DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345515	A. BUILDING ______ B. WING ______	C 06/04/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEALTH-TOWN CENTER	6300 ROBERTA ROAD HARRISBURG, NC 28075

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observations, record review, staff and resident interview the facility failed to follow the care plan and use interventions to prevent falls for one of five sampled residents for falls. Resident #8. The findings included: Resident #8 was admitted to the facility on 5/9/08 with diagnosis of Parkinson's disease and a history of polio with complicated mobility disorder. The Minimum Data Set (MDS) dated 4/29/15 indicated Resident #8 required extensive assistance of two staff for transfers and toileting. Resident #8 required extensive assistance of one staff for bed mobility and personal hygiene. This MDS indicated she was not able to walk and had some problems with long term memory and impairment with short term memory. The Care Area Assessment Set (CAAS) dated 7/18/14 included the area of falls. This area triggered due to impaired balance during transitions, antidepressants, incontinence, Parkinson's disease, depression and dementia. A decision to proceed with a care plan was made. The care plan dated 7/18/14 included a problem	F 282	Resident #8's high back wheel chair with reclining seat was discontinued per the Resident's request. Resident #8's current pommel cushion was replaced with a new pommel cushion to increase her comfort with dycem to the top and bottom of the pommel cushion to prevent sliding. Resident #8's care plan was updated for both interventions. 6/2/15. A 100 % audit of all Residents with falls will have their care plans reviewed and visible verification by the Director of Health Services (DHS), Assistant Director of Health Services (ADHS) or RN Senior Care Partner (SCP) to ensure all current interventions are in place. All newly admitted Residents will have their care plans reviewed in morning clinical meeting by the DHS/ADHS or SCP to ensure proper fall interventions are in place, with visual verification of the interventions. Any care plans updated by nursing staff for falls between MDS quarterly reviews will also be reviewed in morning clinical meetings by the DHS/ADHS to SCP to ensure proper fall interventions ar verified in place.	7//1/15

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

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345515	A. BUILDING ______ B. WING ______	C 06/04/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEALTH-TOWN CENTER	**6300 ROBERTA ROAD HARRISBURG, NC 28075**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 282	Continued From page 1 of falls due to Parkinson's disease. Areas related to falls included the resident slides forward in wheelchair at times requiring cues and physical assistance to reposition. The approaches included use of positioning devices in the wheelchair as ordered. These included use of a pommel cushion and dycem on top and bottom of the cushion. Review of the updated care plan for 4/30/15 included a problem of potential for fall/ injuries related to tremors, psychotropic meds, impaired mobility and safety awareness. Resident #8 had a history of multiple falls. Approaches included use of recline back wheelchair with nonslip dycem to top/bottom of pommel cushion in posterior pelvic tilt positioning to assist with mobility independence. Review of the physician ' s orders dated 12/18/14 for use of a pommel in the wheelchair. Dycem was ordered on 12/30/14 as a fall intervention. Review of the signed physician ' s orders for May 2015 indicated Resident #8 was to have a bed alarm, anti-tippers to front of wheelchair, high back reclining wheelchair and self- release seatbelt alarm. A pommel cushion with nonslip dycem to the top/bottom of the pommel while in the wheelchair. Observations on 6/1/2015 at 10:36 AM revealed Resident #8 was in a wheelchair wheeling herself in hall by nurses' desk. She was leaning to the left, hips sliding forward and had a self-release belt around her lower abdomen. Observations on 06/02/2015 at 10:32 AM revealed Resident #8 was in a wheelchair with	F 282	Licensed nursing staff will be educated by the Administrator/DHS/ADHS or SCP on updating care plans for falls and verification of all interventions in place per the care plan. All nursing assistants (NA) will be educated by the Administrator/DHS/ADHS or SCP on review of the Activity of Daily living sheets and direction in the Smart Charting system for care instructions and reporting to the licensed nurse when there is any problem with the use of the interventions. Monitoring of the falls with update care plans and verification of interventions will be done the DHS/ADHS or SCP or licensed nurse week end supervisor daily for four (4) weeks. The monitoring will continue twice weekly for four (4) weeks and then weekly for four (4) weeks. The DHS will report all results of the monitoring with tracking and trending to the monthly Quality Assurance and Performance Improvement (QAPI)	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345515	A. BUILDING ______ B. WING ______	C **06/04/2015**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEALTH-TOWN CENTER	**6300 ROBERTA ROAD** **HARRISBURG, NC 28075**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 282	Continued From page 2 her hips slid forward to the edge of the wheelchair. A pommel cushion was not in the wheelchair. Interview on 06/02/2015 at 4:18 PM with the MDS nurse indicated the last update on the care plan was 4/30/15. According to the care plan, due to Parkinson's she was at risk for falls. In reviewing the fall care plan she would expect Resident #8 to be seated in a wheelchair. The MDS nurse explained she would not know if care plan was correct until she saw the resident. The MDS nurse observed the resident and stated she was positioned correctly in the wheelchair. At this observation, Resident #8 did not have a pommel cushion. When asked if that intervention was current, the MDS nurse stated she would have to check with therapy. Interview with the MDS nurse on 6/2/15 at 4:58 PM revealed she had checked with therapy for the proper seating for this resident. The care plan was correct and there should be a pommel cushion and dycem in the wheelchair. No explanation was provided as to why the resident did not have the pommel cushion. Observation on 06/03/2015 at 8:11 AM revealed Resident #8 was in a wheelchair with the tabs alarm, self-release seat belt and a pillow folded in half to support her left side. The pommel cushion was not in the wheelchair. Interview with aide # 1, who was assigned to Resident #8 on 06/03/2015 at 8:15 AM revealed she would know how to provide care for Resident #8 by the care trakker and kardex. Further interview revealed the resident required just one staff to transfer her to a wheelchair. This aide	F 282		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345515	A. BUILDING ______ B. WING ______	C **06/04/2015**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEALTH-TOWN CENTER	**6300 ROBERTA ROAD** **HARRISBURG, NC 28075**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 282	Continued From page 3 was asked if any positioning devices were used in the wheelchair. Aide #1 explained there were none. Aide #3 was asked if a pommel cushion was used for the resident. Aide #1 explained she did not use a pommel. Observations on 06/03/2015 at 11:40 AM revealed a pommel cushion was not in Resident #8 ' s wheelchair. Observations on 06/03/2015 at 12:11 PM revealed Resident #8 was seated in the wheelchair with her hips sliding forward and the pommel cushion was not in the wheelchair. Review of the Kardex located in the resident's closet in her room revealed instructions to use dycem on top/bottom of pommel cushion in wheelchair. A second paper with written instructions inside the closet instructed staff on the use of the pommel cushion to the wheelchair. Interview with aide #2 on 06/03/2015 at 1:58 PM revealed she was aware of the kardex posted on the resident's closet door. It was reviewed with her regarding use of dycem and the pommel. She stated the resident did not have a pommel, and was not sure what the dycem was. Observation of the resident with the aide revealed the resident was stood up out of the wheelchair. There was no dycem under or on top of a regular cushion in the wheelchair. Aide # explained she did not know dycem was supposed to be used. 6/3/15 2:10 PM interview with restorative aide #1 revealed Resident #8 was extensive assist to stand. She could not remember when she last saw a pommel cushion in her chair. This aide explained she knew she had one.	F 282		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345515	A. BUILDING ______ B. WING ______	C 06/04/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEALTH-TOWN CENTER	6300 ROBERTA ROAD HARRISBURG, NC 28075

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 282	Continued From page 4	F 282		

Interview with Director of Nursing (DON) on 06/03/2015 at 2:24 PM revealed Resident #8 ' s wheelchair had been washed. The pommel cushion had not been replaced after it was washed.

Interview with maintenance staff #1 on 06/03/2015 at 2:25 PM revealed he comes in at night when the resident is in bed. Resident #8 had her wheelchair washed on Friday. (four days ago) He takes any cushions, alarms etc out of the chair. Those were placed on "that side of the room" and the wheelchair would be returned to the room that night. The aides would dry off the wheelchair and put the alarms or cushions back in the wheelchair.

Observations on 06/03/2015 2:26 PM revealed the nurse had placed the pommel cushion in the wheelchair. The nurse indicated the pommel cushion was found in the bottom drawer of the resident's drawers.

Interview with DON on 6/3/15 at 4:00 PM resident had not had any falls recently. The last fall occurred in December 2014.

Interview with administrator on 6/4/15 at 9:40 AM indicated the resident would ask to not have the cushion in place at times. She further explained Resident #8 can make her own decisions and refuse it.

Interview with Resident #8 on 6/4/15 at 9:45 AM revealed she did not refuse the cushion on 6/3/15. She had the cushion in place on 6/4/15 at 9:40 am.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345515	A. BUILDING ______ B. WING ______	C 06/04/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEALTH-TOWN CENTER	6300 ROBERTA ROAD HARRISBURG, NC 28075

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 282	Continued From page 5 Interview with aide #4 on 06/04/2015 at 1:36PM who had provided care to Resident #8 on 6/1/15 revealed she did not use the pommel due to her refusing. Aide #4 explained " I did not let the nurse know. I got busy and forgot. She had the cushion (regular flat one) and the seat belt and alarm. That was all that was used in her wheelchair on Monday. " Resident (#8) refused the pommel due to " it hurt her between her legs. " Interview with the DON on 6/4/15 at 11:00 AM revealed if a resident refuses the pommel, the aide should notify the nurse. Then make sure she is safe. Would continue using any intervention to help with her safety, and encourage her and try to use again when refused.	F 282	Resident # 54 had their Valporic Acid lab test drawn on 6/4/15. A 100 % medical chart audit was done by the Administrator, Director of Health Services (DHS), Assistant Director of Health Services (ADHS) and RN Senior Care Partner (SCP) to ensure all labs had been drawn as ordered or were scheduled to be drawn as ordered. Completed 6/23/15 All licensed nurses will be educate by the Administrator, DHS , ADHS or SCP for proper procedure for obtaining, ordering and reporting lab results.	7/1/15
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and	F 329	Review of physician orders will occur in morning clinical meetings to ensure all lab test are ordered and drawn, with results obtained by the DHS. ADHS, or SCP. Monitoring of the labs for orders and results will occur by the DHS, ADHS, SCP or the RN week end supervisor daily for four (4) weeks. Continued monitoring will occur twice weekly for four (4) weeks and then weekly for four (4) weeks. The results of the monitoring with tracking and trending will be reported to the Quality Assurance and Performance Improvement	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345515	A. BUILDING ______ B. WING ______	C 06/04/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEALTH-TOWN CENTER	**6300 ROBERTA ROAD** **HARRISBURG, NC 28075**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329	Continued From page 6 behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on staff interviews and record reviews the facility failed to obtain lab values for valporic acid (anti-seizure medication) as ordered by the physician for 1 of 5 residents reviewed for unnecessary drugs. (Resident #54) The findings included: Resident #54 was admitted to the facility on 3/19/15 with diagnosis of congestive heart failure, hypertension, atrial fibrillation and seizure disorder. The most recent Minimum Data Set (MDS) assessment with assessment reference date of 5/8/15 indicated that Resident #54 required extensive assistance with activity of daily living (ADL ' s) and was cognitively intact. The care plan initiated on 3/19/15 identified a problem of seizure disorder with approaches of medications as ordered, labs as ordered and to notify physician of any abnormal findings. A physician order dated 5/1/15 indicated to give Divalproex (valporic acid) 250 milligrams every morning for seizures. A physician order dated 5/21/15 indicated to get a	F 329	QAPI) monthly meeting by the DHS for recommendations and suggestions for change as needed.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345515	A. BUILDING ______ B. WING ______	C 06/04/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEALTH-TOWN CENTER	**6300 ROBERTA ROAD HARRISBURG, NC 28075**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329	Continued From page 7 valporic acid level on 5/25/15 and every 6 months (May and November). A record review on 6/3/15 revealed that lab results for valporic acid level on 5/25/15 could not be located. There were no valporic acid levels available in Resident #54 ' s medical record since admission on 3/19/15. An interview with Nurse #1 on 6/3/15 at 9:15 AM revealed that she signed off the order dated 5/21/15 but did not put the order in the lab book or in the computer for the lab requisition for the valporic acid level and the lab was not done. An interview with the director of nurses on 6/4/15 at 11:30 AM revealed that it is her expectations that the nurse supervisor check the labs each morning to make sure the labs are complete and expects the physician orders for lab values to be obtained as ordered.	F 329		