STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345124	A. BUILDING _____ B. WING _____	C 01/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEALTH-ELKIN	560 JOHNSON RIDGE ROAD ELKIN, NC 28621

(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 No deficiencies were cited as a result of the complaint investigation survey. Event ID #1WMQ11.	F 000		
F 221 SS=D	483.10(e)(1), 483.12(a)(2) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(1) The right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2). 42 CFR §482.12, 483.12(a)(2) The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's symptoms. (a) The facility must- (1) Ensure that the resident is free from physical or chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. When the use of restraints is indicated, the facility must use the least restrictive alternative for the least amount of time and document ongoing re-evaluation of the need for restraints.	F 221		2/18/17

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

Electronically Signed | 02/10/2017

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F 221	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on observation, record reviews, and staff interviews, the facility failed to provide on-going assessments, seatbelt release time frames, and alternate interventions for the continued use of a seatbelt restraint to a wheelchair for 1 of 1 sampled residents (Resident #47). Findings included: Resident #47 was admitted to the facility on 4/24/08 with diagnoses which included: dementia with behavior disturbances, delusional disorder, anxiety, agitation, psychosis, osteoporosis, peripheral vascular disease, dementia with schizoaffective disorder, and deep vein thrombosis. Review of the original Physician's Order dated 10/17/13 and the monthly Physician ' s Orders from July 2016 to January 2017 revealed Resident #47 was to have a seatbelt when out of bed in her wheelchair for treatment of abnormal posture due to progressive dementia. The Care Plan dated 7/11/16 revealed Resident #47 had the potential for injury related to the seatbelt in her wheelchair when out of bed for abnormal posture related to progressive dementia. Approaches included: follow facility protocol for release, exercise; document interventions; provide activities program where restraint free time can be provided; review continued need for trunk restraint, and document findings. Most recent Physical Restraint Elimination	F 221	Preparation and/or execution of this plan does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because the provisions of federal and state law require it. Immediate corrective action taken for this alleged deficient practice includes: 1.Resident # 47 had trial restraint reduction by nursing on January 20th where seatbelt was released and within 10 minutes' patient had scooted self onto edge of wheelchair and was at risk for falling. Patient referred to skilled OT for evaluation and treatment. She still remains on caseload but currently she is still requiring seatbelt as positioning due to her scooting and inability to correct posture to keep from falling off wheelchair. Resident with potential to be affected. 1.No current resident is affected at this time due to there are no other restrictive devices in use. 2.Future potential residents with restrictive devices have potential to be affected. These residents will have their initial and quarterly restrain elimination evaluation	

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F 221	Continued From page 2 Evaluation was completed on 9/27/16, but did not include a release time frame or alternative interventions attempted. Also, there was no restraint evaluation completed during the assessment period in December 2016 in the resident ' s medical record. The review of the Quarterly MDS (Minimum Data set) dated 12/13/16 indicated Resident #47 was severely, cognitively impaired; had no behavior; required extensive assistance of two staff for transfers; no walking during assessment period; and, the resident required the use of a restraint (chair prevent rising) Review of the clinical records revealed that on 1/17/17 Resident #47 was able to slide her legs off of her low bed to the floor mat. The resident received no injuries. On 1/18/17 at 2:03pm, Resident #47 was observed sitting in a hi-back wheelchair with a tab alarm attached to the back. The resident was noted with a self-release seatbelt across her lap which the resident was unable to release when asked by facility staff. The resident was alert and verbal, but very confused when responding to questions. During an interview on 1/18/17 at 4:22pm, the DON (Director of Nursing) confirmed Resident #47 was not able to release the seatbelt in her wheelchair on command, but was able to release it, sporadically. The DON revealed the self-release seatbelt was quarterly assessed and coded on the MDS as a restraint. During an interview on 1/19/17 at 3:22pm, N#1	F 221	completed on admission and quarterly thereafter by the Licensed Nurse. Measures put into place to assure that the alleged deficient practice does not recur include: 1.The Director of Health Service, Clinical Competency Coordinator and/or Nurse Managers began education with the Licensed Nurses on Completing the Quarterly restraint elimination evaluation on 1/23/2017. Licensed Nurses who have not completed the training will be educated prior to their next scheduled shift. 2.When a resident requires a restraint device a Quarterly restraint elimination evaluated will be completed on application and quarterly by a licensed nurse. 3.The Director of Health Services, and/or Nurse Manager will complete a documented review and ensure that the quarterly physical restraint elimination evaluation is completed timely. This will occur daily for 7 days, then weekly for 3 weeks then monthly for 6 months. Monitoring put in place to assure the alleged deficient practice does not recur includes: 1.The Director of Health Services will take the findings of the documented review of the completed quarterly restraint elimination evaluations to the Quality	

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F 221	Continued From page 3 (Nurse #1) revealed due to multiple falls, Resident #47's family frequently requested the Physician place a seatbelt to the resident ' s wheelchair. NA#1 stated that alternate interventions had been attempted before the seatbelt was applied to the wheelchair; such as a tab- alarm, dycem (non-slip seat mat) to wheelchair, and therapy.NA#1 also revealed the resident was able to propel herself in the wheelchair; but, staff would escort the resident to the group activities. During an interview on 1/19/17 at 3:55pm, the DON revealed Resident #47 has had the seatbelt attached to her wheelchair for more than a year due to multiple falls resulting from the resident scooting her bottom to end of the seat in the wheelchair. The DON listed the alternates to the seatbelt restraint that were attempted: high-back wheelchair; anti-thrust cushion; dycem in wheelchair; off and on therapy caseload for positioning; leg-rests to wheelchair; frequent toileting; rest periods; and a fall mat to the floor when resident in the bed. She stated that activity programs were attempted, but the resident was not easily redirected when she became disruptive due to her dementia. The resident's medications were also assessed and dosages reduced; such as, Ativan (anxiety medication) .5mg (milligram) three times a day and prn (whenever needed) was reduced to .5mg twice a day and prn since the initiation of the seatbelt. On 1/19/17 at 5:09pm, after review of the medical record, the DON stated that her expectation was for a quarterly restraint assessment and evaluation to have been completed for the continued use of the seatbelt restraint for Resident #47 by 12/13/16; which was not done.	F 221	Assurance Performance Improvement Committee Meetings for review until 6 months on continued compliance is established.	

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F 356 SS=C	483.35(g)(1)-(4) POSTED NURSE STAFFING INFORMATION 483.35 (g) Nurse Staffing Information (1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law) (C) Certified nurse aides. (iv) Resident census. (2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. (3) Public access to posted nurse staffing data.	F 356		2/18/17

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F 356	Continued From page 5 The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. (4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews, the facility failed to post accurate nurse staffing information at the beginning of each shift for 4 of 4 days reviewed (1/17/17, 1/18/17, 1/19/17 and 1/20/17). The findings included: An observation made on 1/17/17 at 10:15 AM revealed a daily nursing staff posting dated 1/17/17 was posted near the entrance to the facility's lobby. The daily staff posting indicated 6 Registered Nurses (RNs) and 6 Licensed Practical Nurses (LPNs) worked on the first shift. Observations made during the initial tour of the facility on 1/17/17 at 10:20 AM revealed Nurse #3 (an RN) was assigned to provide direct patient care on Unit A; Nurse #4 (an LPN) was assigned to Unit B; and, Nurse #5 (an LPN) and Nurse #6 (an LPN) were assigned to provide patient care on Unit C. Nurse #7 (an RN) was working as an RN Supervisor. An interview was conducted on 1/17/17 at 10:30 AM with the facility's Director of Nursing (DON). During the interview, the DON confirmed the names and positions of the licensed nursing staff	F 356	Immediate corrective action taken for this alleged deficient practice includes: 1.Daily posting of staff hours will be completed prior to start of shift by the A/B hall charge nurse, and will only include staff that provides direct patient care Resident with potential to be affected. 1.All residents have the potential to be affected. 2.The A/B Hall nurse will update the daily staffing hours posting at the beginning of each shift. Measures put into place to assure that the alleged deficient practice does not recur include: 1.Administrator and/or Director of Health Services began educating scheduled Licensed Nurses regarding how to post and update the Daily Staffing Hours on 2-1-2017. This education will be completed by 2-18-17. 2.Licensed Nurses who have not been scheduled will receive education	

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F 356	Continued From page 6 who were currently on duty. In addition to the staff already observed, the DON reported two additional LPNs and one additional RN worked on 1st shift. The DON stated Nurse #8 (an LPN) and Nurse #9 (an LPN) provided wound care for residents; and, Nurse #10 (an RN) worked as the facility's Clinical Competency Coordinator. An observation made on 1/17/17 at 4:37 PM revealed the daily nursing staff posting included information for the 1st shift nursing staff only (7:00 AM - 3:00 PM). No information was posted on nurse staffing for the 2nd shift working from 3:00 PM - 11:00 PM. An observation made on 1/18/17 at 5:30 PM revealed the daily nursing staff posting included information for the 1st shift nursing staff only. No information was posted on nurse staffing for the 2nd shift working from 3:00 PM - 11:00 PM. An observation made on 1/19/17 at 7:30 AM revealed the daily nursing staff posting was dated 1/18/17. Information was not posted on nurse staffing for the 1st shift working from 7:00 AM - 3:00 PM on 1/19/17. Accompanied by the facility ' s DON, an observation made on 1/19/17 at 5:13 PM revealed the daily nursing staff posting was not posted. Upon inquiry, the DON reported the staff posting may have been taken down in order to update it. She stated the responsibility for posting nurse staffing information was shared between the facility ' s Administrator and herself. An observation made on 1/20/17 at 7:30 AM revealed the daily staff posting was dated 1/19/17. Information was not posted on nurse	F 356	regarding posting and updating Daily staffing hours, prior to working their next scheduled shift. 3.This education on posting and updating the Daily Staffing hours has been added to the general orientation of the Licensed Nurses. 4.The Daily Staffing hours will be posted for the current date and the Director of Health Services and/or Nurse Manager will post the following day sheet prior to them leaving for the day. 5.The A/B hall charge nurse will update the direct care nursing staff hours and census on the Daily Staffing hours each shift. 6.The Administrator and/or Human Resource Director will remove and review the Daily Staff Postings for accuracy on the next business day for 7 days the weekly for 3 weeks then Monthly thereafter until 3 consecutive months of compliance are met. Monitoring put in place to assure the alleged deficient practice does not recur includes: 1.The Administrator will take the findings of the staffing review to the Quality Assurance Performance Improvement Committee monthly until three months of consecutive compliance is established.	

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F 356	Continued From page 7 staffing for the 1st shift working from 7:00 AM - 3:00 PM on 1/20/17. An interview was conducted on 1/20/17 at 9:07 AM with the facility's Administrator. During the interview, inquiry was made as to whether the number of licensed staff reported on the posting reflected the actual number of nursing staff assigned to provide direct patient care. Upon review of the 1st shift work schedule dated 1/17/17, the Administrator reported additional licensed nursing staff (in addition to those observed and reported by the DON on 1/17/17) were included in the staff numbers posted on 1/17/17. The additional staff members were identified as: Nurse #11 (an RN who worked as a Senior Care Partner), Nurse #12 (an RN who worked as an Assistant Director of Nursing/Unit Manager), Nurse #13 (an LPN who worked as a Minimum Data Set or MDS nurse); and, Nurse #14 (an RN who assumed responsibilities as the MDS Coordinator). The Administrator indicated some of the licensed staff included in the nursing staff posting had administrative duties at the facility. When asked what her expectations were in regards to the posting times for the nurse staffing information, the Administrator acknowledged this information needed to be posted at the beginning of each shift.	F 356		
F 441 SS=D	483.80(a)(1)(2)(4)(e)(f) INFECTION CONTROL, PREVENT SPREAD, LINENS (a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:	F 441		2/18/17

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(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards (facility assessment implementation is Phase 2);

(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:

(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;

(ii) When and to whom possible incidents of communicable disease or infections should be reported;

(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;

(iv) When and how isolation should be used for a resident; including but not limited to:

(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.

(v) The circumstances under which the facility must prohibit employees with a communicable

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F 441	Continued From page 9 disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi) The hand hygiene procedures to be followed by staff involved in direct resident contact. (4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. (e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. (f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review and staff interviews, the facility failed to post an accurate isolation sign for one of 4 residents on isolation precautions (resident #78) and failed to keep precaution signs posted on the carts for two of four residents on isolation precautions (Resident #129 and #63). 1. On 1/17/17 at 12:30PM, a tour of the facility revealed the following rooms with PPE (personal protective equipment) carts outside of their doors-room 100, room 101, room 304 and room 500. There was not a PPE cart by the door of Resident #78. On 1/18/17 at 12 noon, an observation revealed a PPE cart outside of Resident #78 ' s room with a precaution sign that indicated Resident #78 was on droplet precautions. Droplet precautions are	F 441	Immediate corrective action taken for this alleged deficient practice includes: 1.The correct isolations signs were posted outside the residents doors for resident #78, #63, and #129 Resident with potential to be affected. 1.All Residents that requires isolation has the potential to be affected. Measures put into place to assure that the alleged deficient practice does not recur include: 1.The Facility is now posting the infection control signs outside the patient door on the wall instead of on the isolation cart. 2.Education began on 1/22/2017 for Licensed staff (who have been scheduled) has been in-serviced on correct signage	

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F 441	Continued From page 10 implemented when there is a potential for transmission of infections directly from the respiratory tract of an infected individual through coughing, sneezing or talking. A review of the medical record for Resident #78 revealed a physician ' s order dated 12/16/16 for contact isolation (precautions) for clostridium difficile (c-diff). Contact precautions are used to prevent infections that are spread by person-to person contact. On 1/19/17 at 8:05 AM, Nurse #2 was observed to go to Resident #78 ' s room. There was a droplet precaution sign placed on top of the PPE drawer cart. Nurse #2 changed the sign to contact precautions. Upon inquiry, the nurse stated the signage was supposed to be for " contact precautions." On 1/19/17 at 11:00AM, the infection control nurse provided a list of residents currently under isolation precautions. Resident #78 was listed as having contact precautions. She stated the facility followed CDC (Center for Disease Control) guidelines for the use of isolation signage and procedures. The infection control nurse provided a copy of the facility policy for contact precautions revised April 15, 2016 which stated, in part, to place a contact precautions sign outside the patient's room to notify anyone entering the room of the situation. On 1/19/2017 at 4:53PM, an interview was conducted with the infection control nurse. She stated nursing staff obtained the PPE cart when a resident was placed on isolation. The precaution signs were put into place at the time the carts were placed outside of the resident ' s room. She	F 441	based on type of isolation required by the infection control nurse, Clinical Competency Coordinator and Director of Health Services. The Licensed Staff not scheduled will be educated prior to their next shift. 3.Documented daily checks are completed by the administrative nursing staff, to ensure correct signage is in place outside the residents room door, for 7 days then weekly times 3 weeks. Monitoring put in place to assure the alleged deficient practice does not recur includes: 1.The Director of Health Services will take the findings of the documented resident signage review, to the Quality Assurance Performance Improvement Committee monthly until three months of consecutive compliance is established.	

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stated the precaution signs were placed on top of the cart and not on the door of the resident room. The infection control nurse stated she expected the correct precaution sign to be placed on the PPE cart.

On 1/19/2017 at 5:08PM, an interview was conducted with the Director of Nursing. She said there was a resident who kept taking the precaution signs off the top of the PPE cart and nursing staff tried to replace then as soon as they noticed the signs were gone. She stated she expected the proper precaution sign to be placed on the PPE cart for the correct type of isolation ordered. She stated the droplet precaution sign on Resident #78 ' s PPE cart should have indicated contact precautions.

2. On 1//17/17 at 11:10AM, an initial tour of the facility was conducted. A PPE cart was observed sitting outside of Resident #63 ' s room. There was no precaution sign posted on the door, by the side of the door or on top of the PPE cart.

Medical record review revealed a physician ' s order dated 12/31/16 for contact precautions due to left foot cellulitis-MRSA (Methicillin-Resistant-Staphylococcus Aureus) positive wound culture.

On 1/17/17 at 12:30PM, an observation of Resident #63 ' s room revealed a PPE cart outside of the room by the door. There was no precaution sign posted on the door, by the side of the door or on top of the PPE cart.

On 1/18/2017 at 11:41 AM, an observation of Resident #63 ' s room revealed a PPE drawer cart by the door. There was no precaution sign

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	345124	A. BUILDING _____ B. WING _____	C 01/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEALTH-ELKIN	560 JOHNSON RIDGE ROAD ELKIN, NC 28621

(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 441	Continued From page 12	F 441		

posted on the door, by the side of door or on top of the PPE cart.

On 1/18/17 at 12 noon, an observation revealed a contact precaution sign had been placed on the top of Resident #63 ' s PPE cart.

On 1/19/17 at 11:00AM, the infection control nurse provided a list of residents currently under isolation precautions. Resident #63 was listed under contact precautions. She stated the facility followed CDC (Center for Disease Control) guidelines for the use of isolation signage and procedures. The infection control nurse provided a copy of the facility policy for contact precautions revised April 15, 2016 which stated, in part, to place a contact precautions sign outside the patient's room to notify anyone entering the room of the situation.

On 1/19/2017 at 4:53PM, an interview was conducted with the infection control nurse. She stated nursing staff obtained the PPE cart when a resident was placed on isolation. The precaution signs were put into place at the time the carts were placed outside of the resident ' s room. She stated the precaution signs were placed on top of the cart and not on the door of the resident room.

On 1/19/2017 at 5:08PM, an interview was conducted with the Director of Nursing. She said there was a resident who kept taking the precaution signs off the top of the PPE cart and nursing staff tried to replace then as soon as they noticed the signs were gone.

On 1/19/17 at 5:35PM, an observation revealed a resident was observed rolling down the hallway in

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	345124	A. BUILDING _____ B. WING _____	C 01/21/2017

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her wheelchair across from the 500/600 hall nursing station holding an isolation precaution sign.

On 1/19/17 at 6:40PM, an interview was conducted with the infection control nurse who confirmed that there had been a problem with residents taking the signs off the PPE cart and the resident observed rolling down the hallway was one of the residents who picked up the signs.

3. On 1/17/17 at 12:30PM, a tour of the facility was conducted. There was a PPE cart noted by the door of Resident #129 that indicated Resident #129 was on droplet precautions.

Medical record review revealed a physician ' s order dated 12/9/16 for droplet precautions for MRSA and pneumonia.

On 1/19/17 at 7:50 AM, an observation revealed Resident #129 had a PPE drawer cart with no precautions sign posted on the door, by the side of the door or on top of the PPE cart. Nurse #1 stated Resident #129 was on droplet precautions and the sign was there yesterday. She indicated possibly a wandering resident may have picked up the sign. Nurse #1 requested another nurse (Nurse #2) to replace the sign. Nurse #2 replaced the sign at 8:00 AM.

On 1/19/17 at 11:00AM, the infection control nurse provided a list of residents currently under isolation precautions. Resident #129 was listed under droplet precautions. She stated the facility followed CDC (Center for Disease Control) guidelines for the use of isolation signage and procedures.

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On 1/19/17 at 4:35PM, an observation revealed the PPE cart for Resident #129 was at the door. There was no precaution sign posted on the door, by the side of the door or on top of the PPE cart.

On 1/19/2017 at 4:53PM, an interview was conducted with the infection control nurse. She stated nursing staff obtained the PPE cart when a resident was placed on isolation. The precaution signs were put into place at the time the carts were placed outside of the resident ' s room. She stated the precaution signs were placed on top of the cart and not on the door of the resident room.

On 1/19/2017 at 5:08PM, an interview was conducted with the Director of Nursing. She said there was a resident who kept taking the precaution signs off the top of the PPE cart and nursing staff tried to replace then as soon as they noticed the signs were gone.

On 1/19/17 at 5:35PM, an observation revealed a resident was observed rolling down the hallway in her wheelchair across from the 500/600 hall nursing station holding an isolation precaution sign.

On 1/19/17 at 6:40PM, an interview was conducted with the infection control nurse who confirmed that there had been a problem with residents taking the signs off the PPE cart and the resident observed rolling down the hallway was one of the residents who picked up the signs.