| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345105 | A. BUILDING _____ B. WING _____ | 12/20/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| PRUITTHEALTH-HIGH POINT | 3830 N MAIN STREET HIGH POINT, NC 27265 |

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| E 000 | Initial Comments<br><br>An unannounced Recertification survey was conducted on 12/17/19 through 12/20/19. The facility was found in complaince with the requirement CFR 483.73, Emergency Preparedness. Event ID # YDCD11. | E 000 | | |
| F 558 SS=D | Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3)<br><br>§483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observations, record review and resident and staff interviews, the facility failed to provide a resident access to turn on and off sconce lighting on the wall as desired for 1 of 20 residents (Resident #179) reviewed.<br><br>The findings included:<br><br>Resident #179 was admitted to the facility on 12/2/19 with diagnosis of right fibula fracture.<br><br>A nursing admission assessment dated 12/2/19 revealed Resident #179 was cognitively intact and was non-ambulatory; he required a wheelchair for mobility.<br><br>A care plan dated 12/3/19 indicated problem of a decline in activities of daily living related to a fracture. The goal was for Resident #179 to have his needs met and to maximize his independence potential within the constraints of disease through | F 558 | This plan of correction constitutes a written allegation of substantial compliance with Federal and Medicaid requirements. Preparation and/or execution of this correction do not constitute admission or agreement by the provider of the truth of items alleged or conclusions set forth for the alleged deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provision of the state and federal law. It also demonstrates our good faith and desire to continue to improve the quality of care and services to our residents.<br><br>What corrective action accomplished for those affected?<br><br>A pull string was added to the light cord in the room for resident #179. The resident | 1/17/20 |

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

Electronically Signed | 01/17/2020

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| F 558 | Continued From page 1<br>next 30 days. Approaches included: encourage the resident to do as much as possible for himself, provide assistive device and set up resident to complete activities of daily living.<br><br>An observation on 12/18/19 at 8:50 AM revealed Resident #179 lying in bed in dark room. Resident #179 requested the surveyor to turn on the light. The surveyor observed the light switch on the wall on the left side immediately upon entering the room. Upon turning on the light, the surveyor observed a sconce light on the wall to the left side of the resident ' s bed. The light had a short chain attached to it to turn the light on and off. The chain was so short that it was out of reach of the resident to use to turn the sconce light on and off. During the observation, an interview was conducted with Resident #179. He stated he was in the facility for therapy after he suffered a fall at home and broke his right fibula. He stated he was not to bear any weight to the right leg so was utilizing a wheelchair for mobility. He stated and it was also observed, Resident #179 could propel himself in the wheelchair but was unable to get to the other side of the bed where the light chain was because there wasn ' t enough room between the foot of the bed and the dresser for the wheelchair to fit through. He stated there had never been a string or anything attached to the chain and he would like to be able to use the wall light as it was a softer light, but he was unable to reach it.<br><br>An interview was conducted on 12/20/19 at 4:33 PM with the part time maintenance worker. He stated the Maintenance Director was on vacation and he was filling in. He stated he thought maintenance did room checks on a monthly basis but wasn ' t sure what the schedule was. He | F 558 | was being discharged that afternoon and the bed was turned so that the headboard is against the wall with the sconce light. This made it reachable for the next resident.<br><br>METHODS TO IDENTIFY ANY OTHER RESIDENTS WHO MIGHT BE AFFECTED<br><br>The Maintenance Director audited all rooms to ensure that the light cord was long enough for the resident to turn on the overbed light.<br><br>SYSTEMIC CHANGES<br><br>The Maintenance and Housekeeping Supervisors will be in-serviced to check for lights without proper length strings during monthly Room inspection checks.<br><br>MONITORING PROCESS<br><br>The sconce light cords will be audited by the Maintenance Supervisor, Maintenance Assistant or designee. The audits will look at the light strings being in reach of resident□s bed, in 5 resident rooms 5 times a week for 1 month. Then 5 rooms twice a week for 2 months.<br><br>The administrator and Director of health care services will verify completion and report findings to the quality assurance improvement committee until 3 months of substantial compliance is obtained and quarterly thereafter. | |

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| F 558 | Continued From page 2<br>stated the sconce lighting on the walls should have strings attached so the residents are able to reach them. | F 558 | Date of completion 01-17-2020 | |
| F 584 SS=B | Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7)<br><br>§483.10(i) Safe Environment.<br>The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.<br><br>The facility must provide-<br>§483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible.<br>(i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk.<br>(ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft.<br><br>§483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior;<br><br>§483.10(i)(3) Clean bed and bath linens that are in good condition;<br><br>§483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv);<br><br>§483.10(i)(5) Adequate and comfortable lighting levels in all areas; | F 584 | | 1/17/20 |

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| F 584 | Continued From page 3<br>§483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and<br><br>§483.10(i)(7) For the maintenance of comfortable sound levels.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observations and staff interviews, the facility failed to maintain a safe environment in good repair as evidenced by an exit door in the hallway leading to the therapy gym and activity room with broken glass.<br><br>The findings included:<br><br>Observation on 12/20/19 at 12:52 PM revealed a glass door on the back hallway connecting the 200 hall to the activity room and a therapy gym that had 9 areas of cracked glass extending from one side of the door to the other. The cracked glass was observed to have duct tape covering them. Residents and staff were observed using the hallway where the broken door was located throughout the survey.<br><br>An interview was conducted on 12/20/19 at 12:52 PM with the facility Social Worker. She stated the door to the outside had been broken for several months. She recalled it being hot outside when it happened.<br><br>An interview was conducted on 12/20/19 at 12:59 PM with the maintenance worker. The door in the hallway got broken by a floor cleaning machine and he was waiting for a new one to be put in.<br><br>An interview was conducted on 12/20/19 at 4:21 | F 584 | What Corrective action will be accomplished for the residents found to have been affected by the deficient practice?<br><br>The exit door glass in the back hallway connecting the 200 to the Activities room was replaced on 1/16/2020.<br><br>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?<br><br>The Maintenance Director inspected all facility windows and glass doors to ensure there were no other□s in need of replacement.<br><br>What measures will be put in place or what systemic changes will be made to ensure that the deficient practice will not reoccur?<br><br>The Maintenance man will be in-serviced by the Reginal Director of Maintenance as to the importance of inspecting and making timely repairs that could effect the safety of residents and staff. | |

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| F 584 | Continued From page 4<br>PM with the Administrator. She informed the surveyor the broken door to the outside will be replaced, she stated she had a quote but couldn ' t locate it, she stated she may have sent it directly to corporate. | F 584 | How will the corrective action be monitored to assure that the deficient practice will not reoccur, i.e., what quality assurance program will be put in place for monitoring to assure continued compliance.<br><br>The Maintenance Director, Assistant Maintenance or designee will audit windows and glass doors. They will inspect the whole facility weekly for 1 month, and then twice a month for 2 months and monthly after that during preventative maintenance rounds.<br><br>The administrator and Director of health care services will verify completion and report findings to the quality assurance improvement committee until 3 months of substantial compliance is obtained and quarterly thereafter.<br><br>Date of Compliance:<br>January 17, 2020 | |
| F 609 SS=D | Reporting of Alleged Violations<br>CFR(s): 483.12(c)(1)(4)<br><br>§483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must:<br><br>§483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in | F 609 | | 1/17/20 |

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| F 609 | Continued From page 5<br>serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures.<br><br>§483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.<br>This REQUIREMENT is not met as evidenced by:<br>Based on resident and staff interviews and record review, the facility failed to submit a 2 hour initial allegation report and 5 working day investigation report to the State Survey Agency within the required timeframes for 1 of 1 resident (Resident #24) reviewed for abuse.<br><br>Findings included:<br><br>Resident #24 was admitted to the facility on 4/9/19 with diagnoses that included, in part, hypertension and diabetes.<br><br>The quarterly Minimum Data Set (MDS) assessment dated 9/19/19 revealed Resident #24 was cognitively intact and had no negative behaviors.<br><br>Resident #330 was admitted to the facility on 7/3/19 with diagnoses that included, in part, | F 609 | What Corrective action will be accomplished for the residents found to have been affected by the deficient practice?<br><br>The investigation report for resident #24 although it was not within the 2hr and 5-day guidelines, it was faxed to the State Survey Agency with confirmation of fax.<br><br>Resident #24 incident was reported to Adult Protective Services on 1/23/2020.<br><br>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?<br><br>All future Allegations to the State survey Agency are at risk for untimely reporting. | |

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| F 609 | Continued From page 6 | F 609 | | |

dementia. He discharged from the facility on 11/19/19.

The quarterly MDS assessment dated 10/10/19 indicated Resident #330 was cognitively intact.

The facility's abuse investigations revealed on 11/19/19 Resident #24 reported an allegation of abuse.

The facility's Administrator completed an Initial Allegation Report to the State Agency on 11/19/19. The report designated the type of allegation as "Resident Abuse" and indicated the facility became aware of the allegation at 7:50 PM on 11/19/19. Allegation details revealed Resident #24 and his roommate (Resident #330) had a verbal altercation during which Resident #24 called Resident #330 some names and then Resident #330 punched Resident #24 in the face. The Transmission Verification Report was dated and timed as 11/19/19 at 10:53 PM, three hours and three minutes after the facility became aware of the allegation of abuse.

An Investigation Report was completed and signed by the Administrator on 11/26/19. The Transmission Verification Report was dated and timed as 11/27/19 at 5:47 PM, six working days after the facility became aware of the allegation of abuse.

An interview was completed with Resident #24 on 12/17/19 at 11:09 AM during which he stated about a month ago he and Resident #330 were in their room and the door was closed. Resident #24 reported he asked Resident #330 to open the door to the room since he expected the nurse to bring him medications. Resident #24 explained

An audit was completed on all reportable allegations for last 30 days on 1/17/2020 and findings were 2 out of the 4 reportable were identified as late reporting. These four allegations were reported to Adult Protective Services on 1/23/2020

What measures will be put in place or what systemic changes will be made to ensure that the deficient practice will not reoccur?

The Administrator, Director of Nursing, Clinical Competency Coordinator and Social Worker have been in-serviced by the Regional Nurse Consultant as to the state requirements for reporting all allegations of Abuse within 2 hours then the investigation report must be within 5 working days of the first report on 1/16/2020. All staff was educated on Abuse policy and their obligation for reporting allegation of abuse, resident injury, misconduct or missing items immediately to the Administrator. Any staff that has not completed the education because of vacation, FMLA or PRN status they will be required to complete education before their scheduled shift.

How will the corrective action be monitored to assure that the deficient practice will not reoccur, i.e., what quality assurance program will be put in place for monitoring to assure continued compliance.

All allegations will be called into the Nurse

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| F 609 | Continued From page 7<br>Resident #330 "ran at me, knocked the drink out of my hand, tried to flip over the bed side table and punched me in the nose." The resident added he had gotten along with Resident #330 and there had never been any other altercations prior to the incident. Resident #24 said he reported the allegation to staff, the police were called and the facility completed an investigation.<br><br>During an interview with the Administrator on 12/19/19 at 5:10 PM she explained when an allegation was made and the facility suspected abuse the goal was to "get the initial allegation report in within two hours." She defined physical abuse as "any actual hitting or banging, anything in contact with the body." She confirmed an initial allegation report should have been sent to the State Agency within two hours and an investigation report sent within five working days. The Administrator acknowledged the initial allegation report was not sent within two hours because she had frequent interruptions when she typed the report that included notification of the police and Resident #24's guardian and conversation with the police officer when he arrived at the facility. The Administrator added she miscounted the number of days when she submitted the investigation report and stated the report should have been sent on 11/26/19, "I signed it as completed on the 26th. I got interrupted before faxing it on the 26th and then ended up not sending it until the 27th." | F 609 | Consultant or Area Vice President. The allegation will be placed on a monitoring form and scanned to the Nurse Consultant or Area Vice President for 3 months. The Audit for will indicate the time of allegation, 2hr, 24hour and 5 day report with confirmation.<br><br>The administrator and Director of health care services will verify completion and report findings to the quality assurance improvement committee until 3 months of substantial compliance is obtained and quarterly thereafter.<br><br>Date of Compliance:<br>January 17, 2020 | |
| F 636 SS=D | Comprehensive Assessments & Timing<br>CFR(s): 483.20(b)(1)(2)(i)(iii)<br><br>§483.20 Resident Assessment<br>The facility must conduct initially and periodically a comprehensive, accurate, standardized | F 636 | | 1/17/20 |

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| F 636 | Continued From page 8 | F 636 | | |

reproducible assessment of each resident's functional capacity.

§483.20(b) Comprehensive Assessments
§483.20(b)(1) Resident Assessment Instrument.
A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following:
(i) Identification and demographic information
(ii) Customary routine.
(iii) Cognitive patterns.
(iv) Communication.
(v) Vision.
(vi) Mood and behavior patterns.
(vii) Psychological well-being.
(viii) Physical functioning and structural problems.
(ix) Continence.
(x) Disease diagnosis and health conditions.
(xi) Dental and nutritional status.
(xii) Skin Conditions.
(xiii) Activity pursuit.
(xiv) Medications.
(xv) Special treatments and procedures.
(xvi) Discharge planning.
(xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS).
(xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and nonlicensed direct care staff members on all shifts.

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| F 636 | Continued From page 9<br>§483.20(b)(2) When required. Subject to the timeframes prescribed in §413.343(b) of this chapter, a facility must conduct a comprehensive assessment of a resident in accordance with the timeframes specified in paragraphs (b)(2)(i) through (iii) of this section. The timeframes prescribed in §413.343(b) of this chapter do not apply to CAHs.<br>(i) Within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or therapeutic leave.)<br>(iii)Not less than once every 12 months.<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review and staff interviews, the facility failed to complete and submit comprehensive Minimum Data Set (MDS) assessments for 1 of 3 residents (Resident #7) reviewed for activities of daily living.<br><br>The findings included:<br><br>Resident #7 was admitted to the facility on 9/11/09 with diagnoses of, in part, schizophrenia and Alzheimer ' s.<br><br>A record review revealed Resident #7 had a quarterly assessment completed and submitted on 7/30/19. Resident #7 ' s last annual comprehensive assessment was dated 11/9/18. The record revealed an open annual assessment dated 10/30/19 that was marked "not completed".<br><br>An interview was conducted on 12/19/19 at 3:42 PM with the MDS Nurse. She stated she had only | F 636 | What Corrective action will be accomplished for the residents found to have been affected by the deficient practice?<br><br>A Comprehensive Assessment was completed for Resident # 7 on 1/10/2020.<br>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?<br><br>"Late Comprehensive assessment will be reviewed by Interdisciplinary team to identify any residents who have not had a timely comprehensive assessment.<br>"Comprehensive assessments that are already late will be scheduled so that two assessments are completed each week until all is done<br>"Comprehensive assessments that are | |

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| F 636 | Continued From page 10<br>been working at the facility for a month and a half and prior to her employment there was an MDS nurse that only worked part time and the assessments had gotten behind.<br><br>An interview was conducted with the Administrator on 12/20/19 at 4:21 PM. She revealed she had a lot of turnover in the MDS department this year and knew they were behind. She stated she was working on a plan to get the MDS assessments caught up. | F 636 | coming due, we will complete no later than 365 days from prior full comprehensive assessment<br><br>What measures will be put in place or what systemic changes will be made to ensure that the deficient practice will not reoccur?<br><br>The Clinical Reimbursement Coordinator in-serviced on 1/13/20 the Dietary Manager, MDS Coordinator, Social Worker, and Activities Director on the requirements of completing quarterly MDS assessments within 365 days of the previous full comprehensive assessment as required. The Resident MDS 3.0 Status Report will be printed and reviewed by the Interdisciplinary Team in morning meeting.<br><br>How will the corrective action be monitored to assure that the deficient practice will not reoccur, i.e., what quality assurance program will be put in place for monitoring to assure continued compliance.<br><br>The Administrator and the Director of Health Services will review the due Quarterly Assessments 5 days a week for 4 weeks, then weekly for 2 months and then quarterly thereafter until compliance has been maintained for 3 quarters.<br><br>The administrator and Director of health care services will verify completion and report findings to the quality assurance improvement committee until 3 months of | |

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| F 636 | Continued From page 11 | F 636 | substantial compliance is obtained and quarterly thereafter.<br><br>Date of Compliance:<br>January 17, 2020 | |
| F 637 SS=D | Comprehensive Assessment After Signifcant Chg CFR(s): 483.20(b)(2)(ii)<br><br>§483.20(b)(2)(ii) Within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a "significant change" means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.)<br>This REQUIREMENT is not met as evidenced by:<br>Based on staff interviews and medical record review, the facility failed to complete a significant change comprehensive assessment within 14 days of an identified significant change in status for 1 of 1 resident (Resident # 49) reviewed.<br><br>The findings included:<br><br>Resident #49 was admitted to the facility on 1/30/19. She discharged to the hospital on 11/1/19 and re-admitted to the facility on 11/6/19 with diagnoses that included, in part, respiratory failure and muscle weakness.<br><br>The quarterly Minimum Data Set (MDS) | F 637 | What Corrective action will be accomplished for the residents found to have been affected by the deficient practice?<br><br>A significant change MDS modification was completed for Resident # 49 on 12/31/19.<br><br>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?<br><br>An audit was completed on 1/15/2020 for | 1/17/20 |

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| F 637 | Continued From page 12<br>assessment dated 10/15/19 revealed Resident #49 was cognitively intact.<br><br>A significant change MDS assessment dated 11/6/19 indicated the assessment was in progress. Sections C, D, E, F, G, H, I, J, K, L, M, N, P and Q had not been completed.<br><br>An interview was completed with the MDS Nurse on 12/20/19 at 10:29 AM. She said a significant change assessment was in process for 11/6/19 since Resident #49 returned from the hospital with a urostomy and had some decline in activities of daily living. She reported the significant change was identified on 11/6/19 and stated the facility had 14 days before the assessment needed to be completed, which was on 11/20/19. The MDS Nurse added she had been employed at the facility for a month and, "When I started working I noticed the MDS assessments were behind." She explained her plan was that current MDS assessments were completed on time and the MDS office worked on the backlog of assessments as they were able. She further added she had two other nurses who helped her on a part time basis.<br><br>On 12/20/19 at 4:09 PM the Administrator was interviewed. She recalled the facility had employed 8 different MDS nurses since the beginning of 2019. She admitted there were issues with staff retention in the MDS office and because of frequent staff turnover the completion of MDS assessments had fallen behind schedule. The Administrator said the facility identified the backlog of MDS assessments as an issue in October and started a performance improvement plan in November. | F 637 | all resident assessment for last 90 days, there was 4 significant changes that were identified, three significant change assessments have been completed and transmitted with one being completed today 1/22/2020.<br><br>What measures will be put in place or what systemic changes will be made to ensure that the deficient practice will not reoccur?<br><br>The Clinical Reimbursement Coordinator in-serviced on 1/13/20 the Dietary Manager, MDS Coordinator, Social Worker, and Activities Director on the requirements of completing significant change comprehensive assessment within 14days as per Resident Assessment Instrument Guidelines. The Resident MDS 3.0 Status Report will be printed and reviewed by the Interdisciplinary Team in morning meeting.<br><br>How will the corrective action be monitored to assure that the deficient practice will not reoccur, i.e., what quality assurance program will be put in place for monitoring to assure continued compliance.<br><br>The Administrator and the Director of Health Services will review the assessment with Significant Change for timely completion 5 days a week for 4 weeks, then weekly for 2 months and then quarterly thereafter until compliance has been maintained for 3 quarters. | |

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| F 637 | Continued From page 13 | F 637 | The administrator and Director of health care services will verify completion and report findings to the quality assurance improvement committee until 3 months of substantial compliance is obtained and quarterly thereafter.<br><br>Date of Compliance:<br>January 17, 2020 | |
| F 638 SS=D | Qrtly Assessment at Least Every 3 Months<br>CFR(s): 483.20(c)<br><br>§483.20(c) Quarterly Review Assessment<br>A facility must assess a resident using the quarterly review instrument specified by the State and approved by CMS not less frequently than once every 3 months.<br>This REQUIREMENT is not met as evidenced by:<br>Based on staff interviews and medical record review, the facility failed to complete a quarterly Minimum Data Set (MDS) assessment within 92 days of the Assessment Reference Date of the previous MDS assessment for 1 of 22 residents (Resident #13) reviewed for timely completion of MDS assessments; and the facility failed to quarterly assess the placement of a wanderguard to the ankle of 1 of 2 sampled residents (Resident #61) reviewed for elopement risk.<br><br>The findings included:<br><br>1. Resident #13 was admitted to the facility on 10/28/15 with diagnoses that included, in part, polyneuropathy and muscle weakness.<br><br>The quarterly MDS assessment dated 8/14/19 revealed Resident #13 was cognitively intact. | F 638 | What Corrective action will be accomplished for the residents found to have been affected by the deficient practice?<br><br>A Quarterly Review Assessment was completed for Resident # 13 on 1/05/2020.<br><br>Resident #61 quarterly elopement risk observation completed on 01/02/2020.<br><br>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?<br><br>An audit was completed on 1/15/2020, there were 5 quarterly assessments which | 1/17/20 |

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| F 638 | Continued From page 14<br><br>A quarterly MDS assessment dated 11/6/19 indicated the assessment was in progress. Sections A, B, C, G, H, I, J, K, L, M, N, O and P had not been completed.<br><br>An interview was completed with the MDS Nurse on 12/20/19 at 10:29 AM. She verified that quarterly assessments were to be completed within 92 days of the previous MDS assessment and stated Resident #13's quarterly assessment should have been completed on 11/15/19. The MDS Nurse said she had been employed at the facility for a month and, "When I started working I noticed the MDS assessments were behind." She explained her plan was that current MDS assessments were completed on time and the MDS office worked on the backlog of assessments as they were able. She further added she had two other nurses who helped her on a part time basis.<br><br>On 12/20/19 at 4:09 PM the Administrator was interviewed. She recalled the facility had employed 8 different MDS nurses since the beginning of 2019. She admitted there were issues with staff retention in the MDS office and because of frequent staff turnover the completion of MDS assessments had fallen behind schedule. The Administrator said the facility identified the backlog of MDS assessments as an issue in October and started a performance improvement plan in November.<br><br>2. Resident #61 was admitted to the facility on 9/7/18 with the diagnoses which included: Alzheimer's disease, dementia, and bipolar disorder. | F 638 | were considered late but has already been completed and transmitted.<br><br>Late quarterly assessments will be reviewed by Interdisciplinary team to identify any residents who have not had a timely quarterly assessment. Quarterly assessments that are already late will be scheduled so that five assessments are completed each week until all is done. Quarterly assessments that are coming due, we will complete no later than 92 days from prior OBRA assessment<br><br>An Elopement quarterly observation was completed for all resident on 01-04-2020. An audit was conducted by the Director of Health services and Nurse Manager of all residents and new admissions for the past 30 days and all residents had an elopement assessment completed to be brought into compliance. There were 81 elopement observations completed.<br><br>What measures will be put in place or what systemic changes will be made to ensure that the deficient practice will not reoccur?<br><br>The Clinical Reimbursement Coordinator in-serviced on 1/13/20 the Dietary Manager, MDS Coordinator, Social Worker, and Activities Director on the requirements of completing quarterly MDS assessments within 92 days of the previous assessment as required.<br><br>The Resident MDS 3.0 Status Report will be printed and reviewed by the | |

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| F 638 | Continued From page 15<br>A review of the physician's order dated 7/24/19 revealed a wanderguard was placed on Resident #61's left ankle for safety and positioning. The wanderguard was to be checked for placement during each shift.<br><br>The review of the most recent minimum data set dated 11/15/19 indicated Resident #61 was moderately, cognitively intact; had no wandering behaviors; required supervision with walking; and had daily use of a wander/elopement alarm.<br><br>The revised Care Plan dated 12/13/19 revealed Resident #61 wore a wanderguard bracelet due to his risk for wandering/elopement. The wanderguard bracelet was to be checked every shift for placement and function by the nursing staff.<br><br>A review of Resident #61's clinical records provided no quarterly assessment documentation indicating the continued use of the wanderguard was appropriate.<br><br>During an observation of the secured unit of the facility on 12/17/19 at 11:45 p.m., Resident #61 was observed ambulating into his room from the hallway; he was wearing a wanderguard on his left ankle.<br><br>During an interview on 12/19/19 at 8:58 a.m., Nurse #2 revealed that after attempting to leave the facility after admission, Resident #61 was assessed as an elopement risk and a wanderguard was placed on his ankle. Nurse #2 stated that the nursing staff mostly used word of mouth when reassessing the residents' wanderguards. | F 638 | Interdisciplinary Team in morning meeting.<br><br>Director of Health Services and Clinical Competency Coordinator educated all license nurses on the process of completing Clinical Quarterly Assessment based on the MDS schedule calendar on 1/17/2020. Any license nurses that have not completed the education because of FMLA, vacation or PRN status will be required to complete education prior to next schedule shift.<br><br>How will the corrective action be monitored to assure that the deficient practice will not reoccur, i.e., what quality assurance program will be put in place for monitoring to assure continued compliance.<br><br>The Administrator and the Director of Health Services will review the due Quarterly Assessments 5 days a week for 4 weeks, then weekly for 2 months and then quarterly thereafter until compliance has been maintained for 3 quarters.<br><br>The Director of Health Service, Case Mix Coordinators and Clinical Competency Coordinator will review all new admissions/re-admission and quarterly assessment based on MDS calendar daily for the next 7 days then weekly for 4 weeks then, monthly until sustained compliance is maintain.<br><br>The administrator and Director of health care services will verify completion and report findings to the quality assurance | |

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| F 638 | Continued From page 16<br>During an interview on 12/19/19 at 3:56 p.m., the DON (Director of Nursing) stated after reviewing Resident #61's clinical records, she was unable to locate any quarterly assessments of the resident's continued use/need for the wanderguard. She revealed that during the quarterly review, nursing, social services, and minimum data set staff were to assess if the wanderguard continued to be the appropriate intervention for the resident. | F 638 | improvement committee monthly until 3 months of substantial compliance is sustained and quarterly thereafter.<br><br>Date of Compliance:<br>January 17, 2020 | |
| F 645 SS=D | PASARR Screening for MD & ID<br>CFR(s): 483.20(k)(1)-(3)<br><br>§483.20(k) Preadmission Screening for individuals with a mental disorder and individuals with intellectual disability.<br><br>§483.20(k)(1) A nursing facility must not admit, on or after January 1, 1989, any new residents with:<br>(i) Mental disorder as defined in paragraph (k)(3)(i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission,<br>(A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and<br>(B) If the individual requires such level of services, whether the individual requires specialized services; or<br>(ii) Intellectual disability, as defined in paragraph (k)(3)(ii) of this section, unless the State intellectual disability or developmental disability authority has determined prior to admission-<br>(A) That, because of the physical and mental condition of the individual, the individual requires | F 645 | | 1/17/20 |

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| F 645 | Continued From page 17 | F 645 | | |

the level of services provided by a nursing facility; and
(B) If the individual requires such level of services, whether the individual requires specialized services for intellectual disability.

§483.20(k)(2) Exceptions. For purposes of this section-
(i)The preadmission screening program under paragraph(k)(1) of this section need not provide for determinations in the case of the readmission to a nursing facility of an individual who, after being admitted to the nursing facility, was transferred for care in a hospital.
(ii) The State may choose not to apply the preadmission screening program under paragraph (k)(1) of this section to the admission to a nursing facility of an individual-
(A) Who is admitted to the facility directly from a hospital after receiving acute inpatient care at the hospital,
(B) Who requires nursing facility services for the condition for which the individual received care in the hospital, and
(C) Whose attending physician has certified, before admission to the facility that the individual is likely to require less than 30 days of nursing facility services.

§483.20(k)(3) Definition. For purposes of this section-
(i) An individual is considered to have a mental disorder if the individual has a serious mental disorder defined in 483.102(b)(1).
(ii) An individual is considered to have an intellectual disability if the individual has an intellectual disability as defined in §483.102(b)(3) or is a person with a related condition as

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| F 645 | Continued From page 18<br>described in 435.1010 of this chapter.<br>This REQUIREMENT is not met as evidenced by:<br>Based on staff interview and record review, the facility failed to obtain a Level II Preadmission Screening and Resident Review (PASRR) for a resident with an active diagnosis of a serious mental illness for one of one resident reviewed for PASRR (Resident #47).<br><br>Findings included:<br><br>Resident #42 was admitted on 9/19/17 for aftercare following a gunshot to the head, Cognitive Loss, Depression, Anxiety, and Schizophrenia.<br><br>Resident #42's PASRR Level I Determination Notification document dated 9/19/17 revealed nursing facility placement was appropriate and that there was no diagnosis that would require a PASRR Level II to be done.<br><br>The quarterly Minimum Data Set (MDS) assessment dated 11/4/19 revealed Resident #47 was moderately-severely cognitively impaired. The MDS further revealed that Resident #47 required extensive assistance with transfers, bed mobility, and toileting. The resident was noted to exhibit verbal behaviors towards others and was occasionally combative with care.<br><br>Resident #47's medical record showed that a current care plan was in place for his diagnosis of Schizophrenia. The record also revealed that resident had been treated by a Behavioral Health group at regularly intervals since admission and was prescribed Seroquel 150 milligrams twice daily. | F 645 | What Corrective action will be accomplished for the residents found to have been affected by the deficient practice?<br><br>The Social Worker reviewed the past Psychiatric Progress notes for resident #42. Verified the New Psychiatric Diagnosis and care plan was updated and PASRR Level 2 was obtained on 12/30/2019.<br><br>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?<br><br>An Audit of all resident was completed identifying those with diagnosis□s falling in the Axis 1 disorders, by the Social Worker on 1/06/2020. A PASRR Level 2 from NCMUST will be requested for those residents identified with an Axis 1 diagnosis. This will be completed for 5 residents a week until everyone has been reviewed by NCMUST.<br><br>What measures will be put in place or what systemic changes will be made to ensure that the deficient practice will not reoccur?<br><br>The Social Worker was educated by the Clinical District Director of Nursing on the requirement s and importance of identifying and requesting PASRR Level | |

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| F 645 | Continued From page 19<br><br>An interview was conducted with the facility's social worker on 12/20/19 at 9:10 am revealed she was unaware that Resident #42 had a diagnosis of Schizophrenia and did not have a PASRR Level II completed.<br><br>An interview was conducted with the facility's Administrator on 12/20/19 at 4:39 PM who was aware of Resident #47's diagnoses of Schizophrenia but was unaware that he had not had a PASRR Level II completed. | F 645 | 2□s. 1/13/2020 The Social Worker met with the PASRR 2 representative from NCMUST and reviewed those diagnosis included in the Axis 2 category. New Mental Health progress notes will be reviewed by the Social Worker or a Nurse who is part of the IDT for changes or new diagnosis. All new admissions will be reviewed by the Social Worker, MDS, DHS or IDT member for having an Axis 1 diagnosis requiring a level 2 PASRR.<br><br>How will the corrective action be monitored to assure that the deficient practice will not reoccur, i.e., what quality assurance program will be put in place for monitoring to assure continued compliance.<br><br>The Administrator will review the Social Workers progress of the completion of those residents currently in the facility requiring PASRR 2 screening and new admissions 5 times a week for 1 month and 2 times a week for 2 months.<br><br>The Administrator and Director of Health Care Services will verify completion and report findings to the quality assurance improvement committee until 3 months of substantial compliance is obtained and quarterly thereafter.<br><br>Date of completion 01-17-2020<br><br>Date of Compliance:<br>January 17, 2020 | |
| F 655 | Baseline Care Plan | F 655 | | 1/17/20 |

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| F 655 SS=D | Continued From page 20<br>CFR(s): 483.21(a)(1)-(3)<br><br>§483.21 Comprehensive Person-Centered Care Planning<br>§483.21(a) Baseline Care Plans<br>§483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must-<br>(i) Be developed within 48 hours of a resident's admission.<br>(ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to-<br>(A) Initial goals based on admission orders.<br>(B) Physician orders.<br>(C) Dietary orders.<br>(D) Therapy services.<br>(E) Social services.<br>(F) PASARR recommendation, if applicable.<br><br>§483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan-<br>(i) Is developed within 48 hours of the resident's admission.<br>(ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section).<br><br>§483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to:<br>(i) The initial goals of the resident.<br>(ii) A summary of the resident's medications and | F 655 | | |

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| PRUITTHEALTH-HIGH POINT | 3830 N MAIN STREET HIGH POINT, NC 27265 |

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| F 655 | Continued From page 21<br>dietary instructions.<br>(iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility.<br>(iv) Any updated information based on the details of the comprehensive care plan, as necessary.<br>This REQUIREMENT is not met as evidenced by:<br>Based on resident and staff interviews and record review, the facility failed to develop a baseline care plan for a resident with an indwelling catheter for 1 of 1 residents reviewed for catheters (Resident #51), and failed to provide a written summary of the baseline care plan to the resident for 1 of 6 (Resident #329) residents reviewed with baseline care plans.<br><br>The findings included:<br><br>1. Resident #51 was admitted to the facility on 11/2/19 with a diagnosis of, in part, urinary retention.<br><br>A review of and admission Minimum Data Set assessment dated 11/12/19 revealed Resident #51 utilized an indwelling catheter.<br><br>A review of the physician ' s orders revealed an order for indwelling catheter.<br><br>A physician ' s progress note dated 11/8/19 revealed Resident #51 was seen for admission follow up. The progress note indicated the indwelling catheter continues without hematuria.<br><br>An observation on 12/18/19 at 8:59 AM revealed Resident #51 lying in bed. A catheter bag was observed on the side of the bed. | F 655 | What Corrective action will be accomplished for the residents found to have been affected by the deficient practice?<br><br>Care planning meeting was set for Resident # 329 and completed on 12/27/19. Care plan summary was discussed with Resident #329. A copy of care plan was given to Resident #329. Resident # 51 indwelling catheter was discontinued on 12/20/19 and care plan updated.<br><br>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?<br><br>An audit of all residents admitted within the month of December 2019 and January 2020 was completed. A care plan meeting was set up with the interdisciplinary team for Residents admitted in December of 2019 and January of 2020. Resident□s care plan was discussed with Resident or responsible party. A copy of the care plan was given to Resident or Responsible party. An audit was done on Residents admitted within the month of December of | |

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| F 655 | Continued From page 22<br>A record review revealed Resident #51 did not have a baseline care plan that included the use and care of an indwelling catheter. A problem of urinary retention requiring the use of an indwelling catheter was not added to the care plan until 11/23/19.<br><br>An interview was conducted with Nurse #3 on 12/19/19 at 9:30 AM. She revealed the admission nurse is responsible for developing the baseline care plan and Resident #51 should have had a baseline care plan that included the use of an indwelling catheter.<br><br>2. Resident #329 was admitted to the facility on 11/26/19 with diagnoses that included, in part, hypertension, diabetes and congestive heart failure.<br><br>The comprehensive Minimum Data Set (MDS) assessment dated 12/3/19 revealed Resident #329 was cognitively intact.<br><br>The medical record indicated Resident #329 was her own responsible party/representative.<br><br>A baseline care plan was completed 11/27/19. There was no documented evidence that a written summary of the baseline care plan was given to Resident #329.<br><br>On 12/17/19 at 3:50 PM an interview was completed with Resident #329. She said she had not received a summary of the baseline care plan or a list of her medications.<br><br>During an interview with the MDS Nurse on | F 655 | 2019 and January of 2020 with a Foley catheter to make sure Foley catheter care is on baseline care plan.<br><br>What measures will be put in place or what systemic changes will be made to ensure that the deficient practice will not reoccur?<br><br>The Clinical Reimbursement Coordinator in-serviced on 1/13/20 the Dietary Manager, MDS Coordinator, Social Worker, and Activities Director on the policy and procedure of the Baseline Care plans. The interdisciplinary team will participate in the development of Resident□s baseline care plan within 24hrs of admission and will be completed and implemented within 48hrs of admission. A care plan summary will be printed and discussed with Resident or Resident□s responsible party within 48hrs of admission.<br><br>How will the corrective action be monitored to assure that the deficient practice will not reoccur, i.e., what quality assurance program will be put in place for monitoring to assure continued compliance.<br><br>The Administrator and Director of Healthcare Services will verify that all new admissions have baseline care plan initiated in MatrixCare. Social Worker will print out care plan summary to be reviewed with resident or responsible family and a copy given to resident or responsible party. A copy of care plan | |

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| F 655 | Continued From page 23<br>12/19/19 at 3:31 PM she indicated she had been employed at the facility for one month. She explained the baseline care plan was completed by the admission nurse and the social worker scheduled a 72 hour meeting and/or a comprehensive care plan meeting where the written summary was then provided to the resident. Once the summary was provided to the resident the social worker documented in the medical record that a copy of the baseline care plan was given to the resident. The MDS Nurse reported she had met with Resident #329 and completed her MDS assessment but the team had not yet met with the resident and reviewed the care plan.<br><br>The facility Social Worker was interviewed on 12/19/19 at 3:55 PM. She revealed typically the care plan team met with a new resident and reviewed the baseline care plan. The Social Worker then provided a written summary of the baseline care plan and documented in the medical record that the copy was given to the resident. The Social Worker admitted that the process wasn't always completed and added she had not given a written summary of the baseline care plan to Resident #329 because she hadn't had time.<br><br>On 12/19/19 at 5:21 PM an interview was completed with the Administrator. She stated the Director of Nursing (DON), Social Worker and MDS Nurse oversaw the care plan process. She explained the facility's goal was to have a 48 or 72 hour meeting with residents and/or families where the baseline care plan was reviewed and a copy provided to the resident/family. The Administrator said she knew the Social Worker and Resident #329 had talked "quite a bit" but | F 655 | summary will be kept in a book for verification as part of our auditing process. Administrator and Director of Healthcare Services will check daily for 4 weeks, weekly for 2 months, and then quarterly thereafter. The administrator and Director of health care services will verify findings and report to the Quality Assurance Performance Improvement committee until 3 months of substantial compliance is obtained and quarterly thereafter.<br><br>Date of Compliance:<br>January 17, 2020 | |

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| F 655 | Continued From page 24<br>didn't know whether Resident #329 had received a written summary of the baseline care plan. | F 655 | | |
| F 686 SS=D | Treatment/Svcs to Prevent/Heal Pressure Ulcer<br>CFR(s): 483.25(b)(1)(i)(ii)<br><br>§483.25(b) Skin Integrity<br>§483.25(b)(1) Pressure ulcers.<br>Based on the comprehensive assessment of a resident, the facility must ensure that-<br>(i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and<br>(ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observations, record review and staff interviews, the facility failed to follow a physician ordered intervention for the use of pressure reduction of the elbows for 1 of 3 residents (Resident #51) reviewed for pressure ulcers.<br><br>The findings included:<br><br>Resident #51 was admitted to the facility on 11/2/19 with diagnoses of, in part, diabetes mellitus type 2, kidney disease and neuropathy.<br><br>An admission Minimum Data Set dated 11/12/19 revealed Resident #51 was cognitively intact. She required extensive assistance with bed mobility, transfers, dressing and meals with 1-2 people. She was totally dependent for toileting, hygiene | F 686 | IMMEDIATE CORRECTIVE ACTION<br><br>Resident # 51 Heel and elbow protectors have been discontinued on 12/20/2019.<br><br>METHODS TO IDENTIFY ANY OTHER RESIDENTS WHO MIGHT BE AFFECTED<br><br>An audit of 100 % resident physician orders was completed by Director of Health services and Nurse Managers was completed on 01/15/2020 to ensure all residents has appropriate pressure reducing devices in place. Two residents did not need current order and the orders were discontinued on 01/15/2020. | 1/17/20 |

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| F 686 | Continued From page 25<br>and bathing. Resident #51 was not ambulatory. The assessment indicated Resident #51 had no pressure ulcers present and was at risk for pressure ulcers. She utilized a pressure reducing device to her bed.<br><br>A review of the care plan dated 11/4/19 revealed a problem of impaired skin integrity related to a diabetic ulcer to right ankle with a goal for the ulcer to heal without complications. Interventions included, in part, avoid friction and shearing forces during transfers or position changes, keep bony prominences from direct contact with one another with pillows as needed. The care plan was updated on 12/4/19 to reflect a pressure ulcer to Resident #51 ' s sacrum.<br><br>A record review revealed a physician ' s order for heel and elbow protectors at all times dated 12/13/19.<br><br>An observation on 12/18/19 at 3:37 PM revealed Resident #51 in bed. No elbow protectors observed on.<br><br>An observation on 12/19/19 at 8:41 AM revealed Resident #51 in bed. No elbow protectors observed on.<br><br>An interview was conducted with Nurse #2 on 12/20/19 at 10:26 AM. He stated Resident #51 was only to wear the elbow protectors while in bed. When the surveyor informed him Resident #51 did not have the elbow protectors on at all, he stated he would have to check the order.<br><br>An interview was conducted with the Wound Nurse on 12/20/19 at 11:330 AM. She revealed Resident #51 did not like getting out of bed but | F 686 | All residents with the potential of skin impairment are at risk.<br><br>SYSTEMIC CHANGES<br><br>The Clinical Competency Coordinator and Director of Health Services have educated all nursing staff on the identification /implementing treatments for prevention and treatment of skin integrity issues.<br><br>All nursing has been educated on the use of proper devices or dressing and the identification of any new pressure issues. Training Completed on 01/15/2020.<br><br>All New employees will be trained during their orientation.<br><br>MONITORING PROCESS<br><br>The Clinical Competency Coordinator and the Director of Health services will audit 2 residents to ensure treatments are in place daily for a week and then 5 a week for 4 weeks and then monthly for 3 months.<br><br>The administrator and Director of health care services will verify completion and report findings to the quality assurance improvement committee until 3 months of substantial compliance is obtained and quarterly thereafter.<br><br>Date of completion 01-17-2020 | |

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| F 686 | Continued From page 26<br>was getting better about getting up for a little while each day. The Wound Nurse further stated the sacral wound was improving. When asked about pressure reducing devices, she stated she made sure the devices were in place when she completed the treatments, but the nursing assistants and hall nurses were responsible for making sure they were in place throughout the shift. | F 686 | | |
| F 690 SS=D | Bowel/Bladder Incontinence, Catheter, UTI<br>CFR(s): 483.25(e)(1)-(3)<br><br>§483.25(e) Incontinence.<br>§483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain.<br><br>§483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that-<br>(i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary;<br>(ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and<br>(iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. | F 690 | | 1/17/20 |

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| F 690 | Continued From page 27<br><br>§483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observations, record review and staff interviews, the facility failed to initiate a trial void per the hospital discharge summary for 1 of 1 resident (Resident #51) reviewed for catheters.<br><br>The findings included:<br><br>Resident #51 was admitted to the facility on 11/2/19 with a diagnosis of urinary retention.<br><br>A review of the admission Minimum Data Set assessment dated 11/12/19 revealed Resident #51 had an indwelling catheter. Resident #51 had moderately impaired cognition.<br><br>A review of the hospital discharge summary dated 11/2/19 revealed "patient had urinary retention early in the hospital course and required a catheter. Voiding trial was attempted after ensuring constipation was not contributing. However, she was unable to void spontaneously after the catheter was removed. She had large bladder volume of 1,000 milliliters and subsequently 497 milliliters on 10/30/19. Catheter was replaced 10/30/19. Would continue indwelling catheter for at least 2 weeks before attempting voiding trial. Consider outpatient urology referral if unsuccessful. Hopefully, as she regains strength and mobility, she will be able to | F 690 | IMMEDIATE CORRECTIVE ACTION<br><br>The Foley catheter was removed from resident #51 on12/21/2019 per physician without any adverse effect.<br><br>METHODS TO IDENTIFY ANY OTHER RESIDENTS WHO MIGHT BE AFFECTED<br><br>An 100% audit was conducted by the Director of Health Services and Nurse Managers, of all residents regarding urinary catheter devices.<br>No additional residents were found to be affected.<br><br>SYSTEMIC CHANGES<br><br>All Licensed Nurses were educated on a resident with indwelling catheter, including diagnosis, voiding trials, etc. Completed on 01/15/2020.<br>All Residents admitted with Foley catheters will have their orders and discharge summary reviewed by charge nurse and verified for necessity, appropriate diagnosis, and potential voiding trials. All new admissions orders | |

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| F 690 | Continued From page 28<br>void spontaneously."<br><br>A physician ' s progress note dated 11/8/19 revealed Resident #51 was seen for admission follow up. The note indicated the "catheter continues with no hematuria (blood in the urine)."<br><br>An observation on 12/18/19 at 8:59 AM revealed Resident #51 lying in bed. A catheter drainage bag was observed to the right side of the bed. The catheter was draining clear, yellow urine. The resident was unable to be interviewed at that time about her catheter due to her cognitive status.<br><br>An interview on 12/19/19 at 9:30 AM with Nurse #3 revealed when a resident is admitted to the facility with an indwelling catheter and there is no diagnosis, there will be trial void. If there is a diagnosis, the physician will address the catheter usage.<br><br>An interview on 12/20/19 at 10:36 AM with the Nurse Practitioner revealed she couldn ' t recall what she did about Resident #51 ' s catheter. She stated she should have written an order for a voiding trial, but she must have missed it. | F 690 | and discharge summary will be review the Director of Health Services and Nurse Managers to ensure that there is appropriate diagnosis.<br><br>MONITORING PROCESS<br><br>The Director of Health Service, Case Mix Coordinators and Clinical Competency Coordinator will track, trend and analyze the Foley catheter checklist on all new admissions: Daily for the next 5 days then weekly for 4 weeks then, monthly until 6 months of sustained compliance is obtained.<br><br>The Director of Health Care Services will present the findings of the Foley Catheter review to the Quality Assurance and Performance Improvement Committee monthly until three months of continued compliance is maintained then quarterly thereafter. | |
| F 867 SS=D | QAPI/QAA Improvement Activities<br>CFR(s): 483.75(g)(2)(ii)<br><br>§483.75(g) Quality assessment and assurance.<br><br>§483.75(g)(2) The quality assessment and assurance committee must:<br>(ii) Develop and implement appropriate plans of action to correct identified quality deficiencies;<br>This REQUIREMENT is not met as evidenced by:<br>Based on staff interviews and record review, the | F 867 | What Corrective action will be | 1/17/20 |

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| F 867 | Continued From page 29<br>facility's Quality Assurance Performance Improvement Committee (QAPI) failed to maintain implemented procedures and monitor interventions that the committee put into place following the 1/10/19 recertification and complaint survey. This was for two recited deficiencies in the area of timely completion of Minimum Data Set (MDS) assessments. These deficiencies were cited again on the current recertification survey on 12/20/19. The continued failure of the facility during two federal surveys of record shows a pattern of the facility's inability to sustain an effective QAPI Program.<br><br>Findings included:<br><br>This tag is cross referenced to:<br><br>F-637: Based on staff interviews and medical record review, the facility failed to complete a significant change comprehensive assessment within 14 days of an identified significant change in status for 1 of 1 resident (Resident # 49) reviewed.<br><br>During the recertification and complaint survey of 1/10/19 the facility was cited at F-637 because they failed to complete a significant change assessment within the required time frame for 2 residents reviewed for significant change assessments.<br><br>F-638: Based on staff interviews and medical record review, the facility failed to complete a quarterly Minimum Data Set (MDS) assessment within 92 days of the Assessment Reference Date of the previous MDS assessment for 1 of 22 residents (Resident #13) reviewed for timely completion of MDS assessments. | F 867 | accomplished for the residents found to have been affected by the deficient practice?<br><br>Facility addressed the repeated cited deficiencies for the affected residents listed below and held a QAPI meeting 12/30/19 reviewing the PIP□s initiated for late assessments and repeat citations. F637 Comprehensive Assessment After Significant Change and F638. Quarterly Review Assessment. In attendance was Administrator, Director of Nursing, MDS Coordinator, Medical Director, Clinical Education Coordinator, Social Worker, Activities Director and other members.<br>F637, significant change MDS modification was completed for Resident # 49 on 12/31/19.<br>F638, A Quarterly Review Assessment was completed for Resident # 13 on 1/05/2020.<br><br>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?<br><br>Audits were started for repeated deficiencies as outlined in the included POC for Tag #□s F637 and F638 and will be completed by1/17/20. The facility QAPI committee will meet monthly to identify issues related to Quality assessments and assurance activities as needed. They will develop and implement appropriate plans of action for identified facility concerns. | |

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| F 867 | Continued From page 30<br><br>During the recertification and complaint survey of 1/10/19 the facility was cited at F-638 because they failed to complete a quarterly assessment within the required time frame for 2 of 20 residents reviewed for resident assessments.<br><br>An interview was conducted with the Administrator on 12/20/19 at 4:09 PM. The Administrator reported that when a concern was identified by the facility, a performance improvement plan was developed, implemented and reviewed monthly. She recalled the facility had employed 8 different MDS nurses since the beginning of 2019. She admitted there were issues with staff retention in the MDS office and because of frequent staff turnover the completion of MDS assessments had fallen behind schedule. The Administrator said the facility identified the backlog of MDS assessments as an issue in October and started a performance improvement plan in November. She then added that the facility had monitored MDS assessments earlier in the year through the QAPI process but then the assessments "started falling off" and admitted the facility should have incorporated it back into the QAPI process. | F 867 | What measures will be put in place or what systemic changes will be made to ensure that the deficient practice will not reoccur?<br><br>On 12/31/20 the Administrator was in-serviced by the Clinical Nurse Consultant on QAPI, Root Cause Analysis. The importance of maintaining and reviewing identified areas needing improvement. The Main Department Managers were assigned QAPI training through Pruitt□s Reliance Training System.<br><br>How will the corrective action be monitored to assure that the deficient practice will not reoccur, i.e., what quality assurance program will be put in place for monitoring to assure continued compliance.<br><br>The QAPI committee will continue to meet monthly. The Attendance sheet and Notes concerning the progress of cited deficiencies will be sent to a Corporate consultant for review and verification monthly.<br><br>The administrator and Director of health care services will verify completion and report findings to the quality assurance improvement committee until 3 months of substantial compliance is obtained and quarterly thereafter.<br>Date of completion 01-17-2020<br><br>Date of Compliance:<br>January 17, 2020 | |

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| PRUITTHEALTH-HIGH POINT | 3830 N MAIN STREET HIGH POINT, NC 27265 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
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