d that there was no call for he didn't get sores from the He then stated it made him hen staff don't change him ent him from soaking nd bedding. ducted on 02/08/24 at 9:15 stant (NA) #11. She stated t of bed and dressed sitting n she came on shift at 7:00 A had gotten him up. She o sheets on the bed when . She stated normally t they were wet, soiled, or it ower day. She verified	F 677				

Facility ID: 080171

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	-	ID HUMAN SERVICES MEDICAID SERVICES					FORM): 03/22/2024 MAPPROVED
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, <i>i</i>		E CONSTRUCTION		(X3) DATE COMP	LETED
		345566	B. WING			_		C 16/2024
NAME OF P	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STA	ATE, ZIP CODE		
				3	510 WEST HIGHWAY 74			
PRUITINE	ALTH-UNION POINTE			N	MONROE, NC 28110			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION TIVE ACTION SHOULD B ICED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 677	Continued From page sheets.	33	F	677				
	The shower schedule revealed Resident #6 Tuesdays and Fridays	5						
	AM with the Director of stated Resident #69 v as needed and should	ften. No residents' clothing						
	Assistant (NA) #12 fro 02/08/24 with no answ	vere made to the Nursing om 02/07/24 through ver. She was assigned to 7/24 from 7:00 PM-7:00 AM.						
	04/22/22 and readmit diagnoses that include (congestive) heart fail behavioral disturbanc urinary incontinence, hemiplegia with hemip	ed chronic diastolic lure, vascular dementia with e, pulmonary hypertension, chronic pain syndrome, paresis following cerebral t non-dominant side, and						
	Date Set (MDS) dated Resident #48 was mo impaired. She was ab needs to staff and req to total dependence w living. Resident #48 w bowel and bladder.							
		at Resident was resistive to						

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	0: 03/22/2024 APPROVED 0: 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,				LETED
		345566	B. WING		_		C 16/2024
NAME OF P	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, ST	ATE, ZIP CODE		
PRUITTH	EALTH-UNION POINTE			510 WEST HIGHWAY 74 IONROE, NC 28110			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	EPLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 677	activities of daily living was also care plan the total care of one to tw ADL care. During an observation Resident #48 could be hollering for help. The not on. Upon entry in urine odor was present On 02/08/24 a continu where Resident #48 r starting at 8:15 am ur aide (NA) was observe timeframe. Resident help during the continu On 02/08/24 at 8:50 a unidentified person w area on the unit. Resident On 02/08/24 at 8:55 a to holler out. NA #8 as wanted, and Resident her hands up and dow On 02/08/24 at 9:05 a conducted with NA #8 was the scheduler/tra on the floor today as a indicated that she wo assigned to this Resident #48 was we Resident #48 was we	and she would refuse g (ADL) care. Resident #48 at she needed extensive to o plus staff for most of her n on 02/08/24 at 8:15 am e heard from the hallway e Resident's call light was to Resident #48 room, a nt in the room. Louis observation of the hall esided was conducted til 8:47 am and no nurse red on the hall during this #48 continued to holler for uous observation. am NA#8 and another ere observed in the sitting ident #48 continued to holler #48's call light was on. am Resident #48 continued sked Resident #48 what she t #48 was observed moving vn in front of her brief. am an interview was 8, and she indicated that she nsporter but was assisting	F 677				

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		D HUMAN SERVICES					FORM	03/22/2024 APPROVED
STATEMENT (S FOR MEDICARE & I	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í		CONSTRUCTION		(X3) DATE COMP	LETED
		345566	B. WING			_	(02/	C 16/2024
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, ST	ATE, ZIP CODE		
PRUITTHE	EALTH-UNION POINTE				510 WEST HIGHWAY 74 IONROE, NC 28110			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD BI ICED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 677	An observation was c am of NA #8 performin Resident #48. NA#8 r was observed to be sa noted to have a strong skin was intact. NA #8 urine smell. NA #8 ap Resident #48 after ap An interview was cond 02/08/24 at 10:30 am performed her round a to help with feeding of that Resident #48 did am that she was wet a not provided. NA #10 only NA on the hall to 02/08/24 until 7pm. NA #22 was identified aide assigned to Resi third shift (11:00 pm u On 02/08/24 at 12:45 and stated she had no Monday, 02/05/24 and Resident #48. Attempts were made finurse on duty for the nurse was unable to b The Director of Nursir interviewed on 2/8/24 explained she was no low on 2/8/24 and she staffing sheets. DON	onducted on 2/8/24 at 10:10 ng incontinence care on emoved the old brief, and it aturated with urine and g urine smell. The resident's 3 confirmed she smelled the plied a new brief on plying barrier cream. ducted with NA #10 on . The NA revealed she after breakfast, and she had n another hall. She stated not communicate at 8:00 and incontinence care was indicated that she was the care for 26 residents on I by DON #1 as the nurse dent #48 on 02/07/24 during intil 7:00 am). pm NA #22 was interviewed of worked in the facility since d did not recall working with to contact Resident #48's evening of 02/07/24 but the be reached for an interview. ng (DON) #1 was	F	677				

Facility ID: 080171

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM): 03/22/2024 MAPPROVED). 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345566	B. WING		_		C 16/2024
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, ST	ATE, ZIP CODE		
			:	3510 WEST HIGHWAY 74			
PRUITTHE	EALTH-UNION POINTE		1	MONROE, NC 28110			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE) CROSS-REFEREI	EPLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 677	Continued From page	36	F 677				
	facility was 02/05/24 a had been in the facilit 5. Resident #339 was 12/19/22 with the diag dementia. Resident #339's quar dated 2/17/23 docum cognitive deficient. The for bathing and an ex- personal hygiene. The incontinent of bowel a Active diagnoses wer stroke. Resident #339 had a activities of daily living assistance as needed The resident was no l a. On 02/06/24 at 11 conducted with Resid The family member st dependent on staff for member visited freque had stool that dried to a concern the residen The family member st concerns to the attent Nursing and the care family member stated	8/24 at 4:50 pm the and that his start date with the and the DON indicated she y for two weeks. Is admitted to the facility on gnosis of a stroke and terly Minimum Data Set ented he had a severe he resident was dependent tensive assist of 2 staff for te resident was always and had a urinary catheter. e neurogenic bladder and care plan dated 2/17/23 for g (ADL) deficit set up with l. onger at the facility 16 am an interview was ent #339's family member. tated the resident was r all his care. The family ently and found the resident o his buttocks and there was it was not cleaned for hours. tated she had brought her tion of the Director of had not improved. The the care concerns ary 2023 until July 2023					

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM): 03/22/2024 MAPPROVED). 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345566	B. WING		_		C 16/2024
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, ST	ATE, ZIP CODE		
				3510 WEST HIGHWAY 74			
PRUITTHI	EALTH-UNION POINTE			MONROE, NC 28110			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE) CROSS-REFEREI	EPLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 677	7 Continued From page 37		F 677				
	record for February 2 incontinent of stool all a day. Personal hygic was not documented February 2023 on dat 2/22/23, 2/24/23, 2/26 documentation in the on 2/28/23. Nursing assigned to the reside February 2023. On 2/7/24 at 2:03 pm with NA #8. NA #8 st facility for 5 years. SI February, and March 3 NAs on the 3:00 pm responsible for 90 res 7:00 pm and other da residents (8 hours). N could not be complete completed it was dela be very soiled when s care. The resident's A completed because th b. On 02/06/24 at 11 conducted with Resid The family member si dependent on staff for member visited freque had body odor and di member stated she has the attention of the Di resident received a bac consistent. The famil	 3/23. There was no system for any type of care Assistant (NA) #8 was ent frequently during an interview was conducted ated she had worked at the ne had worked in January, 2023 when there were only to 7:00 pm schedule sidents until staff arrived at y shifts she had 20 NA #8 stated resident care ed and when care was ended and when care was ended ated she had here had worked in January, 2023 when there were only to 7:00 pm schedule sidents until staff arrived at y shifts she had 20 NA #8 stated resident care ed and when care was ended and when care was ended and when care was not here care was not provide the residents would staff was able to provide the for an interview was ent #339's family member. The family ently and found the resident rty looking hair. The family and brought her concerns to rector of Nursing and the ath that day, but it was not y member stated the care for February 2023 until July 					

Facility ID: 080171

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 03/22/2024 MAPPROVED D. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345566	B. WING		-		C 16/2024
NAME OF P	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, STA	ATE, ZIP CODE		
PRUITTH	ALTH-UNION POINTE			510 WEST HIGHWAY 74 IONROE, NC 28110			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION TIVE ACTION SHOULD BE CED TO THE APPROPRIA EFICIENCY)		(X5) COMPLETION DATE
F 677	7 Continued From page 38		F 677				
F 684 SS=D	for February 2023 door received 7 baths out of The 4 times bathing w partial bed baths and other. The resident w almost every day, 1 to On 2/7/24 at 2:03 pm with Nursing Assistan had worked at the face worked in January, Fe when there were only 7:00 pm schedule res until staff arrived at 7: she had 20 residents resident care bathing The resident's ADL do completed because th On 2/8/24 at 4:10 pm with the Director of Nu was not aware reside completed and had no Quality of Care CFR(s): 483.25 § 483.25 Quality of care duality of care is a fun applies to all treatment facility residents. Base assessment of a reside that residents receive accordance with profe practice, the compreh care plan, and the reside	an interview was conducted t (NA) #8. NA #8 stated she ility for 5 years. She had ebruary, and March 2023 3 NAs on the 3:00 pm to ponsible for 90 residents 00 pm and other day shifts (8 hours). NA #8 stated could not be completed. ocumentation was not he care was not provided. an interview was conducted ursing. The DON stated she nt care was not being o further comments. are indamental principle that nt and care provided to ed on the comprehensive dent, the facility must ensure treatment and care in essional standards of itensive person-centered	F 684				3/11/24

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		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: FORM A OMB NO. (PPROVED
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SU COMPLE	
		345566	B. WING		C 02/16	/2024
NAME OF PF	ROVIDER OR SUPPLIER	·		STREET ADDRESS, CITY, STATE, ZIP CODE		
			:	3510 WEST HIGHWAY 74		
PRUITINE	ALTH-UNION POINTE		1	MONROE, NC 28110		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 684	Continued From page	e 39	F 684	L		
	by: Based on record revid director interviews, the weights as ordered for failure and prescribed This was for 1 of 8 re- nutrition. The findings included Resident #70 was ad 10/16/23 with diagnos failure. He was discha 10/18/23 and did not A review of Resident included the following - An order dated 10/1 diuretic medication) 2 by mouth once a day - An order dated 10/1 and to notify the prov than three pounds was The admission Minima assessment dated 10 #70 was cognitively in A review of the Octob Administration Record weights were not doc refused by Resident at A review of the Nove the daily weight was the following the admission the Nove the daily weight was the following the daily weight was the following the daily weight was the following the following the Nove the daily weight was the following the following the Nove the daily weight was the following the following the Nove the following the fol	iew, staff and medical ne facility failed to obtain daily or a resident with heart d a diuretic (Resident #70). sidents reviewed for : mitted to the facility on ses that included heart arged to the hospital on return to the facility. #70's physician orders g: 6/23 for Torsemide (a 20 milligrams (mg) one tablet 7/23 to obtain daily weights ider if weight gain of greater as present. num Data Set (MDS) 0/23/23 indicated Resident ntact.		 Address how corrective actia accomplished for those resider have been affected by the defice practice: Resident # 70 is no longer a reactive facility. Address how the facility will other residents having the pote affected by the same deficient Current residents have the pote affected. The Director of Health Services Assistant Director of Health Services (ADHS), Registered Nurse Sup (RNS), Clinical Competency Co (CCC), Minimal Data Set (MDS) and/or Staff Nurse(s) will comp audit of 100% of resident set health record to identify any resi- heart failure and prescribed a co ensure resident is having weigh obtained as ordered. The Direct Health Services (DHS), Assistat of Health Services (ADHS), Rei Nurse Supervisors (RNS), Clin Competency Coordinator (CCC) Data Set (MDS) Nurses and/or Nurse(s) will address any conc identified during the audit. The be completed by 3/11/2024. Address what measures will 	esident in identify ential to be practice . ential to be s (DHS), rvices pervisors pordinator b) Nurses obervisors oordinator b) Nurses obete an ectronic sident with diuretic to hts ctor of ant Director egistered ical C), Minimal Staff eerns audit will	
	A review of the Decer	mber 2023 MAR revealed		place or systematic changes m ensure that the deficient practic	ade to	

Facility ID: 080171

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TATEMENT (DF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í		CONSTRUCTION	(X3) DA	NO. 0938-039 TE SURVEY MPLETED
		345566	B. WING				C
	ROVIDER OR SUPPLIER	040000			TREET ADDRESS, CITY, STATE, ZIP CODE	0	2/16/2024
					510 WEST HIGHWAY 74		
PRUITTHE	ALTH-UNION POINTE				IONROE, NC 28110		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 684	Continued From page	e 40		584			
1 004				504	10 0 U F		
	or refused by Reside	not documented as obtained nt #70 on 12/1/23, 12/2/23,			recur.		
	12/3/23, 12/9/23 and	12/10/23.			The Director of Health Services, Clin	ical	
					Competency Coordinator, RN		
		as completed with Nurse #1			Supervisors, and/or designee will pro		
		. She was assigned to 7:00 PM to 7:00 AM shift on			education to 100% of current nursing noting weights are to be obtained as		
		not recall Resident #70 or			ordered for residents with a heart fail		
		weight was documented as			who are prescribed a diuretic. Educa		
		Nurse #1 stated a list of was			will be completed by 3-11-2024. Afte		
	provided to the Nurse	e Aides for weights to be			3-11-2024, any nursing staff who hav		
		She stated if the weight			worked or received the education wil		
	wasn't documented t	hen it must not have been			receive it prior to the next scheduled	work	
	obtained.				shift. All newly hired nursing staff will		
					receive the same education during		
		 a phone interview occurred was assigned to Resident 			general facility orientation.		
		o 7:00 AM shift on 12/2/23			The Director of Health Services, Clin	ical	
	and could not recall F	Resident #70 or why there			Competency Coordinator, RN		
		alue. She added if the			Supervisors, and/or designee will au	dit	
	weight wasn't docum	ented then it most likely			current residents with heart failure		
	wasn't obtained.				prescribed a diuretic with weight orde	ers to	
					ensure weights are being obtained a		
		ewed by phone on 2/7/24 at			ordered. Audits will be conducted 3 t		
		ssigned to Resident #70 on			a week x 4 weeks, weekly x4 weeks,	and	
		AM shift on 12/10/23 and			then monthly x1.		
	•	he daily weight was not alue or as refused and most			A Indicate how the facility plane to		
	likely wasn't obtained				 Indicate how the facility plans to monitor its performance to make sure 	a that	
					solutions are sustained.	5 mar	
		curred with Nurse #8 on					
		he was assigned to Resident			The Director of Health Services will t	rack	
		o 7:00 AM shift on 12/9/23			and trend the results via the Weekly	1. 1 . h	
		why the daily weight was			Weights Audit Tool weekly and repor	ine	
		alue or as refused. She /asn't documented then it			findings to the Quality Assurance Performance Improvement Committee		
	wasn't obtained on th				monthly x 3 months or until substanti		
		iar auy.			compliance is achieved and then	a	
	An interview was con				quarterly.		

Facility ID: 080171

	-	ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 03/22/202 FORM APPROVE OMB NO. 0938-039
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345566	B. WING		C 02/16/2024
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	·
PRUITTHE	EALTH-UNION POINTE			3510 WEST HIGHWAY 74 MONROE, NC 28110	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION
F 684	Continued From page 41 Nursing #1 on 2/8/24 at 9:54 AM and stated that she expected daily weights to be obtained as ordered and documented with the value or if the resident refused.		F 684	Compliance date: 3-11-2024	
	on 2/8/24 at 2:49 PM resident had a diagno on a diuretic, daily we	d with the Medical Director and explained that when a osis of heart failure and was eights were important in adjust the medications as			
	2/6/24 to 2/8/24 with assigned to Resident and 12/1/23.	were made to Nurse #2 from out an answer. She was #70 on 11/3/23, 11/17/23 ards/Supervision/Devices (2)	F 689		3/11/24
	as free of accident ha §483.25(d)(2)Each re				
	This REQUIREMENT by: Based on staff, Nurs Medical Director (MD and record review, th Resident #16 who wa impulsive. The reside room without any sta with the back of her w of a stone hearth. Wh	F is not met as evidenced e Practitioner, (NP) #1 and o) interviews, observations is facility failed to supervise as cognitively impaired and ent was eating in a dining ff present in the room and wheelchair positioned in front hile passing trays on the 300 Resident #16 aggressively		 Address how corrective action will accomplished for those residents four have been affected by the deficient practice: Resident #16 remains in the facility a provided with supervision when out o in the dining room during mealtime. 	nd to

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			()(0)			OMB NO.	
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI			(X3) DATE SU COMPLE	
			A. BUILDIN	G			
		345566	B. WING			C	
		545566				02/16	6/2024
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
PRUITTH	EALTH-UNION POINTE						
				MONRO	DE, NC 28110		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PREFIX (EACH CORRECTIVE ACTION SHOU			(X5) COMPLETION DATE
F 689	Continued From page	e 42	F 68	39			
	10	air and suddenly flip her			Address how the facility will identify		
		s hitting her head on the			er residents having the potential to l	be	
		accident resulted in acute			ected by the same deficient practice		
		and thoracic 1 fractures. The					
	fall on 12/23/23 resul	ted in pain at a level of 6 out		Cur	rrent residents have the potential to	be	
	-	a hard cervical collar. This		affe	ected.		
		nts reviewed for accidents					
	(Resident #16).				e Director of Health Services (DHS),	,	
	The finalization in almala	1.			sistant Director of Health Services		
	The findings included	1:			OHS), Nurse Supervisors (NS), Clini		
	Resident #16 was ad	mitted on $1/2/21$ with			mpetency Coordinator (CCC), Minin ta Set (MDS) Nurses and/or Staff	lai	
	cumulative diagnoses			rse(s) will complete an audit of curre	ent		
		pheral vascular disease with			idents with cognitive impairment to		
		amputation (AKA) and a			sure adequate supervision is being		
	history of falls.	,			vided during mealtime in dining area	a.	
				The	e Director of Health Services (DHS),	,	
		re planned on 5/13/23 for		Ass	sistant Director of Health Services		
		memory recall problem. An			OHS), Nurse Supervisors (NS), Clini		
		rovide verbal and visual			mpetency Coordinator (CCC), Minim	nal	
	reminders.				ta Set (MDS) Nurses and/or Staff		
	A lasta adia ain lina ama T				rse(s) will address any concerns		
		eam note (IDT) evaluation /23 fall determined Resident			ntified during the audit. The audit wi completed by 3/11/2024.	11	
	•	oor safety awareness and		De	completed by 3/11/2024.		
		without assistance. The		3. A	Address what measures will be put i	nto	
	intervention added to	the care plan was to remind		pla	ce or systematic changes made to		
	her to call for assistar	nce with transferring.			sure that the deficient practice will no	ot	
				rec	ur.		
		on initiated on 7/27/23 was		TL	Director of Loolth Convision Official	- I	
	for increased supervi	SION.			e Director of Health Services, Clinica mpetency Coordinator, Nurse	31	
	Resident #16's quarte	erly Minimum Data Set			pervisors, and/or designee will provi	de	
	-	indicated Resident #16 had			ication to 100% of current nursing s		
		airment, impairment to one			ing adequate supervision is to be		
	lower extremity and s				vided to cognitively impaired resider	nts	
	-	fers from sit to stand and			he dining area during mealtimes.		
	transfers from bed to	wheelchair and wheelchair			ucation will be completed by 3-11-20	024.	
	to bed. She was code	ed for one fall with minor			er 3-11-2024, any nursing staff who		

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			0.00			
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	· · ·	ATE SURVEY OMPLETED
			A. BUILDING			С
		345566	B. WING			02/16/2024
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		02/16/2024
				3510 WEST HIGHWAY 74		
PRUITTHE	ALTH-UNION POINTE			MONROE, NC 28110		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF COF	RECTION	(X5)
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)		COMPLETION
F 689	Continued From page	2 43	F 68	q		
			1 00	have not worked or received th		
	injury.			education will receive it prior to		
	Review of a nursing n	note dated 12/23/23 at 5:36		scheduled work shift. All newly		
	PM read Resident #1			nursing staff will receive the sa		
		ng room. She had eaten her		education during general facili		
		parently had locked her		orientation.	- 9	
		s she attempted to push her				
	wheelchair back away			The Director of Health Service	s. Clinical	
	wheelchair tipped bac			Competency Coordinator, and		
		her head on the hearth of		Supervisors will audit supervis		
	-	hind where she was seated.		provided during mealtime in di	-	
		oted with an open area to		times a week x 4 weeks, week	•	
	the back of her head.	•		weeks, and then monthly x1.	,	
	emergency room for a	an evaluation. This note was				
	written by Nurse #18.			4. Indicate how the facility plar	ns to	
	•			monitor its performance to ma		
	Review of an event re	eport completed by Nurse		solutions are sustained.		
	#18 dated 12/23/23 a	t 5:41 PM read Resident				
	#16 was eating her di	inner in the dining room. The		The Director of Health Service	s will track	
	report did not include	any further details. There		and trend the results via the S	upervision	
	were no IDT evaluation	on notes and the report read		During Mealtime in Dining Area	a audit tool	
	not applicable (NA)-e	vent still open:"		weekly and report the findings	to the	
				Quality Assurance Performance		
	An interview was com	npleted on 2/7/24 at 2:19 PM		Improvement Committee mont		
	with Nurse #18. She	stated she was assigned		months or until substantial con	npliance is	
		500 hall on 12/23/23 when		achieved and then quarterly.		
		ad on the stone fireplace				
		ated she was down the hall		Compliance date: 3-11-2024		
		Resident #16 was in the				
		nner. She was not aware if				
		dining room at the time of				
		velled and she went to the				
	•	s Resident #16. She stated				
		od from a laceration on the				
		she complained of neck				
	-	d she immediately called				
	-	of Nursing (DON) and				
	emergency medical s	anyioon (EMS) for a boonital	1	1		1

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DEPARTMENT OF HEALTH					RINTED: 03/22/2024 FORM APPROVED
CENTERS FOR MEDICARE STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		ABNO. 0938-0391 B) DATE SURVEY COMPLETED
	345566	B. WING			C 02/16/2024
NAME OF PROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STAT	E, ZIP CODE	
		3	510 WEST HIGHWAY 74		
PRUITTHEALTH-UNION POINT	Ξ		IONROE, NC 28110		
PREFIX (EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECT CROSS-REFERENC	LAN OF CORRECTION IVE ACTION SHOULD BE ED TO THE APPROPRIATE FICIENCY)	(X5) COMPLETION DATE
 cervical and thorace An interview was of with NA #9 who work PM and was assign assisting Resident not recall locking he was known to do the passing trays on the could feed herself. weekend and they normally one person and assist in the difficult think there was an Resident #16's fall were also passing their rooms. NA #9 right across from the could observe the dining room. A telephone intervit 10:13 AM with NA 12/23/23 at the time dining room. She so the 300 hall which room, and she saw bouncing her whee not notice that Reson were locked when wheelchair backwas stone fireplace. A telephone intervit 10:39 AM with NA #16's fall on 12/23/ three aides working 	when she learned about the	F 689		PICIENCY)	

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DEPARTMENT OF HEALTH AND H CENTERS FOR MEDICARE & MEDICARE					FORM): 03/22/2024 1 APPROVED). 0938-0391
	PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
	345566	B. WING		_	(02/ [,]) 16/2024
NAME OF PROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, ST	ATE, ZIP CODE		
		3	510 WEST HIGHWAY 74			
PRUITTHEALTH-UNION POINTE		N	IONROE, NC 28110			
PREFIX (EACH DEFICIENCY MU	IENT OF DEFICIENCIES ST BE PRECEDED BY FULL DENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE) CROSS-REFEREI	S PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 689Continued From page 45 trays or feeding residents stated there was no staff dining room and there was residents eating there. Sh she observed in the dining were independent or set u #10 stated she was walking when she saw Resident # midair and before she could backwards striking her hee fireplace. NA #10 stated a #16's wheelchair brakes w complained of pain immed An interview was complete AM with Nurse #11. She so on 12/23/23 but she was 400 halls. She stated Resident # room at a table with her b fireplace. She stated appay was attempting to leave h flipped her wheelchair strificeplace hearth. She state anti-tippers on her wheelch artificeplace intervention recommended she be pre- relaxers and nonsteroidal	normally assigned to the is approximately 8-10 ne stated the residents g room on 12/23/23 up assistance only. NA ng by the dining room #16's wheelchair in uld react, she fell ead on the stone apparently Resident were locked and she diately. ted on 2/8/24 at 10:20 stated she was working assigned the 300 and sident #16 had a lot of and thought Resident bilities. Nurse #11 stated 16 eating in the dining pack to the stone arently Resident #16 her table when she iking her head on the ed there were no chair at the time of the dated 12/24/23 at 11:55 rived back to the facility oughout her spine and oted read there was no mmended and orders rd collar neck brace for follow up with a o read that it was escribed opiates, muscle	F 689				

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM APPROVED OMB NO. 0938-0391			
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED		
		345566	B. WING				C 16/2024		
NAME OF PI	ROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE	-			
PRUITTHE	EALTH-UNION POINTE			3510 WEST HIGHWAY 74 MONROE, NC 28110					
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE		
F 689	This note was written Review of the Decem new order dated 12/2 acetaminophen 5mg- needed. She received on 12/25/23 and 12/2 Ibuprofen once on 12 given on 12/28/23 for hydrophone-acetamir which she received at An observation was of AM. Resident #16 sitt her brakes unlocked. cushion to the seat of A telephone call was 11:59 AM with former about 2 weeks ago, s facility and recalled R 12/23/23. NP #1 stat Resident #16. She sta required close superv An interview was com with the MD. He state to be impulsive. He st supervision of the res room and it sounded	as needed for pain control. by Nurse #6. ber Physician orders read a 5/23 for hydrocodone-a 325mg every 6 hours as d the pain medication once 6/23. She received /28/23. New orders were scheduled hophen four times daily s ordered. completed on 2/5/24 at 11:00 ting up in her wheelchair with There was a padded t the wheelchair. completed on 2/8/24 at NP. She stated up until he was working at the tesident #16's fall on ed she was familiar with ated she was impulsive and rision. pleted on 2/8/24 at 2:40 PM ed Resident#16 was known tated there should be closer idents eating in the dining	F 6	689					
F 690 SS=D	Bowel/Bladder Incont CFR(s): 483.25(e)(1)- §483.25(e) Incontiner	-(3) nce.	F 6	90			3/11/24		
	§483.25(e)(1) The fac	cility must ensure that							

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · /		CONSTRUCTION	(X3) DATE	
		345566	B. WING				C 16/2024
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
DOUNTTU				3	510 WEST HIGHWAY 74		
PRUITIHE	EALTH-UNION POINTE			N	IONROE, NC 28110		
(X4) ID PREFIX TAG	IX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE				(X5) COMPLETION DATE		
F 690	admission receives so maintain continence of condition is or become not possible to mainta §483.25(e)(2)For a re- incontinence, based of comprehensive assess ensure that- (i) A resident who entri indwelling catheter is resident's clinical con- catheterization was n (ii) A resident who entri indwelling catheter or is assessed for remov- as possible unless that demonstrates that cat and (iii) A resident who is receives appropriate of prevent urinary tract i continence to the exter §483.25(e)(3) For a re- incontinence, based of comprehensive assess ensure that a residen receives appropriate of restore as much norm possible. This REQUIREMENT by: Based on record revisi- staff, the facility failed order to obtain a urine culture and sensitivity	ters the facility with an subsequently receives one val of the catheter as soon e resident's continence is ain. assident with urinary on the resident's assment, the facility must ers the facility without an not catheterized unless the dition demonstrates that ecessary; ters the facility with an subsequently receives one val of the catheter as soon e resident's clinical condition theterization is necessary; incontinent of bladder treatment and services to nefections and to restore ent possible. esident with fecal on the resident's assment, the facility must t who is incontinent of bowel treatment and services to	F	690	1. Address how corrective action will b accomplished for those residents found have been affected by the deficient practice:		

Facility ID: 080171

		ND HUMAN SERVICES MEDICAID SERVICES			FOF	ED: 03/22/202 MAPPROVE O. 0938-039
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION		E SURVEY IPLETED
		345566	B. WING		02	C 2/16/2024
NAME OF P	ROVIDER OR SUPPLIER	1		STREET ADDRESS, CITY, STATE, ZIP CODE		
PRUITTHE	EALTH-UNION POINTE			3510 WEST HIGHWAY 74 MONROE, NC 28110		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE
F 690	Continued From page	e 48	F 690			
		ary tract infection (Resident		Resident #343 remains in the c Urine sample was obtained per order on 2/12/24.		
		dmitted to the facility on nosis of urinary retention.		2. Address how the facility will i other residents having the pote affected by the same deficient	ential to be	
	(MDS) dated 1/30/24	ission Minimum Data Set documented the resident urinary catheter and had the retention.		Current residents have the pote affected.		
		d 1/29/24 documented er urinary catheter removed		The Director of Health Services Assistant Director of Health Ser (ADHS), Nurse Supervisors (NS Competency Coordinator (CCC	rvices S), Clinical C), Minimal	
	documented the resid was noted sitting in h talking incoherently to	es' note dated 2/2/24 dent had delusions. Resident er wheelchair at the bedside o herself. The resident's		Data Set (MDS) Nurses and/or Nurse(s) will complete an audit 30 days of active lab orders for and culture and sensitivity to er samples were obtained. The D	of the last urinalysis nsure Director of	
	complained of discon notified, and a bladde revealed 867 milliliter bladder. The physicia	ded, and the resident nfort. The physician was er scan was completed which rs of urine in the resident's an was notified of urine er was received to insert a to obtain urine for a		Health Services (DHS), Assista of Health Services (ADHS), Nu Supervisors (NS), Clinical Com Coordinator (CCC), Minimal Da (MDS) Nurses and/or Staff Nur address any concerns identified audit. The audit will be complet	rse apetency ata Set 'se(s) will d during the	
	-	& sensitivity, documented		3/11/2024. 3. Address what measures will	-	
		ted 2/2/24 for Resident #343 y catheter and obtain urine ulture and sensitivity.		place or systematic changes m ensure that the deficient practic recur.	ade to	
	reported Resident #3 Flomax (medication t started, a urinary cat	2/2/24 documented nursing 43 had urine retention and o improve urine flow) was heter was placed, and a a & sensitivity was ordered.		The Director of Health Services Competency Coordinator, Nurs Supervisors, and/or designee w education to 100% of licensed noting physician orders are to b	se vill provide nursing	

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	-	D HUMAN SERVICES MEDICAID SERVICES			FORM	D: 03/22/2024 MAPPROVED D. 0938-0391
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		345566	B. WING			C / 16/2024
NAME OF PF	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, STATE, ZIP CODE		
	ALTH-UNION POINTE		3	510 WEST HIGHWAY 74		
			N	IONROE, NC 28110		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 690	Continued From page	• 49	F 690			
	The resident was con	fused.		and urine samples are to be obtained all ordered urinalysis and culture and		
	Nurses' note docume	nted on 2/5/24 at 12:14 pm		sensitivity laboratory orders. Educati		
		ent had a urinary catheter		will be completed by 3-11-2024. After		
	2/2/24. The diagnosis	ne sample for confusion on		3-11-2024, any nursing staff who hav worked or received the education wil		
		r for urinalysis and culture		receive it prior to the next scheduled		
	-	otained, documented by		shift. All newly hired licensed nurses	will	
	Nurse #12.			receive the same education during general facility orientation.		
	On 2/7/24 at 2:30 pm	an interview was attempted		general facility onentation.		
	with Nurse #12, but sl			The Director of Health Services, Clin	cal	
	reached.			Competency Coordinator, Nurse		
	The Director of Nursir	ng was unavailable for		Supervisors, and/or designee will aud orders for urinalysis and culture and	lit lab	
		survey and information		sensitivities to ensure physician orde	rs	
		e Corporate MDS Nurse as		were followed and urine sample was		
	directed.			obtained. This audit will be conducted	3	
	On 2/6/24 at 3:30 nm	an interview was conducted		times a week x 4 weeks, weekly x4 weeks, and then monthly x1.		
	with the Corporate MI					
	Nursing was unavaila	ble). She stated the		4. Indicate how the facility plans to		
		& sensitivity ordered for		monitor its performance to make sure	e that	
	2/2/24 and she would	issed, not obtained on notify the physician		solutions are sustained.		
				The Director of Health Services will the	ack	
		r for urinalysis and culture &		and trend the results via the Urinalys		
	-	ed from the physician for		and Culture and Sensitivity audit tool		
	Resident #343.			weekly and report the findings to the Quality Assurance Performance		
	On 2/8/24 at 4:10 pm	an interview was conducted		Improvement Committee monthly x 3		
	with the Director of Nu	ursing (DON). The DON		months or until substantial compliance		
	stated she was not av #343 was missed. Th	vare the lab for Resident		achieved and then quarterly.		
	comments.			Compliance date: 3-11-2024		
F 695 SS=D		tomy Care and Suctioning	F 695			3/11/24

Event ID:9U2E11

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		345566	B. WING _				C 16/2024
NAME OF P	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE	<u>, , , , , , , , , , , , , , , , , , , </u>	
				35	10 WEST HIGHWAY 74		
PRUITTH	EALTH-UNION POINTE				ONROE, NC 28110		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
F 695	§ 483.25(i) Respirator tracheostomy care an The facility must ensu- needs respiratory care care and tracheal suc- care, consistent with p practice, the compreh care plan, the residen and 483.65 of this suf This REQUIREMENT by: Based on record revi interviews, the facility at the prescribed rate for respiratory care (F The findings included Resident #18 was add 09/04/23 with diagnos heart failure and chro disease (COPD). A review of the active an order dated 12/06/ liters per minute via n Sats at 92% or above A quarterly Minimum assessment dated 12 #18 was cognitively in receiving intermittent A review of Resident #18 reviewed 02/02/24, in read Resident #18 reviewed resident reviewed 02/02/24, in read Resident #18 reviewed resident #18 reviewed resident reviewed 02/02/24, in read Resident #18 reviewed resident #18 reviewed resident reviewed 02/02/24, in read Resident #18 reviewed resident #18 reviewed resident reviewed 02/02/24, in read Resident #18 reviewed resident #18 reviewed resident reviewed resident #18 reviewed reviewed resident #18 reviewed resident #18 reviewed	ry care, including ad tracheal suctioning. are that a resident who e, including tracheostomy titioning, is provided such professional standards of nensive person-centered ats' goals and preferences, opart. is not met as evidenced ew, observations and staff failed to administer oxygen for 1 of 1 resident reviewed Resident #18). : mitted to the facility on ses that included congestive nic obstructive pulmonary physician orders revealed (23, for oxygen (O2) at 2 asal cannula to keep O2 a. Data Set (MDS) /08/23 indicated Resident ntact. She was coded as oxygen therapy. #18's active care plan, last cluded a focus area that quired oxygen therapy aturation and shortness of proaches was to provide	F	695	 Address how corrective action will be accomplished for those residents found have been affected by the deficient practice: Resident #18 remains in the center and oxygen is being administered at the prescribed rate of 2Lpm. Address how the facility will identify other residents having the potential to affected by the same deficient practice Current residents have the potential to affected. The Director of Health Services (DHS), Assistant Director of Health Services (ADHS), Nurse Supervisors (NS), Clini Competency Coordinator (CCC), Minin Data Set (MDS) Nurses and/or Staff Nurse(s) will complete an audit of currer residents receiving oxygen therapy to ensure oxygen is being administered at the prescribed rate. The Director of Health Services (ADHS), Nurse Supervisors (NS), Clinical Competency 	d to d be be cal nal ent t	

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DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION COMPLETED A. BUILDING С 345566 B. WING 02/16/2024 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 3510 WEST HIGHWAY 74 **PRUITTHEALTH-UNION POINTE** MONROE, NC 28110 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (X4) ID ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 695 Continued From page 51 F 695 Coordinator (CCC), Minimal Data Set Medication Administration Record (MAR) (MDS) Nurses and/or Staff Nurse(s) will revealed oxygen was signed off as being address any concerns identified during the administered at 2 liters per minute from 02/01/24 audit. The audit will be completed by through 02/06/24. 3/11/2024. On 02/05/24 at 1:52 PM, an observation was 3. Address what measures will be put into made of Resident #18 while she was lying in bed. place or systematic changes made to The oxygen (O2) regulator on the concentrator ensure that the deficient practice will not was set at 4 liters per minute when viewed recur. horizontally, at eye level. The Director of Health Services, Clinical On 02/06/24 at 8:51 AM, an observation was Competency Coordinator, Nurse made of Resident #18 while she was lying in bed. Supervisors, and/or designee will provide The oxygen (O2) regulator on the concentrator education to 100% of licensed nurses, was set at 4 liters per minute when viewed noting residents are to receive oxygen horizontally, at eye level. therapy at prescribed rate. Education will be completed by 3-11-2024. After An observation and interview were conducted on 3-11-2024, any nursing staff who have not 02/07/24 at 9:40 AM of Resident #18, which worked or received the education will revealed the oxygen regulator on the concentrator receive it prior to the next scheduled work was set at 4 liters per minute by nasal cannula shift. All newly hired licensed nurses will when viewed horizontally at eye level. Resident receive the same education during #18 stated she did not know what the oxygen was general facility orientation. set on, all she knew was that she needed the The Director of Health Services, Clinical oxygen because it made it easier to breathe. Competency Coordinator, Nurse An interview was conducted on 02/07/24 at 9:52 Supervisors, and/or designee will audit AM with Nurse #11. She was not the nurse residents receiving oxygen therapy to assigned to Resident #18 but stated she did have ensure oxygen is being administered at residents that required oxygen therapy. She the prescribed rate. This audit will be stated the nurse was responsible for checking the conducted 3 times a week x 4 weeks. oxygen (O2) saturations and verifying the O2 weekly x4 weeks, and then monthly x1. concentrators were set per the physician orders. 4. Indicate how the facility plans to On 02/07/24 at 10:05 AM, an observation of monitor its performance to make sure that Resident #18 was completed with Director of solutions are sustained. Nursing (DON) #1 in conjunction with an interview with DON #1. DON #1 was assisting a new nurse The Director of Health Services will track

FORM CMS-2567(02-99) Previous Versions Obsolete

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	DF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA		PLE CONSTRUCTION		NO. 0938-03
	CORRECTION	IDENTIFICATION NUMBER:	. ,	G		OMPLETED
						С
		345566	B. WING			02/16/2024
NAME OF PI	ROVIDER OR SUPPLIER	-		STREET ADDRESS, CITY, STATE, ZIP	CODE	
PRUITTHE	ALTH-UNION POINTE			3510 WEST HIGHWAY 74		
				MONROE, NC 28110		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ((EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETIC DATE
F 695	Continued From page	÷ 52	F 69	95		
		500 hall which included		and trend the results via	the Oxygen audit	
		rified Resident #18 ' s		tool weekly and report the		
		rator was set to 4 liters per		Quality Assurance Perfor		
		horizontally at eye level. She		Improvement Committee		
		responsible for verifying the e set per order every shift.		months or until substantia	-	
		ident #18's O2 order read			arry.	
		ivered at 2L. She then				
		oxygen should be delivered		Compliance date: 3-11-2	024	
	at the prescribed rate					
F 725	0		F 72	25		3/11/24
SS=H	CFR(s): 483.35(a)(1)	(2)				
	§483.35(a) Sufficient	Staff.				
		e sufficient nursing staff with				
		etencies and skills sets to				
		elated services to assure tain or maintain the highest				
	•	mental, and psychosocial				
		sident, as determined by				
	•	and individual plans of care				
	and considering the n	, ,				
	-	ity's resident population in				
	accordance with the f at §483.70(e).	acility assessment required				
		cility must provide services				
	-	of each of the following				
		a 24-hour basis to provide idents in accordance with				
	resident care plans:					
	.,	ed under paragraph (e) of				
	this section, licensed	nurses; and sonnel, including but not				
	limited to nurse aides	-				
	§483.35(a)(2) Except	when waived under				
	paragraph (e) of this					

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		MEDICAID SERVICES				OMB NC	
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · ·		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			A. BUILDI	NG _			C
		345566	B. WING				_ 16/2024
NAME OF PI	ROVIDER OR SUPPLIER	I		S	TREET ADDRESS, CITY, STATE, ZIP CODE		
				3	510 WEST HIGHWAY 74		
PRUITIHE	EALTH-UNION POINTE			м	IONROE, NC 28110		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETIO DATE
E 725	Continued From non	- 50		705			
F 725	Continued From page			725			
		nurse to serve as a charge					
	nurse on each tour of	is not met as evidenced					
	by:	IS NOT THE AS EVICENCED					
	-	ns, record reviews, and			1. Address how corrective action will b)e	
		Practitioner, and Medical			accomplished for those residents found	d to	
		ne facility failed to provide			have been affected by the deficient		
		f which resulted in residents			practice:		
		ndignified manner when left					
	incontinent of urine of	r stool (Resident #192, #34,			Resident #192, #34, #48, #390, and #3	339	
		nen a urinary catheter bag			are no longer residents in the facility.		
		Resident #390). These					
		eling upset, angry, mad and			Resident #69 remains in the center and	d is	
	unimportant. The fac				provided timely incontinence care.		
	-	f to assist with activities of			Desident #40 nemering in the facility on	al ia	
		e for dependent residents #69, #48, and #339). The			Resident #16 remains in the facility and provided with supervision when out of		
		vise a resident who was at			in the dining room during mealtime.	beu	
		ch resulted in acute cervical					
		oracic fractures due to a fall			2. Address how the facility will identify		
		affected 9 of 86 residents			other residents having the potential to	be	
	reviewed for sufficien				affected by the same deficient practice		
	The findings include:				Current residents have the potential to affected.	be	
	This tag is crossed re	ferenced to F 550:					
	-				3. Address what measures will be put i	nto	
		ews and staff interviews, the			place or systematic changes made to		
		ct residents' dignity when			ensure that the deficient practice will ne	ot	
		iled in stool and saturated in			recur.		
		ents reviewed for dignity					
		2, Resident #34, Resident			The Director of Health Services (DHS)	WIII	
		i9), and failed to provide a			provide education to the Nursing Staff	n to	
		rinary catheter drainage bag viewed for urinary catheters			Scheduler noting immediate notification the DHS is required when staffing data		
		ident #192, Resident #34,			indicates insufficient nursing staffing. In		
		esident #192, Resident #34,			the event staffing numbers are not		
		nd like they did not matter at			deemed sufficient, the DHS or designe	e	
		ot provided incontinence			will adjust staffing in house by unit, use		

Facility ID: 080171

			0				
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			A. BUILDING	G			C
		345566	B. WING				」 16/2024
NAME OF P	ROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE	02/	10/2024
					510 WEST HIGHWAY 74		
PRUITTHE	EALTH-UNION POINTE			М	IONROE, NC 28110		
(X4) ID PREFIX		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFIX		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B	E	(X5) COMPLETIO
TAG		LSC IDENTIFYING INFORMATION)	TAG		CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		DATE
F 725	Continued From page	e 54	F 72	25			
		felt upset that "everyone			ancillary staff that are certified, use		
		The reasonable person			non-ancillary staff to assist within their		
	concept was applied	for Resident #48 due to her			scope, and activate the call list and off		
		er feelings and a reasonable			incentive bonuses as needed to cover		
	-	miliated and degraded			open shifts. All newly hired Nursing Sta		
	having to holler for as	ssistance.			Scheduler will receive the same educa	tion	
	This tag is crossed re	ferenced to F 677:			during general facility orientation.		
	Based on observatior	ns, record reviews and			The Director of Health Services, Clinica	al	
		s, family member, and staff,			Competency Coordinator, RN		
		ovide incontinence care for			Supervisors, and/or designee will audit	t	
		(Resident #192, Resident esident #48, and Resident			supervision being provided during mealtime in dining area, interview 5 of		
	#339), and failed to p				residents using questionnaire to ensure		
	, , , , , , , , , , , , , , , , , , , ,	Resident #339) for 5 of 16			incontinence care is being provided tim		
		r activities of daily living.			3 times a week x 4 weeks, weekly x4	,	
					weeks, and then monthly x1. The Area		
					Vice President of Operations/ Regiona	I	
	This tag is crossed re	eferenced to F689:			Nurse Consultant will also conduct		
	Basad on staff Nurse	Prostitionar (ND) #1 and			weekly reviews of planned nursing stat for subsequent 7 days weekly x 4 weekly		
		e Practitioner, (NP) #1 and) interviews, observations			then monthly x2 months. Ongoing, the		
		e facility failed to supervise			center currently has an active recruitme		
		as cognitively impaired and			and retention plan.		
		ent was eating in a dining					
	room without any stat	ff present in the room and			4. Indicate how the facility plans to		
		vheelchair positioned in front			monitor its performance to make sure t	that	
		ile passing trays on the 300			solutions are sustained.		
		Resident #16 aggressively			The Director of Leelth Convises will tre	alı	
		ir and suddenly flip her s hitting her head on the			The Director of Health Services will tra and trend the results via the Nursing S		
		accident resulted in acute			Audit Tool weekly and report the finding		
		and thoracic 1 fractures. The			to the Quality Assurance Performance		
		ted in pain at a level of 6 out			Improvement Committee monthly x 3		
	of 10 and the use of a	a hard cervical collar. This			months or until substantial compliance	is	
		ts reviewed for accidents			achieved and then quarterly.		
	(Resident #16).						
					Compliance date: 3-11-2024		

Facility ID: 080171

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	-	D HUMAN SERVICES					FORM): 03/22/2024 MAPPROVED
STATEMENT (S FOR MEDICARE & I OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION		(X3) DATE COMP	LETED
		345566	B. WING			_		C 16/2024
NAME OF P	ROVIDER OR SUPPLIER		-	S	TREET ADDRESS, CITY, ST	ATE, ZIP CODE		
				3	510 WEST HIGHWAY 74			
PRUITTHE	EALTH-UNION POINTE			N	IONROE, NC 28110			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD BI ICED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 725	On 2/7/24 at 2:03 pm with Nursing Assistan this past Saturday (2// long-term care hall (H other NA and 48 resides stated, yesterday (2/6 pm I was the only NA with 87 residents. NA Director of Nursing (D informed her. The resident and not received any answered by me during she had spoken with the and informed her. The resident and informed her the showed her that Reside through to the bed flow received care for hour Corporate Float DON best and answer call If resident call lights we minutes. NA #8 state licensed nursing staff personal care to the m NA #8 stated that the become unsafe for state currently the staffing v in the 5 years she had facility. A review of the nursing revealed there was 1 7:00 pm on the long-to due to call outs. The halls 100 - 400) was 7 On 2/7/24 at 2:03 pm with NA #8. She state	an interview was conducted t (NA) #8. NA #8 stated, 4/24), she worked on the alls 400 and 500) with 1 lents on day shift. NA #8 //24), from 3:00 pm to 5:30 on the long-term care hall A #8 stated she texted the OON) #1 multiple times and sidents residing on Hall 500 care or had call lights ng this time. NA #8 stated the Corporate Floating DON care was not completed and dent #339 was soaked oded with urine and had not rs. NA #8 stated the informed her to "do her lights." NA #8 stated some re answered after 30 d she had not observed provide incontinence or esidents during this time. staffing problem had aff and residents and was the worst she had seen d been employed at the g staffing for 2/6/24 NA scheduled from 3:00 to erm care Hall (400 and 500) census for the facility (4 78. an interview was conducted ed on 2/3/24 and 2/6/24 ttely 40 residents to care for	F	725				

Facility ID: 080171

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STATEMENT (DF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION	(X3) DATE	O. 0938-039 E SURVEY PLETED
		345566	B. WING			02	C / 16/2024
NAME OF P	ROVIDER OR SUPPLIER		I		STREET ADDRESS, CITY, STATE, ZIP CODE		
PRUITTHE	EALTH-UNION POINTE				MONROE, NC 28110		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 725	Continued From page	e 56	F	725			
F 761 SS=E	she was frequently punursing call outs for a medication. The IP s assignment during the of time when there were for 80 to 90 residents had 8 hours shifts for moving to 12 hours she caused the occasionate to 7:00 pm NA scheded. On 2/8/24 at 4:10 pm with the Director of N stated she was scheder aware of a NA staffing she would need to rear The DON had no furth Label/Store Drugs and CFR(s): 483.45(g) Labeling of Drugs and biologicals labeled in accordance professional principle appropriate accessor instructions, and the explicable. §483.45(h) Storage of §483.45(h)(1) In according to the fact t	at 11:55 am. The IP stated ulled to cover licensed hall assignment to pass tated she was on the floor e 3:00 pm to 7:00 pm block ere few NAs. She was e only 3 NAs during this time . The prior Administration NAs and the facility was hifts for the NAs which al low staff gap from 3:00 pm ule. an interview was conducted ursing #1 (DON). The DON duling nursing staff and not g shortage/coverage and view the staffing sheets. her comments. d Biologicals (1)(2) of Drugs and Biologicals s used in the facility must be e with currently accepted s, and include the y and cautionary	F	761			3/11/24

Facility ID: 080171

If continuation sheet Page 57 of 84

	-	ID HUMAN SERVICES MEDICAID SERVICES				FOR	M APPROVED D. 0938-0391	
STATEMENT (OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED	
		345566	B. WING				C / 16/2024	
NAME OF P	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE			
PRUITTHE	EALTH-UNION POINTE				10 WEST HIGHWAY 74 ONROE, NC 28110			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATI DEFICIENCY)				(X5) COMPLETION DATE	
F 761	personnel to have act §483.45(h)(2) The fac locked, permanently a storage of controlled the Comprehensive E Control Act of 1976 a abuse, except when t package drug distribu quantity stored is min be readily detected. This REQUIREMENT by: Based on record revi interview of facility sta label/date an opened solution to test for tub discard an opened ex of 2 medication storage the short-term hall an respectively. Findings included: The manufacturer's in read "initial and date opened" and to "discar days after opening." On 2/8/24 at 11:04 ar medication storage re revealed that a tubero not dated. The Infect	cess to the keys. clility must provide separately affixed compartments for drugs listed in Schedule II of orug Abuse Prevention and nd other drugs subject to he facility uses single unit tion systems in which the imal and a missing dose can is not met as evidenced ew, observation and aff, the facility failed to vial of tuberculin (injectable perculosis) and failed to upired vial of tuberculin for 2 ge refrigerators observed on d long-term hall estructions for tuberculin the tuberculin vial when ard the tuberculin vial 30 in the short-term hall effigerator observation culin vial was opened and ion Preventionist (IP) was	F7	761	 Address how corrective action will be accomplished for those residents found have been affected by the deficient practice: No residents were affected. Address how the facility will identify other residents having the potential to affected by the same deficient practice: Current residents have the potential to affected. The Director of Health Services (DHS) Assistant Director of Health Services (ADHS), Nurse Supervisors (NS), Clinit Competency Coordinator (CCC), Minitr Data Set (MDS) Nurses and/or Staff Nurse(s) will complete an audit of the medication preparation rooms and 	be be be cal		
	medication storage re revealed that a tubero not dated. The Infect present for observatio should have been dat discarded the vial. On 2/8/24 at 11:04 ar	frigerator observation culin vial was opened and ion Preventionist (IP) was on and stated the tuberculin ted when opened and			Competency Coordinator (CCC), Minir Data Set (MDS) Nurses and/or Staff Nurse(s) will complete an audit of the	nal s of ed.		

Facility ID: 080171

If continuation sheet Page 58 of 84

TATEMENT	OF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · ·	E CONSTRUCTION	OMB NO. 0938-039 (X3) DATE SURVEY COMPLETED			
		345566	B. WING		C 02/16/2024			
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	02/10/2024			
PRUITTH	EALTH-UNION POINTE			3510 WEST HIGHWAY 74 MONROE, NC 28110				
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE COMPLETION			
F 761	required to date all m to check for expired m to discard. On 2/8/24 at 11:29 ar medication storage re revealed that a tubero which was written open had expired 30 days a vial was discarded by interview with Nurse a how long an open Tub before expiring. She worked on the short-t used before they exp On 2/8/24 at 4:10 pm with the Director of N was not aware of the	stated that nursing staff was edication when opened and nedication during their shift in the long-term hall efrigerator observation culin vial had a date tag ened on 1/6/24. The vial after opening, 2/6/24. The v Nurse #15. Concurrent #15 stated she did not know berculin vial could be used further commented that she erm hall and the vials were	F 761	Competency Coordinator (CCC), I Data Set (MDS) Nurses and/or St Nurse(s) will address any concerr identified during the audit. The au be completed by 3/11/2024. 3. Address what measures will be place or systematic changes mad ensure that the deficient practice or recur. The Director of Health Services, O Competency Coordinator, Nurse Supervisors, and/or designee will education to 100% of licensed nur noting tuberculin vials are to be da when opened and discarded 30 da the open date. Also, other medica are to be labeled /dated with oper as required and discarded when e Education will be completed by 3- After 3-11-2024, any nursing staff have not worked or received the education will receive it prior to the scheduled work shift. All newly hir licensed nurses will receive the sa education during general facility orientation. The Director of Health Services, O Competency Coordinator, Nurse Supervisors, and/or designee will medication storage rooms and are ensure tuberculin vials and other drugs/medications are labeled/dat required and that all expired medi have been discarded. This audit w conducted 3 times a week x 4 wee	aff is dit will put into e to will not Clinical provide rses, ated ays after tions n dates expired. 11-2024. who e next red ame Clinical audit eas to ted as cations vill be			

Facility ID: 080171

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	S FOR MEDICARE & I	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	TIPLE (CONSTRUCTION		NO. 0938-03 ATE SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	· ,			· · ·	OMPLETED
		345566	B. WING				02/16/2024
NAME OF PR	ROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
PRUITTHE	ALTH-UNION POINTE				10 WEST HIGHWAY 74 ONROE, NC 28110		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETIO DATE
F 761	Continued From page	• 59	F	761			
					 Indicate how the facility plans to monitor its performance to make s solutions are sustained. 		
					The Director of Health Services wi and trend the results via the Medic Storage audit tool weekly and repo- findings to the Quality Assurance Performance Improvement Comm monthly x 3 months or until substa compliance is achieved and then quarterly.	cation ort the ittee	
F 777 SS=D	Radiology/Diag Srvcs CFR(s): 483.50(b)(2)(Ordered/Notify Results i)(ii)	F	777	Compliance date: 3-11-2024		3/11/24
	physician; physician a or clinical nurse speci State law, including s (ii) Promptly notify the physician assistant, n nurse specialist of res clinical reference rang facility policies and pr practitioner or per the This REQUIREMENT by:	adiology and other hly when ordered by a assistant; nurse practitioner alist in accordance with cope of practice laws.			1. Address how corrective action	will be	
	staff interviews, the far results for a resident	icility failed to obtain x-ray with nausea and poor 0). This was for 1 of 8			accomplished for those residents thave been affected by the deficient practice: Resident #70 is no longer a reside	found to it	

Event ID:9U2E11

Facility ID: 080171

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	DF DEFICIENCIES	MEDICAID SERVICES	(X2) MU		CONSTRUCTION		IO. 0938-039 TE SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	· ,			· /	IE SURVEY MPLETED
							С
		345566	B. WING			0	2/16/2024
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
				3	510 WEST HIGHWAY 74		
PRUITINE	EALTH-UNION POINTE			Μ	IONROE, NC 28110		
(X4) ID PREFIX	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFI		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD	BE	(X5) COMPLETION DATE
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG		CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	IATE	
F 777	Continued From page	e 60	F	777			
	The findings included	:			facility.		
		mitted to the facility on			2. Address how the facility will identify		
	10/16/23 with diagnos				other residents having the potential to		
		uiring surgical intervention eritoneal cavity, the space			affected by the same deficient practice	J .	
		dominal and pelvic organs).			Current residents have the potential to affected.	be	
	The admission Minim	um Data Set (MDS)					
	assessment dated 10	/23/23 indicated Resident			The Director of Health Services (DHS),	
	#70 was cognitively ir	ntact.			Assistant Director of Health Services		
	A				(ADHS), Nurse Supervisors (NS), Clin		
	A physician progress	70 reported having loose			Competency Coordinator (CCC), Mini Data Set (MDS) Nurses and/or Staff	mai	
		o days, intermittently.			Nurse(s) will complete an audit of the		
					previous 30 days of x-ray orders to en	sure	
	A nursing progress no	ote dated 10/23/23 revealed			x-ray test were performed, results hav		
		d for a STAT KUB (kidney,			been obtained, and results are availab		
	ureter, bladder) x-ray	to rule out an obstruction.			the electronic health record for viewing The Director of Health Services (DHS		
	A review of the physic	cian orders for resident #70			Assistant Director of Health Services		
		ted 10/23/23 for a KUB x-ray			(ADHS), Nurse Supervisors (NS), Clin		
	to be obtained.				Competency Coordinator (CCC), Mini Data Set (MDS) Nurses and/or Staff	mal	
	A physician progress	note dated 10/24/23 cites			Nurse(s) will address any concerns		
	Resident #70 was be	ing seen for poor intake and			identified during the audit. The audit w	/ill	
		e note further read that a			be completed by 3/11/2024.		
		d on 10/23/23, resident				• •	
		npleted, however no results			3. Address what measures will be put	into	
	were available at that	. ume.			place or systematic changes made to ensure that the deficient practice will r	not	
	A physician progress	note dated 10/31/23			recur.		
		70 was being seen for					
	complaints of poor ap	ppetite and nausea. The			The Director of Health Services, Clinic	al	
	report indicated that t				Competency Coordinator, Nurse		
		ailable and nursing was to			Supervisors, and/or designee will prov		
	call and obtain the rea	sults for review.			education to 100% of licensed nurses		
	A	note dated 11/15/23			noting residents with x-ray orders sho have those x-ray test performed, resu		

Facility ID: 080171

If continuation sheet Page 61 of 84

STATEMENT	OF DEFICIENCIES	MEDICAID SERVICES	(X2) MUITIPI	E CONSTRUCTION	(X3) DATE SURVEY	
	CORRECTION	IDENTIFICATION NUMBER:	· ,		COMPLETED	
					С	
		345566	B. WING		02/16/2024	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
				3510 WEST HIGHWAY 74		
PRUITTHE	EALTH-UNION POINTE			MONROE, NC 28110		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLÉTIC	
F 777	Continued From non	- 64		_		
F ///	Continued From page		F 77			
		sults from 10/23/23 were not		should be obtained from x-ray comp		
	available.			and results should be available for v in the electronic health record. Educ	•	
	A review of Resident	#70's medical record on		will be completed by 3-11-2024. After		
		the results of the KUB x-ray		3-11-2024, any nursing staff who ha		
	results from 10/23/23	-		worked or received the education wi		
				receive it prior to the next scheduled	l work	
	On 2/6/24 at 4:45 PM			shift. All newly hired licensed nurses	s will	
		rdinator explained that the		receive the same education during		
	-	bile X-ray company and		general facility orientation.		
		ay results on 2/6/24 and that		The Divertee of Linelth Comission Oliv	via al	
	record. The results of	n Resident #70's medical		The Director of Health Services, Clir Competency Coordinator, Nurse		
	negative for any acut	-		Supervisors, and/or designee will au	Idit	
		e mangs.		residents with x-ray orders to ensure		
	The Medical Records	s coordinator was		are performed, results are obtained,		
	interviewed on 2/7/24	at 1:34 PM and stated the		results are available for viewing in th		
	KUB x-ray results we	re not part of Resident #70's		electronic health record. This audit v	vill be	
	medical record and w	vere obtained on 2/6/24. She		conducted 3 times a week x 4 weeks	,	
		Iltiple fax machines in the		weekly x4 weeks, and then monthly	x1.	
	facility that informatio					
	sometimes the inform			4. Indicate how the facility plans to		
		distributed to the right areas.		monitor its performance to make sur solutions are sustained.	ethat	
		curred with Nurse #14 on			h	
		he indicated there was a		The Director of Health Services will and trend the results via audit the X		
	•	s were not being received ut wasn't sure if it was a fax		and trend the results via audit the X- Audit tool weekly and report the find	-	
		someone was getting them		to the Quality Assurance Performance		
		inging them to the correct		Improvement Committee monthly x		
		indicated this has improved		months or until substantial complian		
	over the past couple			achieved and then quarterly.		
		as completed with the former		Compliance date: 3-11-2024		
		on 2/8/24 at 11:53 AM. She				
		as no longer at the facility as				
		never saw the results of the completed on 10/23/23 for				
		idded that x-ray results were				

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					OMB NO. 0938-03		
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · ·	CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
					с		
		345566	B. WING		02/16/2024		
NAME OF P	ROVIDER OR SUPPLIER		ST	REET ADDRESS, CITY, STATE, ZIP CODE	•		
PRUITTHE	EALTH-UNION POINTE			10 WEST HIGHWAY 74 ONROE, NC 28110			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	IOULD BE COMPLETIO		
F 777	Continued From page	e 62	F 777				
	she had asked the nu times. The Nurse Pr provided Resident #7 monitored his lab wo	n she was at the facility, and urses to follow-up several ractitioner added she '0 with an appetite stimulant, rk, and ensured that he was urgeon for his appetite					
	at 9:54 AM and indica for all x-ray results to the resident's medica days. She explained the facility in January any concerns with res						
F 802 SS=E	, , , ,		F 802		3/11/24		
	appropriate competer out the functions of th taking into considerat individual plans of ca and diagnoses of the	bloy sufficient staff with the ncies and skills sets to carry he food and nutrition service, tion resident assessments, re and the number, acuity facility's resident population he facility assessment e).					
		vide sufficient support nd effectively carry out the					
	Services staff must p	r of the Food and Nutrition articipate on the as required in § 483.21(b)					

Event ID:9U2E11

Facility ID: 080171

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	-	ID HUMAN SERVICES MEDICAID SERVICES			FOF	C. 0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTI	PLE CONSTRUCTION		E SURVEY
	CORRECTION	IDENTIFICATION NUMBER:				IPLETED
				<u> </u>		с
		345566	B. WING			2/16/2024
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	1 0/	2/10/2024
				3510 WEST HIGHWAY 74		
PRUITTHE	ALTH-UNION POINTE			MONROE, NC 28110		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORF	RECTION	(X5)
PREFIX			PREFIX	(EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A		COMPLETION DATE
TAG	REGULATORT OR L	SC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	PROPRIATE	
F 000						
F 802	Continued From page	9 03	F 8	02		
	by:					
		ew, and resident, family and		1. Address how corrective action		
		acility failed to have an		accomplished for those residen		
		sure there was sufficient		have been affected by the defic	ient	
		y staff available on 12/31/23		practice:		
		nis failure had the potential				
		who received meals from		The Facility has not utilized volu		
	the kitchen.			staff, not employed by PruittHea		
	The finalized included			Union Pointe in the Dietary Dep	artment	
	The findings included			since 12/31/2023.		
	The facility's meal del	ivery times were recorded		2. Address how the facility will i	dentify	
	as follows:			other residents having the pote	-	
				affected by the same deficient p		
	· Breakfast - 7:00 AM	- 8:30 AM		All residents have the potential		
				affected.		
	· Lunch - 12:00 AM -	1:30 PM				
				3. Address what measures will	be put into	
	· Dinner - 5:00 PM - 6	:30 PM		place or systematic changes ma	ade to	
				ensure that the deficient practic	e will not	
	An interview was con	ducted on 02/07/24 at 12:25		recur.		
	PM with the Infection	Preventionist Nurse. She				
	stated a group email			On 2/16/24 the Administrator ed		
		2/30/23 at approximately		the Dietary manager on approp		
		anyone that was available to		utilization of dietary staff and no	-	
	· · ·	k in the kitchen on 12/31/23		personnel that are not employe	-	
	· ·	f. She responded saying she		PruittHealth Union Pointe to		
	-	. She arrived at 6:00 AM		and/or volunteer in the kitchen.		
		etary Staff #1 was already		education has been added to th	-	
	-	ne stated Dietary Staff #1		orientation of newly hired Dieta	ry	
		he breakfast trays up which		Managers.		
		dicated she read the meal				
	tickets and made sure			The Dietary Manager will review		
	· ·	s were blended to a smooth		staffing daily for 7 days then we	-	
	•	ed that her husband came		weeks then monthly thereafter		
		kitchen as well. She verified		only employees employed with		
		an employee at the facility		Health Union Pointe are schedu		
		is work experience in a		work and has worked in the die	tary	
	kitchen. She explaine	d she had helped in the past		department.		

Facility ID: 080171

	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIF	PLE CONSTRUCTION		<u>NO. 0938-039</u> TE SURVEY
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	ŝ	CO	MPLETED
		345566	B. WING		0	C 2/16/2024
NAME OF PI	ROVIDER OR SUPPLIER	I	STREET ADDRESS, CITY, STATE, ZIP CODE			
PRUITTHE	ALTH-UNION POINTE			3510 WEST HIGHWAY 74 MONROE, NC 28110		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 802	Continued From page	e 64	F 80	02		
		ned to cook in the kitchen.				
		at time breakfast was served				
	on 12/31/23 but it wa	s served late.		4. Indicate how the facility p monitor its performance to n		
	An interview was con	ducted on 02/08/24 at 11:25		solutions are sustained.		
	-	#1. She stated she was		The Distant Management ill an		
		12/31/23 but she had called She could not remember		The Dietary Manager will pr analysis of the daily staffing		
		She indicated there have		Quality Assurance and Perfe		
	-	past that Nursing Assistants		Improvement Committee mo	•	
	(NAs) have had to as	sist her with cooking. Iornings was served late but		three months of sustained c achieved then quarterly ther	•	
		Dietary Aide #1 stated she			ealler.	
	did not work on 12/31			Compliance date 3/11/2024		
	Review of the dietary staff schedule and time					
		12/31/23 revealed Dietary				
	Aide #1 did not work.					
	A phone interview wa	s conducted on 02/08/24 at				
		strator #2. She indicated that				
		n 12/30/23 from the facility				
		ll out for the kitchen for d leave them with no staff for				
		id not recall who notified her				
		cplained that she sent a				
	• .	e administrative staff to				
		ld assist with preparing 3. She received a response				
		eventionist that she would				
		were extra staff scheduled				
		omeone from the nursing Ip if needed. She also				
		nderstanding the shift was				
	covered. She further	explained that she did call				
	-	anager (DM) #1 on 12/31/23				
	to have him come in a	as well to assist.				
	An interview was con					

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	-	D HUMAN SERVICES					FORM): 03/22/2024 MAPPROVED
STATEMENT C	S FOR MEDICARE & I	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` <i>`</i>		CONSTRUCTION		(X3) DATE	0. 0938-0391 SURVEY LETED
		345566	B. WING			_	(02/	C 16/2024
NAME OF PR	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, ST	ATE, ZIP CODE	-	
DDUUTTUE				3	510 WEST HIGHWAY 74			
PRUITINE	ALTH-UNION POINTE			N	IONROE, NC 28110			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD BE ICED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 802	was called by Adminis approximately 9:00 Al staff showed up for th to come in to work. He 11:00 AM. He explain interim DM and was w buildings. He indicate Assistant (NA) were a to assist in getting bre He also stated he did breakfast was served served later than the verified the nurse and on working in the kitch additional staff were h occurred since 01/01/ now they have 2 cook a supervisor during da An interview was come PM with a family men stated she comes to t breakfast and dinner. had been late on man She also stated that s and 8:00 AM on the m breakfast was not ser that was unacceptable family member had a mellitus and although stable, he needed to a approximately the sar further indicated it had but had improved late An interview was come	ager (DM) #1. He stated he strator #2 on 12/31/23 at M and was told no dietary e early shift and he needed e arrived at the facility at ed at that time he was the vorking at two different d a nurse, and a Nursing sked to work in the kitchen eakfast out to the residents. not recall what time to the residents, but it was regularly scheduled time. He NAs had not had training hen. He further stated ired and this has not 24. He then indicated that s, 2 aides, 2 managers, and ay shift. ducted on 02/07/24 at 1:43 aber for Resident #69. She he facility every day for She indicated breakfast y mornings in December. he arrived between 7:30 AM horning of 12/31/23 but wed until after 10:00 AM and e. She further explained her diagnosis of type 2 diabetes his blood sugar remained eat his breakfast at ne time each day. She d been an ongoing problem ly.	F	802				
	but had improved late An interview was cond AM with Resident # 69	ly.						

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM): 03/22/2024 MAPPROVED). 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · /			(X3) DATE COMP	SURVEY LETED
		345566	B. WING				C 16/2024
NAME OF P	ROVIDER OR SUPPLIER		s	STREET ADDRESS, CITY, STA	TE, ZIP CODE		
PRUITTHE	EALTH-UNION POINTE			510 WEST HIGHWAY 74			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S (EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION TIVE ACTION SHOULD BE CED TO THE APPROPRIA EFICIENCY)		(X5) COMPLETION DATE
F 802 F 842 SS=D	latest being at approx explained he had a di mellitus and takes dia twice a day and insuli his blood sugar has b nervous when he doe stated he was very dis with the facility. An interview was com PM with Resident # 5 late on many days in made her feel as if the for the residents to ma meals on time. An interview was com PM with Director of N indicated she received from a family member served late on 12/31/2 she investigated the of 12/31/23 no dietary st to work. She indicated Preventionist came in Nurse # 3 was pulled verified breakfast was exact time it was serv Resident Records - Io CFR(s): 483.20(f)(5), §483.20(f)(5) Resider (ii) The facility may not re resident-identifiable to accordance with a con	imately 10:15 AM. He agnosis for type 2 diabetes betic medications by mouth n at bedtime. He indicated een good, but it makes him sn't eat by 9:00 AM. He sappointed and frustrated ducted on 02/07/24 at 1:07 7. She stated breakfast was December. She indicated it e facility did not care enough ake sure they get their ducted on 02/07/24 at 12:05 ursing (DON) #3. She d a complaint on 01/02/24 that breakfast had been 23. She explained that when concern, she found that on taff showed up to the facility d that the Infection to cook breakfast and that from the floor to assist. She alate but could not recall the ed. lentifiable Information 483.70(i)(1)-(5)	F 802				3/11/24

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM): 03/22/2024 MAPPROVED). 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE COMP	SURVEY LETED
		345566	B. WING		_		C 16/2024
NAME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, S	TATE, ZIP CODE		
PRUITTHE	ALTH-UNION POINTE			3510 WEST HIGHWAY 74 MONROE, NC 28110			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 842	to do so. §483.70(i) Medical rea §483.70(i)(1) In accor professional standard must maintain medicat that are- (i) Complete; (ii) Accurately docume (iii) Readily accessible (iv) Systematically org §483.70(i)(2) The faci all information contair regardless of the form records, except when (i) To the individual, o representative where (ii) Required by Law; (iii) For treatment, pay operations, as permitt with 45 CFR 164.506 (iv) For public health a neglect, or domestic v activities, judicial and law enforcement purp purposes, research purp medical examiners, fu a serious threat to heal by and in compliance §483.70(i)(3) The faci record information ag- unauthorized use. §483.70(i)(4) Medical	he facility itself is permitted cords. dance with accepted is and practices, the facility al records on each resident ented; e; and ganized lity must keep confidential hed in the resident's records, n or storage method of the release is- r their resident permitted by applicable law; yment, or health care ted by and in compliance ; activities, reporting of abuse, <i>v</i> iolence, health oversight administrative proceedings,	F 84	2			
	§483.70(i)(4) Medical for-	records must be retained					

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STATEMENT (OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPLE	CONSTRUCTION	OMB NO. 0938-03 (X3) DATE SURVEY	
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	NG _		COMPLETED C 02/16/2024	
		345566	B. WING				
NAME OF PI	ROVIDER OR SUPPLIER		1	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
				3	510 WEST HIGHWAY 74		
PRUITTHEALTH-UNION POINTE				N	IONROE, NC 28110		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 842	Continued From page	e 68	F	842			
1 0 12		required by State law; or	•	042			
		he date of discharge when					
	there is no requireme	•					
		ars after a resident reaches					
	legal age under State						
	6400 70/i)/C) The same						
		edical record must contain- ion to identify the resident;					
		sident's assessments;					
		ive plan of care and services					
	provided;	'					
	(iv) The results of any	y preadmission screening					
	and resident review e						
	determinations condu						
		e's, and other licensed					
	professional's progre	logy and other diagnostic					
		equired under §483.50.					
		T is not met as evidenced					
	by:						
		iew and staff interviews, the			1. Address how corrective action w		
	-	tain complete and accurate			accomplished for those residents fo	und to	
		e area of wound care			have been affected by the deficient		
	(Resident #70) for 1 (reviewed for surgical				practice:		
		would care.			Resident #70 is no longer a residen	t in the	
	The findings included	d:			facility.		
		lmitted to the facility on			2. Address how the facility will ident		
	10/16/23 with diagno				other residents having the potential		
		uiring surgical intervention			affected by the same deficient pract	ice.	
		peritoneal cavity, the space			Current regidents have the neterity	taha	
	inal contains your ab	dominal and pelvic organs).			Current residents have the potential affected.	io pe	
	The admission Minim	num Data Set (MDS)					
		0/23/23 indicated Resident			The Director of Health Services (DF	S),	
		ntact and received surgical			Assistant Director of Health Service	,	
	wound care.	-			(ADHS), Nurse Supervisors (NS), C	linical	
	1				Competency Coordinator (CCC), Mi	nimal	

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					ON Ive		
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		(X3) DATE SURVEY COMPLETED	
			A. BUILDING	۱ 		С	
		345566	B. WING			02/16/2024	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CI	TY, STATE, ZIP CODE	02/10/2024	
				3510 WEST HIGHWAY	Y 74		
PRUITTH	EALTH-UNION POINTE			MONROE, NC 281	10		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRECT PREFIX (EACH CORRECTIVE ACTION SHOU TAG CROSS-REFERENCED TO THE APPRO DEFICIENCY)		ORRECTIVE ACTION SHOULD BE FERENCED TO THE APPROPRIATE	(X5) COMPLET DATE	
F 842	Continued From page	69	F 84	2			
1 042			F 04		S) Nurses and/or Staff		
	orders dated 10/16/2	included the following			S) Nurses and/or Staff complete an audit current		
	- Midline abdominal ir			vounds to ensure there are			
		er the two proximal (nearest			d accurate medical records		
		dy) sites and most distal			wound care as evidenced by	,	
		al of the body) site with a			treatment administration	,	
	foam gauze twice a d			The Director of Health			
	-	ncision site at the umbilicus			S), Assistant Director of		
		bund cleanser and apply			es (ADHS), Nurse		
		th gauze and secure with			NS), Clinical Competency		
	foam dressing every	-			CCC), Minimal Data Set		
		nd with Penrose drain:			and/or Staff Nurse(s) will		
		leanser, prep the peri-area			oncerns identified during the	9	
		ilm for protection, loosely			lit will be completed by		
		ed gauze into wound, cover		3/11/2024.			
	with an absorbent dre	essing and secure with tape					
	every day.			3. Address wh	at measures will be put into		
				place or system	matic changes made to		
	A review of the Octob	er 2023 Treatment		ensure that the	e deficient practice will not		
	Administration Record	d (TAR) revealed the		recur.			
		nad not been documented					
	as completed or refus	sed by Resident #70 on the		The Director o	of Health Services, Clinical		
	7:00 AM to 7:00 PM s	shift on 10/19/23, 10/20/23			Coordinator, Nurse		
	and 10/22/23.				and/or designee will provide		
					00% of licensed nurses		
		included the following		-	ments are to be completed		
	orders dated 10/26/23				d documented as		
		vound: clean with normal			refused by the resident on		
		nser. Apply normal saline			administration record (TAR)		
	-	he wound bed. Cover with a			be completed by 3-11-2024	.	
	dry dressing twice a c	-			24, any nursing staff who		
		wounds: clean with normal			ed or received the		
		nser. Cover with Vaseline			receive it prior to the next		
		nd dry dressing every day			rk shift. All newly hired		
	and as needed.				es will receive the same		
					ing general facility		
		mber 2023 TAR revealed the		orientation.			
		nad not been documented sed by Resident #70 on the			f Llashih Camilera Olivia		
	as completed or refus	sed by Resident #/() on the		I he Director o	of Health Services, Clinical	1	

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		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		COMPLETED
		345566	B. WING		C
	ROVIDER OR SUPPLIER	040000		TREET ADDRESS, CITY, STATE, ZIP CODE	02/16/2024
				510 WEST HIGHWAY 74	
PRUITTHE	EALTH-UNION POINTE			IONROE, NC 28110	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE COMPLÉTIO
F 842	Continued From page	> 70	F 842		
1 012		shift on 11/4/23, and 11/9/23.	1 042	Competency Coordinator, Nurse	
		sint on 11/4/23, and 11/9/23.		Supervisors, and/or designee will a	audit
	Review of the nursing	progress notes from		documentation on the TAR to ensu	
		did not reveal any refusals		documentation is completed to not	e
	of wound care by Res	sident #70.		wound care as completed or refuse	-
				the resident. This audit will be cond	
		M, an interview occurred		3 times a week x 4 weeks, weekly	x4
	she completed wound	Nurse. She explained that		weeks, and then monthly x1.	
		ay. She reviewed the TAR's		4. Indicate how the facility plans to	
		completing the wound care		monitor its performance to make s	
		t #70 on 10/19/23, 10/20/23		solutions are sustained.	
	and 11/9/23. She stat	ed that she completed the			
		ed but got busy and forgot to		The Director of Health Services will	
	sign the treatments o	ff as completed.		and trend the results via Treatmen	
	A phone interview we	a completed with Nurse #9		Administration Record audit tool w	•
		s completed with Nurse #8 and was assigned to care		and report the findings to the Quali Assurance Performance Improvem	
		he 7:00 AM to 7:00 PM shift		Committee monthly x 3 months or	
		alled completing the surgical		substantial compliance is achieved	
	wound care to Reside	ent #70 and stated she		then quarterly.	
	forgot to document th	at it was completed.			
				Compliance date: 3-11-2024	
		l, a phone interview was			
		e #6, who was assigned to			
) on the 7:00 AM to 7:00 PM recalled he had surgical			
		ed that she got busy and			
	forgot to sign it off as				
	The Director of Nursi	ng was interviewed on			
	2/8/24 at 9:54 AM and				
		irsing staff to complete			
		ed as well as to document			
F 007		or refused by the resident.	E 007		0/44/04
F 867 SS=E	QAPI/QAA Improvem CFR(s): 483.75(c)(d)(F 867		3/11/24

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	-	ID HUMAN SERVICES MEDICAID SERVICES					FORM): 03/22/2024 / APPROVED). 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,		CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345566	B. WING			_		C 16/2024
NAME OF P	ROVIDER OR SUPPLIER		I	S	TREET ADDRESS, CITY, ST	ATE, ZIP CODE		
PRUITTHE	EALTH-UNION POINTE				510 WEST HIGHWAY 74 IONROE, NC 28110			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 867	monitoring. A facility must establis policies and procedur collections systems, a adverse event monito procedures must inclu following: §483.75(c)(1) Facility systems to obtain and from direct care staff, resident representativ information will be use are high risk, high vol opportunities for impre §483.75(c)(2) Facility systems to identify, co information from all de not limited to the facili §483.70(e) and include will be used to develop indicators. §483.75(c)(3) Facility and evaluation of perf including the methodo systematically identify analyze and use data adverse events in the	eedback, data systems and sh and implement written es for feedback, data and monitoring, including ring. The policies and ude, at a minimum, the maintenance of effective d use of feedback and input other staff, residents, and res, including how such ed to identify problems that ume, or problem-prone, and ovement. maintenance of effective oblect, and use data and epartments, including but ity assessment required at ling how such information p and monitor performance development, monitoring, formance indicators, ology and frequency for such ring, and evaluation. adverse event monitoring, s by which the facility will v, report, track, investigate, and information relating to facility, including how the ta to develop activities to	F	867				

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	-	D HUMAN SERVICES //EDICAID SERVICES					FORM): 03/22/2024 MAPPROVED). 0938-0391
STATEMENT OF DE AND PLAN OF COR	EFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345566	B. WING _			_		C 16/2024
NAME OF PROVI	DER OR SUPPLIER		•	ST	REET ADDRESS, CITY, ST	ATE, ZIP CODE		
PRUITTHEALT	TH-UNION POINTE				10 WEST HIGHWAY 74 ONROE, NC 28110			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	((EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD BE ICED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
§44sys§44aimimpandimp(ii)detimp(ii)detimp(iii)detimp(iii)of iens§44§44saf(iii)of iens§44safsaf(iii)of ienssafs	stemic action. 83.75(d)(1) The fac ned at performance plementing those ac d track performance provements are rea 83.75(d)(2) The fac plement policies ad How they will use a termine underlying pacting larger syste How they will deve I be designed to effi- vel to prevent quality fety problems; and) How the facility will its performance improvem 83.75(e) Program a 83.75(e)(1) The fac rformance improver gh-risk, high-volume nsider the incidence problems in those a tcomes, resident sa sident choice, and q 83.75(e)(2) Perform tivities must track m sident events, analy plement preventive	ystematic analysis and ility must take actions improvement and, after ctions, measure its success, a to ensure that lized and sustained. ility will develop and dressing: systematic approach to causes of problems ms; lop corrective actions that ect change at the systems y of care, quality of life, or Il monitor the effectiveness provement activities to ents are sustained. inctivities. ility must set priorities for its ment activities that focus on a, or problem-prone areas; a, prevalence, and severity ureas; and affect health fety, resident autonomy, uality of care.	F 8	967				

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	
		345566	B. WING				C 16/2024
NAME OF PR	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE	•	
				3	510 WEST HIGHWAY 74		
PRUITTHE	ALTH-UNION POINTE			Ν	MONROE, NC 28110		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 867	Continued From page	973	F	867			
	§483.75(e)(3) As part improvement activities distinct performance in number and frequence conducted by the faci and complexity of the available resources, a assessment required Improvement projects annually a project tha problem-prone areas collection and analysi (c) and (d) of this sec §483.75(g) Quality as §483.75(g)(2) The qu assurance committee governing body, or de functioning as a gove activities, including im program required und (e) of this section. The (ii) Develop and imple action to correct ident (iii) Regularly review a data collected under to resulting from drug re available data to mak This REQUIREMENT by: Based on observatio family member, physi	a of their performance s, the facility must conduct mprovement projects. The y of improvement projects lity must reflect the scope facility's services and as reflected in the facility at §483.70(e). must include at least t focuses on high risk or identified through the data s described in paragraphs tion. esessment and assurance. ality assessment and reports to the facility's esignated person(s) rning body regarding its oplementation of the QAPI ler paragraphs (a) through e committee must: ement appropriate plans of ified quality deficiencies; and analyze data, including the QAPI program and data gimen reviews, and act on e improvements. is not met as evidenced ns, record review, resident, cian, nurse practitioner, and acility's Quality Assurance provement committee			1. Address how corrective action will b accomplished for those residents found have been affected by the deficient practice:		
	procedures and monit	tor the interventions that the			No residents were affected.		

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			0			IO. 0938-03
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · /	LE CONSTRUCTION	· · ·	E SURVEY
			A. BUILDING	;		С
		345566	B. WING			2/16/2024
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO		2/10/2024
				3510 WEST HIGHWAY 74		
PRUITTHE	EALTH-UNION POINTE			MONROE, NC 28110		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT) CROSS-REFERENCED TO TH DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETIO DATE
F 867	Continued From page	- 74	F 86	7		
1 007	committee put into pla		F 00			
	complaint investigatio			2. Address how the facility v	will identify	
		recertification and complaint		other residents having the p	-	
	investigation of 6/30/2	•		affected by the same deficie		
		eas of F677 Activities of				
		-842 Accuracy of Records,		No residents have the poter	ntial to be	
		Professional Standards, and		affected.		
	F883 Influenza and P	neumococcai e deficiencies were recited		3. Address what measures	will be put into	
		fication and complaint		place or systematic change		
	investigation survey of 2/16/2024. The contin	-		ensure that the deficient pra		
		uring two or more federal		recur.		
	surveys of record sho	ows a pattern of the facility's				
	inability to sustain an	effective QAPI program.		On 2-9-2024, the Regional		
				Consultant completed an in		
	The findings included	:		the Administrator, Director of		
	This tag is cross refe	rred to:		Services (DHS), Assistant E Health Services (ADHS), N		
				Supervisors (NS), Minimum		
	F677: Based on obse	ervations, record reviews and		(MDS) nurses, Social Work		
		s, family member, and staff,		Manager, Maintenance Dire	•	
	the facility failed to pr	ovide incontinence care for		Environmental Services Ma	nager	
		(Resident #192, Resident		(Interdisciplinary Team) not		
		esident #48, and Resident		Assurance and Performanc		
	#339), and failed to p	-		Improvement policy and pro		
		Resident #339) for 5 of 16 or activities of daily living.		facility with emphasis on co monitor and evaluating prior		
		activities of daily living.		during past surveys. All new		
	During the complaint	investigation of 3/12/2021		interdisciplinary team memb		
		ovide a dependent resident		receive the same education		
	with shaving assistan	ce for 1 of 4 residents		general facility orientation fr	om the Clinical	
	reviewed for activities	s of daily living (ADL).		Competency Coordinator, A		
	F842: Based on reco	rd review and staff		and/or Director of Health Se	ervices.	
		railed to maintain complete		The Area Vice President of	Operations for	
		I records in the areas of		Coastal North Division and		
	surgical wound care ((Resident #70) for 1 of 1		Regional Nurse Consultant	will attend the	
	resident record review	wed for surgical wound care.		monthly QAPI meetings to e	ensure that the	
				repeat tags are monitored, i	monthly times	

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OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		(X3) DATE S COMPLE	URVEY	
	345566	B. WING		C 02/16/2024		
		STREET ADDRESS, CITY, STATE, ZIP CODE 3510 WEST HIGHWAY 74				
(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOL	LD BE	(X5) COMPLETION DATE	
During the complaint is the facility failed to do medication dosage or administration record for 1 of 1 resident rever- record. F684: Based on record director interviews, the weights as ordered for failure on a diuretic (F 1 of 8 residents review During the recertificate dated 6/30/2022, the document, and treat se resident receiving ant three sampled resider care. F883: Based on record interviews, the facility influenza vaccine for a consent form to receive document an influenz 1 of 5 residents review (Resident #58). During the recertificate dated 6/30/2022, the pneumococcal vaccine documentation in the education or vaccinate pneumococcal vaccine residents reviewed for vaccinations.	survey dated 10/22/2021, ocument the correct in the electronic medication (eMAR) for Fentanyl patch iewed for accurate medical efficiency staff and medical efficiency failed to obtain daily or a resident with heart Resident #70). This was for wed for nutrition. tion and complaint survey facility failed to assess, skin tears, resulting in the tibiotic treatment, for one of ints reviewed for wound rd reviews and staff failed to administer an a resident who signed a ve an influenza vaccine or ta vaccine was received for wed for infection control tion and complaint survey facility failed to offer the he and include resident's medical record of ion status for the nation for two of five r the pneumococcal	F 867	 6 months, then quarterly times 3 quarterly times a quarterly times a quarterly times a quarterly times a quarterly time annually. Opportunities to be corrected as identified during the G process. 4. Indicate how the facility plans to monitor its performance to make su solutions are sustained. The results of the Monthly Quality Assurance meeting minutes will be presented by the Administrator to t quality Assurance Committee Quarterly and the identification of trends, development of action plan indicated to determine the need and the identification. 	API ure that ne rterly x f s as		
	OF DEFICIENCIES F CORRECTION ROVIDER OR SUPPLIER EALTH-UNION POINTE SUMMARY ST. (EACH DEFICIENC REGULATORY OR I Continued From page During the complaint the facility failed to do medication dosage of administration record for 1 of 1 resident rev record. F684: Based on record director interviews, th weights as ordered for failure on a diuretic (F 1 of 8 residents review During the recertificat dated 6/30/2022, the document, and treat s resident receiving and three sampled reside care. F883: Based on record interviews, the facility influenza vaccine for consent form to recei document an influenz 1 of 5 residents review (Resident #58). During the recertificat dated 6/30/2022, the pneumococcal vaccin documentation in the education or vaccinat pneumococcal vaccin residents reviewed for vaccinations.	FORRECTION IDENTIFICATION NUMBER: JUDENTIFICATION NUMBER: JUDENTIFICATION NUMBER: SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 75 During the complaint survey dated 10/22/2021, the facility failed to document the correct medication dosage on the electronic medication administration record (eMAR) for Fentanyl patch for 1 of 1 resident reviewed for accurate medical record. F684: Based on record review, staff and medical director interviews, the facility failed to obtain daily weights as ordered for a resident with heart failure on a diuretic (Resident #70). This was for 1 of 8 residents reviewed for nutrition. During the recertification and complaint survey dated 6/30/2022, the facility failed to assess, document, and treat skin tears, resulting in the resident receiving antibiotic treatment, for one of three sampled residents reviewed for wound care. F883: Based on record reviews and staff interviews, the facility failed to administer an influenza vaccine for a resident who signed a consent form to receive an influenza vaccine or document an influenza vaccine was received for 1 of 5 residents reviewed for infection control (Resident #58). During the recertification and complaint survey dated 6/30/2022, the facility failed to offer the pneumococcal vaccination for two of five residents reviewed for the pneumococcal vaccinations.	OP DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLI IDENTIFICATION NUMBER: A BUILDING 345566 B. WING ROVIDER OR SUPPLIER ID EALTH-UNION POINTE ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID Continued From page 75 ID During the complaint survey dated 10/22/2021, the facility failed to document the correct medication dosage on the electronic medication administration record (eMAR) for Fentanyl patch for 1 of 1 resident reviewed for accurate medical record. F 867 F684: Based on record review, staff and medical director interviews, the facility failed to obtain daily weights as ordered for a resident with heart failure on a diuretic (Resident #70). This was for 1 of 8 residents reviewed for nutrition. During the recertification and complaint survey dated 6/30/2022, the facility failed to assess, document, and treat skin tears, resulting in the resident receiving antibiotic treatment, for one of three sampled residents reviewed for wound care. F883: Based on record reviews and staff interviews, the facility failed to administer an influenza vaccine for a resident who signed a consent form to receive an influenza vaccine or document an influenza vaccine was received for 1 of 5 residents reviewed for infection control (Resident #58). During the recertification and complaint survey dated 6/30/2022, the facility failed to offer the pneumococcal vaccination for two of five residents reviewed for the pneumococ	OF DEFICIENCIES (X1) PROVIDERSUPPLERCLA (X2) MULTIFLE CONSTRUCTION 345566 B. WING ROWDER OR SUPPLIER STREET ADDRESS, GTY, STATE, ZIP CODE Saturd State Stat	OP DEFICIENCIES (X1) PROVIDERISUPPLIERCLIA DENTIFICATION NUMBER: (X2) MULTIPE CONSTRUCTION A BUILING 	

Facility ID: 080171

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	D: 03/22/2024
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		(X3) DATE COMP	LETED
		345566	B. WING		_		C 16/2024
NAME OF P	ROVIDER OR SUPPLIER		ST	REET ADDRESS, CITY, ST	ATE, ZIP CODE	•=.	
PRUITTHE	EALTH-UNION POINTE			010 WEST HIGHWAY 74			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 867 F 883 SS=D	11:19 AM and they rebeen conducted in Deareas of concern were Reimbursement Conseptans of correction were several performance in Regional Nurse Const the follow-up a couplet that the facility was not plans of correction were at the facility was 20% of correction were at the facility was 20% reported the QAPI constructed the QAPI constructed the QAPI constructed the QAPI constructed the compliance, the QAPI areas of concern and to 6 months if necess. Influenza and Pneum CFR(s): 483.80(d) (1) (1) (1) \$483.80(d) (1) Influenza and procedure (i) Before offering the each resident or the receives education repotential side effects of (ii) Each resident is of immunization October annually, unless the interval of the procedure (ii) and the procedure offering the each resident is of immunization October annually, unless the interval of the procedure of t	sultant RN on 2/8/2024 at vealed a mock survey had ecember 2023 and multiple a identified. The Clinical sultant RN reported several ere in place as well as improvement plans. The ultant explained that during a weeks ago, the team found of meeting metrics and the ere modified. s interviewed on 2/8/2024 at strator explained his first day 2024. The Administrator mmittee met monthly and onitored areas of concern by onitoring guidelines. The ed that to maintain committee would review track the audit results for up ary. ococccal Immunizations (2) and pneumococcal za. The facility must develop es to ensure that- influenza immunization, esident's representative garding the benefits and of the immunization; fered an influenza r 1 through March 31 mmunization is medically e resident has already been	F 867				3/11/24

Facility ID: 080171

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		D HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345566	B. WING				C 16/2024
NAME OF P	ROVIDER OR SUPPLIER		•	S	STREET ADDRESS, CITY, STATE, ZIP CODE	-	
PRUITTH	EALTH-UNION POINTE				3510 WEST HIGHWAY 74 MONROE, NC 28110		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG	FIX (EACH CORRECTIVE ACTION SHOULD BE C			
F 883	 (iii) The resident or th has the opportunity to (iv)The resident's med documentation that in following: (A) That the resident of was provided education and potential side effect immunization; and (B) That the resident of immunization or did n immunization or did n immunization due to re- refusal. §483.80(d)(2) Pneument must develop policies that- (i) Before offering the immunization, each re- representative received benefits and potential immunization; (ii) Each resident is of immunization; (iii) Each resident or th has the opportunity to (iv)The resident or the has the opportunity to (iv)Th	e resident's representative or refuse immunization; and dical record includes dicates, at a minimum, the or resident's representative on regarding the benefits ects of influenza either received the influenza ot receive the influenza medical contraindications or ococcal disease. The facility and procedures to ensure pneumococcal esident or the resident's es education regarding the side effects of the ffered a pneumococcal the immunization is ated or the resident has zed; e resident's representative or feuse immunization; and dical record includes dicates, at a minimum, the or resident's representative on regarding the benefits ects of pneumococcal	F	883			

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		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 03/22/2 FORM APPRO\ OMB NO. 0938-03	
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · ·	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345566	B. WING		- C - 02/16/2024	
NAME OF P	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP C		
	ALTH-UNION POINTE			3510 WEST HIGHWAY 74		
PRUITINE	ALTH-UNION POINTE			MONROE, NC 28110		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE COMPLETI HE APPROPRIATE DATE	
F 883	Continued From page	e 78	F 88	33		
1 000	contraindication or re		1.00			
		T is not met as evidenced				
	by:					
		riews and staff interviews, the		1. Address how corrective		
		nister an influenza vaccine		accomplished for those residues		
		gned a consent form to vaccine or document an		have been affected by the opractice:	deficient	
	influenza vaccine wa			practice.		
		or infection control (Resident		Resident #58 is no longer a	a resident in the	
	#58).	Υ.		facility.		
	The findings included	1:		2. Address how the facility	-	
				other residents having the p		
		Imitted to the facility on ntry date of 10/16/23.		affected by the same deficient	ent practice.	
				Current residents have the	potential to be	
	Resident #58's quarter	erly Minimum Data Set		affected.		
	· · ·	lated 10/18/23 revealed				
	Resident #58 was co	gnitively intact.		The Director of Health Serv		
				Assistant Director of Health		
	Review of Resident #	rso's medical record I "Resident Influenza (Flu)		(ADHS), Nurse Supervisors Competency Coordinator (
	-	fusal" form on 10/31/23.		Data Set (MDS) Nurses and		
		hark on the line that read I do		Nurse(s) will complete an a		
		u vaccine depending on the		residents to ensure educati		
	availability of the vac	cine. There was a		declination of Pneumonia a	nd/or Influenza	
		he top of the form that read,		vaccines, and administratio		
	"Do not receive went	to hospital."		and eligible vaccinations ha		
	Review of Resident +	\$58's medical record showed		initiated. The Director of He (DHS), Assistant Director o		
		a hospital on 11/13/23 and		Services (ADHS), Nurse St		
	returned to the facility	•		(NS), Clinical Competency		
		-		(CCC), Minimal Data Set (N		
		#58's hospital records dated		and/or Staff Nurse(s) will ad	ddress any	
		documentation Resident #58		concerns identified during t		
	received an influenza hospitalization.	a vaccine during his		audit will be completed by 3	3/11/2024.	
				3. Address what measures	will be put into	
	An interview was atte	empted on 2/8/24 at 9:20		place or systematic change		

Facility ID: 080171

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		OMB NO. 0938-0391 (X3) DATE SURVEY
		COMPLETED
B. WING		C 02/16/2024
	STREET ADDRESS, CITY, STATE, ZIP CODE	
	3510 WEST HIGHWAY 74	
	MONROE, NC 28110	
ID PREFIX TAG		
F 88	 ensure that the deficient practice will near recur. The Director of Health Services, Clinical Competency Coordinator, Nurse Supervisors, and/or designee will provie education to 100% of licensed nurses noting upon admission and readmission the admitting nurse should provide write education for Pneumonia and Influenza vaccination as appropriate, attempt to obtain consent or declination for Pneumonia vaccinations all year and complete for Influenza during the month of October through March, and docume consent or declinations in the electronic health record. The Director of Health Services, Clinical Competency Coordinator/Infection Preventionist, and Nurse Supervisors will ensure orders a obtained and implemented for eligible residents with floor staff nurses responsible for administration and documentation of administration of ordered vaccines. Education will be completed by 3-11-2024. After 3-11-202 any nurses who have not worked or received the education will receive it pr to the next scheduled work shift. All net hired licensed nurses will receive the same education during general facility orientation. The Director of Health Services, Clinical Competency Coordinator, Nurse Supervisors, and/or designee will audit admissions and readmissions to ensure they have been offered the Pneumonia 	al de n, ten a hs ent c d/or re 24, ior wly al
	ID PREFIX TAG	STREET ADDRESS, CITY, STATE, ZIP CODE 3510 WEST HIGHWAY 74 MONROE, NC 28110 ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) F 883 ensure that the deficient practice will not recur. The Director of Health Services, Clinica Competency Coordinator, Nurse Supervisors, and/or designee will provie education to 100% of licensed nurses noting upon admission and readmission the admitting nurse should provide write education for Pneumonia and Influenza vaccination as appropriate, attempt to obtain consent or declination for Pneumonia vaccinations all year and complete for Influenza during the month of October through March, and docume consent or declinations in the electronia health record. The Director of Health Services, Clinical Competency Coordinator/Infection Preventionist, and Nurse Supervisors will ensure orders a obtained and implemented for eligible residents with floor staff nurses responsible for administration and documentation of administration of ordered vaccines. Education will be completed by 3-11-2024. After 3-11-202 any nurses who have not worked or received the education will receive it pr to the next scheduled work shift. All net hired licensed nurses will receive the same education during general facility orientation.

Event ID:9U2E11

Facility ID: 080171

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	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPI	E CONSTRUCTION	OMB NO. 0938-03 (X3) DATE SURVEY	
	CORRECTION	IDENTIFICATION NUMBER:			COMPLETED	
		345566	B. WING		С	
	ROVIDER OR SUPPLIER	343300		STREET ADDRESS, CITY, STATE, ZIP CODE	02/16/2024	
				3510 WEST HIGHWAY 74		
PRUITTHE	ALTH-UNION POINTE			MONROE, NC 28110		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE COMPLETIC	
F 883	Continued From page	≥ 80	F 883	 consent and declinations are documented, and administration consented vaccinations are con This audit will be conducted 3 ti week x 4 weeks, weekly x4 wee then monthly x1. Ongoing monifibe completed by DHS and Infect Preventionist for the facility by k running audit of Pneumonia and vaccine compliance and update needed. 4.Indicate how the facility plans its performance to make sure the solutions are sustained. The Director of Health Services Infection Preventionist will track the results via the Immunization tool weekly and report the findir Quality Assurance Performance Improvement Committee month months or until substantial compactive and then quarterly. 	and/or and trend and trend	
F 947 SS=D	Required In-Service T CFR(s): 483.95(g)(1)-	Fraining for Nurse Aides -(4)	F 947	Compliance date: 3-11-2024	3/11/24	
	§483.95(g) Required aides. In-service training mu	in-service training for nurse st-				
	§483.95(g)(1) Be suff continuing competend be no less than 12 ho	ce of nurse aides, but must				
	§483.95(g)(2) Include	dementia management				

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	-	D HUMAN SERVICES MEDICAID SERVICES			FOF	RM APPROVED IO. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
		345566	B. WING		0	C 2/16/2024
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
				3510 WEST HIGHWAY 74		
PRUITTHE	EALTH-UNION POINTE			MONROE, NC 28110		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE
F 947	training and resident a §483.95(g)(3) Address determined in nurse a and facility assessme address the special n determined by the face §483.95(g)(4) For nur to individuals with cog address the care of th This REQUIREMENT by: Based on record revi facility failed to compl of annual in-services Aides (NA #22, and N The findings included Review of the person hire date of 7/14/21. Review of the person hire date of 8/11/21. Review of NA #22's E training did not includ mandatory in-servicin Review of NA #23's E training did not includ mandatory in-servicin Review of all the facil documentation reveal	abuse prevention training. s areas of weakness as aides' performance reviews nt at § 483.70(e) and may eeds of residents as cility staff. se aides providing services gnitive impairments, also ne cognitively impaired. is not met as evidenced ew and staff interviews, the ete mandatory twelve hours training for 2 of 5 Nursing IA #23) reviewed. : nel file of NA #22 revealed a nel file of NA #23 revealed a iducational Record for yearly e 12 hours of the annual g for 2023. iducational Record for yearly e 12 hours of annual	F 94	 47 1. Address how corrective actio accomplished for those resident have been affected by the defici practice: No residents were identified as 2. Address how the facility will ic other residents having the poten affected by the same deficient p The Clinical Competency Coord (CCC) will complete an audit of certified nursing assistants□ (Cf education records to ensure the mandatory twelve hours of annu in-services training have been in The Clinical Competency Coord (CCC) and or Director of Health (DHS) will address any concerns during the audit. The audit will b completed by 3/11/2024. 3. Address what measures will b place or systematic changes ma ensure that the deficient practice 	s found to ent affected. lentify tial to be ractice. inator current VA) al itiated. inator Services s identified e pe put into ide to	

Event ID: 9U2E11

Facility ID: 080171

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		ID HUMAN SERVICES			PRINTED: 03/22/2024 FORM APPROVED
STATEMENT O	S FOR MEDICARE & OF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	OMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED
		345566	B. WING		C 02/16/2024
NAME OF PI	ROVIDER OR SUPPLIER	I		STREET ADDRESS, CITY, STATE, ZIP CODE	
				3510 WEST HIGHWAY 74	
PRUITTHE	ALTH-UNION POINTE			MONROE, NC 28110	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE COMPLETION
F 947	interviewed on 02/07/ the facility used an or she was aware that a annual mandatory in- Clinical Reimburseme she was helping the f facility training record and she could not find for either NA for 2023 During an interview w on 02/08/24 at 11:30	rsement Coordinator was /24 at 9:30 AM. She stated nline in-service program and ill nurse aides must have the service training. The ent Coordinator indicated facility out and reviewed the is for NA #22 and NA #23 d any documented education B. with the Director of Nursing AM, she indicated she had ty for less than 2 weeks and	F 947	 recur. The Director of Health Services provide education the Clinical Competency Coordinator noting certified nursing assistants mus mandatory twelve hours of in-set training must be completed ann covering various topics including cognitively impaired residents. The Clinical Competency Coordinate provide education to certified nursing assistants, noting they must correspondent of the education will be completed and the education will be completed to the next scheduled work shift hired certified nursing assistants receive the same education during general facility orientation. The Director of Health Services Clinical Competency Coordinate current certified nursing assistants and the education will receive the same education during general facility orientation. The Director of Health Services are completed by the certified nursing assistant ensure assigned in-service completed by the conducted weekly then monthly x 2 months. Ongo monitoring of in-service completed by the Clinical Competency Coordinator. Indicate how the facility plans monitor its performance to make solutions are sustained. The Director of Health Services 	g current t complete ervices ually g care of The or will ursing mplete a ervices ompleted any ted or tive it prior t. All newly s will ting and/or or will audit nt staff to be being ng staff. / x 4 weeks ing tion will be betency s to e sure that
	7(02-99) Previous Versions Obs	solete Event ID: 9U2E1			will track

Event ID:9U2E11

Facility ID: 080171

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TATEMENT (DF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		TRUCTION	(X3) DA	IO. 0938-039 E SURVEY IPLETED	
		345566					С	
	ROVIDER OR SUPPLIER	545566			ADDRESS, CITY, STATE, ZIP CODE	0	02/16/2024	
NAME OF FI	TOWDER OR SUPPLIER				EST HIGHWAY 74			
PRUITTHE	ALTH-UNION POINTE			MONRO				
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETIOI DATE	
F 947	Continued From page	e 83	F 9	and In-s Ass find Per mol con qua	t trend the results via Annual services for Certified Nursing sistants audit tool weekly and re- lings to the Quality Assurance formance Improvement Comm nthly x 3 months or until substa npliance is achieved and then arterly. mpliance date: 3-11-2024	ittee		

Facility ID: 080171

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