PRINTED: 04/15/2021 FORM APPROVED OMB NO. 0938-0391

NAME OF PROVIDER OR SUPPLIER	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
NAME OF PROVIDER OR SUPPLIER  PRUITTHEALTH-HIGH POINT    SAME OF PROVIDER OR SUPPLIER   SAME OF PROVIDER OR SUPPLIER   SAME OF CONTROL OF PROVIDER OF PROVIDERS PLAN OF CORRECTION OF PREPIX TAG			345105	B. WING		
PREFIX   (EACH DEFICIENCY MUST BE PRECEDED BY FULL   TAG   CROSS-REFERENCED TO THE APPROPRIATE   CROSS-REFERENCED TO THE APPROPED   CROSS-REFERENCED TO THE APPROPED   CROSS-REFERENCED TO THE APPROPED   CROSS-REFERENCED T			1 040100		3830 N MAIN STREET	03/12/2021
The survey team entered the facility and conducted an on-site complaint investigation on 3/10/21. Additional information was obtained offsite on 3/10/21. 3/12/21. Therefore, the exit date was 3/12/21. Event ID# X65F 11. Two (2) of the 4 complaint allegations were substantiated with citations identified at F655 and F686.  F 655  Baseline Care Plan  F 655  SS=E  CFR(s): 483.21(a)(1)-(3)  \$483.21(a) Baseline Care Plans  \$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.  (i) Be developed within 48 hours of a resident's admission.  (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to-  (A) Initial goals based on admission orders.  (B) Physician orders.  (C) Dietary services.  (E) Social services.  (E) Social services.  (F) PASARR recommendation, if applicable.  \$483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan-  (i) is developed within 48 hours of the resident's admission.  (ii) Meets the requirements set forth in paragraph	PREFIX	(EACH DEFICIENC	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO	LD BE COMPLETION
conducted an on-site complaint investigation on 3/10/21. Additional information was obtained offsite on 3/11/21-3/12/21. Event ID# X63F11. Two (2) of the 4 complaint allegations were substantiated with citations identified at F655 and F686.  F 655  Baseline Care Plan  CFR(s): 483.21(a)(1)-(3)  §483.21 Comprehensive Person-Centered Care Planning  §483.21(a) Baseline Care Plans  §483.21(a) Baseline Care Plans  §483.21(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- (i) Be developed within 48 hours of a resident's admission.  (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders.  (B) Physician orders.  (C) Dietary orders.  (D) Therapy services.  (E) Social services.  (F) PASARR recommendation, if applicable.  §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) is developed within 48 hours of the resident's admission.  (ii) Meets the requirements set forth in paragraph	F 000	INITIAL COMMENTS	8	F 00	0	
Planning §483.21(a) Baseline Care Plans §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- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable.  §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph		conducted an on-site 3/10/21. Additional in offsite on 3/11/21-3/2 date was 3/12/21. Ethe 4 complaint alleg with citations identified Baseline Care Plan	e complaint investigation on information was obtained 12/21. Therefore, the exit event ID# X63F11. Two (2) of gations were substantiated ed at F655 and F686.	F 65	5	3/19/21
		Planning §483.21(a) Baseline §483.21(a)(1) The faimplement a baseline that includes the insteffective and person that meet profession. The baseline care pl (i) Be developed with admission.  (ii) Include the minim necessary to properlincluding, but not lim (A) Initial goals base (B) Physician orders (C) Dietary orders. (D) Therapy services (E) Social services. (F) PASARR recomm §483.21(a)(2) The facomprehensive care care plan if the comp (i) Is developed with admission.	Care Plans acility must develop and ac care plan for each resident cructions needed to provide -centered care of the resident al standards of quality care. an must- nin 48 hours of a resident's num healthcare information y care for a resident ited to- d on admission orders.  S.  Inendation, if applicable.  Incility may develop a plan in place of the baseline orehensive care plan- nin 48 hours of the resident's			
		, ,				

Electronically Signed 03/22/2021

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 (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	IPLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED	
		345105	B. WING _			C 03/12/2021
	ROVIDER OR SUPPLIER	1		STREET ADDRESS, CITY, STATE, ZIP CODE 3830 N MAIN STREET HIGH POINT, NC 27265	<u>'</u>	00/12/2021
(X4) ID PREFIX TAG	(EACH DEFICIENCE	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CORR ( (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 655	this section).  §483.21(a)(3) The foresident and their report of the baseline care limited to: (i) The initial goals of (ii) A summary of the dietary instructions. (iii) Any services an administered by the on behalf of the facil (iv) Any updated infoof the comprehensive This REQUIREMENT by:  Based on staff interwith a family member facility failed to dever which included dietar required component information) for 3 of Resident #2, and Rebaseline care plans; provide a written surplan to the resident.	acility must provide the presentative with a summary plan that includes but is not of the resident. The resident's medications and distriction to the resident's medications and distriction based on the details are care plan, as necessary. The is not met as evidenced views, telephone interview or, and record reviews, the lop a baseline care plan ry orders/instructions (a of the healthcare and, the facility failed to many of the baseline care is Responsible Party (RP) for sident #1) whose baseline ewed.	F6	· · · · · · · · · · · · · · · · · · ·	edicaid or ont ent by the eged or eged tion is y because the state ove the s our good	
	10/5/20. Her cumul part, COVID-19 acut hypertension, and no A review of the resid	admitted to the facility on ative diagnoses included, in e respiratory disease, on-Alzheimer 's dementia.  ent 's admission orders ed an order for a Cardiac,		quality of care and services to o residents.  What Corrective action will be accomplished for the residents have been affected by the defici practice?	found to	

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		345105	B. WING			С
NAME OF D	DOVIDED OD CLIDDLIED	343103	B: Willo	STREET ADDRESS, CITY, STATE, ZIP CODE		3/12/2021
NAME OF PI	ROVIDER OR SUPPLIER					
PRUITTHE	ALTH-HIGH POINT			3830 N MAIN STREET		
				HIGH POINT, NC 27265		
(X4) ID PREFIX TAG			PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 655	Continued From page	e 2	F 65	55		
F 655	Mechanical Soft diet.  Resident #1 's Basel dated 10/5/20 includeImprove Activities o to maintain independResident 's ADL ne independence potent constraints of diseaseDischarge planning discharge back to an (ALF);Resident will not su through next 30 daysResident will benefi without side effects theResident will not ex throughout the reviewResident 's sympto complications and withospitalization.  The Baseline Care Paddressed Physician However, these orderesident 's diet order	line Care Plan Summary ed the following goals: If Daily Living (ADL) function ence through next 30 days; eds will be met and ial maximized within through next 30 days; will begin upon admission to Assisted Living Facility stain injury related to falling through next 30 days; perience any adverse effects or period; or simple without thout requiring  lan Summary also and Nursing Orders. It is did not include the or dietary instructions.	F 65	Resident #1 and RP swere in the facility failed to provide a wasummary of their baseline care Resident #1 and their RP have and reviewed their baseline Callow will you identify other resist having the potential to be affect same deficient practice and who corrective action will be taken?  All residents may have potential affected. A 100% review of all admissions in the last 30 days conducted by the DON,RCC and designee to identify residents were received a written summary of the baseline care plan All residents identified who did not received summary of their baseline care have their care plan reviewed supdated and a written summar resident centered care plan wireviewed and given to the Residents identified.  What measures will be put in presidents will be put in presidents.	rritten e plan. e received are Plan. dents cted by the nat o ally been new will be nd/or who did not heir s and RP s a written e plan will and ry of their ll be idents and	
	(MDS) was not yet due at the time of her discharge (on 10/16/20).			what systemic changes will be ensure that the deficient practi reoccur?	made to	
	PM with the facility 's During the interview, and MDS Nurse prim for developing the resplans.  An interview was con	ducted on 3/10/21 at 1:50 s Social Worker (SW). the SW reported that she arily assumed responsibility sidents ' baseline care ducted on 3/10/21 at 2:20 rse. The MDS Nurse		The Director of Health Service in-serviced on 03/12/2021 the Manager, MDS Coordinator, S Worker, and Activities Director nurses on the policy and proce Baseline Care plans. The inter team will participate in the dev Resident s baseline care plans	Dietary ocial and the edure of the disciplinary elopment of	

Facility ID: 923250

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			ATE SURVEY DMPLETED
			D MANAGE			С
		345105	B. WING _			03/12/2021
NAME OF PR	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZI	PCODE	
DDIJITTUE	ALTH-HIGH POINT			3830 N MAIN STREET		
PROITINE	ALIN-HIGH POINT			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 ( (EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETION DATE
F 655		Care Plan Summary was	F 6	55 24hrs of admission and v	•	
	admission to the facili "pulled" from the phys Upon request, the ME #1's Baseline Care F she confirmed the res	ty with the information sician 's admission orders. OS Nurse reviewed Resident Plan Summary. At that time, ident 's dietary order and/or		admission. A care plan s printed and discussed wi Resident⊡s responsible of admission.	ummary will be th Resident or party within 72hrs	
	summary.  On 3/10/21 at 3:15 Pt conducted with the fa (DON). During the in-	ere not included in the  M, an interview was cility 's Director of Nursing terview, the DON reported ent 's baseline care plan to		How will the corrective a monitored to assure that practice will not reoccur, assurance program will be monitoring to assure concompliance.	the deficient i.e., what quality pe put in place for	
	be done upon admiss she would expect all i baseline care plan to	ion. The DON also stated required components of the be included in the summary.		The Administrator and Di Healthcare Services will admissions have baselin initiated in MatrixCare. S	verify that all new e care plan ocial Worker will	
	2/12/21. Her cumula part, COVID-19, pneu sclerosis.  A review of the reside	nt ' s admission orders		print out care plan summ reviewed with resident or family and a copy given to responsible party. A copy summary will be kept in a verification as part of our	r responsible to resident or y of care plan a book for	
	Pureed diet with Nect	d an order for a Regular ar-Thickened Liquids.		Administrator and Director		
	dated 2/12/21 includeImprove Activities of to maintain independeResident's ADL ne independence potenti constraints of diseaseDischarge planningResident's initial go goal will be met;	Daily Living (ADL) function ence through next 30 days; eds will be met and al maximized within through next 30 days; will begin upon admission; pals of care and discharge		Services will check daily weekly for 2 months, and thereafter. The administr of health care services wand report to the Quality Performance Improveme until 3 months of substar obtained and quarterly the Date of Compliance:  March 19, 2021	I then quarterly ator and Director will verify findings Assurance ent committee ntial compliance is	

Facility ID: 923250

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	PLE CONSTRUCTION  G	, ,	(X3) DATE SURVEY COMPLETED	
		345105	B. WING			C <b>03/12/2021</b>
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE  3830 N MAIN STREET  HIGH POINT, NC 27265	•	00/12/2021
(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 CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 655	of infection by nextResident will bene without side effectsResident will not e throughout the revie The Baseline Care I addressed Physicia However, these ord resident 's diet order Resident 's diet order (MDS) dated 2/16/2 severely impaired ordecision making. The received a mechanical An interview was copy M with the facility During the interview and MDS Nurse printers.	ee from signs and symptoms review date; fit from medication use through next 30 days; xperience any adverse effects ew period. Plan Summary also an and Nursing Orders. ers did not include the er or dietary instructions.  ission Minimum Data Set 1 revealed the resident had ognitive skills for daily his assessment indicated she	F 6:	55		
	PM with the MDS N reported the Baselir typically generated admission to the fact "pulled" from the ph On 3/10/21 at 3:15 conducted with the (DON). During the she expected a resibe done upon admisshe would expect al	urse. The MDS Nurse the Care Plan Summary was the day of a resident 's fillity with the information tysician 's admission orders.  PM, an interview was facility 's Director of Nursing the				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION  G	, ,	OATE SURVEY OMPLETED
		345105	B. WING _			C <b>03/12/2021</b>
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 3830 N MAIN STREET HIGH POINT, NC 27265		03/12/2021
(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 COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 655	Continued From pa	ge 5	F 6	55		
	12/15/20. Her cum part, COVID-19, hy	admitted to the facility on nulative diagnoses included, in pertension, and heart failure.				
	A review of the resident 's admission orders dated 12/15/20 included an order for a No Added Salt diet.  Resident #3 's Baseline Care Plan Summary					
	dated 12/15/20 inclu- Improve Activities to maintain indepen Resident's ADL r independence pote constraints of disea Discharge plannin	eline Care Plan Summary uded the following goals: of Daily Living (ADL) function idence through next 30 days; needs will be met and intial maximized within se through next 30 days; g will begin upon admission; goals of care and discharge				
	therapy plan of care Resident will receinext 30 days; Resident will not s	ive therapy services through sustain injury related to falling				
	resident goals throu Resident will have	omfortable as measured by				
	Resident will bene without side effects Demonstrate adec evidenced by blood within normal paran	efit from medication use through next 30 days; quate cardiac output as pressure and pulse rate neters for resident; ble to tolerate activity without				
	syncope (temporary chest pain through	ea (difficulty breathing),  / loss of consciousness), or  next 30 days;  experience any adverse effects				

1, ,		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		CONSTRUCTION	(X3) DATE COMP	SURVEY
		345105	B. WING				C <b>12/2021</b>
	ROVIDER OR SUPPLIER			S'	TREET ADDRESS, CITY, STATE, ZIP CODE 830 N MAIN STREET IIGH POINT, NC 27265	<u>  US/</u>	12/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 655	complications and withospitalization;Resident's oral caveResident's ulcer we complications. The Baseline Care Pladdressed Physician However, these order resident's diet order Resident #3's admis (MDS) dated 12/19/2 moderately impaired decision making. This received a therapeuting An interview was cone PM with the facility's During the interview, and MDS Nurse prime for developing the resiplans.  An interview was cone PM with the MDS Nurse prime for developing the resiplans.  An interview was cone PM with the MDS Nurse prime for developing the resiplans.  An interview was cone PM with the MDS Nurse prime for developing the resiplans.  On 3/10/21 at 3:15 Pleconducted with the facil "pulled" from the physically generated the pulled" from the physically generated the deducted with the facil "pulled" from the physical pulled at 3:15 Pleconducted with the facil pulled at 3:	weriod; ms will be managed without chout requiring  wity will be free from pain; ill heal without  an Summary also and Nursing Orders. The dietary instructions.  The sion Minimum Data Set The resident had cognitive skills for daily as assessment indicated she and the dietary instructions.  The sion Minimum Data Set The sident had cognitive skills for daily as assessment indicated she and the dietary instructions.  The sident had cognitive skills for daily assessment indicated she and the dietary instructions.  The sident had cognitive skills for daily assessment indicated she and the dietary instructions.  The sident had cognitive skills for daily assessment indicated she and the dietary instructions.  The sident had cognitive skills for daily assessment indicated she and cognitive skills for daily assessment indicated she are doily assessment indicated she	F	855			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345105	B. WING		C 03/12/2021
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 3830 N MAIN STREET HIGH POINT, NC 27265	1 00/12/2021
(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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETION
F 655	Continued From pa	ge 7	F 65	5	
	10/5/20. Her cumu part, COVID-19 acu hypertension, and n The resident 's prof record (EMR) indica Responsible Party ( Resident #1 's Base dated 10/5/20 includeImprove Activities to maintain indepenResident 's ADL n independence poter constraints of diseaseDischarge planning discharge back to alResident will not set through next 30 dayResident will benewithout side effectsResident will not ethroughout the revieeResident 's sympt complications and whospitalization.  A Social Services not AM revealed the resident Status (BIMS severely impaired codecision making.  Further review of Rerevealed there was progress notes to in	eline Care Plan Summary ded the following goals: of Daily Living (ADL) function dence through next 30 days; eeds will be met and ntial maximized within se through next 30 days; g will begin upon admission to n Assisted Living Facility; ustain injury related to falling s; fit from medication use through next 30 days; xperience any adverse effects w period; oms will be managed without			

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>12/2021</b>
NAME OF PR	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	U3/	12/2021
PRUITTHE	EALTH-HIGH POINT				830 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 PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 655	Continued From page	e 8 rehensive Minimum Data	F	655			
	Set (MDS) was not yet discharge to another	et due at the time of her facility on 10/16/20.					
	PM with the facility 's During the interview,	the SW reported she					
	resident 's baseline of Upon inquiry, the SW	ty to mail the summary of a care plan to his/her RP. stated she did not on the summary in the					
	resident 's permanen asked, the SW report	it medical record. When ed she was "not sure" if ine Care Plan Summary had					
	On 3/10/21 at 3:15 PI conducted with the fa (DON). During the in she expected a reside be completed upon a Care Plan Summary   RP. The DON also si provision of the Base						
F 686 SS=D	inquiry, the RP stated summary of Resident during the resident 's Treatment/Svcs to Pr	a 3/11/21 at 12:28 PM. Upon she did not receive a #1 's baseline care plan stay at the facility.  event/Heal Pressure Ulcer	F	686			3/19/21
	§483.25(b) Skin Integ §483.25(b)(1) Pressu						

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345105	B. WING _			C 03/12/2021	
NAME OF PI	ROVIDER OR SUPPLIER	<u> </u>		STI	REET ADDRESS, CITY, STATE, ZIP CODE	1 03/	12/2021
				383	30 N MAIN STREET		
PRUITTHE	ALTH-HIGH POINT				GH POINT, NC 27265		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	×	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLETION DATE
F 686	Continued From page	e 9	F 6	686			
	Based on the compre	hensive assessment of a					
	resident, the facility n	nust ensure that-					
		s care, consistent with					
		ls of practice, to prevent					
	•	does not develop pressure					
		vidual's clinical condition					
		ey were unavoidable; and essure ulcers receives					
		and services, consistent					
	with professional star						
		vent infection and prevent					
	new ulcers from deve	eloping.					
	This REQUIREMENT	is not met as evidenced					
	by:						
	Based on staff interv	The state of the s			IMMEDIATE CORRECTIVE ACTION		
		d reviews, the facility failed			O		
	to conduct and/or acc	skin assessment and weekly			Complete head to toe skin assessment were done on the remaining two reside		
		ensure skin breakdown			and documented. No unknown skin	IIIS	
		ated for 1 of 3 residents			issues were found. On 03/12/2021, all		
		ed for pressure ulcers.			staff were in-serviced by the Director of	f	
	, ,	•			Health Services on skin assessments a		
	The findings included	:			checking skin while doing ADL care.		
	Resident #1 was adm	nitted to the facility on			METHODS TO IDENTIFY ANY OTHER	₹	
	10/5/20 from a hospit	al. Her cumulative			RESIDENTS WHO MIGHT BE		
	_	n part, COVID-19 acute			AFFECTED		
	respiratory disease, h						
	non-Alzheimer 's der	mentia.			Complete head to toe skin assessment	.S	
	The mediate \$1 !!	and managed in about 2 - 1 - 1 - 1 - 1			were done on the remaining two		
		cal record included a Long n dated 10/5/20. The FL-2			residents. No unknown skin issues wer found.	е	
		n/assessment tool which			iouriu.		
		of the resident 's medical			SYSTEMIC CHANGES		
		s, and medications. This			2.2.2		
	form reported Reside				Weekly skin assessments will continue	on	
		ear right hip" with treatment			every resident.		
	instructions noted.						
					All licensed staff were educated on skir	า	

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		345105	B. WING		<del></del>	03/	12/2021
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
DDI IITTUE	ALTH-HIGH POINT			3	830 N MAIN STREET		
PRUITINE	ALI H-HIGH POINT			Н	IIGH POINT, NC 27265		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PRÉFIX TAG	,	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLETION DATE
F 686	Continued From page	e 10	F	686			
		ssion orders to the facility		000	assessments and skin care by the		
		nd included the following:			Director of Health Services on		
		right hip with NS (normal			03/12/2021.		
		I name of a nonadherent,			The Director of Health Services/Design	ee	
	highly absorbent, gen				will audit the head to toe skin		
		ily and as needed." A review			assessments of any resident		
		ober 2020 Treatment			admitted/readmitted to ensure they are		
	Administration Record	d (TAR) revealed this			being completed.		
		ined in place through the					
	date of her discharge	on 10/16/20.			The Director of Health Services/Design		
	<u></u>				will monitor weekly skin assessments fi	ve	
		#1 's Baseline Care Plan			times a week x 4 weeks, weekly x 4		
	-	/20 was conducted. Neither ondition nor treatment were			weeks, then monthly x 2 months.		
	addressed in her base				How will the corrective action be		
	addressed in her base	eline care plan.			monitored to assure that the deficient		
	An Admission Observ	vation form reported			practice will not reoccur, i.e., what qual	itv	
		dent #1 were conducted on			assurance program will be put in place	- 1	
	10/5/20 at 2:45 PM by				monitoring to assure continued		
		ation was recorded in the			compliance.		
	resident' s medical re	cord by Nurse #1 on 10/7/20			·		
	at 8:29 AM. At that ti	me, Nurse #1 documented			Audit results will be reported to the Qua	ality	
		as cool and dry with a			Assurance Performance Improvement		
	normal color and norr	_			Committee by the DHS to identify trend	s	
	l	there were no alterations in			and further opportunities for quality		
	the observation of Re				improvement and any needs for addition		
		were made about the			education until substantial compliance	S	
	condition of her skin.				achieved.		
	Further review of Pos	sident #1 's medical record			Date of Compliance:		
		o documentation of weekly			03/19/2021		
		aving been completed for			00/10/2021		
	this resident.	<u> </u>					
	Resident #1 ' s admis	ssion Minimum Data Set					
	(MDS) and individuali	ized, comprehensive care					
	'	e at the time of her discharge					
	on 10/16/20.						

Facility ID: 923250

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION  G		OATE SURVEY COMPLETED
		345105	B. WING _			C 03/12/2021
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 3830 N MAIN STREET HIGH POINT, NC 27265	I	03/12/2021
(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 CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE
F 686	another Skilled Nurs 10/16/20 for further medical record at the Nursing Progress Not PM which read, in pa #1) remains on a prewhen in bed, also had cushion in seat or chas a 2 x 11 bruise to red will apply (brand antifungal cream q (of (bruised)) areas to leright lower leg, 5 x 3 scarring to both legs left heel 1 x 2 hard bounded. Will cleanse and apply skin preponded with Nursidentified as the nurse to the facility on 10/5 the nurse reported sand could not provide admission or care. Note that the could have a could not provide a could not	charged from the facility to ing Facility (SNF) on rehabilitation. Resident #1's receiving SNF included a ote dated 10/16/20 at 7:34 ret: "Skin integrity: (Resident ressure redistribution mattress as a pressure redistribution mair with OOB (out of bed). Propositioned frequentlyshe to lower abdomen, buttock name) moisture barrier revery) shift, has ecchymotic ft lower arm, 4 x 6 bruise to bruise to right lower leg, hasHas unstageable wound to lack eschar. No drainage wound with normal saline	F 6	86		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED	
			5 14/11/0			С
345105			B. WING STREET ADDRESS, CITY, STATE, ZIP CODE			03/12/2021
NAME OF PROVIDER OR SUPPLIER  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	(EACH CORRECTIVE ACTION S	PROVIDER'S PLAN OF CORRECTION (X5 (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  (X5 COMPLE DAT	
F 686	her right hip prior to be and admission orders treatment to this area stated, "So, did my nu. The DON reported her a resident came into the nurse needed to go in introduce herself, and assessment on the real skin assessment was completed 7 days after the DON confirmed that to indicate a weekly sedone. The DON states found on a resident 'selection be reported to her bear responsibility for doing the facility 's consulting DON stated wound resident or the selection of the selecti	eing admitted to their facility were written on 10/5/20 for on her hip. The DON urse look at her skin? No." er expectation was that when the facility, the admitting to the resident 's room, I at least do a skin sident. The DON reported as also expected to be er admission. When asked, here was no documentation kin assessment had been ed whenever a concern was as skin, it was supposed to cause she assumed g weekly wound rounds with hing wound specialist. The bunds were not conducted use she did not know the	F	586		