STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345105	A. BUILDING _____ B. WING _____	C 03/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The survey team entered the facility and conducted an on-site complaint investigation on 3/10/21. Additional information was obtained offsite on 3/11/21-3/12/21. Therefore, the exit date was 3/12/21. Event ID# X63F11. Two (2) of the 4 complaint allegations were substantiated with citations identified at F655 and F686.	F 000		
F 655 SS=E	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. 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	F 655		3/19/21

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

Electronically Signed | 03/22/2021

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F 655	Continued From page 1 (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 staff interviews, telephone interview with a family member, and record reviews, the facility failed to develop a baseline care plan which included dietary orders/instructions (a required component of the healthcare information) for 3 of 3 residents (Resident # 1, Resident #2, and Resident #3) reviewed for baseline care plans; and, the facility failed to provide a written summary of the baseline care plan to the resident ' s Responsible Party (RP) for 1 of 3 residents (Resident #1) whose baseline care plans were reviewed. The findings included: 1. Resident #1 was admitted to the facility on 10/5/20. Her cumulative diagnoses included, in part, COVID-19 acute respiratory disease, hypertension, and non-Alzheimer ' s dementia. A review of the resident ' s admission orders dated 10/5/20 included an order for a Cardiac,	F 655	This plan of correction constitutes a written allegation of substantial compliance with Federal and Medicaid requirements. Preparation and/or execution of this correction do not constitute admission or agreement by the provider of the truth of items alleged or conclusions set forth for the alleged deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provision of the state and federal law in order to remove the deficiency, It also demonstrates our good faith and desire to continue to improve the quality of care and services to our residents. What Corrective action will be accomplished for the residents found to have been affected by the deficient practice?	

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F 655	Continued From page 2 Mechanical Soft diet. Resident #1 ' s Baseline Care Plan Summary dated 10/5/20 included the following goals: --Improve Activities of Daily Living (ADL) function to maintain independence through next 30 days; --Resident ' s ADL needs will be met and independence potential maximized within constraints of disease through next 30 days; --Discharge planning will begin upon admission to discharge back to an Assisted Living Facility (ALF); --Resident will not sustain injury related to falling through next 30 days; --Resident will benefit from medication use without side effects through next 30 days; --Resident will not experience any adverse effects throughout the review period; --Resident ' s symptoms will be managed without complications and without requiring hospitalization. The Baseline Care Plan Summary also addressed Physician and Nursing Orders. However, these orders did not include the resident ' s diet order or dietary instructions. Resident #1 ' s admission Minimum Data Set (MDS) was not yet due at the time of her discharge (on 10/16/20). An interview was conducted on 3/10/21 at 1:50 PM with the facility ' s Social Worker (SW). During the interview, the SW reported that she and MDS Nurse primarily assumed responsibility for developing the residents ' baseline care plans. An interview was conducted on 3/10/21 at 2:20 PM with the MDS Nurse. The MDS Nurse	F 655	Resident #1 and RP□s were notified that the facility failed to provide a written summary of their baseline care plan. Resident #1 and their RP have received and reviewed their baseline Care Plan. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? All residents may have potentially been affected. A 100% review of all new admissions in the last 30 days will be conducted by the DON,RCC and/or designee to identify residents who did not receive a written summary of their baseline care plan All residents and RP□s identified who did not received a written summary of their baseline care plan will have their care plan reviewed and updated and a written summary of their resident centered care plan will be reviewed and given to the Residents and RP□s identified. What measures will be put in place or what systemic changes will be made to ensure that the deficient practice will not reoccur? The Director of Health Services in-serviced on 03/12/2021 the Dietary Manager, MDS Coordinator, Social Worker, and Activities Director and the nurses on the policy and procedure of the Baseline Care plans. The interdisciplinary team will participate in the development of Resident□s baseline care plan within	

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F 655	Continued From page 3 reported the Baseline Care Plan Summary was typically generated the day of a resident ' s admission to the facility with the information "pulled" from the physician ' s admission orders. Upon request, the MDS Nurse reviewed Resident #1 ' s Baseline Care Plan Summary. At that time, she confirmed the resident ' s dietary order and/or dietary instructions were not included in the summary. On 3/10/21 at 3:15 PM, an interview was conducted with the facility ' s Director of Nursing (DON). During the interview, the DON reported she expected a resident ' s baseline care plan to be done upon admission. The DON also stated she would expect all required components of the baseline care plan to be included in the summary. 2. Resident #2 was admitted to the facility on 2/12/21. Her cumulative diagnoses included, in part, COVID-19, pneumonia, and multiple sclerosis. A review of the resident ' s admission orders dated 2/12/21 included an order for a Regular Pureed diet with Nectar-Thickened Liquids. Resident #2 ' s Baseline Care Plan Summary dated 2/12/21 included the following goals: --Improve Activities of Daily Living (ADL) function to maintain independence through next 30 days; --Resident ' s ADL needs will be met and independence potential maximized within constraints of disease through next 30 days; --Discharge planning will begin upon admission; --Resident ' s initial goals of care and discharge goal will be met; --Resident will not sustain injury related to falling through next 30 days;	F 655	24hrs of admission and will be completed and implemented within 48hrs of admission. A care plan summary will be printed and discussed with Resident or Resident□s responsible party within 72hrs of admission. How will the corrective action be monitored to assure that the deficient practice will not reoccur, i.e., what quality assurance program will be put in place for monitoring to assure continued compliance. The Administrator and Director of Healthcare Services will verify that all new admissions have baseline care plan initiated in MatrixCare. Social Worker will print out care plan summary to be reviewed with resident or responsible family and a copy given to resident or responsible party. A copy of care plan summary will be kept in a book for verification as part of our auditing process. Administrator and Director of Healthcare Services will check daily for 4 weeks, weekly for 2 months, and then quarterly thereafter. The administrator and Director of health care services will verify findings and report to the Quality Assurance Performance Improvement committee until 3 months of substantial compliance is obtained and quarterly thereafter. Date of Compliance: March 19, 2021	

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F 655	Continued From page 4	F 655		

--Resident will be free from signs and symptoms of infection by next review date;
--Resident will benefit from medication use without side effects through next 30 days;
--Resident will not experience any adverse effects throughout the review period.
The Baseline Care Plan Summary also addressed Physician and Nursing Orders. However, these orders did not include the resident ' s diet order or dietary instructions.

Resident #2 ' s admission Minimum Data Set (MDS) dated 2/16/21 revealed the resident had severely impaired cognitive skills for daily decision making. This assessment indicated she received a mechanically altered diet.

An interview was conducted on 3/10/21 at 1:50 PM with the facility ' s Social Worker (SW). During the interview, the SW reported that she and MDS Nurse primarily assumed responsibility for developing the residents ' baseline care plans.

An interview was conducted on 3/10/21 at 2:20 PM with the MDS Nurse. The MDS Nurse reported the Baseline Care Plan Summary was typically generated the day of a resident ' s admission to the facility with the information "pulled" from the physician ' s admission orders.

On 3/10/21 at 3:15 PM, an interview was conducted with the facility ' s Director of Nursing (DON). During the interview, the DON reported she expected a resident ' s baseline care plan to be done upon admission. The DON also stated she would expect all required components of the baseline care plan to be included in the summary.

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F 655	Continued From page 5	F 655		

3. Resident #3 was admitted to the facility on 12/15/20. Her cumulative diagnoses included, in part, COVID-19, hypertension, and heart failure.

A review of the resident ' s admission orders dated 12/15/20 included an order for a No Added Salt diet.

Resident #3 ' s Baseline Care Plan Summary dated 12/15/20 included the following goals:
--Improve Activities of Daily Living (ADL) function to maintain independence through next 30 days;
--Resident ' s ADL needs will be met and independence potential maximized within constraints of disease through next 30 days;
--Discharge planning will begin upon admission;
--Resident ' s initial goals of care and discharge goal will be met;
--Resident ' s therapy goal(s) will be met per therapy plan of care;
--Resident will receive therapy services through next 30 days;
--Resident will not sustain injury related to falling through next 30 days;
--Resident will be comfortable as measured by resident goals through next 30 days;
--Resident will have relief or reduction in pain intensity after receiving interventions through next 30 days;
--Resident will benefit from medication use without side effects through next 30 days;
--Demonstrate adequate cardiac output as evidenced by blood pressure and pulse rate within normal parameters for resident;
--Resident will be able to tolerate activity without symptoms of dyspnea (difficulty breathing), syncope (temporary loss of consciousness), or chest pain through next 30 days;
--Resident will not experience any adverse effects

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F 655	Continued From page 6	F 655		

throughout the review period;
--Resident ' s symptoms will be managed without complications and without requiring hospitalization;
--Resident ' s oral cavity will be free from pain;
--Resident ' s ulcer will heal without complications.
The Baseline Care Plan Summary also addressed Physician and Nursing Orders. However, these orders did not include the resident ' s diet order or dietary instructions.

Resident #3 ' s admission Minimum Data Set (MDS) dated 12/19/20 revealed the resident had moderately impaired cognitive skills for daily decision making. This assessment indicated she received a therapeutic diet.

An interview was conducted on 3/10/21 at 1:50 PM with the facility ' s Social Worker (SW). During the interview, the SW reported that she and MDS Nurse primarily assumed responsibility for developing the residents ' baseline care plans.

An interview was conducted on 3/10/21 at 2:20 PM with the MDS Nurse. The MDS Nurse reported the Baseline Care Plan Summary was typically generated the day of a resident ' s admission to the facility with the information "pulled" from the physician ' s admission orders.

On 3/10/21 at 3:15 PM, an interview was conducted with the facility ' s Director of Nursing (DON). During the interview, the DON reported she expected a resident ' s baseline care plan to be done upon admission. The DON also stated she would expect all required components of the baseline care plan to be included in the summary.

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F 655	Continued From page 7	F 655		

4. Resident #1 was admitted to the facility on 10/5/20. Her cumulative diagnoses included, in part, COVID-19 acute respiratory disease, hypertension, and non-Alzheimer ' s dementia. The resident ' s profile in the electronic medical record (EMR) indicated a family member was her Responsible Party (RP).

Resident #1 ' s Baseline Care Plan Summary dated 10/5/20 included the following goals:
--Improve Activities of Daily Living (ADL) function to maintain independence through next 30 days;
--Resident ' s ADL needs will be met and independence potential maximized within constraints of disease through next 30 days;
--Discharge planning will begin upon admission to discharge back to an Assisted Living Facility;
--Resident will not sustain injury related to falling through next 30 days;
--Resident will benefit from medication use without side effects through next 30 days;
--Resident will not experience any adverse effects throughout the review period;
--Resident ' s symptoms will be managed without complications and without requiring hospitalization.

A Social Services notation dated 10/8/20 at 9:04 AM revealed the resident ' s Brief Interview of Mental Status (BIMS) score indicated she had severely impaired cognitive skills for daily decision making.

Further review of Resident #1 ' s medical record revealed there was no documentation in the progress notes to indicate a summary of the resident ' s baseline care plan was provided to her RP.

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F 655	Continued From page 8 Resident #1 ' s comprehensive Minimum Data Set (MDS) was not yet due at the time of her discharge to another facility on 10/16/20. An interview was conducted on 3/10/21 at 1:50 PM with the facility ' s Social Worker (SW). During the interview, the SW reported she assumed responsibility to mail the summary of a resident ' s baseline care plan to his/her RP. Upon inquiry, the SW stated she did not document the provision of this summary in the resident ' s permanent medical record. When asked, the SW reported she was "not sure" if Resident #1 ' s Baseline Care Plan Summary had been mailed to the resident ' s RP. On 3/10/21 at 3:15 PM, an interview was conducted with the facility ' s Director of Nursing (DON). During the interview, the DON reported she expected a resident ' s baseline care plan to be completed upon admission and the Baseline Care Plan Summary provided to the resident's RP. The DON also stated she would expect this provision of the Baseline Care Plan Summary to be documented in the resident ' s medical record, as required. A telephone interview was conducted with Resident #1 ' s RP on 3/11/21 at 12:28 PM. Upon inquiry, the RP stated she did not receive a summary of Resident #1 ' s baseline care plan during the resident ' s stay at the facility.	F 655		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers.	F 686		3/19/21

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F 686	Continued From page 9 Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on staff interviews, staff telephone interviews, and record reviews, the facility failed to conduct and/or accurately document a resident's admission skin assessment and weekly skin observation(s) to ensure skin breakdown was identified and treated for 1 of 3 residents (Resident #1) reviewed for pressure ulcers. The findings included: Resident #1 was admitted to the facility on 10/5/20 from a hospital. Her cumulative diagnoses included, in part, COVID-19 acute respiratory disease, hypertension, and non-Alzheimer ' s dementia. The resident ' s medical record included a Long Term Care FL-2 Form dated 10/5/20. The FL-2 Form is an evaluation/assessment tool which provided a summary of the resident ' s medical condition, care needs, and medications. This form reported Resident #1 had "scattered bruises" and a "skin tear right hip" with treatment instructions noted.	F 686	IMMEDIATE CORRECTIVE ACTION Complete head to toe skin assessments were done on the remaining two residents and documented. No unknown skin issues were found. On 03/12/2021, all staff were in-serviced by the Director of Health Services on skin assessments and checking skin while doing ADL care. METHODS TO IDENTIFY ANY OTHER RESIDENTS WHO MIGHT BE AFFECTED Complete head to toe skin assessments were done on the remaining two residents. No unknown skin issues were found. SYSTEMIC CHANGES Weekly skin assessments will continue on every resident. All licensed staff were educated on skin	

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F 686	Continued From page 10 Resident #1 ' s admission orders to the facility were dated 10/5/20 and included the following: "Cleanse skin tear to right hip with NS (normal saline). Apply (brand name of a nonadherent, highly absorbent, general purpose sterile dressing), change daily and as needed." A review of the resident ' s October 2020 Treatment Administration Record (TAR) revealed this treatment order remained in place through the date of her discharge on 10/16/20. A review of Resident #1 ' s Baseline Care Plan Summary dated 10/5/20 was conducted. Neither the resident ' s skin condition nor treatment were addressed in her baseline care plan. An Admission Observation form reported observations for Resident #1 were conducted on 10/5/20 at 2:45 PM by Nurse #1. This observational information was recorded in the resident' s medical record by Nurse #1 on 10/7/20 at 8:29 AM. At that time, Nurse #1 documented the resident ' s skin was cool and dry with a normal color and normal skin turgor. The assessment indicated there were no alterations in the observation of Resident #1's skin; no additional comments were made about the condition of her skin. Further review of Resident #1 ' s medical record revealed there was no documentation of weekly skin assessment(s) having been completed for this resident. Resident #1 ' s admission Minimum Data Set (MDS) and individualized, comprehensive care plan were not yet due at the time of her discharge on 10/16/20.	F 686	assessments and skin care by the Director of Health Services on 03/12/2021. The Director of Health Services/Designee will audit the head to toe skin assessments of any resident admitted/readmitted to ensure they are being completed. The Director of Health Services/Designee will monitor weekly skin assessments five times a week x 4 weeks, weekly x 4 weeks, then monthly x 2 months. How will the corrective action be monitored to assure that the deficient practice will not reoccur, i.e., what quality assurance program will be put in place for monitoring to assure continued compliance. Audit results will be reported to the Quality Assurance Performance Improvement Committee by the DHS to identify trends and further opportunities for quality improvement and any needs for additional education until substantial compliance is achieved. Date of Compliance: 03/19/2021	

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F 686	Continued From page 11	F 686		

Resident #1 was discharged from the facility to another Skilled Nursing Facility (SNF) on 10/16/20 for further rehabilitation. Resident #1's medical record at the receiving SNF included a Nursing Progress Note dated 10/16/20 at 7:34 PM which read, in part: "Skin integrity: (Resident #1) remains on a pressure redistribution mattress when in bed, also has a pressure redistribution cushion in seat or chair with OOB (out of bed). To be turned and repositioned frequently...she has a 2 x 11 bruise to lower abdomen, buttock red will apply (brand name) moisture barrier antifungal cream q (every) shift, has ecchymotic (bruised) areas to left lower arm, 4 x 6 bruise to right lower leg, 5 x 3 bruise to right lower leg, has scarring to both legs...Has unstageable wound to left heel 1 x 2 hard black eschar. No drainage noted. Will cleanse wound with normal saline and apply skin prep q day..."

On 3/11/21 at 6:25 PM, a telephone interview was conducted with Nurse #1. This nurse was identified as the nurse who admitted Resident #1 to the facility on 10/5/20. During the interview, the nurse reported she did not recall this resident and could not provide any specifics regarding her admission or care. When asked, Nurse #1 reported she would have typically completed a skin observation and a full body assessment for a resident upon his/her admission to the facility.

An interview was conducted on 3/10/21 at 3:15 PM with the facility ' s Director of Nursing (DON). During the interview, the DON reported she reviewed Resident #1 ' s medical record and noted the admission skin assessment indicated there were no skin concerns identified for this resident. However, she acknowledged Resident #1 ' s FL-2 Form indicated she had a skin tear on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345105	A. BUILDING _____ B. WING _____	C 03/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 12	F 686		

her right hip prior to being admitted to their facility and admission orders were written on 10/5/20 for treatment to this area on her hip. The DON stated, "So, did my nurse look at her skin? No." The DON reported her expectation was that when a resident came into the facility, the admitting nurse needed to go into the resident ' s room, introduce herself, and at least do a skin assessment on the resident. The DON reported a skin assessment was also expected to be completed 7 days after admission. When asked, the DON confirmed there was no documentation to indicate a weekly skin assessment had been done. The DON stated whenever a concern was found on a resident ' s skin, it was supposed to be reported to her because she assumed responsibility for doing weekly wound rounds with the facility ' s consulting wound specialist. The DON stated wound rounds were not conducted for Resident #1 because she did not know the resident had a wound requiring treatment.