A recertification and complaint investigation survey was conducted from 5/10/22 through 05/12/22. Event ID# DZ6M11. The following intakes were investigated: NC00188557, NC00188317, NC00185368, and NC00178327.

1 of the 12 complaint allegations were substantiated resulting in a deficiency.

A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes:

- Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care.
- Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment.

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.
NAME OF PROVIDER OR SUPPLIER: PRUITTHEALTH-SEALEVEL

STREET ADDRESS, CITY, STATE, ZIP CODE: 468 HIGHWAY 70 EAST SEALEVEL, NC 28577

PROVIDER'S PLAN OF CORRECTION

<table>
<thead>
<tr>
<th>ID PREFIX</th>
<th>TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
<th>ID PREFIX</th>
<th>TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
<th>COMPLETION DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>F 644</td>
<td></td>
<td>Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to ensure a resident assessment for Level II Preadmission Screening and Resident Review (PASRR) was completed for 1 of 1 resident (Residents #50) reviewed for Level II PASARR. Findings included: Review of Resident #50's PASRR Level I Determination Notification dated 6/3/18 indicated that &quot;No further PASARR screening is required unless a significant change occurs within the individual's status which suggests a diagnosis of mental illness or mental retardation or, if present, suggests a change in treatment needs for these conditions.&quot; Resident #50 was admitted to the facility on 11/08/19 with diagnoses that included stroke with right sided paralysis. Review of Resident #50's medical record indicated a new diagnosis of bipolar disorder dated 4/7/21. Resident #50's comprehensive Minimum Data Set (MDS) dated 5/4/22 indicated diagnoses of bipolar disorder and depression. He received an antidepressant for the past 7 days. During an interview on 5/11/22 at 11:00 AM, the Social Worker indicated that she had not submitted the PASRR Level II Determination for Resident #50. She indicated that the evaluation should be completed with a new mental illness diagnosis. She revealed the MDS nurse usually</td>
<td>F 644</td>
<td></td>
<td>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. 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: Upon identification of the problem a new FL-2 for resident #50 was obtained from the MD and a request for a new PASSAR was completed on 5/12/22. We received a new PASSAR for Resident #50 on 5/16/22 that was a level C PASSAR, and it is without an expiration date. The need to review all new admission diagnosis and all re-admit diagnosis was discussed with the Interdisciplinary Team on 5/13/22. The CMD will review all diagnosis and notify the administration team of any diagnosis that does not have supporting documentation. The DHS, CMD, SW and administration team will discuss each new and re-admitted resident upon admission during the morning meetings daily to review all diagnosis and need to obtain new PASSARs. Team will review all new</td>
<td></td>
</tr>
</tbody>
</table>

This REQUIREMENT is not met as evidenced by:
Based on record review and staff interviews, the facility failed to ensure a resident assessment for Level II Preadmission Screening and Resident Review (PASRR) was completed for 1 of 1 resident (Residents #50) reviewed for Level II PASARR.

Findings included:
Review of Resident #50's PASRR Level I Determination Notification dated 6/3/18 indicated that "No further PASARR screening is required unless a significant change occurs within the individual's status which suggests a diagnosis of mental illness or mental retardation or, if present, suggests a change in treatment needs for these conditions."

Resident #50 was admitted to the facility on 11/08/19 with diagnoses that included stroke with right sided paralysis.

Review of Resident #50's medical record indicated a new diagnosis of bipolar disorder dated 4/7/21.

Resident #50's comprehensive Minimum Data Set (MDS) dated 5/4/22 indicated diagnoses of bipolar disorder and depression. He received an antidepressant for the past 7 days.

During an interview on 5/11/22 at 11:00 AM, the Social Worker indicated that she had not submitted the PASRR Level II Determination for Resident #50. She indicated that the evaluation should be completed with a new mental illness diagnosis. She revealed the MDS nurse usually
alerted her of new mental health diagnoses, and she submitted the Level II PASRR evaluation.

During an interview on 5/12/22 at 10:45 AM, the Administrator revealed any new mental illness diagnosis required a PASRR Level II screening.

admission and re-admission diagnosis for any potential psych diagnosis, mental health diagnosis, and any intellectual diagnosis weekly x 1 month then monthly until a level of compliance is obtained.

Address how the facility will identify other residents having the potential to be affected by the same deficient practice:

The administrator in-serviced department managers on PASSAR requirements for each resident admitted to a skilled nursing facility on 5/13/22. The social worker reviewed all current residents for mental health diagnosis and who did not already have a level II PASSAR. Other than resident #50 no other patient was found to need a corrected PASSAR. 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.

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
### SUMMARY STATEMENT OF DEFICIENCIES

<table>
<thead>
<tr>
<th>ID</th>
<th>PREFIX</th>
<th>TAG</th>
<th>ID</th>
<th>PREFIX</th>
<th>TAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>F 644</td>
<td>Continued From page 3</td>
<td>F 644</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

understanding of PASSAR protocol. The need to review all new admission diagnosis and all re-admit diagnosis was discussed with the Interdisciplinary Team on 5/13/22. The CMD will review all diagnosis and notify the administration team of any diagnosis that does not have supporting documentation. The DHS, CMD, SW and administration team will discuss each new and re-admitted resident upon admission during the daily morning meetings to review all diagnosis and need of a level II PASSAR. The Interdisciplinary Team will review all new admission and re-admission diagnosis for any potential psych diagnosis, mental health diagnosis, and any Intellectual diagnosis weekly x 1 month then monthly until a level of compliance is obtained. 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 PASSARs 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
<table>
<thead>
<tr>
<th>F 644</th>
<th>Continued From page 4</th>
<th>F 644</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>F 925 Maintains Effective Pest Control Program</strong>&lt;br&gt;<strong>CFR(s): 483.90(i)(4)</strong></td>
<td><strong>F 925</strong></td>
<td>6/1/22</td>
</tr>
</tbody>
</table>

$483.90(i)(4)$ Maintain an effective pest control program so that the facility is free of pests and rodents.  
This **REQUIREMENT** is not met as evidenced by:

- Based on resident and family interviews, staff interviews, and record review, the facility failed to have an effective rodent control program.

Findings included:

- Record review of invoices from the pest service company indicated exterior and interior rodent service was completed on 3/2/22, 4/8/22, and 5/5/22. Services included checking and replacing exterior bait stations and checking and resetting traps throughout the facility.

- During an interview on 5/10/22 10:10 AM, Resident #52’s family member reported that upon admission to the facility, she was told to buy plastic containers for food and belongings due to a mouse infestation. She had not seen a mouse since admission.

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.

Compliance Date: 6-01-22

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.  
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:

- Echo lab was contacted while DHHS was
### SUMMARY STATEMENT OF DEFICIENCIES

**F 925 Continued From page 5**

During an interview on 5/10/22 at 10:45 AM, Resident #17 reported the facility had an ongoing problem with mice. She had seen a mouse in her room within the past 2-3 days.

During an interview on 5/11/22 at 2:20 PM, Nurse #1 indicated that the facility had a problem with mice. A pest company comes quarterly but she had seen a mouse within the past week on a trap in a resident's room.

During an interview on 5/11/22 at 2:25 PM, the Maintenance Director revealed a pest control company came to the facility to place mouse traps. He believed the mice were getting in through gaps near the radiators and this was blocked with expanding foam. He indicated the infestation had gotten better but they were still trapping 2-3 mice per week. He further revealed the pest service did not have further recommendations for controlling the mice in the building.

During an interview on 5/12/22 at 9:44 AM, the Administrator revealed that due to location of the facility, mice were an issue. She indicated that the pest service place traps and maintenance had sealed the entry points. The facility encouraged residents to put food in plastic containers and minimize clutter to help control the issue. She was aware the issue was ongoing.

**F 925**

still here completing survey. Echo lab along with facility maintenance director increased outside bait stations, 15 bait stations were placed in the attic, and 10 additional bait strips were placed throughout the facility. Maintenance staff went outside and completed an entire parameter walk and utilized rodent spray with any and all potential entry points and then sealed each of the holes. During QAPI meeting 5/26/22 the maintenance director reports that over the past week they had not found any mice on any of the interior traps or the attic bait stations, since the repairs have been done.

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:

Maintenance will continue to monitor all bait traps / stations 5x weekly x 2 weeks, then weekly x 1 month until a level of compliance is obtained. After compliance is obtained maintenance in conjunction with Echo lab will continue to evaluate monthly and increase evaluations and treatments if problems return.

Indicate how the facility plans to monitor its performance to make sure solutions
<table>
<thead>
<tr>
<th>(X4) ID</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
<th>ID</th>
<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
<th>(X5) COMPLETION DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>F 925</td>
<td>Continued From page 6</td>
<td>F 925</td>
<td>are sustained:</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>The administrator will bring the citation related to rodents in the facility to the Quality Assurance and Performance Improvement committee for review. Maintenance will continue to monitor all bait traps / stations 5x weekly x 2 weeks, then weekly x 1 month until a level of compliance is obtained. After compliance is obtained maintenance in conjunction with Echo lab will continue to evaluate monthly and increase evaluations and treatments if problems return.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Compliance Date:</td>
<td>6/01/22</td>
</tr>
</tbody>
</table>