STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345182	A. BUILDING _____ B. WING _____	C 01/17/2020

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

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E 007 SS=E	EP Program Patient Population CFR(s): 483.73(a)(3) [(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following:] (3) Address [patient/client] population, including, but not limited to, persons at-risk; the type of services the [facility] has the ability to provide in an emergency; and continuity of operations, including delegations of authority and succession plans.** *[For LTC facilities at §483.73(a)(3):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. (3) Address resident population, including, but not limited to, persons at-risk; the type of services the LTC facility has the ability to provide in an emergency; and continuity of operations, including delegations of authority and succession plans. *NOTE: ["Persons at risk" does not apply to: ASC, hospice, PACE, HHA, CORF, CMCH, RHC/FQHC, or ESRD facilities.] This REQUIREMENT is not met as evidenced by: Based on record review, resident council group interviews and staff interviews the failed to notify the State Agency of evacuation of 56 residents during 1 of 1 natural disasters. Two of six residents from the resident council group meeting expressed concerns about the evacuation (Resident #6 & #8). The findings included:	E 007	This plan of correction constitutes a written Allegation of Compliance with federal and state requirements. Preparation and submission of this Allegation of Compliance does not constitute an admission or agreement by the provider of truth of the facts alleged or the corrections of the conclusions set forth on the statement of deficiencies.	1/20/20

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

Electronically Signed | 02/06/2020

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E 007	Continued From page 1 A review of the facility's emergency preparedness manual updated 01/13/20 revealed an Emergency Preparedness Policy between evacuating facility and sheltering facility which revealed: "The state survey agency will be notified within 24 hours of plan activation." Record review revealed that the facility evacuated 56 residents on 09/05/19 from the facility to the Pruitt Health-Neuse facility in New Bern and returned on 09/09/19. Resident #8's Quarterly Minimum Data Set (MDS) assessment dated on 10/16/19 indicated that the resident cognition is intact. The resident was coded as needing extensive assistance with Activities of Daily Living, independent for eating and total for bathing. The resident was coded for using a wheel chair. During an interview with Resident #8 on 01/15/20 at 1:30 PM revealed that she had concerns during the evacuation on 09/05/19 to the Pruitt Health facility in New Bern. Resident #8 stated that the residents were placed in a room with several beds that were very closed together and they were not allowed to go outside of their assigned area. Resident #8 further stated she felt like a prisoner and this made her feel claustrophobic. Resident #6's Quarterly Minimum Data Set (MDS) assessment dated on 10/12/19 indicated that the resident cognition is intact. The resident was coded as needing extensive assistance with Activities of Daily Living, supervision for eating and total for bathing. The resident was coded for using a wheel chair.	E 007	The plan of correction is prepared and submitted solely because of requirements under state and federal law. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: All residents sheltering in place at PruittHealth Neuse were returned to their home facility, PruittHealth Sea Level, on 9-7-19. Address how the facility will identify other residents having the potential to be affected by the same deficient practice: All residents have the potential to be affected by the alleged deficient practice. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: During any emergency situation that requires receiving evacuees or evacuating our facility, the Administrator will ensure that the transfer does not exceed the receiving facility's total bed capacity on a long term basis, and that the proper officials will be contacted regarding the evacuation plan. The State Agency will be notified at the time of evacuation. The Administrator will ensure that the facility does not exceed total bed capacity without obtaining authorization for a temporary increase in bed capacity during	

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E 007	Continued From page 2 During an interview with Resident #6 (Resident Council President) on 01/16/20 at 11:46 AM indicated she had concerns during the evacuation on September 5, 2019 to the Pruitt Health facility in New Bern. Resident #6 further stated that she was placed in a bedroom and was not allowed to go out of her room. She was concerned about the other residents that were housed in cramped areas. Resident #6 indicated that it appeared that the Pruitt facility in New Bern was not prepared for them due to the area being so over crowded. During an interview with the Corporate Director of Partner Services on 01/16/20 at 10:45 AM indicated that it is the corporate office responsible to notify the State Agency of evacuation plans. The Corporate Director of Partner Services further stated at the time of the hurricane the company had multiple facilities being evacuated due to the natural disaster and this facility was missed in contacting the State Agency prior to evacuating and requesting a wavier to transport residents to a facility that would exceed their license capacity. The Corporate Director of Partner Services further stated that the Area Vice President of Pruitt that was in contact with the State Agency during the evacuation on September 6, 2019 is no longer employed with the company. During an interview with the Administrator on 01/16/20 at 11:00 AM indicated that it was her responsibility to make sure that the residents were safe during the natural disaster and that they were transported safely to the facility in New Bern. The Administrator further stated that in the event of another storm she would follow up with	E 007	a natural disaster. Indicate how the facility plans to monitor its performance to make sure solutions are sustained: The administrator will bring the citation related to emergency preparedness to the Quality Assurance and Performance Improvement committee for review and understanding of proper emergency response protocol related to capacity during a natural disaster per the Division of Health Service Regulation. The Administrator will continue to review emergency preparedness quarterly thereafter to ensure compliance is achieved and sustained. This will be monitored during our QAPI Meetings for 3 months or until a pattern of compliance is achieved. Compliance Date: 1-20-20	

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E 007	Continued From page 3 the corporate office to verify that the State Agency is notified.	E 007		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 01/14/20 xx/xx/xx through 01/17/20. Event ID# 53UY11. [X] 1 of the 4 complaint allegations was substantiated resulting in deficiencies.	F 000		
F 645 SS=D	PASARR Screening for MD & ID CFR(s): 483.20(k)(1)-(3) §483.20(k) Preadmission Screening for individuals with a mental disorder and individuals with intellectual disability. §483.20(k)(1) A nursing facility must not admit, on or after January 1, 1989, any new residents with: (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, (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 (B) If the individual requires such level of services, whether the individual requires specialized services; or (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- (A) That, because of the physical and mental condition of the individual, the individual requires	F 645		2/14/20

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F 645	Continued From page 4	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 5 described in 435.1010 of this chapter. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to submit information for Preadmission Screening and Resident Review (PASARR) for a level II re-evaluation for 1 of 2 sampled resident (Resident #26). The findings included: Resident #26 was originally admitted to the facility on 09/06/18 with diagnoses including major depressive disorder, bipolar disorder and schizoaffective disorder. Review of Resident #26's Significant Change Minimum Data Set (MDS) assessment dated on 08/01/19 revealed that the resident cognition was intact. The resident was coded as receiving antipsychotic medication for 7 of the 7 days during the assessment period. The resident was coded on the MDS as having a diagnosis of schizoaffective disorder. Review of Resident #26 ' s care plan dated on 10/01/19 indicated that she was care planned for antidepressant medication use due to having a diagnosis of depression. Resident #26 was also care planned for inappropriate and disruptive behaviors. Review of the hospital discharge summary dated on 07/26/18 revealed that the resident had diagnoses including Bipolar Disorder and a history of schizophrenia. Review of the PASARR screening form dated on 07/27/18 revealed that no was checked for	F 645	Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: A PASSAR was immediately started on Resident #26 on 1-14-20. A FL-2 was obtained, signed by MD and submitted on 1-21-20. The FL-2 was then sent for a Level II screen and the Level II screener uploaded her documents on 1-27-20. The Level II PASSAR was completed on 1-28-20. Address how the facility will identify other residents having the potential to be affected by the same deficient practice: The Facility in-serviced department managers on PASSAR requirements for each resident admitted to a skilled nursing facility. The social worker reviewed all 50 non-level II PASSARs and 39 of those residents were found to have mental health diagnosis. The social worker has started comparing their mental health diagnosis with their mental health screen to make sure that the resident□s mental health diagnosis is on their current PASSAR screen. If the resident□s mental health is not addressed on their screen the social worker will submit a new screen that will have the appropriate diagnosis before the resident□s next quarterly review.	

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F 645	Continued From page 6 mental health diagnoses. During an interview with the Administrator on 01/17/20 at 10:50 AM indicated that the Social Worker handles the PASSRR's and going forward all residents PASARR's from the hospital will be checked against their diagnoses to make sure the screening is accurate. During an interview with the Social Worker on 01/17/20 at 11:15 AM indicated that she was not aware that she needed to check the PASARR's screening application from the hospital to make sure mental health illnesses were included if the resident has a diagnosis of mental health illness. She further stated that moving forward she will recheck the PASARR's from the hospital to make sure they are accurate. If they are not accurate the resident will be re-evaluated for PASSAR level II.	F 645	Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: The administrator will bring the citation related to PASSAR to the Quality Assurance and Performance Improvement committee for review and understanding of PASSAR protocol. The Social Worker will review each new admission to the facility for need of a Level II PASSAR. The Social Worker will report new admissions, their diagnosis, and if there is a need for a Level II PASSAR to the Quality Assurance and Performance Improvement committee monthly. The Quality Assurance and Performance Improvement committee will continue to review PASSAR□s monthly thereafter to ensure compliance is achieved and sustained. Indicate how the facility plans to monitor its performance to make sure solutions are sustained: The administrator will bring the citation related to Level II PASSARs to the Quality Assurance and Performance Improvement committee for review and understanding of proper screening for Level II PASSARs related to residents with mental health. The Quality Assurance and Performance Improvement committee will continue to review PASSAR□s monthly thereafter to ensure compliance is achieved and sustained.	

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F 645	Continued From page 7	F 645	Compliance Date: 2-14-20	