STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345124	A. BUILDING _____ B. WING _____	C 02/28/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEALTH-ELKIN	**560 JOHNSON RIDGE ROAD ELKIN, NC 28621**

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E 000	Initial Comments An unannounced Recertification survey was conducted on 2/24/19 through 2/28/19. The facility was found in complaince with the requirement CFR 483.73, Emergency Preparedness. Event ID # OCYJ11.	E 000		
F 000	INITIAL COMMENTS No deficiencies were cited as a result of the complaint investigation survey completed 2/24/19-2/28/19. Event ID# OCYJ11.	F 000		
F 636 SS=D	Comprehensive Assessments & Timing CFR(s): 483.20(b)(1)(2)(i)(iii) §483.20 Resident Assessment The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. §483.20(b) Comprehensive Assessments §483.20(b)(1) Resident Assessment Instrument. A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following: (i) Identification and demographic information (ii) Customary routine. (iii) Cognitive patterns. (iv) Communication. (v) Vision. (vi) Mood and behavior patterns. (vii) Psychological well-being. (viii) Physical functioning and structural problems. (ix) Continence. (x) Disease diagnosis and health conditions.	F 636		3/25/19

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

Electronically Signed | 03/20/2019

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F 636	Continued From page 1 (xi) Dental and nutritional status. (xii) Skin Conditions. (xiii) Activity pursuit. (xiv) Medications. (xv) Special treatments and procedures. (xvi) Discharge planning. (xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS). (xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and nonlicensed direct care staff members on all shifts. §483.20(b)(2) When required. Subject to the timeframes prescribed in §413.343(b) of this chapter, a facility must conduct a comprehensive assessment of a resident in accordance with the timeframes specified in paragraphs (b)(2)(i) through (iii) of this section. The timeframes prescribed in §413.343(b) of this chapter do not apply to CAHs. (i) Within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or therapeutic leave.) (iii)Not less than once every 12 months. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interview, the facility failed to assess 1 of 1 sampled resident (Resident #48) reviewed as a fall risk during a significant change assessment period.	F 636	This plan of correction constitutes a written Allegation of Compliance with federal and state requirements. Preparation and submission of this	

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F 636	Continued From page 2 Findings included: Resident #48 was admitted to the facility on 11/22/18 with diagnoses which included: left hip fracture, fractured shaft of the humerus, coronary artery disease, muscle weakness, abnormalities of gait and mobility, dementia, and glaucoma. Review of the clinical records revealed that on 2/8/19 Resident #48 scooted to the front of the seat of her wheelchair causing it to tip forward resulting in the resident falling, hitting the left side of her forehead and the left side of her body. The resident was assessed, a minor skin tear to her left elbow was treated, and the resident was sent to the hospital's emergency department for evaluation due to her complaint of a headache and left side pain. The physician and the resident's responsible party were notified. The resident returned from the emergency room (with no new physician's orders) and no complaints of pain. Upon her return, the resident attempted to get out of bed unassisted multiple times and was placed in a chair in front of the nurse' station for observation. The review of the Significant Change Minimum Data Set (MDS) dated 2/15/19 indicated Resident #48 was severely, cognitively impaired; required extensive assistance with bed mobility, transfers, and toileting; had an unsteady balance; and had 1-fall (not major). Review of the facility records revealed a Fall Risk Assessment was not completed of Resident #48 for the Significant Change MDS.	F 636	Allegation of Compliance does not constitute an admission or agreement by the provider of truth of the facts alleged or the corrections of the conclusions set forth on the statement of deficiencies. The plan of correction is prepared and submitted solely because of requirements under state and federal law. 1)Fall Risk Assessment was by DHS completed on resident #48 on 2)Review of all current residents that required significant change assessments have fall risk assessments complete by DHS and CCC. 3)Residents requiring a significant change MDS to be completed will be discussed in morning meeting and fall risk assessment will be completed within the ARD range by DHS and CCC. 4) Facility will check MDS scheduler weekly to ensure compliance. All findings will be taken to PI committee by DHS monthly times 3 months then quarterly times 3. 5) Date of Compliance: 3/25/19	

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F 636	Continued From page 3 The Care Plan dated 2/19/19 revealed Resident #48 had the potential for injury from a fall causing hospitalization related to a history of falls with fractures to the left arm and hip, muscle weakness, gait and mobility abnormalities and unsteadiness on feet; impaired range of motion to bilateral upper and lower extremities; and impaired vision related to glaucoma. Approaches included: always keep bed in low position; shoes or gripper socks on when out of bed; keep call light within reach while in bed. During an observation on 2/27/19 at 12:53 p.m., Resident #48 was sitting in the hall, near the nurse's station in a wheelchair with bilateral legs elevated and covered with a throw blanket. During an interview on 2/27/19 at 1:25 p.m., the MDS Coordinator stated a fall risk assessment was to be completed on each resident on admission, quarterly, and during a significant change assessment by the facility nursing staff. She acknowledged she was unable to locate a Fall Risk Assessment completed during the Significant Change look back period for Resident #48.	F 636		
F 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care.	F 655		3/25/19

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F 655	Continued From page 4 The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interview, the facility failed to complete a dialysis Baseline Care Plan for 1 of 1 sampled resident receiving dialysis	F 655	1)Baseline care plan for resident #287 was updated by CMD to include dialysis 3 times/week and permacath to	

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F 655	Continued From page 5 treatment (Resident #287). Findings included: Resident #287 was admitted to the facility on 2/15/19 with diagnoses which included: end-stage renal disease, diabetes mellitus, cerebral infarction due to thrombosis of cerebral artery, and dysphagia. Review of the clinical records indicated Resident #287 began dialysis treatment while in the hospital prior to his admission to the facility. The review of Resident #287's Baseline Care Plan dated 2/15/19 revealed no plan of care for the resident's diagnosis of end-stage renal disease and dialysis treatment. During an observation on 2/26/19 at 1:35 p.m., Resident #287 was transferred from his wheelchair to his bed assisted by the nursing assistant and the Physical Therapist. The resident was alert and oriented indicating he had just completed a therapy session and was. When asked about the bandage observed on his right upper chest, the resident revealed he received dialysis treatments on Mondays, Wednesdays, and Fridays. During an interview on 2/26/19 at 2:15 p.m., SN#1 (Staff Nurse) stated that Resident #287 received dialysis treatment at a dialysis center on Mondays, Wednesdays, and Fridays. She revealed the resident had a perma-catheter (dialysis site) to his right upper chest and the dressing was changed three times per week at the dialysis center. She also revealed the facility	F 655	right upper chest on 2/28/19. 2)Baseline care plans on all recently admitted dialysis patients have been reviewed by CMD, DHS, and admin to ensure dialysis and point of access are addressed on care plan. 3)All new admissions/readmissions baseline careplans will be reviewed within 48 hours in morning clinical meeting by CMD, DHS, and other admin to ensure accuracy of dialysis information on careplan. 4)The DHS will take all findings to PI committee monthly times 3 Months then quarterly times 3. 5) Compliance date: 3/25/19	

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F 655	Continued From page 6 nurse's responsibility was to monitor the perma-catheter site for edema and redness; this was to be documented on the medication administration record. During an interview on 2/28/19 at 9:19 a.m., the Clinical Competency Coordinator stated that Resident #287's dialysis treatment care plan was not included on the Baseline Care Plan in error.	F 655		
F 805 SS=D	Food in Form to Meet Individual Needs CFR(s): 483.60(d)(3) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(3) Food prepared in a form designed to meet individual needs. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, and staff interview, the facility failed to prepare and serve food in the form as ordered by the Physician for 1 of 3 sampled residents reviewed for nutrition (Resident #19). Findings included: Resident #19 was originally admitted to the facility on 6/7/18 with diagnoses which included: diabetes mellitus, dementia, and chronic embolism and thrombosis of the right femoral vein. Review of the significant change minimum data set dated 12/12/18 indicated Resident #19 was moderately, cognitively impaired; required supervision with eating; had no weight loss or	F 805	1)Administrator received clarification on diet order for resident #19 on 2/26/19. 2)Dietary manager printed off copy of all current diet orders and each order was reconciled by licensed nurses while checking month end orders. 3)At time of patient discharge from facility, dietary manager will discontinue diet orders and new order will be initiated at time of admission/readmission. 4)Dietary manager and DHS will take findings to PI committee monthly times 3 months then quarterly times 3.	3/25/19

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F 805	Continued From page 7 gain; and received a therapeutic diet. A review of the Physician's Order dated 12/31/18 revealed Resident #19 was to receive a mechanical soft, liberalized diabetic diet. During a meal observation on 2/26/19 at 1:00 p.m., Resident #19 was in the dining room feeding herself a lunch meal of regular consistency: pork loin, cabbage, yams, dinner roll, cranberry juice, houseshake, whole white milk, coffee, and chocolate cream pie. The resident was observed cutting the pork loin with a knife (the meat was not chopped or ground). The meal card observed on the table, next to the resident's plated meal, indicated the resident was to receive a regular, liberalized diabetic diet. During an interview on 2/26/19 at 1:24 p.m., the DM (Dietary Manager) stated she would have received a communication notification from nursing staff of any change in the resident's diet. During an interview on 2/27/19 at 1:52 p.m., the DM stated that after further investigation, she was unable to locate a physician's order or a communication notification indicating Resident #19's meal consistency of mechanical soft had changed to a regular consistency. The DM revealed that prior to the resident's most recent hospitalization in December 2018, the resident received a diet of regular consistency. When the resident returned to the facility, the hospital's report indicated the resident was to have a mechanical soft meal consistency which facility staff failed to implement.	F 805	5) Compliance date 3/25/19	