STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345384	A. BUILDING ______ B. WING ______	C 11/30/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEATH-FARMVILLE	4351 SOUTH MAIN STREET FARMVILLE, NC 27828

(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 A complaint investigation survey was conducted on 11/30/2022. Event ID# BZ4211. The following intakes were investigated: NC00194437 and NC00194966. Two of the six complaint allegations were substantiated resulting in a deficiency.	F 000		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observations, record review, resident and staff interviews, the facility failed to provide a full bed bath which included brushing teeth, washing or brushing hair, nail care, and failed to rinse soap from a resident's skin during a bed bath (Resident #2). Findings included: Resident #2 was admitted to the facility on 3/05/22 with diagnoses which included nontraumatic subarachnoid hemorrhage. Review of Resident #2's quarterly Minimum Data Set dated 09/26/22 revealed she was cognitively intact with no behaviors or rejection of care. She was totally dependent on staff for personal hygiene and bathing. Resident #2's care plan revised 9/23/22 included a goal that read in part that the resident's	F 677	Resident #2 was offered a shower on 11/30/2022 but refused. She did allow staff to give a bed bath to her again on evening shift of 11/30/2022 All resident□s that are dependent on staff to perform their ADL care have the potential to be affected by the alleged deficient practice. A list of all residents coded as needing extensive to total assist with their ADL care was obtained by the MDS nurse on 12/1/2022. Education was provided to all Certified Nursing Assistants related to performing ADL care: to include soap that needs washed off, hair care, nail care, oral care and bagging of soiled materials. Any Certified Nursing Assistant who has not completed this education by 12-16-2022 will be removed from the schedule until	12/16/22

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed | TITLE | (X6) DATE: 12/09/2022

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 677 Continued From page 1

activities of daily living (ADL) needs will be met through the next review.

During an observation on 11/30/22 at 10:19 AM, Nursing Assistant (NA) #1 was observed providing a bath for Resident #2. NA #1 gathered bathing supplies which included a basin of warm water, washcloths, towels, lotion, brief, and a bottle of body wash. NA #1 handed Resident #2 a wet washcloth for the resident to wash her face. NA #1 then removed the resident's gown, covered her upper body with a towel, applied the body wash to a wet washcloth, and washed the resident's front chest, arms, and hands. She then dried the chest and arms with a towel. She did not rinse the body wash off the resident. NA #1 assisted the resident to turn on her side and then washed the resident's upper back with the soapy washcloth. She dried the resident's back with the towel. NA #1 did not rinse the body wash off the resident. The NA then applied lotion and deodorant to the resident's upper body and put a shirt on her. NA #1 continued the bed bath by removing the wet brief and placed it on the foot of the bed at the resident's feet, washed the resident's lower torso front to back with a soap washcloth and dried her with a towel. The NA did not rinse the body wash off the resident. A dry brief was applied. The NA then gathered up the soiled brief from the foot of the bed and placed it in a plastic bag. She gathered up the used linens and placed them in another bag and emptied the basin of water. The NA did not offer the resident a toothbrush, toothpaste, hairbrush, or make any attempt to provide either fingernail or toenail care.

During the bed bath observation, the resident was observed to have ½ inch long fingernails which had jagged edges. Her toenails were observed to

F 677

the education is completed. The education related to ADL care: to include soap that needs washed off, hair care, nail care, oral care and bagging of soiled materials to the general orientation of newly hired Certified Nursing Assistants. Random skill checks of bed baths will be conducted by nursing management 3x per week through the next 6 weeks.

The Director of Health Services will present the findings of the ADL care review to the Administrator at the monthly Quality Assurance and Performance Improvement meeting for need of continued monitoring or adjustment to plan. The results of the skills check-off□s for bed baths will be brought through the monthly QAPI meetings to review for the need of continued monitoring or adjustment of plan

Date of Compliance: 12-16-2022

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F 677	Continued From page 2	F 677		

very long, and thick. Some of her toenails were yellow and one was black.

An interview on 11/30/22 at 10:45 AM with NA #1 confirmed she knew should have rinsed the body wash off Resident #2 and did not know why she had not. She stated that the resident had not asked for a toothbrush, and she had not offered. She also confirmed she had not washed the resident's hair or brushed it. The NA confirmed the resident's nails were long and needed to be trimmed but she had not done them. She stated she never provided toenail care to any residents. NA #1 confirmed she should not have placed the soiled brief on the foot of the resident's bed but stated she hadn't put it in the trashcan as it didn't have a liner. She stated she carried plastic bags in her pocket to use for trash.

An interview on 11/30/22 at 11:21 AM with Resident #2 confirmed that her fingernails needed to be trimmed and she was dependent on staff to cut them for her.

An interview on 11/30/22 at 12:53 PM with the Director of Nursing (DON) and Administrator revealed that the body wash should have been rinsed off the resident's skin. They also confirmed that the soiled brief should have been placed in the trash and not placed at the foot of the resident's bed. They also confirmed that the resident should have been provided oral care, hair care, and nail care during her morning ADL care and they did not know why this had not been completed.