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 04/21/2022

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

(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
E 000	Initial Comments An unannounced COVID-19 Focused Emergency Preparedness Survey was conducted on April 20-21, 2022. The facility was found to be in compliance with 42 CFR §483.73 related to E-0024 (b)(6), Subpart-B-Requirements for Long Term Care Facilities. Event ID# YGRX11	E 000		
F 000	INITIAL COMMENTS An unannounced COVID-19 Focused Infection Control Survey and complaint investigation were conducted on April 20-21, 2022. The facility was found to be in compliance with 42 CFR §483.80 infection control regulations and has implemented the CMS and Centers for Disease Control and Prevention (CDC) recommended practices to prepare for COVID-19. Event ID# YGRX11 The following intakes were investigated: NC00186216, NC00185938, NC00186988, NC00185887, NC00185941 and NC00184856. 3 of the 28 complaint allegations were substantiated resulting in deficiencies.	F 000		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following -	F 656		5/19/22

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 05/13/2022

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.

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F 656	Continued From page 1 (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to follow care planned interventions for 1 of 3 residents (Resident #1) reviewed for Nutritional status. The findings included: Resident #1 was admitted to the facility on	F 656	Resident #1 no longer resides in the facility Nurse Manager and CDM Reviewed 100% of resident□s nutritional care plans to identify residents requiring meal documentation. 3 of 94 residents were identified that could	

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F 656	Continued From page 2 12/1/2021 with diagnoses that included a cerebral infarction due to an embolism, aphasia following the cerebral infarction, acute respiratory failure, dementia, and pneumonia. A review of the facility admission minimum data set (MDS), dated 12/5/2021 revealed Resident #1 had severe cognitive impairment, required extensive assistance of one staff member with activities of daily living and minimal assistance with eating that included set up. A review of Resident #1's care plan, dated 12/13/2021 had a focused area that read; Resident #1 has a potential for weight loss related to, he leaves 25 % or more of uneaten food on his meal trays. He has a diagnosis of dysphagia and has a diagnosis of depression with an antidepressant in place. The interventions included: 1) To provide assistance for meals. 2) Offer available substitutes if resident has problems with the food being served. 3) Monitor and record weight. 4) Notify the physician and family of significant weight changes. 5) Monitor need for changing diet consistency to increase ease of eating. 6) Monitor and record food intake. 7) Encourage food and fluid intake. A review of the meal intake log for Resident #1 revealed for the month of December the Resident had 4 meal intake percentages recorded and for the month of January the Resident had one meal intake percentage documented. On 4/21/2022 at 10:59 a.m. an interview was conducted with the Director of Nursing, and she reviewed the meal intake log for Resident #1. She revealed the Resident had 4 meal intake percentages (the amount of food the Resident	F 656	have been affected by this practice DHS and/or nurse manager in-serviced staff on documenting meal intake in EMR as clinically appropriate for each resident identified by resident□s care plan. This was started 04/25/22 and will completed by 05/19/22. Any nursing staff not educated will be in-serviced prior to their shift. This will also be added to the new nursing staff orientation. Residents requiring meal documentation will be reviewed by nurse managers and/or dietary manager for 7 days then weekly thereafter for 4 weeks then monthly. DHS and/or Dietary Manager will take the findings of the audit to Quality Assurance Performance Committee monthly times 4 then quarterly thereafter. Date of Completion May 19, 2022	

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F 656	Continued From page 3 had eaten) for the entire month of December 2021 documented. She then reviewed the care plan for Resident #1 and stated the Resident was care planned to have all meal intake amounts documented. She added that it was her expectation that meal intake amounts be documented when the meal trays are picked up from a resident's room so the administrative team and the hall nurse can evaluate the care of a resident. On 4/21/2022 at 11:32 a.m. an interview was conducted with the facility Administrator, and she revealed for Resident #1 he was evaluated by Speech Therapy (ST) and the ST stated, staff to assist with meals. She revealed it was her expectation that meal intake be documented per the care plan.	F 656		
F 692 SS=D	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health;	F 692		5/19/22

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F 692	Continued From page 4 §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on record review, physician and staff interviews the facility failed to document meal intake for 1 of 3 residents (Resident #1) reviewed for nutritional status. The findings included: Resident #1 was admitted to the facility on 12/1/2021 with diagnoses that included a cerebral infarction due to an embolism, aphasia following the cerebral infarction, acute respiratory failure, dementia, and pneumonia. A review of the hospital discharge paperwork dated 11/30/2021 revealed Resident #1 weighed 174 pounds on 6/4/2021 and 171 pounds on 11/19/2021. A review of the facility admission minimum data set (MDS), dated 12/5/2021 revealed Resident #1 had severe cognitive impairment, required extensive assistance of one staff member with activities of daily living and minimal assistance with eating that included set up. A review of Resident #1's care plan, dated 12/13/2021 had a focused area that read; Resident #1 has a potential for weight loss related to, he leaves 25 % or more of uneaten food on his meal trays. He has a diagnosis of dysphagia and has a diagnosis of depression with an antidepressant in place. The interventions included: 1) To provide assistance for meals. 2)	F 692	Resident #1 no longer resides in the facility Nurse Manager and CDM Reviewed 100% of resident□s nutritional care plans to identify residents requiring meal documentation. 3 of 94 residents were identified that could have been affected by this practice DHS and/or nurse manager in-service staff on documenting meal intake in EMR as clinically appropriate for each resident identified by resident□s care plan. This was started 04/25/22 and will completed by 05/19/22. Any nursing staff not educated will be in-serviced prior to their shift. This will also be added to the new nursing staff orientation. Residents requiring meal documentation will be reviewed by nurse managers and/or dietary manager for 7 days then weekly thereafter for 4 weeks then monthly. DHS and/or Dietary Manager will take the findings of the audit to Quality Assurance Performance Committee monthly times 4 then quarterly thereafter. Date of completion May 19, 2022	

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F 692	Continued From page 5 Offer available substitutes if resident has problems with the food being served. 3) Monitor and record weight. 4) Notify the physician and family of significant weight changes. 5) Monitor need for changing diet consistency to increase ease of eating. 6) Monitor and record food intake. 7) Encourage food and fluid intake. A review of the meal intake log for Resident #1 revealed for the month of December the Resident had 4 meal intake percentages recorded and for the month of January the Resident had one meal intake percentage documented. A review of the facility weight logs documented: 12/3/2021 171 pounds 12/10/2021 168 pounds 12/17/2021 169 pounds 12/24/2021 168 pounds 1/10/2022 164.6 pounds Resident #1 was discharged from the facility on 1/20/2022 and admitted to the Hospital. A review of the hospital paperwork dated 2/11/2022, revealed Resident #1 was admitted to the hospital on 2/10/2022 and the emergency room physician note stated the Resident appeared very emaciated and was dehydrated on admission. The Weight documented at the Hospital was 49.9 kilograms (110.1 pounds) height 5 foot 8 inchs. On 4/21/2022 at 10:59 a.m. an interview was conducted with the Director of Nursing, and she reviewed the meal intake log for Resident #1. She revealed the Resident had 4 meal intake percentages (the amount of food the Resident had eaten) for the entire month of December	F 692		

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F 692	Continued From page 6 2021 documented. She then reviewed the care plan for Resident #1 and stated the Resident was care planned to have all meal intake amounts documented. She added that it was her expectation that meal intake amounts be documented when the meal trays are picked up from a resident's room so the administrative team and the hall nurse can evaluate the care of a resident. On 4/21/2022 at 11:32 a.m. an interview was conducted with the facility Administrator, and she revealed for Resident #1 he was evaluated by Speech Therapy (ST) and the ST stated, staff to assist with meals. She revealed it was her expectation that meal intake be documented per the care plan and she added that a nutritional consult was the facility policy within the first 30 days of admission and for this Resident it was conducted on 1/18/2022.	F 692		