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 10/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEALTH-CRYSTAL COAST	2416 US HIGHWAY 70 EAST BEAUFORT, NC 28516

(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
E 000	Initial Comments An unannounced recertification and complaint investigation survey was conducted on 09/29/2024 through 10/03/2024. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #8Q7G11.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 09/29/2024 through 10/03/2024. Event ID# 8Q7G11. The following intakes were investigated NC00209911, NC00219184 and NC00221951. 10 of the 10 complaint allegations did not result in deficiency. 10/17/24 During quality review by management, it was noted F584 was inadvertently left off the posted CMS 2567. Deficiency added to the statement of deficiency and the survey was reposted.	F 000		
F 580 SS=E	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or	F 580		10/21/24

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

Electronically Signed | 10/17/2024

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 10/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEALTH-CRYSTAL COAST	2416 US HIGHWAY 70 EAST BEAUFORT, NC 28516

(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 580	Continued From page 1 clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on record review, staff interviews and physician interview the facility failed to inform the	F 580	Address how corrective action will be accomplished for those residents found to	

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 10/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEALTH-CRYSTAL COAST	2416 US HIGHWAY 70 EAST BEAUFORT, NC 28516

(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 580	Continued From page 2 physician of a change in the residents' nutritional status and failed to notify the responsible party of changes in a resident's condition including skin integrity impairment and/or weight loss for 4 of 5 residents sampled for nutrition. (Resident #4, Resident #41, Resident #45, and Resident #81) The findings included: 1. Resident #4 was admitted to the facility on 07/08/2015 with diagnoses including dysphagia. Review of Resident #4's weights revealed: 08/06/2024 112.1 pounds (lbs.) 09/03/2024 103.9 lbs. 09/16/2024 105.7 lbs. 09/23/2024 106 lbs. 10/01/2024 104.6 lbs. There was a decrease of 7.31% from 8/06/2024 (112.1lbs) to 9/03/2024 (103.9lbs). Review of Resident #4's medical record for September revealed there was no documentation that the physician was notified of the significant weight loss. An interview with the Physician was conducted on 10/02/24 at 11:46 AM. The physician stated he had not been informed of any weight loss for Resident #4. He also stated that he liked checks and balances and should have been informed of the weight loss. An interview with the DM was conducted on 10/02/24 at 11:42 AM. The DM stated Resident #4 had significant weight loss and when there was a significant weight change of 5% or more the physician should be called. The DM also stated she was responsible for calling the	F 580	have been affected by the deficient practice: Resident #4 □ On 10-02-24 The patient was re-weighed to evaluate for weight loss. The facility contacted the dietician and reviewed the weights of the patient, and the dietician recommended (Standard 2.0 (480 cal/20 gm protein) - Give 120 ml BID) to be provided for the patient. The physician was contacted, and new orders were obtained for the recommended supplement. The responsible party was contacted by the dietary manager to notify them of weight loss and corrective action taken. Resident #41 □ On 10-02-24 The patient was re-weighed to evaluate for weight loss. The facility contacted the dietician and reviewed the weights of the patient, and the dietician recommended (Standard 2.0 (480 cal/20 gm protein) - Give 120 ml BID) to be provided for the patient. The physician was contacted, and new orders were obtained for the recommended supplement. The responsible party was contacted by the dietary manager to notify them of weight loss and corrective action taken. Resident #45 □ On 10-02-24 The patient was re-weighed to evaluate for weight loss. The facility contacted the dietician and reviewed the weights of the patient, and the dietician recommended (Standard 2.0 (480 cal/20 gm protein) - Give 120 ml BID) to be provided for the patient. The physician was contacted, and new orders	

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 10/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEALTH-CRYSTAL COAST	2416 US HIGHWAY 70 EAST BEAUFORT, NC 28516

(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 580	Continued From page 3	F 580		

physician and she did not call due to an oversite.

An interview with the Director of Nursing (DON) was conducted on 10/03/2024 at 1:04 PM. The DON stated when there was a significant weight loss of 5% or greater, the physician was supposed to be made aware and could not say why he was not made aware by the DM.

An interview with the Administrator was conducted on 10/03/2024 at 1:14 PM. The Administrator stated when there was a decrease in weight of 5% or more then the physician was supposed to be made aware.

2. Resident #41 was admitted to the facility on 08/19/2021 with diagnoses including coronary artery disease.

Review of Resident #41 weights revealed:
08/06/2024 148.0 pounds (lbs.)
08/12/2024 141.3 lbs.
08/19/2024 143.7 lbs.
08/26/2024 139.4 lbs.
09/03/2024 144.5 lbs.
09/09/2024 140.2 lbs.
There was a significant weight loss of 5.27% from 8/06/2024 (148) to 9/09/2024 (140.2).

Review of Resident #4's medical record for September revealed there was no documentation the physician was notified of the significant weight loss.

An interview with the Physician was conducted on 10/02/24 at 11:46 AM. The physician stated he had not been informed of any weight loss for the residents. He also stated that he liked checks and balances and should have been informed of the

were obtained for the recommended supplement. The responsible party was contacted by the dietary manager to notify them of weight loss and corrective action taken.

Resident #81 □ Resident was discharged on 9-30-24 to the hospital. The patient was transitioned to the Hospice House for end-of-life care after discharge from hospital.

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

Each patient in the facility was weighed on 10-01-24 or 10-02-24. Each patient was evaluated for weight loss. If a significant weight loss was determined the dietician and physician were contacted, and new orders were obtained for recommended supplements. Each new weight loss received an order for (Standard 2.0 (480 cal/20 gm protein) - Give 120 ml BID). If a hospice patient was identified with a weight loss they received an order for (Magic Cup with supper and lunch) as this would be able to be consumed easier. Responsible parties were contacted by the dietary manager to notify them of weight loss and corrective action taken. If any change in condition is identified including weight loss the physician and responsible party will be notified.

Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not

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 10/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEALTH-CRYSTAL COAST	2416 US HIGHWAY 70 EAST BEAUFORT, NC 28516

(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 580	Continued From page 4 weight loss so that interventions could be implemented. An interview with the DM was conducted on 10/02/24 at 11:42 AM. The DM stated Resident #41 had a significant weight loss and when there was a significant weight change of 5% or more the physician should be called. The DM also stated she was responsible for calling the physician and she did not call due to an oversite. An interview with the Director of Nursing (DON) was conducted on 10/03/2024 at 1:04 PM. The DON stated when there was a significant weight loss of 5% or greater, the physician was supposed to be made aware and could not say why he was not made aware by the DM. An interview with the Administrator was conducted on 10/03/2024 at 1:14 PM. The Administrator stated when there was a decrease in weight of 5% or more then the physician was supposed to be made aware. 3. Resident #45 was admitted into the facility on 8/29/24 with the diagnoses of adult failure to thrive, type 2 diabetes mellitus, severe protein calorie malnutrition and dementia, muscle weakness, chronic kidney disease stage 3, cachexia (loss of muscle, fat mass and weakness), hypertension, multiple myeloma (in remission), gastroesophageal reflux disease, congestive heart failure, diastolic congestive heart failure and metabolic encephalopathy. A review of Resident #45's admission Minimum Data Set dated 9/5/24 revealed he was cognitively intact; his vision was highly impaired; he required his meal tray set up by staff and had	F 580	recur: 100% of Pruitt Health Crystal Coast staff was in-serviced on the need for proper monitoring of weight loss and making sure that the residents are provided with ordered supplements to maintain proper nutrition and weight stability. When monthly, weekly, or daily weights are obtained, and a significant weight loss is found, the dietary manager and/or nursing supervisor will contact the dietician and the physician to obtain orders for supplements. The dietary manager and/or nursing supervisor will contact the responsible parties and notify them of the weight loss and the corrective action taken. If any change in condition is identified including weight loss the physician and responsible party will be notified. This will be discussed each week with the Interdisciplinary Team during our patient at risk meeting. Any changes in weights the dietician, physician, and responsible parties will be notified. Indicate how the facility plans to monitor its performance to make sure solutions are sustained: 100% of Pruitt Health Crystal Coast staff was in-serviced on the need for proper monitoring of weight loss and making sure that the residents are provided with ordered supplements to maintain proper nutrition and weight stability. When monthly, weekly, or daily weights are obtained, and a significant weight loss is	

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 10/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEALTH-CRYSTAL COAST	2416 US HIGHWAY 70 EAST BEAUFORT, NC 28516

(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 580	Continued From page 5 no skin issues. A review of Resident #45's wound assessments revealed on 9/18/24 an area on his sacrum measuring 2 cm x 1cm was noted, on 10/1/24 a pressure area on his right heel measuring 2 centimeters (cm) x 2 cm was noted, also on 10/1/24 a stage I (intact blister) was noted on his left ankle. A review of Resident #45's weight record indicated on 8/29/24 he weighed 168.70 pounds and on 9/5/24 he weighed 149.70 a loss of 11.26% in one week, 9/29/24 he weighed 116 pounds indicating a 31.24 % weight loss in one month. A review of Resident #45's physician orders included an order for a liquid supplement twice a day with a start date of 9/11/24, on 10/2/24 an appetite stimulant was ordered, a liquid shake supplement ordered with meals three times a day, and another liquid supplement ordered four times a day with medications. An interview conducted with the resident's Responsible Party on 10/2/24 at 11:13 AM revealed that she was not notified by the facility of either the weight loss or the development of pressure areas. She stated that when she arrived at the facility, she was shocked when she pulled down the covers and saw how much weight he had lost. She further stated that because she does help with turning and repositioning that she had seen the area on his sacrum. She stated no one from the facility had notified her yesterday (10/1/24) regarding the newly developed areas on his right heel and left ankle.	F 580	found the dietary manager and/or nursing supervisor will contact the dietician and the physician to obtain orders for supplements. The dietary manager and/or nursing supervisor will contact the responsible parties and notify them of the weight loss and the corrective action taken. This will be discussed each week with the Interdisciplinary Team during our weight loss meeting. Any changes in weights the dietician, physician, and responsible parties will be notified. The Dietary Manager, Director of Health Services, Unit Managers, and/or the Administrator will attend the weekly weight loss meetings to assure that the weight loss process is being followed per policy. This system will be audited weekly x 2 months then monthly and will be presented during our QAPI Meetings for 3 months or until a pattern of compliance is achieved. Compliance Date: 10-21-24	

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 10/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEALTH-CRYSTAL COAST	2416 US HIGHWAY 70 EAST BEAUFORT, NC 28516

(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 580	Continued From page 6	F 580		

An interview conducted with the Dietary Manager on 10/2/24 at11:18 AM indicated that the facility does have a weekly weight meeting which consisted of the two Social Workers, the MDS Coordinator, Activity Director and herself. She stated that the Physician should have been notified after the first significant weight loss and interventions should have been put into place and it was an oversight on her part. She further stated that she had not called Resident #45's Responsible Party or the Physician regarding his weight loss and realized she should have.

An interview conducted with the Physician on 10/02/24 11:46 AM indicated that he had not been informed of any weight loss of the residents. He stated that he liked checks and balances and should have been informed of the weight loss so that interventions could be implemented.

An interview with the Wound Care Nurse on 10/2/24 at 1:00 PM revealed that she did not call the responsible party regarding new skin issues, but she does call them if the treatment was changed. She stated that she does not document when she talks to the resident's responsible parties and documents the bare minimum on areas that she is treating due to the amount of wound care that she does. She further revealed that she had not talked to or called Resident #45's Responsible Party regarding his areas on his sacrum, right heel or left ankle.

An interview was conducted with the Administrator on 10/2/24 at 2:00 PM indicated that resident's responsible party should be notified of any changes in a resident's condition which included new orders, test results, and any areas that impacted the residents care and/or

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 10/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEALTH-CRYSTAL COAST	2416 US HIGHWAY 70 EAST BEAUFORT, NC 28516

(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 580	Continued From page 7	F 580		

treatment.

4. Resident #81 was admitted into the facility on 7/25/24 with the diagnoses of pneumonia, hip fracture, cerebrovascular accident, dementia and anxiety disorder.

A review of Resident #81's Minimum Data Set dated 8/1/24 included she had moderately difficulty in hearing and used hearing aids, had no problems communicating, moderately cognitively impaired, had no behaviors or rejection of care and no indicators of psychosis.

A telephone interview conducted with a family member on 10/2/24 at 6:00 PM revealed that Resident #81 was unable to speak and was in the dying process and she was the point of contact for her mother. She revealed that the family was not made aware of new orders, test results and the overall decline of their mother. She stated the family had seen a pressure ulcer above the crack of her mother's buttocks that they were never informed of during their mother's care. On Saturday September 28th, 2024, the family walked in, and Resident #81 was "kind of" communicating with them but not at all what she normally did and on Sunday September 29, 2024, Resident #81 would not wake up at first and later woke up a little and there was no notification from the facility on either day regarding their mother's condition. The family member further stated that Resident #81's anxiety medication that she had taken for 20 plus years was discontinued without their knowledge. During this time Resident #81 was confused, hallucinating, and paranoid. The family found out Resident #8's antianxiety medication had been discontinued on 8/29/24 once it was restarted on 9/9/24 all her mothers'

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 10/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEALTH-CRYSTAL COAST	2416 US HIGHWAY 70 EAST BEAUFORT, NC 28516

(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 580	Continued From page 8 symptoms of confusion, paranoia, and hallucinations were resolved. An interview was conducted with the Administrator on 10/2/24 at 2:00 PM indicated that families should be notified of any changes in a resident's condition which included new orders, test results, and any areas that impacted the residents care and/or treatment.	F 580		
F 584 SS=E	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. 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. The facility must provide- §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. (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. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition;	F 584		10/21/24

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 10/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEALTH-CRYSTAL COAST	2416 US HIGHWAY 70 EAST BEAUFORT, NC 28516

(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 584	Continued From page 9 §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §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 §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on record review, and resident, ombudsman, and staff interviews, the facility failed to allow the residents to personalize their space by restricting their ability to hang any items on the walls or doors to their rooms to include pictures and decorations and not permitting the residents to bring in their own furniture. The residents expressed feeling as though it was impossible to make their rooms homelike with these restrictions. This deficient practice affected 5 out of 5 residents (Resident #19, # 54, #50, #16 and #25) reviewed for homelike environment and had the potential to affect other facility residents. The findings included: A review of the Residents Council minutes revealed that on 1/16/24 a Resident Council meeting was attended by Residents #22, #27, #46, #24, #16, #37, #65, #3, #70, #57, #55, and #35. The meeting was conducted to explain and prepare the residents for the move to a new building. In that meeting it was discussed that certain things would not be allowed these	F 584	Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: Resident #19 □ On 10-17-24 the administrator went to visit with Resident #19. The bulletin board was decorated as well as the window seal with fall decorations. She was reminded that she has the availability to have pictures on the furniture in her room, have a bulletin board that she can hang personal effects or pictures on and can place seasonal decals on her windows, and is able to place pictures and plants in her window seal. We discussed the placement of the bulletin board and that they are beside the beds instead if in front of them where they could better see their pictures. Discussion was made that we would add another bulletin board in her room that was directly in front of her bed so that she could enjoy pictures and other personal	

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 10/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEALTH-CRYSTAL COAST	2416 US HIGHWAY 70 EAST BEAUFORT, NC 28516

(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 584	Continued From page 10 included: - No items on the walls - No tape on the walls - No nails in the walls - Nothing on the floor - Nothing in the blinds - Nothing on the doors - No refrigerators The 5 residents (#19, #54, #50, #16, and #25) in the Resident Council Meeting conducted on 10/1/24 at 2:45 PM all stated that they were unable to make their own rooms to their liking which included hanging pictures on the walls and/or wreaths on the doors. The Resident Council President (Resident #50) stated they felt that not being able to decorate at all but put a few pictures on the furniture in the room was stopping them from making their rooms feel like their home. They further stated they wanted pictures of their families or just beautiful pictures on the wall and they only had a cloth-covered bulletin board to hang anything on. The residents also stated they were not able to keep any food from families in the facility refrigerators or have a refrigerator of their own. The residents in the Resident Council meeting stated it was impossible to make their rooms homelike with such restrictions. An interview was conducted with the Resident #50 10/1/24 at 3:30 PM who stated she wanted to be able to put pictures of her family on the walls, that right now her room was just like every other room in the building, so it did not feel like her home. An interview was conducted with Resident #54 on	F 584	items. Concerns of wreaths on the doors and other furniture was discussed that they could be a fire hazard for the resident as well as the staff due to most of these items are not made of fire-retardant materials. Residents understood and agreed with us that obtaining an additional bulletin board would enhance her room into a more home-like environment. She looked around her room and said that her sister had already decorated, and she enjoyed her decorations. Resident #50 □ On 10-17-24 the administrator went to visit with Resident #50. The bulletin board was decorated as well as the window seal with personal effects. She was reminded that she has the availability to have pictures on the furniture in her room, have a bulletin board that she can hang personal effects or pictures on and can place seasonal decals on her windows, and is able to place pictures and plants in her window seal. We discussed the placement of the bulletin board and that they are beside the beds instead of in front of them where they could better see their pictures. Discussion was made that we would add another bulletin board in her room that was directly in front of her bed so that she could enjoy pictures and other personal items. Concerns of wreaths on the doors and other furniture were discussed that they could be a fire hazard for the resident as well as the staff due to most of these items are not made of fire-retardant materials. Residents understood and agreed with us that obtaining an additional	

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 10/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEALTH-CRYSTAL COAST	2416 US HIGHWAY 70 EAST BEAUFORT, NC 28516

(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 584	Continued From page 11 10/1/24 at 3:40 PM who stated with the holidays coming up she wanted to hang different wreaths on her door to celebrate them but was not allowed to. She further stated that the only thing they had in their room was a cloth-covered bulletin board to put pictures on, which was not enough room for what she wanted to put up. She further stated that she wanted to be able to decorate her room how she wanted to make it feel like hers. An observation of a resident's room on 10/2/24 at 4:05 PM noted there was an area on the wall that had a wardrobe with shelves the residents could use to put pictures or whatever they wanted to on, a bedside table, and a cloth-covered bulletin board. An interview with the Ombudsmen on 10/2/24 at 2:50 PM revealed that the residents had also brought concerns of not being able to decorate the room or hang pictures on the walls to her attention when she met with them. She stated she was glad the residents brought their concern regarding not being able to put pictures on the walls or decorate their doors as she felt they should be able to but felt like her hands were tied. She stated she had discussed this with the Administration after the meeting and it was a directive from the corporate office that was being followed. The Ombudsmen further stated she had told the residents to continue to be patient, work with the facility and remember it was a new building. An interview with the Administrator on 10/3/24 at 9:00 AM indicated the directive she received from the corporate office said nothing on the walls, or doors, and residents may not bring their own	F 584	bulletin board would enhance her room into a more home-like environment. Resident #54 □ On 10-17-24 the administrator went to visit with Resident #54. She did not have many personal effects in her room. She was reminded that she has the availability to have pictures on the furniture in her room, have a bulletin board that she can hang personal effects or pictures on and can place seasonal decals on her windows, and is able to place pictures and plants in her window seal. We discussed the placement of the bulletin board and that they are beside the beds instead of in front of them where they could better see their pictures. Discussion was made that we would add another bulletin board in her room that was directly in front of her bed so that she could enjoy pictures and other personal items. Concerns of wreaths on the doors and other furniture were discussed that they could be a fire hazard for the resident as well as the staff due to most of these items are not made of fire-retardant materials. Residents understood and agreed with us that obtaining an additional bulletin board would enhance her room into a more home-like environment. She said that she is waiting until Christmas to add her Christmas decorations to her room. Resident #16 □ On 10-17-24 the administrator went to visit with Resident #16. The bulletin board was decorated as well as the window seal with personal effects. She was reminded that she has	

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 10/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEALTH-CRYSTAL COAST	2416 US HIGHWAY 70 EAST BEAUFORT, NC 28516

(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 584	Continued From page 12 furniture into the building. She stated prior to moving into the new building the residents that were coming over from the old building were made aware of the rules and it was part of the admission packet for all residents. She stated she was following the direction of her corporate office. She further stated that in the other building the residents covered their walls with pictures so that you could hardly see the color of the walls which was the reason for no pictures on the walls. She further stated that there was a wardrobe in the room with areas the residents could put pictures on along with a bedside table, so the residents were able to have pictures in their rooms.	F 584	the availability to have pictures on the furniture in her room, have a bulletin board that she can hang personal effects or pictures on and can place seasonal decals on her windows, and is able to place pictures and plants in her window seal. We discussed the placement of the bulletin board and that they are beside the beds instead of in front of them where they could better see their pictures. Discussion was made that we would add another bulletin board in her room that was directly in front of her bed so that she could enjoy pictures and other personal items. Concerns of wreaths on the doors and other furniture were discussed that they could be a fire hazard for the resident as well as the staff due to most of these items are not made of fire-retardant materials. Residents understood and agreed with us that obtaining an additional bulletin board would enhance her room into a more home-like environment. Resident #25 □ On 10-17-24 the administrator went to visit with Resident #25. The bulletin board had pictures of her family as well as the window seal had some of her own personal effects. She was reminded that she has the availability to have pictures on the furniture in her room, have a bulletin board that she can hang personal effects or pictures on and can place seasonal decals on her windows, and is able to place pictures and plants in her window seal. We discussed the placement of the bulletin board and that they are beside the beds instead of in front of them where they could better see	

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 10/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEALTH-CRYSTAL COAST	2416 US HIGHWAY 70 EAST BEAUFORT, NC 28516

(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 584	Continued From page 13	F 584		

their pictures. Discussion was made that we would add another bulletin board in her room that was directly in front of her bed so that she could enjoy pictures and other personal items. Concerns of wreaths on the doors and other furniture were discussed that they could be a fire hazard for the resident as well as the staff due to most of these items are not made of fire-retardant materials. Residents understood and agreed with us that obtaining an additional bulletin board would enhance her room into a more home-like environment. She said that she was very satisfied with her room.

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

A resident Counsel meeting was held on 10-8-24 to discuss concerns regarding survey results. During our discussion of results, we discussed their need to make their rooms feel more home-like. We discussed the expectations to maintain the beauty of the building without putting holes in the walls or removing paint but allow them to make their rooms more home-like. They were reminded that they have already have the availability to have pictures on the furniture in their rooms, have a bulletin board that they can hang personal effects or pictures and many of the other current resident have decals on their windows, pictures and plants in their window seal. We discussed the

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 10/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEALTH-CRYSTAL COAST	2416 US HIGHWAY 70 EAST BEAUFORT, NC 28516

(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 584	Continued From page 14	F 584	placement of the bulletin boards and that they are beside the beds instead if in front of them where they could better see their pictures. Discussion was made that we could add another bulletin board in their rooms that was directly in front of their beds so that they could enjoy pictures and other personal items. Concerns of wreaths on the doors and other furniture was discussed that they could be a fire hazard for the resident as well as the staff due to most of these items are not made of fire-retardant materials. Residents understood and agreed with us that obtaining an additional bulletin board would enhance their rooms into a more home-like environment. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: 100% of Pruitt Health Crystal Coast staff was in-serviced on the need to allow each resident to add personal effect to their room within the restraints of not damaging the property of placing the facility at risk with hazards. This will be discussed each month at the resident council meeting to address any additional concerns. Any additional request or concerns will be discussed with the Interdisciplinary team and corporate managers so that we can work together with the residents for a reasonable resolution. Indicate how the facility plans to monitor	

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 10/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEALTH-CRYSTAL COAST	2416 US HIGHWAY 70 EAST BEAUFORT, NC 28516

(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 584	Continued From page 15	F 584	its performance to make sure solutions are sustained: 100% of Pruitt Health Crystal Coast staff was in-serviced on the need to allow each resident to add personal effect to their room within the restraints of not damaging the property of placing the facility at risk with hazards. This will be discussed each month at the resident council meeting to address any additional concerns. Any additional request or concerns will be discussed with the Interdisciplinary team and corporate managers so that we can work together with the residents for a reasonable resolution. This system will be audited monthly and will be presented during our QAPI Meetings for 3 months or until a pattern of compliance is achieved. Compliance Date: 10-21-24	
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to code the Minimum Data Set (MDS) accurately for hospice for 1 of 1 resident reviewed for hospice (Resident #6). The findings included:	F 641	Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: On 10-02-2024, resident #6□s MDS modified to correct coding to indicate	10/21/24

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 10/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEALTH-CRYSTAL COAST	2416 US HIGHWAY 70 EAST BEAUFORT, NC 28516

(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 641	Continued From page 16 Resident #6 was admitted into the facility on 8/29/24 with diagnoses that included dementia, and chronic obstructive pulmonary disease. A review of Resident #6 Physician orders dated 8/31/24 revealed an order to admit to hospice services. A review of Resident #6's primary payer on her face sheet revealed it was hospice. A review of Resident #6's care plan dated 9/5/24 revealed a care plan problem of Resident #6 is receiving hospice services. A review of Resident #6's admission Minimum Data Set dated 9/5/24 indicated that the resident was not on hospice care but did have a a condition or chronic disease that may result in a life expectancy of less than 6 months A review of Resident #6's Care Area Assessment for MDS dated 9/5/24 revealed under cognitive loss/dementia section detailed under supporting documentation was noted to see the Brief Interview for Mental Status Assessment, Progress Notes, Hospice Notes, the International Classification of Diseases 10, and Mood Assessment. An interview conducted with the MDS Coordinator on 10/1/24 at 1:24 PM indicated that Resident #6 was admitted to hospice care on 8/31/24 and that hospice services are ongoing. A review of the admission MDS dated 9/5/24 indicated Resident #6 was not on hospice care was reviewed with the MDS Coordinator. The MDS Coordinator revealed the admission MDS assessment was incorrectly coded for hospice. She stated that it	F 641	receiving Hospice Services in Section K03007 during the Assessment Reference Date (ARD) lookback. Address how the facility will identify other residents having the potential to be affected by the same deficient practice: On 10-02-24, the Case Mix Director completed a 100% of all current residents who are receiving Hospice Services. Of the 5 other residents who were receiving Hospice Services 100% were coded correctly on their current MDS. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: On 10-03-24, the two MDS nurses received education related to the accuracy of assessments per the RAI guidelines by the Clinical Reimbursement Coordinator. On 10-03-24, the Administrator in-service the DHS, Dietary manager, the Therapy Coordinator, Social Worker and Activity Director on accuracy of assessment completion. Indicate how the facility plans to monitor its performance to make sure solutions are sustained: 100% of Pruitt Health Crystal Coast staff was in-serviced on the importance of coding accuracy.	

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 10/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEALTH-CRYSTAL COAST	2416 US HIGHWAY 70 EAST BEAUFORT, NC 28516

(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 641	Continued From page 17 was simply an oversight on her part. An interview conducted with the Administrator on 10/2/24 at 9:00 AM stated the admission MDS assessment for resident # 6 should have been marked to indicate hospice and a modification would be completed.	F 641	The Case Mix Coordinator will complete a weekly audit of five MDS□s completed by the Case Mix Director. All inaccuracies will be corrected at the time of review. The Case Mix Director will maintain a log of all identified inaccurate MDS and corrections made. These audits will continue weekly for 4 weeks, then monthly for 4 months. The Case Mix Director will maintain a log of all identified inaccurate MDS and corrections made. The Case Mix Director will present the analysis of the MDS Accuracy of Assessments data to the Administrator at our QAPI Meetings for 3 months or until a pattern of compliance is achieved. Compliance Date: 10-21-24	
F 805 SS=D	Food in Form to Meet Individual Needs CFR(s): 483.60(d)(3) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(3) Food prepared in a form designed to meet individual needs. This REQUIREMENT is not met as evidenced by: Based on observation, record review, resident interview and staff interviews the facility failed to provide food in a form to meet the individual needs of a resident with a physician's order to upgrade diet to mechanical soft/finger foods with thin liquids for 1 of 5 Residents sampled for nutrition (Resident #4).	F 805	Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: On 10-02-24 Communication between the dietary manager and speech therapist corrected the diet order so the patient	10/21/24

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 10/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEALTH-CRYSTAL COAST	2416 US HIGHWAY 70 EAST BEAUFORT, NC 28516

(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 805	Continued From page 18 Findings included: Resident#4 was admitted to the facility on 07/08/2015 with diagnoses including dysphagia. Review of a progress note by the Dietary Manager (DM) dated 08/05/2024 revealed Resident receiving a puree diet. Resident stated no chewing or swallowing problems. Resident wants to be upgraded in his diet and informed resident he must be evaluated by Speech Therapy (ST) before that can happen and he understood. Resident # 4 was independent with meals after tray set up. Continue to monitor weight and meal intake. The quarterly Minimum Data Set (MDS) dated 09/11/2024 had Resident #4 coded as cognitively intact, required supervision with eating and he was on a mechanically altered diet with no oral issues. Review of a speech therapy note dated 09/17/2024 revealed Resident #4 was currently on puree diet. The Resident has had eating trials of mechanically soft diet with no overt signs and symptoms of aspiration. Review of physician's order dated 09/20/2024 revealed an order to upgrade diet to mechanical soft/finger foods with thin liquids. Review of speech therapy note dated 09/26/2024 revealed Resident #4 seen in room for dysphagia therapy. Trial meal mechanical soft with thin liquids. There were no overt signs or symptoms of aspiration with solids or liquids. Resident #4 does need assist to cut finger foods into manageable pieces. Recommend diet upgrade to	F 805	would receive the corrected diet. Address how the facility will identify other residents having the potential to be affected by the same deficient practice: On 10-02-24 Communication between the dietary manager and speech therapist corrected the diet so the patient would receive the corrected diet. 100% of Pruitt Health Crystal Coast staff was in-serviced on the need to make sure any changes in patient diets are corrected immediately in the dietary department so there is not a delay in changes of diet, as it could affect the patients overall nutritional needs. A system has been put in place that the Speech Therapy will provide Nursing and dietary with a dietary communication form regarding the change in diet. The Speech Therapist and the Dietary Manager will communicate verbally as well as in writing with any needed changes in diet is identified by the Speech Therapist. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: A system has been put in place that the Speech Therapy will provide Nursing and dietary with a dietary communication form regarding the change in diet. The Speech Therapist and the Dietary Manager will communicate verbally as well as in writing with any needed changes in diet is identified by the Speech Therapist. A weekly audit and discussion will occur	

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 10/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEALTH-CRYSTAL COAST	2416 US HIGHWAY 70 EAST BEAUFORT, NC 28516

(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 805	Continued From page 19 mechanical soft/ finger foods with thin liquids. Review of Resident #4's meal ticket dated 09/30/2024 revealed regular pureed diet. Observation of Resident #4 on 09/30/2024 at 12:26 PM Resident #4 was served a pureed regular diet. Review of dietary communication form dated 10/03/2024 revealed Resident #4 diet change to mechanical soft with finger foods and regular liquids. An interview with Resident #4 was conducted on 09/30/2024 at 12:26 PM. Resident #4 stated he spoke with the DM and told her he wanted to stop the pureed diet because he did not like the texture. He had speech therapy for about a month and had completed it. Resident #4 indicated he could eat a more textured diet with finger foods. An interview with the DM was conducted on 09/30/2024 at 12:47 PM. The DM stated he was referred to speech therapy and she did not know if he passed his swallow test and did not follow up on it. The DM also stated that is the reason he still was on a pureed diet. An interview with Speech Therapy (ST) was conducted on 10/03/2024 at 11:55 AM. The ST stated Resident #4 had been on a pureed diet off and on over the years due to dysphagia. He was referred to speech therapy due to weight loss and he did not have any swallowing issues, and his diet was upgraded to mechanical/soft with finger foods and thin liquids. The ST also stated she put in the order for the upgraded diet and was waiting for the physician to sign the order and did not	F 805	with therapy and dietary to assure that all needed orders have been corrected immediately upon recommended change and physician approval. Indicate how the facility plans to monitor its performance to make sure solutions are sustained: A system has been put in place that the Speech Therapy will provide Nursing and dietary with a dietary communication form regarding the change in diet. The Speech Therapist and the Dietary Manager will communicate verbally as well as in writing with any needed changes in diet is identified by the Speech Therapist. A weekly audit and discussion will occur with therapy and dietary to assure that all needed orders have been corrected immediately upon recommended change and physician approval. The audit will be performed weekly x 2 months and will be presented during our QAPI Meetings for 3 months or until a pattern of compliance is achieved. Compliance Date: 10-21-24	

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 10/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEALTH-CRYSTAL COAST	2416 US HIGHWAY 70 EAST BEAUFORT, NC 28516

(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 805	Continued From page 20 follow up on it. Another interview with the DM was conducted on 10/03/2024 at 12:36 PM. The DM stated when there was an upgraded diet from the ST, the ST gives her a dietary communication form and she changes the diet. The DM also stated she did not receive a communication form for Resident #4 until today (10/03/2024). An interview with the Director of Nursing (DON) was conducted on 10/03/2024 at 1:04 PM. The DON stated when there was a diet change then it was expected to be changed at the time of the change without delay so the residents can receive the most therapeutic diet. An interview with the Administrator was conducted on 10/03/2024 at 1:14 PM. The Administrator stated Resident #4 did have a diet upgrade from the ST and it should have been communicated to the DM at the time of the diet change.	F 805		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable	F 812		10/21/24

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 10/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEALTH-CRYSTAL COAST	2416 US HIGHWAY 70 EAST BEAUFORT, NC 28516

(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 812	Continued From page 21 safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation and staff interviews, the facility failed to label opened food items, stored in their walk-in refrigerator in the kitchen, with the date opened and a use-by or expiration date. This practice had the potential to affect foods served to the residents. The findings included: On 09/29/24 at 11:45 a.m., an observation of the of the walk-in refrigerator in the kitchen was conducted with the Assistant Dietary Manager (ADM). The observation revealed the following: --bag of thawed crab cakes - no label, no date opened, no use-by or expiration date --bag of shredded cheddar cheese - with a handwritten date of 09/23/24, no use-by or expiration date --bag of cheese slices - with a handwritten date of 09/16/24, no use-by or expiration date --bag of sliced ham - with a handwritten date of 09/25/24, no use-by or expiration date --bag of sliced ham - with a handwritten date of 09/23/24, no use-by or expiration date --bag of 1 thawed croissant - with a handwritten date of 09/21/24, no use-by or expiration date --bag of thawed croissants - with a handwritten date of 09/24/24, no use-by or expiration date An interview was conducted with the Assistant	F 812	Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: On 09-29-24 The Assistant Dietary Manager immediately discarded all food items that were not dated appropriately or were past their discard date. Address how the facility will identify other residents having the potential to be affected by the same deficient practice: Each opened food item is to be labeled, dated and an expiration/discard to be placed on each item immediately. Each item will be discarded on the date that is labeled on the package. This will be monitored daily for a period of 2 weeks, then 3 times weekly for a period of 4 weeks, then weekly for a period of 3 months until a pattern of compliance is achieved. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur:	

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 10/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEALTH-CRYSTAL COAST	2416 US HIGHWAY 70 EAST BEAUFORT, NC 28516

(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 812	Continued From page 22 Dietary Manager (ADM) on 09/29/24 at 12:05 p.m. The ADM stated opened food items should be labeled with the date opened and a use-by and/or an expiration date. She stated opened food items should be discarded after three days. An interview was conducted with the Dietary Manager (DM) on 10/02/24 at 11:00 a.m. The DM explained the staff of the Dietary Department had been trained many times to label and date opened food items. She further explained that the number of staff working in the kitchen was based on the facility's census and she thought that their failure to label and date opened food items may have been because the staff felt "hurried" to complete their kitchen tasks timely while still trying to accommodate the residents many requests for certain foods at mealtimes. The DM stated that it was her expectation that staff label and date opened food items and to discard items after three days. An interview was conducted with the Administrator on 10/02/24 at 1:30 p.m. The Administrator stated it was her expectation that any time the kitchen staff open a new food item that it is labeled and dated and then discarded according to their policy.	F 812	On 09-29-24, the assistant Dietary Manager in-serviced 100% of the staff working in dietary that day regarding the need for proper labeling, dating, and expiration date on all opened foods. On 9-30-24 the administrator in-serviced the Certified Dietary Manager. On 9-30-24 the Certified Dietary Manager in-serviced the remaining dietary staff regarding each opened food item is to be labeled, dated and an expiration/discard date to be placed on each item immediately. Each item will be discarded on the date that is labeled on the package. 100% of Pruitt Health Crystal Coast staff was also in-serviced on the need for proper labeling, dating, and expiration date on all opened foods. This will be audited by the Dietary Manager, Assistant Dietary Manager, or Cook daily for a period of 2 weeks, then 3 times weekly for a period of 4 weeks, then weekly for a period of 3 months. Indicate how the facility plans to monitor its performance to make sure solutions are sustained: Each opened food item is to be labeled, dated and an expiration/discard to be placed on each item immediately. Each item will be discarded on the date that is labeled on the package. This will be audited by the Dietary Manager, Assistant Dietary Manager, or Cook daily for a period of 2 weeks, then 3 times weekly for a period of 4 weeks, then weekly for a	

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 10/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEALTH-CRYSTAL COAST	2416 US HIGHWAY 70 EAST BEAUFORT, NC 28516

(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 812	Continued From page 23	F 812	period of 3 months and will be presented during our QAPI Meetings for 3 months or until a pattern of compliance is achieved. Compliance Date: 10-21-24	