SINTERENCE DEPOSENCES AND PLAN OF CONFECTION         (Y) PERVIDENT PLANOR         (PO) MATTPLE CONSTRUCTION A BULD MG         (PO) MATTPLE CONSTRUCTION BULD MG         (PO) MG         (PO) MG         (PO) MG           F 274         483.20(D) (2)(I) COMPREHENSIVE ASSESS SS D         F 274         F 274         77/17         77/17           F 274         483.20(D) (2)(I) COMPREHENSIVE ASSESS SS D         F 274         MG         77/17     <			ID HUMAN SERVICES				FORM APPROVED //B NO. 0938-0391
34105         In WING         OBSIDE TO CODE OF SUPPLIER           PRUTTHEALTH-HIGH POINT         STREET ADDRESS.CITY. STREE, 2P CODE 380 N MAN STREET HIGH POINT, NC. 27265         STREET ADDRESS.CITY. STREE, 2P CODE 380 N MAN STREET HIGH POINT, NC. 27265         STREET ADDRESS.LIN OF CORRECTION (EACH OPERION COLLECTION HIGH POINT NO. 27265         CROSS REPUILING TO CORRECTION (EACH OPERION COLLECTION HIGH POINT NO. 27265         CROSS REPUILING TO CORRECTION (EACH OPERION COLLECTION THE APPROPRIATE CROSS REPUILING TO THE APPROPRIATE (CROSS REPUILING TO THE APPROPRIATE CROSS REPUILING TO THE APPROPRIATE (CROSS REPUILING TO THE APPROPRIATE CROSS REPUILING TO THE APPROPRIATE (CROSS REPUILING TO THE APPROPRIATE (CROSS REPUILING TO THE APPROPRIATE CROSS REPUILING TO THE APPROPRIATE (CROSS REPUILING TO THE APPROPRIATE (CROSS REPUILING TO THE APPROPRIATE (CROSS REPUILING THE APPROPRIATE (CROSS REPUILING TO THE APPROPR	STATEMENT (	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	. ,			B) DATE SURVEY COMPLETED
NAME OF PROVIDER OF SUPPLIER         STREET ADDRESS, CITY STATE 2P CODE           PRUITTHEALTH-HIGH POINT         330 MAIN STATEMENT OF DEFICIENCIES         100 PREFIX         PROVIDERS FLAND OF CORRECTION         000;           F274         483.20(b)(2)(i) COMPREHENSIVE ASSESS         F 274         483.20(b)(2)(i) COMPREHENSIVE ASSESS         F 274         777/17           SS-D         AFTER SIGNIFICANT CHANGE         (0)(2)(ii) Within 14 days after the facility different field is a significant change in the resident's shatus hard in more metal condition. (For purpose of this section, a 'significant change' means a major decline or improvement in the resident's shatus hard interventions, that has an impact on more than one are of the resident's health status, and requires interdisciplinary review or revision of the care jain, or both.)         This plan of Correction constitutes the facility failed to complete a significant change in condition, assessment for 1 of 5 sampled resident shatus shatista, and requires interdisciplinary review or revision of the care jain, or both.)         This plan of Correction constitutes the facility failed to complete a significant change in condition, or do ceretorwascular accident.         This plan of Correction constitutes the facilities written allegation of compliance for the deficiencies exist or that the molecines exist or that the facility failed to complete a significant change in compliance for the deficiencies exist or that complicaties exist or that the molecines exist or that complicate extensive assistance for bed mobility, eating a mainty in the commolity esting and waiking in			345105	B. WING			-
PRUTTHEATH-HIGH POINT         HIGH POINT, NC 27285           (%1)0 PHETRX TAC         SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MIST BE RECEIVED BY FULL ASSULTORY OR USC DENTIFICATION)         ID PHETRX TAC         PROVIDER'S PLAND CORRECTIVE ACTORS HOLD BE (CACES REFERENCE) TO THE APPROPRIATE DEFICIENCY         004 (CACES REFERENCES TO THE APPROPRIATE DEFICIENCY         004 (CACES REFERENCES TO THE APPROPRIATE </td <td>NAME OF PI</td> <td>ROVIDER OR SUPPLIER</td> <td></td> <td></td> <td>STREET ADDRESS, CITY, STATE, ZIP CODE</td> <td>· · ·</td> <td></td>	NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	· · ·	
PREFIX TAO         (EACH CORRECTIVE ACTION SHOLLD BE REGULTORY OR LSC DENTIFYING INFORMATION)         PREFIX TAG         CROSE REFERENCE TO THE APPROPRIATE DEFICIENCY         COMMETCION INFO           F 274         483.20(b)(2)(ii) COMPREHENSIVE ASSESS AFTER SIGNIFICANT CHANGE         F 274         7/7/17           (b)(2)(ii) Within 14 days after the facility (defermines, or should have determined, that there has been a significant change in the resident's physical or mental condition, (For purpose of this section, a "significant change" means a major decline or improvement in the resident's shust have and impact on more than one area of the resident's head disaded disease-related clinical interventions, that has an impact on more than one area of the resident's head status, and requires interdisciplinary review or revision of the care plan, or both.)         This plan of Correction constitutes the facility failed to complete a significant change in condition assessment for 1 of 5 sampled resident #4's diagnoses included dementia and history of a cerebrovascular accident.         The significant change in requires interdisciplinary review or revision of the care plan, or both.)           The finding included:         The ensult Minimum Data Set (MDS) dated 22/17, specified Resident #4's diagnoses included dementia and history of a cerebrovascular accident.         1.Resident affected         2.Resident shit he potential to be affected         a.All residents with a Quartery,         Deated with a G	PRUITTHE	ALTH-HIGH POINT					
SS=D       AFTER SIGNIFICANT CHANGE         (b)(2)(i)       Within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a "significant change" means a major decline or improvement in the resident's status that will not normally resolve itistelf without further interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on record review, and staff interview, the facility failed to complete a significant change in condition assessment for 1 of 5 sampled residents (Resident #4).       This plan of Correction constitutes the facility failed to complete a significant change in condition assessment for 1 of 5 sampled resident status diagnoses included dementia and history of a cerebrovascular accident.         The finding included:       The annual Minimum Data Set (MDS) dated 22/17, specified Resident #4 required limited assistance for bed mobility, eating and walking in the room. The resident was also assessed to be moderately cognitively impaired.       1.Resident affected         Resident #4 required minet assistance for bed mobility, eating and walking in the room. This MDS indicated the resident was severely cognitively impaired.       2.Residents with the potential to be affected         a All residents with a Quarterly.       2.Residents with a Quarterly.	PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A	SHOULD BE	COMPLETION
		AFTER SIGNIFICAN (b)(2)(ii) Within 14 da determines, or should there has been a sign resident's physical or purpose of this sectio means a major declin resident's status that itself without further in implementing standar interventions, that has one area of the reside requires interdisciplin care plan, or both.) This REQUIREMENT by: Based on record revi facility failed to compl condition assessment residents (Resident # The finding included: Resident #4's diagnos history of a cerebrova The annual Minimum 2/2/17, specified Resi assistance for bed mo the room. The resider moderately cognitively The quarterly MDS da Resident #4 required bed mobility, eating, a This MDS indicated th	T CHANGE ays after the facility I have determined, that ificant change in the mental condition. (For n, a "significant change" e or improvement in the will not normally resolve intervention by staff or by d disease-related clinical is an impact on more than ent's health status, and ary review or revision of the " is not met as evidenced ew, and staff interview, the ete a significant change in t for 1 of 5 sampled 4). sess included dementia and iscular accident. Data Set (MDS) dated ident #4 required limited obility, eating and walking in nt was also assessed to be y impaired. ated 5/15/17, specified extensive assistance for and walking in the room.	F 27	<ul> <li>This plan of Correction constit facilities written allegation of co for the deficiencies cited. How submission of this plan of corre an admission that deficiencies that one was cited correctly. T correction is submitted to mee requirements established by fe state law.</li> <li>1.Resident affected</li> <li>Resident #4 had significant ch completed 6/16 and transmitte</li> <li>2.Residents with the potential affected</li> <li>a.All residents have the potent affected</li> </ul>	ompliance vever, ection is not exist or This plan of t ederal and ange d 6/19. to be	t
					b.An audit of all residents with	a Quarterly	(X6) DATE

**Electronically Signed** 

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.

06/28/2017

NAME OF PROVIDER OR SUPPLIER       STREET ADDRESS, CITY, STATE, ZIP CODE         PRUITTHEALTH-HIGH POINT       330 N MAIN STREET         (X4) ID PREFIX TAG       SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)       ID PROVIDER'S PLAN OF CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)         F 274       Continued From page 1 MDS Coordinator #1 was interviewed on 6/7/17 at 3:40 PM, about this resident's significant change in activities of daily living and cognition. MDS Coordinator #1 agreed the 5/15/17 assessment should have triggered a Significant Change in Condition assessment, but it had been missed.       F 274         On 6/8/17 at 10:28 AM, the Director of Nursing said he had been made aware a Significant Change in Condition assessment should have been dore for this resident. He stated they had been trying very hard to hire another MDS Coordinator but to date, had been unsuccessful.       F 274       Annual, Significant Change OBRA assessment. The audit will be conducted as follows: 25% of all current patients with a completed Quarterly or Annual assessment. The audit will be conducted as sessment. The weekly to identify any change that would warrant the completion of a Significant Change in Status Assessment. The weekly unitif this survey she felt the facility was in substantial compliance with regard to significant change in fundings will be placed on the Significant	)  4/2017 
345105         B_WING         06/14           NAME OF PROVIDER OR SUPPLIER         STREET ADDRESS, CITY, STATE, ZIP CODE         3330 N MAIN STREET           PRUITHEALTH-HIGH POINT         STREET ADDRESS, CITY, STATE, ZIP CODE         3330 N MAIN STREET           (X4)ID         SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)         ID         PROVIDERS PLAN OF CORRECTION (EACH DEFICIENCY)         OR ORDER         OPERATION         OPERATION SHOULD BE         OPERATION         <	1 <b>4/2017</b> (X5)
MAKE OF PROVIDER OR SUPPLIER       ID	(X5)
PRUITTHEALTH-HIGH POINT         3830 N MAIN STREET HIGH POINT, NC 27265           (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 OF DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)         PREFIX TAG           F 274         Continued From page 1 MDS Coordinator #1 was interviewed on 6/7/17 at 3:40 PM, about this resident's significant change in activities of daily living and cognition. MDS Coordinator #1 agreed the 5/15/17 assessment should have triggered a Significant Change in Condition assessment, but it had been missed.         F 274           On 6/8/17 at 10:28 AM, the Director of Nursing said he had been made aware a Significant Change in Condition assessment should have been done for this resident. He stated they had been trying very hard to hire another MDS Coordinator but to date, had been unsuccessful.         F 274           The Administrator was interviewed on 6/8/17 at 10:55 AM. The Administrator stated they were trying to find someone for MDS but until this survey she felt the facility was in substantial compliance with regard to significant change in         F 274	
IGH POINT, NC 27265         (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 CORRECTVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)       PROVIDER'S PLAN OF CORRECTION (EACH CORRECTVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)         F 274       Continued From page 1 MDS Coordinator #1 was interviewed on 6/7/17 at 3:40 PM, about this resident's significant change in activities of daily living and cognition. MDS Coordinator #1 agreed the 5/15/17 assessment should have triggered a Significant Change in Condition assessment, but it had been missed.       F 274         On 6/8/17 at 10:28 AM, the Director of Nursing said he had been made aware a Significant Change in Condition assessment should have been done for this resident. He stated they had been trying very hard to hire another MDS Coordinator but to date, had been unsuccessful.       F 274         The Administrator was interviewed on 6/8/17 at 10:55 AM. The Administrator stated they were trying to find someone for MDS but until this survey she felt the facility was in substantial compliance with regard to significant change in Status Assessment. The weekly adits will occur weekly until 100% complete. The findings will be placed on the Significant	
PRÉFIX TAG(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)PRÉFIX TAG(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFENCED TO THE APPROPRIATE DEFICIENCY)F 274Continued From page 1 MDS Coordinator #1 was interviewed on 6/7/17 at 3:40 PM, about this resident's significant change in activities of daily living and cognition. MDS Coordinator #1 agreed the 5/15/17 assessment should have triggered a Significant Change in Condition assessment, but it had been missed.F 274Annual, Significant Change OBRA assessment will be completed by the Interdisciplinary Team (comprised of the Case Mix Director, the Social Services Director, the Dietary Manager, the Skin Integrity Coordinator, the Activities Director, and the Director of Health Services) to identify any significant change in Condition assessment should have been done for this resident. He stated they had been trying very hard to hire another MDS Coordinator but to date, had been unsuccessful.Services assessment. The audit will be conducted assessment will be reviewed by the Interdisciplinary team weekly to identify any change that would warrant the completion of a Significant they were trying to find someone for MDS but until this survey she felt the facility was in substantial compliance with regard to significant change in status Assessment. The weekly until 100% complete. The findings will be placed on the Significant	
MDS Coordinator #1 was interviewed on 6/7/17 at 3:40 PM, about this resident's significant change in activities of daily living and cognition. MDS Coordinator #1 agreed the 5/15/17 assessment should have triggered a Significant Change in Condition assessment, but it had been missed.Annual, Significant Change OBRA assessment will be completed by the Interdisciplinary Team (comprised of the Case Mix Director, the Social Services Director, the Dietary Manager, the Skin Integrity Coordinator, the Activities Director, and the Director of Health Services) to identify any significant change in Condition assessment should have been done for this resident. He stated they had been trying very hard to hire another MDS Coordinator but to date, had been unsuccessful.Annual, Significant change of the Case Mix Director, the Social Services Director, the Dietary Manager, the Skin Integrity Coordinator, the Activities Director, and the Director of Health Services) to identify any significant change in status from the prior OBRA assessment. The audit will be conducted as follows: 25% of all current patients with a completed Quarterly or Annual assessment will be reviewed by the Interdisciplinary team weekly to identify any change that would warrant the 10:55 AM. The Administrator stated they were trying to find someone for MDS but until this survey she felt the facility was in substantial compliance with regard to significant change inStatus Assessment. The weekly audits will occur weekly until 100% complete. The findings will be placed on the Significant	COMPLETIC
status assessments.       Change in status audit tool and will be         reviewed by the Administrator weekly and       reported to the Quality Assurance and         Performance Improvement Committee to       ensure compliance.         3.Systematic Change/Intervention       a.Competency education for RAI 3.0-         OBRA completion requirements was       completed 6/20/17 by Case Mix Director,         the Social Services Director, the Dietary       Manager, the Skin Integrity Coordinator,         the Activities Director, and the Director of       Health Services electronically via         Assessment Intelligence Systems (AIS). A       post-test was completed and certificate         granted as proof of competency.       granted as proof of competency.	

Facility ID: 923250

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	07/19/2017 APPROVED 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •		CONSTRUCTION	(X3) DATE S COMPL	SURVEY ETED
		345105	B. WING	ŝ		C 06/1	4/2017
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 000	
DDUUTTU				3	830 N MAIN STREET		
	EALTH-HIGH POINT			н	IIGH POINT, NC 27265		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PRE TAI	FIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 274	Continued From page			÷ 274	team (comprised of the Case Mix Director, the Social Services Director Dietary Manager, the Skin Integrity Coordinator, and the Director of Healt Services) on the utilization of the RUC Analysis Tool (AHT system summary MDS coding) to assist with identifying Significant Change in status by the Director of Clinical Reimbursement at Clinical Reimbursement Consultant. c.The Case Mix Director will review th RUGs Analysis for changes that may warrant a significant change in status assessment with the completion of ea new assessment and bring forward to Interdisciplinary team to make the determination if Significant Change Assessment is needed and documen Significant Change Audit Tool until substantial compliance determined through QAPI. d.The Financial Counselor will notify to Interdisciplinary team of Hospice Admission and Discharge dates durin Weekly Case Mix Meeting. e.The Administrator will verify the rest of the reviews and Significant Change Assessment completion utilizing the Significant Change audit tool 1 X weet for 3 weeks, and then 1 X monthly for months or until substantial compliance determined and report findings to QA 4. Monitoring a.The Administrator will review and tra-	th GS of nd ne ach o the t on the g ults e kly 3 e is PI. end	
	7(02-99) Previous Versions Obs	solete Event ID: EE		<b>F</b> 1	cility ID: 923250 If con	tinuation shee	

Facility ID: 923250

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	-	ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 07/19/20 FORM APPROVE OMB NO. 0938-039
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		(X3) DATE SURVEY COMPLETED C
		345105	B. WING		06/14/2017
NAME OF P	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STATE, ZIP CODE	• • • • • • • • • •
PRUITTHI	Ealth-High Point			830 N MAIN STREET IGH POINT, NC 27265	
(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 E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	
F 274 F 490 SS=D	ADMINISTRATION/R 483.70 Administration A facility must be adm enables it to use its re	ESIDENT WELL-BEING  hinistered in a manner that esources effectively and	F 274 F 490	the findings the findings from the Significant Change audit tool. The Administrator will bring the finds from t audit to the Quality Assurance Performance Improvement Committee meetings x 3 months or until substantia compliance is achieved. Changes will made to the plan by the committee as indicated to include re-education and/o immediate corrective action.	for al be
	well-being of each res This REQUIREMENT by: Based on record revi facility's administratio resources effectively recognized and comp residents with a signif The findings included This tag is cross refer F274: Based on recon interview, the facility f significant change in of 5 sampled resident	mental, and psychosocial sident. is not met as evidenced ew and staff interviews, the n failed to utilize its to ensure the facility leted assessments for ficant change in status. : renced to: rd review, and staff failed to complete a condition assessment for 1 ts (Resident #4). ed for F274 on the current in survey for failing to t change in status		Resident affected a.Resident # 4 had significant change completed on 6/16/2017 and was transmitted on 6/19/2017 2. Residents with the potential to be affected. a.All residents have the potential to be affected b.An audit of all residents with a Quart Annual, and Significant change OBRA assessment will be completed by the interdisciplinary team (Comprised of th Case Mix Director, the Social Services	erly,

Facility ID: 923250

If continuation sheet Page 4 of 11

		ND HUMAN SERVICES MEDICAID SERVICES				FORM	D: 07/19/2017 APPROVED D: 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION		LETED
		345105	B. WING				C 14/2017
NAME OF PI	ROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE	1 00,	1-1/2011
PRUITTHE	PRUITTHEALTH-HIGH POINT			38	330 N MAIN STREET		
				Н	IGH POINT, NC 27265		
(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 I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	ЗE	(X5) COMPLETION DATE
F 490	originally cited during recertification survey significant change in resident who had ele 12/13/16. On 6/14/17 at 1:13 P they had been unable Coordinator and after received assistance f corporate office. The	g and cognition. F274 was the January 2017 for failing to complete a status assessment for a cted the hospice benefit on M, the Administrator stated e to hire a second MDS r the January survey, had for a while from the Administrator indicated t to be done and said,	F	490	Director, the Dietary Manager, the Ski Integrity Coordinator, the Activities Director, and the Director of Health Services to identify any significant chai in the status from the prior OBRA assessment. The audit will be conduct as follows: 25% of all current patients a completed Quarterly or Annual assessment will be reviewed by the interdisciplinary team weekly to identificant any change that would warrant the completion of a significant change in status assessment. The weekly audits will occur weekly until 100% complete The findings will be placed on the significant change in status audit tool a will be reviewed by the Administrator weekly and reported to the Quality Assurance and Performance Improvement Committee to ensure compliance. 3.Systematic Change/Intervention a. Competency education for RAI 3.0 OBRA completion requirements was completed 06/20/17 by Case Mix Dire the Social Services Director, the Dietat Manager, the Skin Integrity Coordinato the Activities Director, the Director of Health Services and the Administrator electronically via Assessment Intellige Systems (AIS). A posttest was comple and certificate granted as proof of competency. b.Education provided to the	eted with y s and ctor, iry or, nce eted	
					interdisciplinary team (comprised of th Case Mix Director, the Social Services		

Event ID: EEFD11

Facility ID: 923250

If continuation sheet Page 5 of 11

DEPARTMENT OF HEALTH A CENTERS FOR MEDICARE &				FOR	D: 07/19/2017 M APPROVED D. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION G	(X3) DATE COM	E SURVEY PLETED
	345105	B. WING			C / <b>14/2017</b>
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
PRUITTHEALTH-HIGH POINT			3830 N MAIN STREET		
			HIGH POINT, NC 27265		
PREFIX (EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 490 Continued From pag	e 5	F 45		tor of istrator) on lysis tool coding) to t change in l view the at may status n of each vard to the he nge ument on til ned QAPI e President 2017 and notify the re during Case Mix gnificant e results of nge g the	

Event ID: EEFD11

Facility ID: 923250

If continuation sheet Page 6 of 11

	-	ID HUMAN SERVICES MEDICAID SERVICES				PRINTED: 07/ FORM APP OMB NO. 093	ROVED
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · /	PLE CONSTRUCTI		(X3) DATE SURVE COMPLETED	
		345105	B. WING			06/14/20	17
NAME OF PF	ROVIDER OR SUPPLIER			STREET ADDRE	SS, CITY, STATE, ZIP CODE	1 00/1 11/20	
PRUITTHE	ALTH-HIGH POINT			3830 N MAIN S	TREET		
				HIGH POINT,	NC 27265		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EA	PROVIDER'S PLAN OF CORRECTIC ACH CORRECTIVE ACTION SHOULD SS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COM	(X5) IPLETION DATE
F 490	Continued From page	e 6	F 4	until subs and report g. A Regi President Consultar Clinical N in the QA their findi Quality As Improven h.CMD w later than due date, schedule be compl previous assessme members I. RN will j.A list of a given by t Administr 4. Monito a.The Add the findin Significar Administr audit to th	stantial compliance is deterr rt findings to QAPI. Ional Team member (Area V t, Clinical Reimbursement nt, Senior Nurse Consultant Iurse Consultant will particip PI process for three months ngs reviewed with the Pruitt ssurance and Performance nent Committee. The complete assessments no 2-3 days after ARD date of whichever comes first. ME for all OBRA assessments eted by the third week of month for all OBRA ents and distributed to all s of the interdisciplinary tear sign MDS s as completed completed assessments will the Case Mix Director to the rator at the end of each wor	rice s, etc. bate s with t o f by DS will n. daily. I be k day. rend n the	
				complian made to t	x 3 months or until substance is achieved. Changes with plan by the committee a to include re-education and	ill be s	

Event ID: EEFD11

Facility ID: 923250

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FOR	D: 07/19/2017 MAPPROVED D. 0938-0391
STATEMENT O	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · /	MULTIPLE CONSTRUCTION		(X3) DATE COMF	SURVEY PLETED
		345105	B. WING				C 14/2017
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	1	
PRUITTHE	ALTH-HIGH POINT				330 N MAIN STREET IGH POINT, NC 27265		
		ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREF TAG		(EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	ЗE	COMPLETION DATE
F 490	Continued From page	97	F	490			
					immediate corrective action.		
					<ul> <li>b. The Administrator will bring results of open PI Plans to the Monthly Quality Assurance Performance Improvement Committee meetings x 3 months or un substantial compliance is achieved to ensure we have appropriate corrective action. Changes will be made to the p by the committee as indicated to incluin re-education and/or immediate correct action</li> <li>c. The Regional Leadership team will review performance improvement plan for the facility monthly X 6 months to ensure effectiveness. Any negative findings will be reviewed at the Region Leadership team at the quarterly Qual Assurance/Performance Improvement meeting for opportunities for re-education</li> </ul>	itil e lan de tive ns nal ity	
F 520 SS=D	483.75(g)(1)(i)-(iii)(2) COMMITTEE-MEMB QUARTERLY/PLANS	ERS/MEET	F	520	or correction.		7/7/17
	(g) Quality assessme	nt and assurance.					
	(1) A facility must mai and assurance comm minimum of:	ntain a quality assessment ittee consisting at a					
	(i) The director of nur	sing services;					
	(ii) The Medical Direc	tor or his/her designee;					
	(iii) At least three othe staff, at least one of w	er members of the facility's /ho must be the					

Event ID: EEFD11

Facility ID: 923250

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		MEDICAID SERVICES			OMB NO. 0938-03
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
					С
		345105	B. WING		06/14/2017
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
PRUITTHI	EALTH-HIGH POINT			3830 N MAIN STREET HIGH POINT, NC 27265	
(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 CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETIC
F 520			F 52	20	
	individual in a leaders	a board member or other ship role; and			
	(g)(2) The quality assessment and assurance committee must :				
	coordinate and evaluate	n respect to which quality			
		ement appropriate plans of tified quality deficiencies;			
	Secretary may not re- records of such comr such disclosure is rel	rmation. A State or the quire disclosure of the nittee except in so far as ated to the compliance of the requirements of this			
	<ul> <li>(i) Sanctions. Good fa committee to identify deficiencies will not b sanctions.</li> <li>This REQUIREMENT</li> </ul>	and correct quality			
		iews, and staff interviews, ssessment and Assurance naintain implemented		1.Resident affected a.No resident was negatively impacted	ed by
	procedures and moni committee put into pla deficiency that was o	tor interventions the ace for one recited		this concern. 2.Residents with potential to be affect	
	recertification survey subsequently cited or	in January of 2017, and was this current complaint 7. The repeated deficiency		a.All residents in the facility have the ability to be impacted by this practice	
	was in the area of res	sident assessment. The facility during two federal		There were no adverse outcomes re to this concern.	

Facility ID: 923250

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	CONTECTION	DENTIFICATION NUMBER.	A. BUILDING		C
		345105	B. WING		06/14/2017
NAME OF P	ROVIDER OR SUPPLIER		5	STREET ADDRESS, CITY, STATE, ZIP CODE	•
PRUITTH	EALTH-HIGH POINT			3830 N MAIN STREET HIGH POINT, NC 27265	
(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 CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE COMPLETIO
F 520	Continued From page	9	F 520		
	inability to sustain an Program. The findings included This tag is cross refer F274: Based on reco interview, the facility f significant change in of 5 sampled resident The facility was recite complaint investigation complete a significant assessment for a resi activities of daily living originally cited during recertification survey significant change in resident who had elec 12/13/16. The Administrator wa 10:55 AM. The Admir the recertification surv put in place and until facility was in substar	renced to: ord review, and staff failed to complete a condition assessment for 1 ts (Resident #4). ed for F274 on the current on survey for failing to t change in status ident with declines in g and cognition. F274 was		<ul> <li>b.On 6/22/17, the Administrator will re-educated by the Vice President Quality Assurance and Performance Improvement on the quality assurate process.</li> <li>3.Systemic Change/Interventions</li> <li>a.Re-education began on 6/20/17 provided via Pruitt U class to all moof the Quality Assurance and Performance Improvement (QAPI) Committee, which is comprised of Administrator, Director of Health Services, Clinical Competency Coordinator, Dietary Manager, Maintenance Director, Housekeepi Supervisor, Financial Counselor, S Services Director, Activity Director, Mix Coordinator, Admissions Director Medical Records Coordinator. Asse class on Pruitt U included PruittHea QAPI Developing and Sustaining a Culture, and QAPI Root Cause Ana and PIP Development for SNF All employees that are on the QAPI committee are full time. There are PRN or weekend staff on this committee amember of the Reguership team to participate in the Quality Assurance/Performance Improvement meetings for the facil</li> </ul>	of ce nce embers the ng ocial Case tor and signed alth Quality alysis no mittee. ations gional ne

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		ND HUMAN SERVICES MEDICAID SERVICES				FOR	D: 07/19/2017 MAPPROVED D. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		345105	B. WING				C / <b>14/2017</b>
NAME OF P	ROVIDER OR SUPPLIER			s	TREET ADDRESS, CITY, STATE, ZIP CODE	1 00.	
PRUITTH	EALTH-HIGH POINT			3	830 N MAIN STREET		
				H	IIGH POINT, NC 27265		1
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG	IX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 520	Continued From page			520	for the facility monthly X 6 months to ensure effectiveness. Any negative findings will be reviewed at the Region Leadership team at the quarterly Qua Assurance/Performance Improvemen meeting for opportunities for re-educa or correction. 4.Plan to Monitor a.The Administrator will bring results of open PI Plans to the Monthly Quality Assurance Performance Improvemen Committee meetings x 3 months or ur substantial compliance is achieved to ensure we have appropriate corrective action. Changes will be made to the p by the committee as indicated to inclu re-education and/or immediate correct action b.The Regional Leadership team will review performance improvement plan for the facility monthly X 6 months to ensure effectiveness. Any negative findings will be reviewed at the Region Leadership team at the quarterly Qua Assurance/Performance Improvemen meeting for opportunities for re-educa or correction.	lity t tion of all t tall e lan ide tive ns nal lity t tion	

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