PRINTED: 10/10/2018 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345105	B. WING		C
NAME OF D	DOVIDED OD SUDDIJED	343103	D: Willo	STREET ADDRESS, CITY, STATE, ZIP CODE	09/08/2018
NAIVIE OF PI	ROVIDER OR SUPPLIER			, , ,	
PRUITTHE	ALTH-HIGH POINT			3830 N MAIN STREET HIGH POINT, NC 27265	
(X4) ID PREFIX	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B	
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE DATE
F 000	INITIAL COMMENTS		F 00	00	
		ntion was conducted from nmediate jeopardy was			
	of (J).	689 at a scope and severity			
	of (J).	835 at a scope and severity			
		ed Substandard Quality of led survey was completed.			
F 677	·	or Dependent Residents	F 67	77	10/3/18
SS=D		. Doponasin i issusino			16/6/16
	out activities of daily I services to maintain opersonal and oral hyg	ent who is unable to carry iving receives the necessary good nutrition, grooming, and giene; is not met as evidenced			
		ns, record review and staff		This plan of correction constitutes a	
		ailed to provide showers, to the resident 's hair for		written allegation of substantial compliance with Federal and Medicaid	
	one of three sampled			requirements. Preparation and/or	
	· ·	nce with Activities of Daily		execution of this correction does not	
	Living (Resident #1).	ise with touvines of Bully		constitute admission or agreement by provider of the truth of items alleged or	
	The findings included	:		conclusions set forth for the alleged deficiencies. The plan of correction is	
	Resident #1 was initia	ally admitted to the facility on		prepared and/or executed solely becau	
	2/7/14 with diagnoses			it is required by the provision of the sta	
	dementia, seizure dis	order and diabetes type 2.		and federal law. It also demonstrates of	our
	Davidson of U. Att. 1	Data Oat (MDC)		good faith and desire to continue to	
		m Data Set (MDS) dated		improve the quality of care and service	s 10
	8/11/18 indicated Res			our residents.	
	behaviors of rejecting	and long-term memory, no care were indicated,		Process that lead to the deficiency	
ABORATORY	DIRECTOR'S OR PROVIDER/S	SUPPLIER REPRESENTATIVE'S SIGNATURE		TITLE	(X6) DATE

ABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

09/29/2018 **Electronically Signed** 

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 A. BUILDING			(X3) DATE SURVEY COMPLETED	
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NAME OF PI	ROVIDER OR SUPPLIER		<u> </u>	STREET ADDRESS, CITY, STATE, ZIP COD	)E	00/00/2010
DDIUTTU	ALTILUIOU BOINT			3830 N MAIN STREET		
PRUITIHE	EALTH-HIGH POINT			HIGH POINT, NC 27265		
(X4) ID		ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION	
PREFIX TAG	'	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	APPROPRIATE	COMPLETION DATE
F 677	Continued From page		F 67	77		
	extensive assistance					
	mobility and total dep			The Certified Nursing Assista		
	transfer, and bathing			unaware that an isolation resi		
	_, ., ,			able to go to the shower room	•	
	I .	nt to the hospital on 8/11/18		The Certified Nursing Assista		
		with diagnoses that included moderate dehydration.		educated by the Nursing Adm that isolation resident could u		
	'	•		shower room as long as the s		
	Resident #1 returned with treatment for Clostridium dificile (bowel infection) and was on			was disinfected after use.	mower room	
		return to the facility and		was distinusted after use.		
	until 8/29/18.			Process for implementing a p	lan of	
				correction for specific deficier		
	Review of the update	d care plan dated 8/30/18				
		dementia with memory		The Clinical Competency Coc		
	1	communication related to		Director of Health Services ar		
		to Alzheimer 's and the		Managers began education o		
		to make needs known, and		Licensed Nurses and Certified	•	
		ated to impaired mobility and		Assistants regarding showers		
		to Alzheimer 's. The		given to isolation residents wi		
		ncluded to ask the resident ticipate her needs, and meet		disinfection practices of the sl surface areas when complete		
	her physical needs.	licipate nei needs, and meet		Licensed Nurses and Certified		
	nor priyologi neede.			Assistants that are not educate		
	Review of the "Show	er Schedule" notebook for		10/03/2018 will be removed fr		
	the Nursing Assistant	ts (NA) indicated Resident		schedule until education is co	mpleted.	
	#1 was scheduled to	have a shower on Monday,		This education has been inco	rporated into	
	Wednesday and Frid	ay, by the 11-7 shift NA 's.		the general orientation for nev	wly hired	
				Licensed Nurses and Certified	d Nursing	
		ation on the "ADL Dressing		Assistants.		
		e" electronic sheet by the NA		The Clinical Competency Cod		
	'	17/18 to 9/5/18, revealed		Director of Health Services ar		
		documented as an activity		Managers began education of		
	I .	the scheduled shower days		Licensed Nurses and Certified	•	
		ovided). The documentation en provided a partial or bed		Assistants regarding providing daily living (grooming and per	-	
	bath daily during this			hygiene) to residents who are		
	bath daily during this	umoname.		carry out these functions then		
	Observations of Resi	dent #1 on 9/5/18 at 1:00		Licensed Nurses and Certified		
	I .	AM and 9/7/18 at 12:00 PM		Assistants that are not educate	_	

OLIVILIY	OT OIL MEDIO/ IILE &	WEDIO/ WE CELLATOR				OIVID ITE	. 0000 000 1
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
				_		(	2
		345105	B. WING				08/2018
NAME OF PI	ROVIDER OR SUPPLIER		<b>I</b>	S <sup>-</sup>	TREET ADDRESS, CITY, STATE, ZIP CODE		
DDIUTTU	ALTIL IIIGU DOINT			38	830 N MAIN STREET		
PRUITIHE	EALTH-HIGH POINT			Н	IIGH POINT, NC 27265		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	,	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLETION DATE
F 677	Continued From page	e 2	F	677			
		lack substance under her		011	10/03/2018 will be removed from the		
		ands. Resident #1 had her			schedule until education is completed.		
	_	ns, and it was coming out of			This education has been incorporated	into	
	the braids.	,gg			the general orientation for newly hired		
		tile braids.			Licensed Nurses and Certified Nursing		
	Interview with NA #1	on 9/5/18 at 1:28 PM			Assistants.		
	revealed she provide	d a partial bath on her shift			The Licensed Nurse will visualize each		
	when she worked. NA #1 explained Resident #1				resident daily to ensure grooming and		
	had showers on the 11-7 shift and nail care would				personal hygiene needs are being met		
	be provided on shower days.				The Licenses nurse will validate the		
		0/0/40 -t 0:45 DM			shower schedule by the visual	·	
		on 9/6/18 at 3:15 PM			appearance of the resident and sign of	ron	
		on the 11-7 shift and had sident #1. NA #2 explained			the shower sheet as complete and /or document reason not completed in the		
	·	ceive showers on her shift			resident s medical record. The Showe		
		day and Friday. She had			sheets will be reviewed and validated f		
	-	because the resident had			completion by the Director of Nursing	·.	
	•	n isolation. Review of the			and/or Nurse Managers.		
	ADL documentation b	by NA #2 revealed she had			_		
	provided care for the	resident after contact			Monitoring to ensure effectiveness of		
		scontinued. NA #2 further			POC		
		d instructed her to do a bed					
	bath due to her being	j "sick."			The Director of Nursing and/or Nurse Manager will validate the residents		
		on 9/6/18 at 4:09 PM			grooming and shower completion by		
		on the 11-7 shift and had			visual observation of nails, hair and		
	-	sident #1. NA #3 explained			showers daily for thirty days, then weel	-	
		ath for the resident. Further			for four weeks, then monthly thereafter		
		ampooing the resident 's s not provided during a bed			until six consecutive months of compliance is maintained then quarterl	V	
		ed that would be done when			thereafter. The Director of Nursing will	у	
	· ·	Ouring the interview, NA #3			track and trend the data from the		
		provided a shower on			grooming observations and report the		
		ed "No." NA #3 explained it			analysis of findings to the Quality		
	-	the resident "did not feel			Assurance and Performance		
	good."				Improvement Committee monthly until	six	
					months of continued compliance is		
		ector of Nursing on 9/7/18 at ne NA 's have a shower			maintained then quarterly thereafter.		

PRINTED: 10/10/2018 FORM APPROVED OMB NO. 0938-0391 (X3) DATE SURVEY

	TEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		345105	B. WING _		C	3/2018
NAME OF PR	ROVIDER OR SUPPLIER	0.0.00		STREET ADDRESS, CITY, STATE, ZIP CODE	09/00	0/2010
PRUITTHE	ALTH-HIGH POINT		3830 N MAIN STREET HIGH POINT, NC 27265			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO ( (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE (	(X5) COMPLETION DATE
F 689 SS=J	the week. The NA's shower schedule she nurse then signed to explained if a residen nurse was to ask the have the shower give refused, the nurse was the nurse 's notes the interview, he was ask #1 had not had a sho and he replied "No." could have a shower C. diff, he explained y the staff would disinfe shower chair.  Free of Accident Haza CFR(s): 483.25(d)(1)(1)(1)(1)(1)(2)(1)(2)(2)(1)(2)(3)(2)(3)(3)(3)(3)(4)(3)(4)(4)(4)(4)(4)(4)(4)(4)(4)(4)(4)(4)(4)	their shift and the days of were expected to initial the et the shower was given, the confirm it was given. He trefused a shower, the resident and attempt to in. If the resident still as expected to document in expected in the was aware Resident wer in the past two weeks. When asked if the resident while on contact isolation for wes, in the shower stall and exit the shower stall and the exards/Supervision/Devices (2)  In the receives adequate stance devices to prevent is not met as evidenced ins, record review, interviews the center staff, representative ansportation company, and	Fé	Title of person responsible for implementing the POC  The Administrator and Director of Nu is responsible to implement the Plan Correction.	duled ter who	0/3/18

A. BUILDING	
NAME OF PROVIDER OR SUPPLIER  PRUITTHEALTH-HIGH POINT    STREET ADDRESS, CITY, STATE, ZIP CODE	
PRUITTHEALTH-HIGH POINT  (X4) ID PREFIX TAG  F 689  Continued From page 4 transportation. The resident was transported back to the facility, but due to the resident's severe cognitive impairment and wandering transport to and from the dialysis center in a  STREET ADDRESS, CITY, STATE, ZIP CODE 3830 N MAIN STREET HIGH POINT, NC 27265  ID PREFIX TAG  PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE  Without assisting the resident to and from the scheduled dialysis appointment or validating the driver □ squalifications. Root cause analysis: The facility made an assumption that the	,
CX4) ID   PREFIX TAG   CEACH DEFICIENCY MUST BE PRECEDED BY FULL TAG   CEACH DEFICIENCY MUST BE PRECEDED BY FULL TAG   CEACH DEFICIENCY MUST BE PRECEDED BY FULL TAG   CEACH CORRECTIVE ACTION SHOULD BE COMPLETIC CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)   CEACH CORRECTIVE ACTION SHOULD BE COMPLETIC CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)   COMPLETIC CROSS-REFERENCED TO THE APPROPRIATE DATE      F 689	
HIGH POINT, NC 27265    (X4) ID   SUMMARY STATEMENT OF DEFICIENCIES   PREFIX TAG   (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)   PREFIX TAG   TAG   (EACH CORRECTIVE ACTION SHOULD BE DEFICIENCY)   DEFICIENCY)	
Cach Deficiency Must be preceded by Full REGULATORY OR LSC IDENTIFYING INFORMATION)   PREFIX TAG   PROVIDER'S PLAN OF CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)   CACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)   CACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)   CACH CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY   CACH CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY   DATE DEFICIENCY   DATE DEFICIENCY   CACH CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY   DATE DEFICIENC	
PRÉFIX TAG  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  F 689  Continued From page 4 transportation. The resident was transported back to the facility, but due to the resident's severe cognitive impairment and wandering tendencies, the lack of staff supervision during transport to and from the dialysis center in a  PREFIX TAG  (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  Without assisting the resident to and from the scheduled dialysis appointment or validating the driver □s qualifications. Root cause analysis:  The facility made an assumption that the	
transportation. The resident was transported back to the facility, but due to the resident's severe cognitive impairment and wandering tendencies, the lack of staff supervision during transport to and from the dialysis center in a  without assisting the resident to and from the scheduled dialysis appointment or validating the driver □s qualifications. Root cause analysis: The facility made an assumption that the	TION
back to the facility, but due to the resident's severe cognitive impairment and wandering tendencies, the lack of staff supervision during transport to and from the dialysis center in a  the scheduled dialysis appointment or validating the driver□s qualifications. Root cause analysis: The facility made an assumption that the	
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severe cognitive impairment and wandering validating the driver □s qualifications. tendencies, the lack of staff supervision during transport to and from the dialysis center in a validating the driver □s qualifications. Root cause analysis: The facility made an assumption that the	
tendencies, the lack of staff supervision during transport to and from the dialysis center in a Root cause analysis:  The facility made an assumption that the	
transport to and from the dialysis center in a The facility made an assumption that the	
non-medical mode of transportation could have Insurance company would send a	
resulted in an adverse outcome to the resident.  medically qualified driver. The facility did	
not brainstorm to figure out how the facility	
Immediate jeopardy began on 5/22/18 when the could transport this resident our self, i.e.	
facility staff failed to supervise Resident #5 who utilizing outside resources such as a	
was cognitively impaired with wandering qualified transportation company and/or	
behaviors during transportation via a non-medical sister facility.	
taxi like service to and from his dialysis	
appointment. The immediate jeopardy was Process for implementing a plan of	
removed on 9/8/18 when the facility provided an correction for specific deficiency	
acceptable credible allegation of Immediate	
Jeopardy removal. The facility will remain out of  On 9/6/2018 the Director of Nursing and	
compliance at a scope and severity of D (not Administrator utilized the appointment	
actual harm with potential for more than minimal schedule to review resident with	
harm that is not immediate jeopardy) to ensure appointments through September 8, 2018	
monitoring and that all staff have been for mobility (ambulatory status) and	
in-serviced. cognitive status utilizing the resident □s	
behaviors, hospital history and physical.	
Findings included:  There are currently 8 residents scheduled	
for appointments requiring transportation	
Resident #5 was admitted to the facility on for the week ending September 8, 2018.	
5/14/18 with the diagnoses of Alzheimer's  disease, dementia with behavioral disturbances,  Transportation for the 8 residents include 7 residents by the Facility van and 1	
and end stage renal disease (ESRD).	
stretcher.	
Review of Resident #5's admission assessment  All current residents have been reviewed	
for Fall Risk of 5/15/18 the resident was at high by the Director of Nursing and/or Licensed	
risk for falls. The Elopement Risk Observation  Nurse on 9/7/2018 to identify their current	
Form documented that the resident needed to be mode of transportation requirements and	
admitted to the locked unit after 3-days of if an escort is needed when a future	
behavior monitoring. appointment may be scheduled. Prior to	
scheduling any new transportation, for	
Review of Nurse's Notes from 5/16/18 revealed current and/or new residents, the	
Resident #5 was noted to wander the unit and his scheduler will notify the Director of	

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		245405				1	С
		345105	B. WING _			09/	08/2018
NAME OF PR	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
PRIJITTHE	ALTH-HIGH POINT			38	30 N MAIN STREET		
PROTTINE	ALIH-HIGH FOINT			HI	GH POINT, NC 27265		
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F 689	Continued From pag	ge 5	F 6	889			
1 009	dialysis treatments of Thursday, and Satur pleasant one minute confused the next.  Review of Physician placed on 5/19/18 for hemodialysis on Tue Saturday.  Review of the reside set (MDS) dated for period from 5/19/18 that the resident had impairment, wander assessment period. supervision of one plocomotion on/off un impaired functional I (ROM) and did not resident transportation depart 5/21/18 by the Insur (INC) #1 revealed and the Facility Reception informed Facility Reception dialysis center. Whi	vere set for Tuesday, reday Resident noted to be and then aggressive and  Orders revealed an order or Resident #5 to receive esday, Thursday, and  ent's Admission minimum data 5/25/18, with a look back through 5/25/18, documented a severe cognitive ed 1 to 3 days during that Resident #5 required the erson for ambulation and for eit. The resident did not have imitation in range of motion equire mobility devices.  #5's insurance company the time (ICTD) notes from ance Navigation Coordinator in outbound call was placed to enist/Scheduler. The INC ceptionist/Scheduler that a last could possibly help with retation from the facility to the let the Facility		0099	Nursing of new appointment and Direct of Nursing and/or Licensed nurse will evaluate resident to ensure the mode of transportation continues to meet their physical and psychological needs.  On 9/7/2018 New resident referrals who have reviewed by the Admissions Direct and/or Registered Nurse prior to admissions to ensure that the facility consafely meet their physical and psychological transportation needs. Upund admissions to the facility the resident who have assessed by a Licensed Nurse with 24 hours of admission to determine the safest mode of transportation for their physical and psychological needs. On 9/6/2018 the Director of Nurses an Nurse Managers began education to the RNIS, LPNIS, C.N. AIS, Receptionis Schedulers, Transport Drivers, Admissions and Senior Nurse Navigator(external pre admission evaluator) on all residents must be assessed prior to scheduling transportation to ensure the correct moof transportation to ensure the correct moof transportation will be used to meet the residents physical and psychological needs and that all scheduling of transportation for the residents will be done by facility staff only. No staff will all scheduling transportation to the residents will be done by facility staff only. No staff will be all supports to the staff will all scheduling transportation to the residents will be done by facility staff only. No staff will be all supports to the staff will be all supports to staff will be all suppo	of  will  or  an  oon  vill  iin  e  d/or  ne  t,	
	INC booked a reserved. The Facility Reception of the details of the fand she then request scheduled for the reand Saturday through	uler was on the phone, the vation through circulation. conist/Scheduler was informed transportation arrangements sted that transport be sident for Tuesday, Thursday, ph 6/2/18.			allowed to work until education is complete.  On 9/6/2018 the Director of Nursing ar or Licensed Nurse educated the clinical staff that when a resident has an appointment, the transportation compawill come into the facility and identify themselves to the Licensed Nurse on a by showing the facility staff their employers.	al iny duty	

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PREFIX (EACH DEFICIENCY MU	MENT OF DEFICIENCIES IST BE PRECEDED BY FULL DENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 689 Continued From page 6 Navigation Coordinator (I inbound call was received Manager (DCM) #1 statin shown up for his dialysis checked the records and transport had been cance rescheduled for 7:15 AM #1 stated that the resider service due to dementia. call the assigned driver to information, but the outbood was not answered. INC i inform her that the driver and the resident was alre dialysis center from the fa requested that Resident i ambulatory transportation and not the non-medical used. A driver was reser from the dialysis center to provided instructions by I request at that time.  Review of the Dialysis Co 5/22/18 revealed that Re treatment began at 7:26 AM.  Review of the facility reco note from 5/22/18 that do had returned from dialysi 126/68 Blood Pressure (I 20 Respiratory Rate (RR (T).  Review of Dialysis Center note from 5/23/18 at 10:0 (DN) #1 stated that her a	d from the Dialysis Clinic of the resident had not treatment yet. INC #2 found that the earlier elled. INC #2 on 5/22/18. The DCM of required door to door INC #2 attempted to communicate this bund call to the driver #2 called DCM #1 to had not been reached eady in route to the acility. The DCM #1 #5 be provided of for future treatments taxi like service being wed for the return trip to the facility and was NC #2 per DCM #1's  enter Records from sident #5's dialysis AM and ended at 10:55  ords revealed a nurse's fourmented the resident swith vital signs of BP); 86 Pulse Rate (PR); he are records revealed a records	F 6	ID badge and/or uniform, president being transported or facility.  All new hires will be educate general orientation to the factor of or Licensed Nurses within the utilizing the Pre / New / reeventransportation audit to review status, cognitive status (behaviors/dementia) to detend safest mode of transportation Effective 5/24/18 the facilities a contracted transportation a supplements the facilities a contracted transportation as supplements the facilities are van to accommodate resider appointment needs in a time.  Monitoring to ensure effective POC  On 9/6/2018 the Administrate Health Services or Nurse Matoreview, and audit the previous admissions for assessment and the proposition of the appropriate of transportation to meet their psychological needs to ensure transportation. This will be consulted the proposition of the proposition of the proposition of the proposition of the proposition. This will be consulted the proposition of the proposition	ed during their cility  Nursing and le facility are aluate le to the mobility lermine the le for resident. It is only utilized lagency which insportation into lely.  The mess of least of an ager began new least of least		

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	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 3830 N MAIN STREET HIGH POINT, NC 27265	•	3/00/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 689	like service [for 5/22//his history of dementi arrangements were minsurance company, the Review of Resident #revealed an inbound worker (DSW) was puthe resident had demiconcerns other transpible made.  Review of Dialysis Center from 5/23/18 at 2 Social Worker (DSW) Social Worker (DSW) Social Worker (DSW) Social Worker (FSW) transportation to and indicated no knowledd DSW spoke with Faciand confirmed that the arranged a non-medic transport the resident DSW informed the Fareceptionist/Schedul concerns with ICTD mental status and reconstructions with ICTD mental status and reconstructions with ICTD mental status and reconstructions with ICTD mental status and reconstructions.  On 9/5/18 at 11:00 All being escorted by a magnification of transport center.  During an interview of Facility Transport Cool	off by a non-medical taxi 8 dialysis treatment] with a. Transportation hade by the resident's he hospital, and the facility. 5's ICTD notes from 5/23/18 call from the Dialysis Social faced to inform them that rentia and that due to safety fort arrangements needed to  enter Records revealed a 2:51 PM from the Dialysis spoke with the Facility to discuss concerns about from dialysis and the FSW ge of any problems. The lity's Receptionist/Scheduler re resident's insurance had cal taxi like service to to and from dialysis. The cility er that she had shared related to the resident's fuested more appropriate y and Saturday as told that it would be  M Resident #5 was observed urse assistant (NA) to the	F 6	Performance Improvement Co The Administrator/ Director of continue to track and trend th appropriate mode of transport and present the analysis to th Assurance and Performance Improvement Committee mor months of continued compliar sustained then quarterly there Title of person responsible for implementing the POC  The Administrator and Director services are responsible for in the plan of correction.  Date of Compliance 10/03/20	Nursing will ne tation form the Quality on the Quality on the tation form the quality on the tation for of Nursing on plementing	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	IPLE CONSTRUCTION  NG		(X3) DATE SURVEY COMPLETED	
			D. MINO			С
		345105	B. WING _		<u> </u>	09/08/2018
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COI 3830 N MAIN STREET	DE	
PRUITTHE	EALTH-HIGH POINT			HIGH POINT, NC 27265		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO ( (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIAT	(X5) COMPLETION DATE
F 689	Continued From page	e 8	F 6	689		
	stated that to her kno miss any appointmen safe transportation w she recalled the resid dialysis on 5/22/18 by service, she stated si	able to start dialysis. She byledge the resident did not ats or dialysis treatments and as provided. When asked if dent being transported to a non-medical taxi like ne did not.				
	Director of Health Se was unaware that the the dialysis center by service on 5/22/18 ur and voiced his conce safety. He stated that his attention the facilit transport the resident services. When aske accompanied the restaxi like service was atthat the resident wen escorted the resident car on 5/22/18, the D When asked if the fac resident's safety he services.	rvices (DHS) he stated he resident was transported to a non-medical taxi like ntil the Ombudsman called rns about the resident's at once this was brought to ty made arrangements to t via their own transportation ed if any staff member ident the day non-medical used for transport, he stated t alone. When asked who from the locked unit to the HS said he was unsure. Cility was responsible for the stated that they were and				
	were made to transpo with their van. When was completed for th happened one time, to facility unharmed, the of the situation, arran transport Resident #8 service. He stated th done because they in problem. The DHS w staff member respon- to the non-medical ta	e of the situation, changes ort the resident to dialysis asked if an investigation e incident he stated that it the resident returned to the emoment they were aware agements were made to using the facility transport at an investigation was not numediately fixed the was unable to identify the sible for walking Resident #5 xi like service driver's car on ew was completed with this				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED		
		345105	B. WING			C (09/2049
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE  3830 N MAIN STREET  HIGH POINT, NC 27265	09	/08/2018
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 689	Ombudsman #1 she safe for the resident unsupervised by a non 5/22/18 with his of tendency, and behave During an interview Dialysis Clinical Marthat DN #1 and DCN center. She stated to contact them for poswere not obtained were not obtained were not obtained were not obtained to stated that she had streamportation for Restanding transportation for Turbaturday dialysis treamportation for Turbaturday dialy	on 9/6/18 at 9:16 AM with a stated she did not feel it was to be transported on-medical taxi like service cognitive status, wandering viors.  on 9/6/18 at 9:54 AM with mager (DCM) #2 she stated at the hat she would attempt to estible interviews. Interviews ith DN #1 and DCM #1.  with Insurance Navigation in 9/6/18 at 12:07 PM she several conversations with inal Nurse (FTN) about the estident #5. The FTN told her unable to arrange esday, Thursday, and atments and had asked this resident's insurance to in the resident because the ted residents using their van aday, and Friday. She stated that ormed of this and that this le transport service unless re out a way to take him to ing their own van. She stated derstand why they elected to eresident's safety was an that a staff member would	F 6	39		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ` ′	PLE CONSTRUCTION  G		(X3) DATE SURVEY COMPLETED	
		345105	B. WING			C 9/08/2018
	ROVIDER OR SUPPLIER	1 23333		STREET ADDRESS, CITY, STATE, ZIP CODE  3830 N MAIN STREET  HIGH POINT, NC 27265		9/06/2016
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOUNDER OF THE APPRENCED TO THE APPRENC	JLD BE	(X5) COMPLETION DATE
F 689	Continued From pag	ge 10	F 68	39		
	telephone number for the nurse identified a Resident #5 at the tidialysis via the non-15/22/18. The facility a name or contact in member who was re Resident #5 from the assisted him into the taxi like service on 5 dialysis treatment.  During an interview Facility Nurse #2 she had reported to her a Resident #5 on their seen it firsthand. Wi incident where Residialysis via a non-mestated that she did not this happening and shave allowed him to had known about it.  During an interview Practitioner on 9/6/1 was not informed of dialysis treatments a were problems with if she thought Resident dialysis with non-medical taxi like resident was not, duthat he lived on a locatendencies. She states.	of the facility DHS provided a per Facility Nurse #2 that was as the nurse assigned the me he was transported to medical taxi like service on DHS was unable to provide a formation for the staff sponsible for walking a locked unit and for who a vehicle of the non-medical a stated that her coworkers aggressive behaviors from a shifts but that she had not hen asked if she recalled an dent #5 was transported to edical taxi like service, she of have any knowledge of stated that she would never go without supervision if she with the Facility Nurse 8 at 5:11 PM she stated she any missed appointments or and was not aware that there transportation. When asked ent #5 was safe to travel to shout facility staff with a service, she stated that the et o his dementia, cognition, asked unit, and had wandering atted that she was not ent by anyone from the				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '	IPLE CONSTRUCTION IG	l \ /	(X3) DATE SURVEY COMPLETED	
		345105	B. WING			C
	ROVIDER OR SUPPLIER	040100		STREET ADDRESS, CITY, STATE, ZIP C 3830 N MAIN STREET HIGH POINT, NC 27265	•	9/08/2018
(X4) ID PREFIX TAG	(EACH DEFICI	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 689	11:41 AM she stata arrange transportal leave the hospital being able to according the facility transportation over. When asket the mode of transportation over. When asket the mode of transportation of the facility transportation over. When asket the mode of transportation over. When asket the two uld have had no idea that a was used to transportation of the second of the important of the personnel to transportation. She stated that should never have due to the resident repersonnel to transportation. On 9/6/18 at 5:32 informed of the important of th	w with the FTN on 9/7/18 at ted that the insurance helped ation so that the resident could earlier due to the facility not ommodate his Tuesday, surday dialysis schedule. The en to twelve days until the alld switch him over to Monday, friday treatments. At that point out service would be able to take diff the INC had informed her of port that was arranged for the dishe had called and confirmed ed. She stated she assumed been a medical transport and a non-medical taxi like service port the resident on 5/22/18. He was shocked because she approved that type of transport at's cognitive status, wandering he fact that he had a sitter in the reasons as well. She stated equired medically trained sport him to and from dialysis.  PM, the administrator was a mediate jeopardy. The facility e allegation of Immediate	F6			
	Jeopardy removal Immediate Jeopar Credible Allegation removal:	on 9/7/18. The allegation of rdy removal indicated:  n of Immediate Jeopardy  ction constitutes a written tantial compliance with Federal				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	FIPLE CONSTRUCTION  NG	(X	X3) DATE SURVEY COMPLETED
		345105	B. WING _			C <b>09/08/2018</b>
	ROVIDER OR SUPPLIER	1	,	STREET ADDRESS, CITY, STATE, 2 3830 N MAIN STREET HIGH POINT, NC 27265	ZIP CODE	30/00/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	X (EACH CORRECTIVE CROSS-REFERENCED	N OF CORRECTION EACTION SHOULD BE TO THE APPROPRIATE EIENCY)	(X5) COMPLETION DATE
F 689	admission or agreen truth of items alleged the alleged deficience prepared and/or exerequired by the provilaw. It also demonstrates to continue to and services to our reconstruction of the services of the	rection does not constitute then by the provider of the d or conclusions set forth for cies. The plan of correction is cuted solely because it is dision of the state and federal rates our good faith and improve the quality of care residents.  Rector of Nursing and d the appointment schedule of the appointment sthrough for mobility (ambulatory e status utilizing the resident's history and physical. There ents scheduled for fing transportation for the hiber 8, 2018. Transportation clude 7 residents by the sident by Life Star her.  Thave been reviewed by the and/or Licensed Nurse on heir current mode of ements and if an escort is the appointment may be scheduling any new furrent and/or new residents, tify the Director of Nursing of d Director of Nursing and/or evaluate resident to ensure retation continues to meet	F	689		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345105	B. WING _			C 09/08/2018
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 3830 N MAIN STREET HIGH POINT, NC 27265		3370072010
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI) TAG	PROVIDER'S PLAN OF CO ( (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 689	psychological transporadmissions to the fact assessed by a License admission to determine transportation for their needs.  On 9/6/2018 the Direct Managers began eductory. Admissions a (external pre admissions a (external pre admissions a transportation to ensutransportation will be physical and psychological and psyc	Infely meet their physical and protation needs. Upon illity the resident will be led Nurse within 24 hours of the the safest mode of a physical and psychological needs and that all and psychological and psychol	F6	889		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	TIPLE CONSTRUCTION  NG		(X3) DATE SURVEY COMPLETED
		345105	B. WING _			C <b>09/08/2018</b>
	ROVIDER OR SUPPLIER	,		STREET ADDRESS, CITY, STATE, ZIP C 3830 N MAIN STREET HIGH POINT, NC 27265	ODE	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF X (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENCE	TION SHOULD BE THE APPROPRIAT	
F 689	contracted transporta supplements the faci accommodate reside timely manner.  On 9/6/2018 the Adm Services or Nurse Ma audit the "pre/new /re and daily/weekly schnew admissions for a for the appropriate m meet their physical a ensure safe transport daily for 2 weeks, the weeks and then week until 6 months of consustained then quarted On 9/6/2018 the Adminitial safe mode of transport Quality Assurance aralmprovement Comminity Assurance aralmprovement Comminity and Performance Improvement the analysisted then quarted The Administrator and services are responsible of correction.  The credible allegation removal was verified evidenced by:  During an observation	facilities only utilized a ation agency which lities transportation van to ints appointment needs in a ministrator, Director of Health anager began to review and evaluation transport audit" eduled transportation and assessment of the resident ode of transportation to ind psychological needs to tation. This will be done in 3 times a week for 6 kly for 1 month then monthly tinued compliance is early thereafter. In an audit to the ind Performance ittee. The Administrator/ill continue to track and imode of transportation form yes to the Quality Assurance provement Committee ins of continued compliance is early thereafter.	F	589		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	PLE CONSTRUCTION  IG	(X3)	) DATE SURVEY COMPLETED
		345105	B. WING _			C <b>09/08/2018</b>
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 3830 N MAIN STREET HIGH POINT, NC 27265	'	33/33/2010
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 689	NA #4 for a shopping signed out and verification put that was started new transportation put that was started new transported by Note that all transportation service every transport binds of the put that would also a start would also a distribution to make so that all transportation made by the facility. Would have the auth for any resident.	asportation Coordinator and g trip. All residents were ed to have been assessed for portation in the facility's audit on 9/7/18 per the facility's policies.  Decords revealed the following expleted with all active facility gh 9/8/18:  Durse #3 was completed to expend to poing to appointments by the expanying them. They were iffy the employee expending to approve the driver before expension of the dri	F 6	89		
	Facility Vice Preside the Administrator an investigations being	nt of Operations to educate d the DHS about efficient done for all incidents that /. A power-point and				

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	IPLE CONSTRUCTION		OATE SURVEY COMPLETED
		345105	B. WING _			C 09/08/2018
	ROVIDER OR SUPPLIER	1		STREET ADDRESS, CITY, STATE, ZIP CODE 3830 N MAIN STREET HIGH POINT, NC 27265		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF ( (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 689	Continued From pag check-list for handlin situations efficiently.	ig immediate jeopardy	F 6	89		
	Review of facility rec were completed star	cords revealed that audits ting on 9/7/18 of:				
	transportation needs schedules - Current and nev reviewed/assessed t transportation requir - Three ne					
	the Weekend Recep educated on the new transport. She state driver was an approvidentification, and ha appointment transport	d that she would verify the ved vendor, check their ave them sign in and out for ortation.				
	Nurse #4 she stated resident would be as of transport. She we appointments that the approved vendor, check the stated resident would be as of transport.	on 9/8/18 at 11:26 PM with that any newly admitted seessed for their safe mode ould also verify on the day of e driver/service was an eeck their identification, and out for appointment				
	Nurse #5 she stated resident would be as of transport. She wo	on 9/8/18 at 11:36 PM with that any newly admitted ssessed for their safe mode ould also verify on the day of e driver/service was an				

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION  B	COMPLETED	
		345105	B. WING			
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE  3830 N MAIN STREET  HIGH POINT, NC 27265	C 09/08/2018  STATE, ZIP CODE  S5  RS PLAN OF CORRECTION ECTIVE ACTION SHOULD BE  COMPLETION	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD   CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION	
F 689		neck their identification, and and out for appointment	F 68		10/3/18	
SS=G	CFR(s): 483.25(g)(1 §483.25(g) Assisted (Includes naso-gasti both percutaneous expercutaneous endosenteral fluids). Base comprehensive asseensure that a reside §483.25(g)(1) Maintof nutritional status, desirable body weigh balance, unless the demonstrates that the preferences indicate §483.25(g)(2) Is offer maintain proper hyd §483.25(g)(3) Is offer maintain proper hyd §483.25(g)(3) Is offer there is a nutritional provider orders a the This REQUIREMEN by:  Based on record repractitioner interview the daily caloric intal assessed by the regone sampled resider tube feeding (Resider	nutrition and hydration. ric and gastrostomy tubes, endoscopic gastrostomy and doopic jejunostomy, and do on a resident's essment, the facility must int- ains acceptable parameters such as usual body weight or int range and electrolyte resident's clinical condition his is not possible or resident otherwise; ered sufficient fluid intake to ration and health; ered a therapeutic diet when problem and the health care erapeutic diet. T is not met as evidenced view, staff and Nurse vs, the facility failed to provide ke by feeding tube as istered dietitian for one of ints receiving total nutrition by ent #4). The resident icant unplanned weight loss		Process that lead to the deficiency  The Nurse Practitioner changed a tub feeding order believing they were increasing the feeding when they decreased the total amount of nutrition. The facility did not notify the Registere Dietitian of the order change when it occurred as per protocol. Therefore, the state of the control of the order change when it occurred as per protocol.	e n. ed	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		CONSTRUCTION		E SURVEY PLETED
		345105	B. WING				C / <b>08/2018</b>
NAME OF P	ROVIDER OR SUPPLIER	1		S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 09	700/2010
TO UNIC OF T	TO VIDER OR OUT FEEL				830 N MAIN STREET		
PRUITTHE	ALTH-HIGH POINT				IIGH POINT, NC 27265		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES  CY MUST BE PRECEDED BY FULL  LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 692	Continued From pag	e 18	F 6	692			
	The findings included	d:			Registered Dietitians could not comple	te	
	, and the second				there review and recommendation to the		
		nitted to the facility on ses including cancer of the			facility.		
	mouth, dysphagia, to	tal nutrition by a feeding tube			Process for implementing a plan of		
	and failure to thrive.				correction for specific deficiency		
	The physician 's mo	nthly orders for April 2018			The Clinical Competency Coordinator		
		g of Glucerna 1.5 to be			and/or Nurse Managers have educated	t	
	provided at 80 millilit	ers (ml) per hour for 20			the Licensed Nurses on the protocol		
	hours of continuous t	feeding. The feeding was to			regarding notification to the Register		
	begin at 12:00 PM ar	nd continue until 8:00 AM.			Dietician related to any tube feeding		
					changes. The Licensed Nurses that ha		
		al Feeding Progress Notes"			not been educated by 10/03/2018 will be	эе	
	_	Registered Dietician (RD)			removed from the schedule until the		
		1's current weight was 157			education is completed. This education		
	1 7	othing by mouth), received			has been added to the general orientat	lion	
		eding tube of Glucerna 1.5, alories in a 24 hour period			for newly hired Licensed Nurses.  When a tube feeding order is changes	b.,	
	-	of 132 grams. The tube			a health care professional the facility	Dy	
		culated for 80 milliliters (ml)			Licensed Nurse will send the Registere	-d	
		s of continuous feeding.			Dietitians a fax	<i>,</i> u	
	po	, c. cog.			The Director of Nursing and/or Nurse		
	Review of the reside	nt ' s care plan revealed it			Managers will review all tube feeding		
		ff on 4/23/18 and included a			order changes to ensure the Licensed		
	problem the resident	was NPO and received			Nurses have notified the Registered		
	nutrition via tube feed	ding. The approaches for the			Dietitian of the Tube Feeding order		
	stated problem include	ded the tube feeding to be			change and recommendation have bee	∍n	
		ered, water flushes as			completed.		
		ghts and labs and check					
	residual per protocol				Monitoring to ensure effectiveness of POC		
		actitioner 's progress note					
		d the diagnoses of urinary			The Director of Nursing and/or Nurse		
		severe protein calorie			Manager will validate the new and/or		
		phagia. The plan included an			changes tube feeding orders daily as the	ney	
		nistered via intravenous			occur to validate Registered Dietitian		
		change tube feeding time to			notification and completion of	c	
	start at 5:00 pm and	continue until 8:00 AM (with			recommendation. This will occur daily t	or	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED		
		345105	B. WING				C <b>08/2018</b>
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 09/	00/2010
TO THE OT THE	TO VIDER OR OUT FEET						
PRUITTHE	ALTH-HIGH POINT				330 N MAIN STREET		
				н	IGH POINT, NC 27265		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 692	Continued From page	e 19	F 6	92			
	would be administere	ne rate the tube feeding and each hour).  ated 5/4/18, written by the NP			thirty days then weekly for four weeks, then monthly until six months of contin- compliance is maintained, then quarter thereafter.		
	indicated the tube fee	eding of Glucerna 1.5 hours changed to 5:00 PM start			The Director of Nursing will track and	-	
		nue to 8:00 AM (a total of 15			trend the tube feeding order changes in relation to the notification to the	1	
	hours of administration	•			Registered Dietitian and completeness		
	Pavious of the Madica	ation Administration Record			the Registered Dietitians recommenda and report the analysis to the Quality	tion	
		revealed beginning on			Assurance and Performance		
		for the tube feeding was			Improvement Committee monthly until	six	
		PM to 5:00 PM and 8:00 AM			consecutive months of compliance is	0.7.	
		e feeding was stopped each			maintained then quarterly.		
		mentation indicated the tube			, , , , , , , , , , , , , , , , , , , ,		
	feeding continued for				Title of person responsible for		
	changed on 5/4/18.	There were no days the			implementing the POC		
	resident did not recei	ve the tube feeding.			The Administrator and the Director of Nursing is responsible for implementat	ion	
	Review of the Minimu	ım Data Set (MDS) dated			for the Plan of Correction.		
	5/25/18 indicated Res	sident #4 had moderate					
	impairment with cogn	ition with short and long					
		nent. He had no change in					
	his ADL activity and c						
		with ADLs. Nutrition was					
		eedings 51% or greater and					
	his weight was docun	nented as 156 pounds.					
		4 's monthly Medication					
	Administration Record	d (MAR) for June 2018					
		18 to 06/14/15 the resident					
		the tube feeding according					
		er at 80 ml per hour from					
	12:00 PM to 8:00 AM						
		y weights for Resident #4 g significant weight loss from 18:					

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED
		345105	B. WING		C 09/08/2018
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE  3830 N MAIN STREET  HIGH POINT, NC 27265	1 03/00/2018
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F 692	pound or 6.4 percent one month).  Review of the consucancer center record 15 pounds in 5 weel instructions "please nutrition through his Recommendations i through G-tube until take nutrition by morat least 5-6 cans (of Review of the RD "E Notes" dated 6/15/1 pounds on 6/8/18 wi 6.4% in one month. 1.5 and the resident the feeding and the remained as 80 ml provide 2400 calories. The RD documented change in the amoureceived the tube feedecrease of 5 hours order change. The been notified of the the consult report from Reasons for possible the RD notes include which may have possible thange, alon.  Interview with the nute 5:15 PM revealed she to the supplementation of the supplementation of the supplementation.	(which equates into a 10 t significant weight loss in a local ded the resident 's as losing as. The note included ensure he gets proper G-tube (feeding tube). Included "Continue feeding he is cleared to swallow (and buth). Please ensure he gets the tube feeding? Included a weight of 146 the a significant weight loss of the diet order was Glucerna aremained NPO. The rate of calories required in 24 hours for 20 hours to the sand 132 grams of protein. In the notes of the order into time the resident had a sof feeding per day due to the RD indicated she had not order change and received for 6/12/18 on 6/14/18. The weight loss documented in the don antibiotic in May for UTI asibly contributed to the gray with the G tube pulled out.  The saw the resident on 5/4/18 at the saw the resident on 5/4/18. Thought she was increasing the actually had decreased the	F 69		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING _	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345105	B. WING			08/ <b>2018</b>
	ROVIDER OR SUPPLIER		3	TREET ADDRESS, CITY, STATE, ZIP CODE 830 N MAIN STREET IIGH POINT, NC 27265	, , , , , ,	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 692	time frame for the fee changed the time to 5 hours of tube feeding explained she had me because the resident hungry in the evening the resident had not resident with the Director of the RD orders included the neorder would fax the RD orders included the neorder would fax the RD orders included the neorder would fax the RD orders included the post of the 5/4/18 to resident #4.  Interview with the Die 10:40 AM revealed he for tube feedings. He notified of a resident resident of the explained if there were nurse would fax the RD is post of the residents feedings. The facility must ensure quire dialysis receive with professional stand comprehensive person the residents' goals a This REQUIREMENT.	wed. She had mistaken the ding as 8:00 PM and 6:00 PM for an additional 3. During the interview she eant to increase the feeding had complained of being had complained feedings.  Sector of Nursing (DON) on evealed the process for of changes in tube feeding had not been tube feeding order change. The many the RD had not been tube feeding order change had been explained the RD would be receiving a tube feeding. Calorie calculations. He had not been tube feeding had been consistent of the information.	F 692			10/3/18
		ew, staff interview, dialysis cility failed to ensure a		Process that lead to the deficiency		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		CONSTRUCTION	` ′	TE SURVEY MPLETED
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		345105	B. WING _			0	9/08/2018
NAME OF PI	ROVIDER OR SUPPLIER	•		S	TREET ADDRESS, CITY, STATE, ZIP CODE		
				3	830 N MAIN STREET		
PRUITTHE	EALTH-HIGH POINT			Н	IIGH POINT, NC 27265		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PRÉFIX TAG	,	NCY MUST BE PRECEDED BY FULL IR LSC IDENTIFYING INFORMATION)		PREFIX (EACH CORRECTIVE ACTION SE			COMPLETION DATE
F 698	Continued From pa	ge 22	F	698			
	resident was transp	oorted to kidney provider and			On 5/17/18 resident number 5 was not		
	dialysis appointmer	nts at scheduled days and			picked up by his insurance pre □arran	ged	
	times, for 1 of 1 res	sidents (Resident #5) reviewed			transportation. The facility did not ensu		
	for hemodialysis.				alternative transportation was provided	l to	
					resident #5 to dialysis when the		
	Findings included:				pre-arranged transportation did not arr		
					as scheduled to transport the resident		
		dmitted to the facility on			dialysis in a timely manner. The facility		
		agnoses of Alzheimer's with behavioral disturbances,			not brainstorm to figure out how the fa	-	
		-			could transport this resident our self, i.	₽.	
	and end stage rena	ii disease (ESRD).			utilizing outside resources such as a qualified transportation company and/o	or	
	Review of Dialysis	Center Records from 5/15/18			sister facility to ensure the resident arr		
		m 10:34 AM documented by			at the dialysis center on time.	vea	
		nager (DCM) #1 stated that			at the dialysis series on this		
	she spoke with the	- ·			Process for implementing a plan of		
		luler regarding the 5/16/18			correction for specific deficiency		
	appointment at 10:4	45 AM. The driver stated that					
	they had a full sche	edule and did not think she			The Clinical Competency Coordinator		
		ing him to his appointment.			and/or Nurse Manager began educatir	ıg	
		st/Scheduler was also informed			the Licensed Nurses, Admission		
	•	pointment on 5/17/18 with			Coordinator, Scheduler, Social Worker	on	
		AM for dialysis and she stated			09/06/2018 regarding the facility		
		brings residents to dialysis on			scheduling appointments utilizing the	I:4	
		ay, Friday and was not sure			facility transportation van and/or a faci		
	she could accommo	odate tris.			contracted medical transport agency. education has been added to the gene		
	Peview of Incurance	e Company Transportation			orientation for newly hired, Licensed	ıaı	
		notes from 5/16/18 at 3:23			Nurses, Admission Coordinators,		
	. , , ,	tial note from an inbound call			Scheduler, and Social Workers.		
		ansitional Nurse (FTN) to the			The facility will ensure that all dialysis		
	l -	ated she had spoken to			appointments transportation will be		
		ous day regarding obtaining			scheduled by the facility and not an		
		igh that service for Resident			outside source, for dialysis transportat	on	
		d that the resident had his			to be received in a timely manner.		
	l -	lays changed to Tuesday,					
		turday and needed roughly six			On 9/6/2018 the Director of Nursing		
		on. The treatments were			and/or Nurse Managers utilized the		
	going to be change	d back to Monday,			appointment schedule to review reside	nt	

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII		CONSTRUCTION	(X3) DATE COMP	SURVEY
			A. BOILDII	<b>'</b> -	<del></del>	Ι ,	С
		345105	B. WING _				08/2018
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 00/	00/2010
				38	330 N MAIN STREET		
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F 698	FTN had called earlie that the ICTD could not was for emergency service the FTN was 5/19/18, 5/22/18, 5/24 time of 6:30 AM to the and the facility van would back to the facility after Review of ICTD notes the ICTD attempted to Resident #5 but was showed that several nother transportation on none were able to face resident.  Review of Dialysis Counter from 5/16/18 at DCM #1 stated that the called to inform the direction of the dialysis Counter from 5/16/18 at DCM #1 and spoke work Receptionist/Schedul had arranged transport they had not shown undialysis. She was tolehim there the next dare	day in about two weeks. The er in the day and was told not set up transport and that transport only. The dates of requesting were 5/17/18, 4/18, and 5/26/18 for a chair edialysis center one way ould transport the resident er treatment.  Is from 5/16/18 revealed that or arrange transport for not successful. The notes more calls were made to companies in that area but collitate transport for the enter Records revealed a 1:14 PM documented by the Physician Assistant #1 it is appointment with enter Records revealed a 1:17 PM documented by with the Facility er and was told that they out with his insurance, but up to take the resident to d that the facility would get y.	F	698	with appointments through September 2018 to validate the residents arrived for dialysis treatment on time. Effective 9/6/18 the facility will only utility a contracted transportation agency whis supplements the facilities transportation van to accommodate residents appointment needs in a timely manner. The Director of Nursing and/or Nurse Manager will review the transportation logs daily for 30 days, weekly for four weeks then monthly thereafter, to ensure the residents arrived to their dialysis appointments in a timely manner to receive services required.  Monitoring to ensure effectiveness of POC  The director of nursing and nurse manager will review that all dialysis residents are transported to their appointments and receive their desired course of treatment, this will be compledaily for 30 days, weekly for four weeks then monthly until continued compliance sustained, then quarterly thereafter. The administration and Director of Nursing continue to track and trend the dialysis form and report the analysis to the Quarterly was an and report the analysis to the Quarterly emphasized and Performance Improvement committee monthly until sconsecutive months of compliance is maintained then quarterly	or ize ich n . ure	
	note from 5/16/18 at a DCM #1 stated that s Director of Health Se	enter Records revealed a 4:03 PM documented by the had spoken to the rvices (DHS) in regards to			Title of person responsible for implementing the POC  The Administrator and the Director of		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '			(X3) DATE SURVEY COMPLETED	
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out to the transport as sure transport was so dialysis treatment or see his kidney provided in the following see his kidney and that fare unable to reach anyour Review of Dialysis Conote from 5/17/18 at stated she spoke with Receptionist/Scheduthat the resident's transplaced on 5/19/18 for hemodialysis on Tue Saturday.  Review of Physician placed on 5/19/18 for hemodialysis on Tue Saturday.  Review of the resident set (MDS) dated for period from 5/19/18 that the resident had impairment, wander assessment period. Supervision of one plocomotion on/off un impaired functional I (ROM) and did not received in the following seems of Resident in Review of Review of Resident in Review of Review of	tion navigation team to make et-up for the resident's in 5/17/18 at 6:00 AM and to der at 2:30 PM the same day.  Senter Records revealed a 7:01 AM by DCM #1 that lid not show up for treatment cility was called and she one.  Senter Records revealed a 11:54 AM by DCM #1 that the Facility's uler and she was informed ansportation did not pick sis. The dialysis treatment 5/18/18.  Orders revealed an order or Resident #5 to receive esday, Thursday, and  ent's Admission minimum data 5/25/18, with a look back through 5/25/18, documented a severe cognitive end 1 to 3 days during that Resident #5 required the erson for ambulation and for it. The resident did not have imitation in range of motion equire mobility devices.	F 6		mplementing		
	ROVIDER OR SUPPLIER  SUMMARY S (EACH DEFICIENT REGULATORY OR SUPPLIER SUMMARY S (EACH DEFICIENT REGULATORY OR SUPPLIER S	Adstrost  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 24 out to the transportation navigation team to make sure transport was set-up for the resident's dialysis treatment on 5/17/18 at 6:00 AM and to see his kidney provider at 2:30 PM the same day.  Review of Dialysis Center Records revealed a note from 5/17/18 at 7:01 AM by DCM #1 that stated the resident did not show up for treatment (dialysis) and that facility was called and she unable to reach anyone.  Review of Dialysis Center Records revealed a note from 5/17/18 at 11:54 AM by DCM #1 that stated she spoke with the Facility's Receptionist/Scheduler and she was informed that the resident's transportation did not pick resident up for dialysis. The dialysis treatment was rescheduled for 5/18/18.  Review of Physician Orders revealed an order placed on 5/19/18 for Resident #5 to receive hemodialysis on Tuesday, Thursday, and	A BUILDIN  345105  B. WING _  SOVIDER OR SUPPLIER  EALTH-HIGH POINT  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 24  out to the transportation navigation team to make sure transport was set-up for the resident's dialysis treatment on 5/17/18 at 6:00 AM and to see his kidney provider at 2:30 PM the same day.  Review of Dialysis Center Records revealed a note from 5/17/18 at 7:01 AM by DCM #1 that stated the resident did not show up for treatment (dialysis) and that facility was called and she unable to reach anyone.  Review of Dialysis Center Records revealed a note from 5/17/18 at 11:54 AM by DCM #1 that stated she spoke with the Facility's Receptionist/Scheduler and she was informed that the resident's transportation did not pick resident up for dialysis. The dialysis treatment was rescheduled for 5/18/18.  Review of Physician Orders revealed an order placed on 5/19/18 for Resident #5 to receive hemodialysis on Tuesday, Thursday, and Saturday.  Review of the resident's Admission minimum data set (MDS) dated for 5/25/18, with a look back period from 5/19/18 through 5/25/18, documented that the resident had severe cognitive impairment, wandered 1 to 3 days during that assessment period. Resident #5 required the supervision of one person for ambulation and for locomotion on/off unit. The resident did not have impaired functional limitation in range of motion (ROM) and did not require mobility devices.  Review of Resident #5's insurance company transportation department (ICTD) notes from	RALTH-HIGH POINT    STREET ADDRESS, CITY, STATE, ZIP OF 3830 N MAIN STREET HIGH POINT, NC 27265   D. PROVIDER'S PLAN OF REGULATORY OR LSC IDENTIFYING INFORMATION)   PREFIX TAG CROSS-REFERENCED TO TO DEFICIENCE ON THE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)   PREFIX TAG CROSS-REFERENCED TO TO DEFICIENCE ON THE PROVIDER'S PLAN OF REGULATORY OR LSC IDENTIFYING INFORMATION)   PREFIX TAG CROSS-REFERENCED TO TO DEFICIENCE ON THE PROVIDER'S PLAN OF REGULATORY OR LSC IDENTIFYING INFORMATION)   PREFIX TAG CROSS-REFERENCED TO TO DEFICIENCE ON THE PROVIDER'S PLAN OF RESERVENCE OF TAG CROSS-REFERENCED TO TO DEFICIENCE ON THE PROVIDER'S PLAN OF RESERVENCE OF TAG CROSS-REFERENCED TO TO DEFICIENCE ON THE PROVIDER'S PLAN OF RESERVENCE OF TAG CROSS-REFERENCED TO TO DEFICIENCE ON TAG CROSS-REFERENCED TO TO DEFICIENCE ON TAG CROSS-REFERENCED TO THE PROVIDER'S PLAN OF RESERVENCE OF TAG CROSS-REFERENCED TO THE PROVIDER'S PLAN OF TAG CROSS-REFERENCED TO THE PROVIDER'S PLAN OF TAG CROSS-REFERENCED TO THE PROVIDER TAG CROSS-REFERENCED TO THE PROVIDER'S PLAN OF TAG CROSS-REFERENCED TAG CROSS	A BUILDING  345105  ROWDER OR SUPPLIER  ALTH-HIGH POINT  SUMMARY STATEMENT OF DEFICIENCIES  REQUATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 24  Out to the transportation navigation team to make sure transport was set-up for the resident's dialysis treatment on 5/17/18 at 1:00 AM and to see his kidney provider at 2:30 PM that stated the resident did not show up for treatment (dialysis) and that facility was called and she unable to reach anyone.  Review of Dialysis Center Records revealed a note from 5/17/18 at 1:154 AM by DCM #1 that stated the resident's transportation did not pick resident up for dialysis. The dialysis treatment was rescheduled for 5/18/18.  Review of Physician Orders revealed an order placed on 5/19/18 for Resident #5 to receive hemodialysis on Tuesday, Thursday, and Saturday.  Review of the resident's Admission minimum data set (MDS) dated for 5/25/18, with a look back period from 5/19/18 through 5/25/18, documented that the resident As severe cognitive impairment, wandered 1 to 3 days during that assessment period. Resident #5 to receive hemodialysis on for person for ambulation and for loccomotion on/off unit. The resident did not have impaired functional limitation in range of motion (ROM) and did not require mobility devices.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDII	TIPLE CONSTRUCTION  NG		(X3) DATE SURVEY COMPLETED		
		345105	B. WING _			C 09/08/2018	
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F 698	the Facility Reception informed Information Reception information info	a outbound call was placed to hist/Scheduler. The INC ceptionist/Scheduler that a sat could possibly help with tation from the facility to the e the Facility ler was on the phone, the ation through circulation. Onist/Scheduler was informed transportation arrangements ted that transport be sident for Tuesday, Thursday, the 6/2/18.  Is from 5/22/18 by Insurance tor (INC) #2 revealed an eived from the Dialysis Clinic stating the resident had not yeis treatment yet. INC #2 and found that the earlier ancelled. INC #2  AM on 5/22/18. The DCM sident required door to door intia. INC #2 attempted to yer to communicate this putbound call to the driver NC #2 called DCM #1 to river had not been reached a already in route to the he facility. The DCM #1	F	698			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	IPLE CONSTRUCTION		ATE SURVEY DMPLETED	
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F 698	- community from page 20		F 6	598		
		t Resident #5's dialysis :26 AM and ended at 10:55				
	note from 5/24/18 at the DCM #1 called the resident's nurse and called transportation would not be at the finurse was made away	enter Records revealed a 6:21 AM documented that he facility and spoke to the was told that when she the nurse was told that they hacility until 7:15 AM. The hare that the resident was he dialysis center at 6:00 AM.				
	note from 5/24/18 at the Dialysis Social W Facility Social Worke not show up for his 6 until 7:45 AM. They Saturday appointment be starting a Monday	enter Records revealed a 8:24 AM documented that Vorker (DSW) notified the er (FSW) that the resident did 6:00 AM dialysis appointment discussed Resident #5's ent and that the resident would 6, Wednesday, Friday enday, May 28, 2018.				
	Facility Transport Co resident had an initial doctor prior to being stated that to her kno miss any appointment safe transportation we she recalled the residual	on 9/5/18 at 3:27 PM with the ordinator, she stated that the all appointment with the kidney able to start dialysis. She owledge the resident did not not sor dialysis treatments and was provided. When asked if dent being transported to y a non-medical taxi like he did not.				
	Ombudsman #2 con 5/25/18. A staff mem appointment was for	on 9/6/18 at 9:16 AM with tacted the dialysis center on ber confirmed the resident's 6:00am, but the resident did d 8:00 AM. As a result, this				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	IPLE CONSTRUCTION  NG		(X3) DATE SURVEY COMPLETED		
		345105	B. WING _			C 09/08/2018	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 3830 N MAIN STREET HIGH POINT, NC 27265	· · · · · · · · · · · · · · · · · · ·	03/03/2010	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF COR ( (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 698	and the resident requipolitic following day on 5/26 Ombudsman #2 visit the DHS and he admitted there was some confit transportation on the During an interview of Coordinator (INC) or stated that she had at the Facility Transition transportation for Rethat the facility was utransportation for Turning an interview of the transportation for Turning an interview of the transportation on Monday, Wedness During an interview of the hospital earlies the hospital earlies are the hospital earlies and Saturd resident needed ten dialysis center could Wednesday and Frid the facility transport sover.  During an interview of Director of Health Settransportation services transportation services transportation services transportation services the best of the settransportation services the property of the settransport of the settranspo	the duration of the session uired another treatment the 6/28 at 6:00 AM. Later, ed the facility and spoke with nitted the mistake and stated fusion about his mode of day of the appointment.  With Insurance Navigation 19/6/18 at 12:07 PM she several conversations with hal Nurse (FTN) about the sident #5. The FTN told her mable to arrange esday, Thursday, and atments and had asked this esident's insurance to the resident because the ed residents using their van day, and Friday.  With the FTN on 9/7/18 at that the insurance helped on so that the resident could rlier due to the facility not	Fé	598			
	admission. He state	nce company prior to his d that the facility would not sident unless this was					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		PLE CONSTRUCTION  G	COMPLETED		
		345105	B. WING _		C 09/08/2018
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE  3830 N MAIN STREET  HIGH POINT, NC 27265	03/00/2010
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE COMPLETION
F 835 SS=J	resident's dialysis tr facility's transportations stated that once the brought to his attential arrangements to train own transportations. Administration CFR(s): 483.70  §483.70 Administration Administration Administration CFR(s): 483.70  §483.70 Administration Administration A facility must be acceptable in the series of	them due to conflicts with the eatment schedule and the on/driver's schedule. He transportation issues were tion the facility made is resources.  Ition. Ition. Ition. Ition. Ition. Ition. Itininistered in a manner that resources effectively and or maintain the highest is mental, and psychosocial esident. It is not met as evidenced itions, record review, interviews titioner (NP), the is center staff, representative transportation company, and ininistration failed to provide riship to facility staff to cortation and analyze an Resident #5) residents cortation. Resident #5, who aired with wandering sported to and from dialysis it like service without	F 6	Process that lead to the deficience.  On 5/22/2018 Resident #5 was sol for transportation to their dialysis oby their insurance company who contracted with Care Navigation U sent an UBER driver to transport the resident to the dialysis center. The allowed the resident to enter the without assisting the resident to an the scheduled dialysis appointment validating the driver squalification Administration failed to provide saft transportation for resident.  The facility did not have adequate	heduled center  nit who he facility ehicle and from his. fe
	facility staff failed to was cognitively impo behaviors during tra taxi like service to a	supervise Resident #5 who aired with wandering insportation via a non-medical		resources to transport resident to of at 6am and the contracted transport could not accommodate the 6am to either. This was resolved by changer residents time for Dialysis.	ortation ime

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI		CONSTRUCTION	(X3) DATE COMP	SURVEY	
		345105	B. WING			l	08/2018	
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 00/	00/2010	
DDUITTUE	EALTH-HIGH POINT			38	830 N MAIN STREET			
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F 835	Continued From page	e 29	F	835				
F 835	conduct a timely and a causative factor that which left Resident #8 for a repeat incident. was removed on 9/8/an acceptable credibl Jeopardy removal. Tompliance at a scop actual harm with pote harm that is not immer monitoring and that a in-serviced.  The findings included  Cross Reference to Fased on observation with the Nurse Practito ombudsman, dialysis from the resident's trafacility staff, the facility staff, the facility supervision to a cogn wandering behaviors from dialysis in a non 1 of 1 (Resident #5) report transportation. The reback to the facility, busevere cognitive imparts	thorough analysis to identify t directly led to the incident, and other residents at risk. The immediate jeopardy 18 when the facility provided e allegation of Immediate he facility will remain out of e and severity of D (not intial for more than minimal ediate jeopardy) to ensure II staff have been:  689:  18. record review, interviews ioner (NP), the center staff, representative insportation company, and y failed to provide itively impaired resident with during transportation to and medical taxi like service for esident was transported at due to the resident's airment and wandering	F	835	Facility did not conduct an investigation determine why this occurred to prevent this event from happening again, as the Director of Health Services assumed the is was an isolated issue and not a systemic issue and had been resolved. The facility did not brainstorm to figure how the facility could transport this resident, i.e. utilizing outside resources such as a qualified transportation company and/or sister facility.  Process for implementing a plan of correction for specific deficiency  The Director of Health Services should have conducted a thorough investigation to determine if this issue could or would affect other residents.  On 9/7/2018 the facility Administration Director of Health Services was in-serviced by the Pruitt Health Area Vin President on the company policy regarding investigating any potential issues regarding potential harm to residents.  On 9/6/2018 the facility began education nursing clinical staff on proper procedure.	on d and ce		
	transport to and from non-medical mode of	of staff supervision during the dialysis center in a transportation could have			for scheduling transportation to ensure resident safety. Clinical nursing staff whave not completed education will be			
	On 9/6/18 at 5:32 PM	, the administrator was			removed from the schedule until education is completed.  Beginning on 9/6/2018 all transportation must be scheduled by facility rather than			
		a credible allegation of removal on 9/7/18. The			must be scheduled by facility rather that outside agency and approved by Administrator or Director of Health Services for safety. If the facility is unal to transport the volume of residents, the	ble		

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI		CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		345105	B. WING _			l	C 08/2018
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 00/	00/2010
				38	830 N MAIN STREET		
PRUITTHE	EALTH-HIGH POINT			Н	IIGH POINT, NC 27265		
(X4) ID PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 835	Continued From page	e 30	F	835			
	indicated:  Credible Allegation of removal:				will utilize their contracted transportation agency to handle high volume transportation.  On 9/7/2018 the Administration began reviewing the grievance log and daily		
	allegation of substant and Medicaid require execution of this corre admission or agreement truth of items alleged	n constitutes a written ial compliance with Federal ments. Preparation and/or ection does not constitute ent by the provider of the or conclusions set forth for			operations report to identify any potent areas that may cause harm. Areas that are deemed with potential for harm will placed on the Potential for Harm form investigation will be completed by the facility Administration.	t be and	
	prepared and/or exec required by the provis law. It also demonstra	es. The plan of correction is cuted solely because it is sion of the state and federal ates our good faith and improve the quality of care esidents.			The Administration will track, trend and analyze the potential for harm form and submit findings to the Quality Assurance and Performance Improvement Committee monthly for 3 months then quarterly thereafter.	d	
	Resident #5 was admitted on May 15, 2018 at 4:15pm from the hospital with diagnosis of End Stage Renal Dialysis and Dementia with behavior disturbance.  On 5/22/2018 Resident #5 was scheduled for transportation to their dialysis center by their insurance company who contracted with Care Navigation Unit who sent a non-medical taxi like service driver to transport the resident to the dialysis center. The facility allowed the resident to enter the vehicle without assisting the resident to and from the scheduled dialysis appointment or validating the driver's qualifications.				On 9/6/2018 the Director of Health Services and Administrator utilized the appointment schedule to review reside with appointments through September 2018 for mobility (ambulatory status) at cognitive status utilizing the resident separations, hospital history and physica There are currently 8 residents schedu for appointments requiring transportation for the week ending September 8, 2018 Transportation for the 8 residents inclu 7 residents by the Facility van and 1 resident by Life Star transportation stretcher.	8, nd s I. led on 3.	
	qualified driver. The fa figure out how the fac resident our self, i.e. t	assumption that the vould send a medically acility did not brainstorm to sility could transport this utilizing outside resources ansportation company			All current residents have been reviewed by the Director of Health Services and/Licensed Nurse on 9/7/2018 to identify their current mode of transportation requirements and if an escort is needed when a future appointment may be scheduled. Prior to scheduling any new	or d	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED		
		345105	B. WING_	B. WING		C 09/08/2018	
NAME OF PE	ROVIDER OR SUPPLIER		<del></del>	S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 03/	06/2016
TO THE OT THE	COVIDER OR GOLF EIER				830 N MAIN STREET		
PRUITTHE	ALTH-HIGH POINT				IIGH POINT, NC 27265		
					 T		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 835	Continued From page	e 31	F 8	335			
	and/or sister facility.				transportation, for current and/or new		
					residents, the scheduler will notify the		
	On 9/6/2018 the Dire	ctor of Nursing and			Director of Health Services of new		
		the appointment schedule			appointment and Director of Health		
	to review resident wit	h appointments through			Services and/or Licensed nurse will		
	September 8, 2018 for	or mobility (ambulatory			evaluate resident to ensure the mode of	of	
		status utilizing the resident's			transportation continues to meet their		
		istory and physical. There			physical and psychological needs.		
	are currently 8 reside				On 9/7/2018 New resident referrals w		
		ng transportation for the			be reviewed by the Admissions Directo	r	
		ber 8, 2018. Transportation			and/or Registered Nurse prior to		
		clude 7 residents by the			admissions to ensure that the facility ca	111	
	Facility van and 1 res transportation stretch				safely meet their physical and psychological transportation needs. Up	on	
	transportation streton	ici.			admissions to the facility the resident w		
	All current residents h	have been reviewed by the			be assessed by a Licensed Nurse with		
		nd/or Licensed Nurse on			24 hours of admission to determine the		
	9/7/2018 to identify th				safest mode of transportation for their		
	transportation require	ements and if an escort is			physical and psychological needs.		
	needed when a future	e appointment may be			On 9/6/2018 the Director of Health		
	scheduled. Prior to so	- ·			Services and/or Nurse Managers bega	n	
	-	rrent and/or new residents,			education to the RN□s, LPN□s, C.N.		
		ify the Director of Nursing of			A□s, Receptionist, Schedulers, Transp	ort	
		d Director of Nursing and/or			Drivers, Admissions and Senior Nurse		
		valuate resident to ensure			Navigator (external pre admission		
	their physical and psy	tation continues to meet			evaluator) on all residents must be assessed prior to scheduling		
	their physical and psy	ychologicai needs.			transportation to ensure the correct mo	de	
	On 9/7/2018 New res	sident referrals will be			of transportation will be used to meet the		
		issions Director and/or			residents physical and psychological		
		or to admissions to ensure			needs and that all scheduling of		
		afely meet their physical and			transportation for the residents will be		
	psychological transpo	ortation needs. Upon			done by facility staff only. No staff will b	Эе	
		ility the resident will be			allowed to work until education is		
		sed Nurse within 24 hours of			complete.		
		ne the safest mode of			On 9/6/2018 the Director of Health		
	· · · · · · · · · · · · · · · · · · ·	ir physical and psychological			Services and/ or Licensed Nurse		
	needs.				educated the clinical staff that when a resident has an appointment, the		

OLITICIT	O T OTT MEDIO, THE G	T SELECTION OF SEL				<u> </u>	7. 0000 0001
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ` ′		CONSTRUCTION	(X3) DATE	SURVEY
74401 2744 01	CONTROL	BENTIL ISANISIN NOMBER.	A. BUILD	NG _			
		345105	B. WING				00/2040
NAME OF P	ROVIDER OR SUPPLIER	0.40100			TREET ADDRESS, CITY, STATE, ZIP CODE	09/	08/2018
IVAIVIL OI II	KOVIDER OR GOLT EIER				830 N MAIN STREET		
PRUITTHE	ALTH-HIGH POINT				IIGH POINT, NC 27265		
(X4) ID	SLIMMARY ST	TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLETION DATE
F 835	Continued From page	e 32	F	835			
		ctor of Nurses and/or Nurse	'	000	transportation company will come into	the	
		ication to the RN's, LPN's,			facility and identify themselves to the	IIIE	
		st, Schedulers, Transport			Licensed Nurse on duty by showing the	۵	
	_	and Senior Nurse Navigator			facility staff their employee ID badge	•	
	(external pre admissi				and/or uniform, prior to the resident		
		sessed prior to scheduling			being transported out of the facility.		
		ure the correct mode of			All new hires will be educated during the	neir	
		used to meet the residents			general orientation to the facility		
	•	ogical needs and that all			On 9/7/2018 the Director of Health		
	scheduling of transportation for the residents will				Services and or Licensed Nurses within	า	
	be done by facility sta			the facility are utilizing the Pre / New /			
	allowed to work until	education is complete.			reevaluate transportation audit to revie	W	
	On 9/6/2018 the Dire	ctor of Nursing and/ or			the mobility status, cognitive status		
		cated the clinical staff that			(behaviors/dementia) to determine the		
	when a resident has				safest mode of transportation for reside		
		iny will come into the facility			Effective 5/24/18 the facilities only utilize		
		ves to the Licensed Nurse on			a contracted transportation agency whi		
		facility staff their employee ID			supplements the facilities transportation	n	
	_	n, prior to the resident being			van to accommodate residents		
	transported out of the	-			appointment needs in a timely.		
		educated during their			NA pritaring to appring affective and of		
	general orientation to	•			Monitoring to ensure effectiveness of POC		
		ector of Nursing and or			On 0/7/0040 the D		
		nin the facility are utilizing the			On 9/7/2018 the Regional Area Vice		
		ate transportation audit" to			President attended the ad-hoc Quality		
	review the mobility st				Assurance and Performance	لم	
		to determine the safest			Improvement committee meeting relate		
	mode of transportation				to policy and procedure regarding safe transportation.		
		facilities only utilized a			The Corporate representative will revie	W	
	contracted transporta				any incidents related to transportation		
		lities transportation van to			monthly and report trends / analysis to	tne	
		nts appointment needs in a			corporate Quality Assurance and		
	timely manner.				Performance Improvement team.		
	On 0/6/2040 # 4 !	siniatratar Disastar of LiIII-			The Regional Area Vice President will		
		ninistrator, Director of Health			review the potential for harm form and		
		anager began to review and			attend the Quality Assurance and		
	audictrie pre/new/re	eevaluation transport audit"	1		Performance Improvement committee		

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION NG		(X3) DATE COMP	SURVEY LETED
		345105	B. WING _			l	C 08/2018
PRUITTHE	ROVIDER OR SUPPLIER  EALTH-HIGH POINT  SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	STREET ADDRESS, CITY, STATE, ZIP 3830 N MAIN STREET HIGH POINT, NC 27265 PROVIDER'S PLAN OF		03/	(X5)
(X4) ID PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		PREFIX TAG		TION SHOULD BE THE APPROPRIA		COMPLETION DATE
F 835	and daily/weekly sche new admissions for a for the appropriate more meet their physical arensure safe transport daily for 2 weeks, the weeks and then week until 6 months of cont sustained then quarter. On 9/6/2018 the Adminitial safe mode of tra Quality Assurance an Improvement Commit Director of Nursing wittend the appropriate and present the analy and Performance Improvement Commit Sustained then quarter and present the analy and Performance Improvement Commit Formation of Correction.  The Administrator and services are responsiplan of correction.  The credible allegation removal was verified evidenced by:  During an observation residents were observation for the Facility Trans NA #4 for a shopping signed out and verifies safe modes of transpring that was started on new transportation points.	eduled transportation and ssessment of the resident ode of transportation to ad psychological needs to tation. Th.is will be done in 3 times a week for 6 kly for 1 month then monthly tinued compliance is erly thereafter.  Ininistrator presented the ansportation audit to the ad Performance ttee. The Administrator/ ill continue to track and mode of transportation form yes to the Quality Assurance provement Committee as of continued compliance is erly thereafter.  Id Director of Nursing ible for implementing the on of Immediate Jeopardy 9/8/18 at 12:00 PM as  In on 9/8/18 at 10:40 AM six eved boarding the facility van sportation Coordinator and trip. All residents were ad to have been assessed for ortation in the facility's audit on 9/7/18 per the facility's	F8	meetings to ensure the fact Administration is identifying analyzing and reporting the potential for harm monthly then quarterly thereafter.  Title of person responsible implementing the POC  The Administrator is responsible implementing the plan of complementing the complementing the complementing the c	ng, trending are areas with or for 3 months of for the for the forecorrection.		

NAME OF PROVIDER OR SUPPLIER  PRUITTHEALTH-HIGH POINT   STREET ADDRESS, CITY, STATE, ZIP CODE  3830 N MAIN STREET  HIGH POINT, NC 27265   (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE  COMPL	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTI A. BUILDIN	PLE CONSTRUCTION  G		(X3) DATE SURVEY COMPLETED		
NAME OF PROVIDER OR SUPPLIER  PRUITTHEALTH-HIGH POINT   (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION)  (X5) PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLIANCE OF CROSS-REFERENCED TO THE APPROPRIATE  (X6) PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLIANCE OF CROSS-REFERENCED TO THE APPROPRIATE  (X7) DAY (COMPLIANCE OF CROSS-REFERENCED TO THE APPROPRIATE DAY (COMPLIANCE OF CROSS-REFERENCED TO THE CROSS-REFER			345105	B. WING _			C 09/08/2018	
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in-services were completed with all active facility staff on 9/6/18 through 9/8/18:  In-service by Nurse #3 was completed to educate staff about new policies in place to sign-out residents going to appointments by the driver/person accompanying them. They were also educated to verify the employee identification/uniform of the driver before departure and to sign the resident back in upon return to the facility. A list of approved transportation services was added to the front of every transport binder located on every unit.  In-service was completed to educate staff about new policies to assess newly admitted residents for safe modes of transport. Each resident would also be reviewed prior to admission to make sure needs would be met.  In-service was completed to educate staff that all transportation arrangements would be made by the facility. No insurance company would have the authority to arrange transportation for any resident.  An in-service was completed on 9/6/18 by the Facility Vice President of Operations to educate the Administrator and the DHS about efficient investigations being done for all incidents that affect resident safety. A power-point and check-list for handling immediate jeopardy situations efficiently.  Review of facility records revealed that audits were completed starting on 9/7/18 of:  - Current residents were reviewed for transportation needs, the mode used, and their	F 835	in-services were constaff on 9/6/18 through the staff about sign-out residents good driver/person acconson also educated to verification/uniform departure and to signeturn to the facility. The staff of the s	impleted with all active facility ligh 9/8/18:  urse #3 was completed to new policies in place to oing to appointments by the appanying them. They were rify the employee in of the driver before in the resident back in upon. A list of approved ces was added to the front of the located on every unit.  completed to educate staff to assess newly admitted odes of transport. Each be reviewed prior to sure needs would be met.  completed to educate staff in arrangements would be a No insurance company nority to arrange transportation as completed on 9/6/18 by the ent of Operations to educate and the DHS about efficient done for all incidents that you have a power-point and the properties of the cords revealed that audits riting on 9/7/18 of:  ats were reviewed for	F 8	35			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345105	B. WING		C 09/08/2018	
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE  3830 N MAIN STREET  HIGH POINT, NC 27265		03/00/2010	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION	
F 835	reviewed/assessed transportation required. Three new were reviewed/asses facility  During an interview the Weekend Receleducated on the new transport. She stated driver was an approxidentification, and happointment transport. During an interview Nurse #4 she stated resident would be an of transport. She wappointments that the approved vendor, chave them sign in a transportation.  During an interview Nurse #5 she stated resident would be an of transport. She wappointments that the approved vendor, chave the stated resident would be an of transport. She wappointments that the approved vendor, chapproved vendor, chapproved vendor, chapped vendor, ch	w residents were for safe modes of red admissions on 9/7/18 - all ssed upon admission to the on 9/8/18 at 11:20 PM with otionist revealed that she was w policies of resident ed that she would verify the ved vendor, check their ave them sign in and out for	F 835			