STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345566	A. BUILDING _____ B. WING _____	R-C 04/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEALTH-UNION POINTE	3510 WEST HIGHWAY 74 MONROE, NC 28110

(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
{F 000}	INITIAL COMMENTS An onsite revisit was conducted on 4/10/24 through 4/11/24. Tags F550, F554, F657, F 677, F689, F695, F725, F802, F883, F690, F761, F777, F842, F867, and F947 were corrected as of 3/11/24. Repeat tags were cited. The facility is still out of compliance.	{F 000}		
{F 684} SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on record review and resident and staff interviews, the facility failed to obtain daily weights as ordered for a resident with a diagnosis of heart failure and prescribed a diuretic (a medication that helps the kidneys produce more urine, to remove extra fluid from the body) (Resident #442). This was for 1 of 3 residents reviewed for nutrition. The findings included: Resident #447 was admitted to the facility on 09/28/22 with diagnoses that included diastolic (congestive) heart failure. A review of Resident #447's physician orders included the following:	{F 684}		

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

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{F 684}	Continued From page 1	{F 684}		

-The April 2024 Medication Administration Record revealed a order for furosemide (a diuretic medication) 20 milligrams (mg) one tablet by mouth once a day for diastolic (congestive) heart failure.

-The April 2024 Medication Administration Record revealed a order to obtain daily weights at 6:00 AM and to notify the provider if weight gain of greater than three pounds was present.

The quarterly Minimum Data Set (MDS) assessment dated 02/06/24 indicated Resident #447 was cognitively intact.

A review of the March Medication Administration Record (MAR) revealed Resident #447 refused weights on 03/12/24, 03/27/24, and 03/28/24. The March MAR also revealed daily weights at 6:00 AM were not documented as obtained or refused for 03/16/24, 03/18/24, 03/21/24, 03/22/24, 03/26/24, and 03/30/24.

Nursing notes revealed no refusals of weights documented from 3/12/24 through 03/18/24.

Unsuccessful attempts were made to contact Nurse #4 by phone. She was assigned Resident #447 on 03/16/24 and 03/ 26/24.

A phone interview was conducted on 04/11/24 at 8:61 AM with Nurse #2. She was assigned to Resident #447 on the 7:00 PM to 7:00 AM shift on 03/18/24 but could not recall why his weight was not obtained at 6:00 AM per orders on this day. She indicated if the weight wasn't documented then it most likely wasn't obtained. She stated Resident #447 had not refused care

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{F 684}	Continued From page 2	{F 684}		

by her.

A phone interview was conducted on 04/10/24 at 6:01 PM with Nurse #3. She was assigned to Resident #447 on the 7:00 PM to 7:00 AM shift on 03/21/24, and 03/22/24 and could not recall why there was no daily weight obtained on those days. She indicated if the weight wasn't documented then it most likely wasn't obtained. She stated at times, not regularly, Resident #447 would refuse for his weight to be obtained.

An interview was conducted on 04/11/24 at 11:39 AM with Nurse #1. She stated Resident #447 had not refused any care from her. She also stated 3rd shift told her about two weeks ago, that he refused for his weight to be obtained.

An interview was conducted on 04/11/24 at 12:01 PM with Resident #447 with his family member present. He stated staff normally obtained his weight daily at 6:00 AM but there had been mornings when they did not obtain it. He did not know why they had not obtained them every day as he had not refused for them to do so.

Review of audit forms titled "Quality Improvement Data Collection" dated and completed between 03/12/24 through 04/05/24 read Resident #447 was audited for daily weights and that the weights had been obtained as ordered. There were no documented comments or actions taken. The form was signed by the Director of Nursing (DON). You can put this info before the DON interview.

An interview was conducted on 04/11/24 at 12:12 PM with the Director of Nursing (DON). She stated that she does not know how she missed

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{F 684}	Continued From page 3 the missing weights when she completed the audits. She also stated the facility was fully staffed and there was no reason the weights should not have been obtained. Resident #447 ' s weights should have been obtained and she should have caught the missed weights when she completed the audits.	{F 684}		
{F 867} SS=E	QAPI/QAA Improvement Activities CFR(s): 483.75(c)(d)(e)(g)(2)(i)(ii) §483.75(c) Program feedback, data systems and monitoring. A facility must establish and implement written policies and procedures for feedback, data collections systems, and monitoring, including adverse event monitoring. The policies and procedures must include, at a minimum, the following: §483.75(c)(1) Facility maintenance of effective systems to obtain and use of feedback and input from direct care staff, other staff, residents, and resident representatives, including how such information will be used to identify problems that are high risk, high volume, or problem-prone, and opportunities for improvement. §483.75(c)(2) Facility maintenance of effective systems to identify, collect, and use data and information from all departments, including but not limited to the facility assessment required at §483.70(e) and including how such information will be used to develop and monitor performance indicators. §483.75(c)(3) Facility development, monitoring, and evaluation of performance indicators, including the methodology and frequency for such	{F 867}		

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{F 867}	Continued From page 4	{F 867}		

development, monitoring, and evaluation.

§483.75(c)(4) Facility adverse event monitoring, including the methods by which the facility will systematically identify, report, track, investigate, analyze and use data and information relating to adverse events in the facility, including how the facility will use the data to develop activities to prevent adverse events.

§483.75(d) Program systematic analysis and systemic action.

§483.75(d)(1) The facility must take actions aimed at performance improvement and, after implementing those actions, measure its success, and track performance to ensure that improvements are realized and sustained.

§483.75(d)(2) The facility will develop and implement policies addressing:
(i) How they will use a systematic approach to determine underlying causes of problems impacting larger systems;
(ii) How they will develop corrective actions that will be designed to effect change at the systems level to prevent quality of care, quality of life, or safety problems; and
(iii) How the facility will monitor the effectiveness of its performance improvement activities to ensure that improvements are sustained.

§483.75(e) Program activities.

§483.75(e)(1) The facility must set priorities for its performance improvement activities that focus on high-risk, high-volume, or problem-prone areas; consider the incidence, prevalence, and severity

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{F 867}	Continued From page 5	{F 867}		

of problems in those areas; and affect health outcomes, resident safety, resident autonomy, resident choice, and quality of care.

§483.75(e)(2) Performance improvement activities must track medical errors and adverse resident events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the facility.

§483.75(e)(3) As part of their performance improvement activities, the facility must conduct distinct performance improvement projects. The number and frequency of improvement projects conducted by the facility must reflect the scope and complexity of the facility's services and available resources, as reflected in the facility assessment required at §483.70(e). Improvement projects must include at least annually a project that focuses on high risk or problem-prone areas identified through the data collection and analysis described in paragraphs (c) and (d) of this section.

§483.75(g) Quality assessment and assurance.

§483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must:

(ii) Develop and implement appropriate plans of action to correct identified quality deficiencies;
(iii) Regularly review and analyze data, including

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{F 867}	Continued From page 6	{F 867}		

data collected under the QAPI program and data resulting from drug regimen reviews, and act on available data to make improvements.
This REQUIREMENT is not met as evidenced by:
Based on observations, record review and staff interviews the facility's Quality Assurance and Performance Improvement (QAPI) committee failed to maintain implemented effective procedures and monitor the interventions that the committee put into place following a recertification and complaint investigation dated 2/16/24 for 2 deficiencies in the areas of Admission, Transfer, and Discharge and Quality of Care The continued failure of the facility during two surveys of record in the same area showed a pattern of the facility's inability to sustain an effective Quality Assurance program.

Findings included.

This tag is cross referenced to:

F684- Based on record review and resident and staff interviews, the facility failed to obtain daily weights as ordered for a resident with a diagnosis of heart failure and prescribed a diuretic (a medication that helps the kidneys produce more urine, to remove extra fluid from the body) (Resident #442). This was for 1 of 3 residents reviewed for nutrition.

F684- cited 2/16/24- Based on record review, staff and medical director interviews, the facility failed to obtain daily weights as ordered for a resident with heart failure and prescribed a diuretic (Resident #70). This was for 1 of 8 residents reviewed for nutrition.

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{F 867}	Continued From page 7 F684- cited 6/30/22- Based on hospital record review, facility record review, family, and staff interviews, the facility failed to assess, document, and treat skin tears, resulting in the resident receiving antibiotic treatment, for one of three sampled residents (Resident #59) reviewed for wound care. An interview was conducted on 04/11/24 at 12:32 PM with the Administrator. He stated he was not aware the audits were not being completed. He also stated the audit forms should reflect correct and accurate information to prevent repeat tag originally cited during the previous recertification survey dated 6/30/22 and 2/16/24.	{F 867}		