STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345182	A. BUILDING _____ B. WING _____	C 06/23/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEALTH-SEALEVEL	468 HIGHWAY 70 EAST SEALEVEL, NC 28577

(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 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on record review, resident and staff interviews, the facility failed to report an abuse allegation to the state agency within 2 hours of the facility being aware of the allegation for 1 of 1 resident to resident abuse investigations reviewed. Resident #1 attempted to smother Resident #2 by placing a pillow over his face with	F 609	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	7/23/18

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		07/16/2018

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345182	A. BUILDING _____ B. WING _____	C 06/23/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEALTH-SEALEVEL	468 HIGHWAY 70 EAST SEALEVEL, NC 28577

(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 609	Continued From page 1 no negative outcome to Resident #2. The findings included: 1 a. Resident #1 was admitted to the facility on 02/22/16 with cumulative diagnoses of Major Depressive Disorder, Insomnia and Anxiety Disorder. Resident #1's Quarterly Minimum Data Set (MDS) dated on 05/29/18 indicated he was cognitively intact. b. Resident #2 was admitted to the facility on 03/16/18. Resident #2's Quarterly MDS dated on 04/30/18 indicated he had moderate cognitive impairment. Review of the Initial Allegation Report dated 06/06/18 indicated that the facility was aware of an incident which occurred on 06/04/18 at 8:30 AM when Resident #1 placed a pillow over Resident #2's face. The incident was reported to the law enforcement on 06/04/18 at 8:45 AM. Review of the facility's Investigation Report dated on 06/06/18 read in part "Resident #1 was angry with Resident #2 because he was loud and talking. According to Resident #2 they were cursing each other and the Resident #1 came over to his bed. Resident #2 said he thought they were friends and at times they curse each other just like friends might do. Resident #2 said that he thought Resident #1 was joking when he picked up the pillow, but realized he was not joking when he placed the pillow over his head. The deputy later asked Resident #2 if he was having any problems breathing when the pillow was over his face and he said I was starting to when he took it off. Resident #1 admitted to becoming angry and placing a pillow over his	F 609	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. Plan of correcting the specific deficiency. The process should address the processes that lead to the deficiency cited: Upon review the facility failed to report an abuse allegation to the state agency within 2 hours of the facility being aware of the allegation. Upon notification of incident the facility immediately reported incident to local law enforcement. Upon facility calling local ombudsman who directed a call to DHHSR, the facility realized that resident to resident abuse should have been reported to DHHSR within 2 hours. Facility immediately sent 24 hour report to DHHSR and followed up with a 5 day report. Procedure for implementing the acceptable plan of correction for the specific deficiency cited: Interim Administrator contacted DHHSR concerning the abuse incident and was immediately in-serviced by Cindy Deporter, SW in regards to tag # 483.10 and the need to report such allegations within a 2 hour window. Interim	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345182	A. BUILDING _____ B. WING _____	C 06/23/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEALTH-SEALEVEL	468 HIGHWAY 70 EAST SEALEVEL, NC 28577

(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 609	Continued From page 2 roommate's face. He stated that he held the pillow for about 10 seconds and then he said common sense and God told him that he should not do that." Further review of the Initial Allegation Report and the Investigation Report revealed it was faxed to the state agency's Health Care Personnel Investigations Section on 06/06/18 at 6:45 PM. During an interview with Resident #2 on 06/21/18 at 10:20 AM he stated Resident #1 did place a pillow over his face earlier in the month, but at first, he thought Resident #1 was just kidding and not really mad at him. During an interview with the Interim Administrator on 06/21/18 at 4:10 PM, she stated that she was not aware that resident to resident abuse had to be reported to the state agency until she made a call to the state agency to verify. She confirmed the facility did not notify the state agency of the 06/06/18 incident when Resident #1 placed a pillow over Resident #2's face until over 10 hours after the facility was aware of the incident. The administrator further stated that it was her expectation that any abuse allegation to include resident to resident abuse be reported to the state agency within 2 hours after the facility was notified of the incident.	F 609	Administrator and Director of Health Services(DHS) were in-serviced by regional Senior Nurse (SNC) regarding abuse reporting guidelines. Facility staff was in-serviced on the guidelines of immediate reporting alleged violations of abuse on 6-22-18 and 6-23-18. Monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements: Each incident of reported abuse will be reviewed in morning clinical meetings by the Administrator, DHS and Inter-disciplinary team (IDT) Any incident of reported abuse will also be immediately discussed and reviewed by our regional SNC to make sure that the facility is in compliance with reporting regulations. Compliance with tag 483.10 will be reported and discussed monthly in the QA meeting. Title of the person responsible for implementing the acceptable plan of correction: Interim Administrator Dates when corrective action will be completed: 7-23-18	