STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345105	A. BUILDING ______ B. WING ______	C 01/14/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEALTH-HIGH POINT	3830 N MAIN STREET HIGH POINT, NC 27265

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to notify the physician about five doses of antibiotic that were not administered to 1	F 157	This plan of correction constitutes a written allegation of substantial compliance with Federal and Medicaid	1/30/16

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 01/29/2016

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 157	Continued From page 1 of 1 sampled resident, resulting in hospitalization (Resident #31). Findings included: Resident #31 was admitted to the facility on 8/9/15 with diagnoses including diabetes mellitus, depression and asthma. Review of the recent Minimum Data Set dated 12/26/15 revealed that the resident was moderately cognitively impaired. Medical records of the hospital ' s discharge notes review revealed that resident #31 received his last dose of ampicillin 2000 milligram (mg) intravenously (IV) in the hospital on 11/25/15 at 6:00 AM. Record review of physician orders, dated 11/25/15, revealed an order for ampicillin (an antibiotic) 2000 mg IV every six hours for the treatment of an infection. Review of the Medication Administration Record (MAR) for 11/25/15 and 11/26/15 revealed that ampicillin was not administered. Record review of the nurses ' notes, dated 11/25/15 at 3:00 PM, revealed that the resident readmitted to the facility from the hospital with discharge orders, including ampicillin 2000 mg IV every six hours, which were faxed to the Nurse Practitioner (NP) for verification. Record review of the nurses ' notes, dated 11/25/15 at 10:00 PM, revealed that the NP confirmed the orders and MAR was sent to the pharmacy. Record review of the nurses ' notes, dated 11/26/15 at 9:00 PM indicated that the Assistant of Director of Nursing was notified that there was no ampicillin available. Record review of the situation background assessment recommendation (SBAR), dated 11/26/15, revealed an order at 9:00 PM to send Resident #31 to the hospital since the facility was unable to give ampicillin 2000 mg every six hours	F 157	requirements. Preparation and/or execution of this correction do not constitute admission or agreement by the provider of the truth of items alleged or conclusions set forth for the alleged deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provision of the state and federal law in order to remove the immediate jeopardy. It also demonstrates our good faith and desire to continue to improve the quality of care and services to our residents. Immediate Corrective Actions 1. Medical Director was notified on 11/26/15. METHODS TO IDENTIFY ANY OTHER RESIDENTS WHO MIGHT BE AFFECTED 1. Licensed Nurse Supervisor completed a daily MAR review of antibiotic administration to ensure any missing antibiotic administration was communicated to Medical Director. SYSTEMIC CHANGES 1. Licensed Nurse Manager or Clinical Competency Coordinator provided education of nursing staff on policy regarding Medical Director notification of missing dosage 2. Director of Health Services or Licensed Nurse Manager will in-service all new nurses during general orientation on policy regarding MD notification of missing dosage	

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F 157	Continued From page 2 as ordered. On 1/11/16 at 2:55 PM, during an interview, Nurse #7 stated that on 11/25/15 and 11/26/15 the facility did not have ampicillin available for administration. He called the pharmacy on 11/26/15 at 3:00 PM to inquire about the status of the ampicillin. The pharmacy staff promised to call the facility when the antibiotic was ready. The physician was not notified at that time. On 11/26/15 at 9:00 PM, Nurse #7 reported the situation to Assistant of Director of Nursing and notified the physician. On 1/13/16 at 3:20 PM, during an interview, nurse supervisor stated that on 11/25/15 he faxed the order for ampicillin to the pharmacy more than once but did not receive this antibiotic during his shift. The nurse passed this information to the next shift, but did not notify physician. On 1/13/16 at 3:30 PM, during an interview, the Administrator indicated that her expectation was if the ordered medication was not available, the staff had to notify MD and responsible party.	F 157	3. The Director of Health Services or Licensed Nurse Manager will review the Medication Administration Registration of missing antibiotics including physician notification of same daily for seven days, weekly for one month and monthly thereafter MONITORING Director of Health Services will bring analysis of tracking and trending of Medical Director notification to monthly QAPI for review and revision as needed.	
F 425 SS=D	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.	F 425		1/30/16

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F 425	Continued From page 3 The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to administer five doses of an antibiotic to 1 of 3 residents, resulting in hospitalization (Resident #31). Findings included: Resident #31 was admitted to the facility on 8/9/15, with diagnoses including diabetes mellitus, depression and asthma. Review of the recent Minimum Data Set, dated 12/26/15, revealed that the resident was moderately cognitively impaired. Record review of physician orders, dated 11/25/15, revealed an order for ampicillin (an antibiotic) 2000 milligram (mg) intravenously (IV) every six hours for the treatment of an infection. Medical records of the hospital ' s discharge notes review revealed that resident #31 received his last dose of ampicillin 2000 mg IV in the hospital on 11/25/15 at 6:00 AM. Review of the Medication Administration Record (MAR) for 11/25/15 and 11/26/15 revealed that ampicillin was not administered. Record review of the nurses ' notes dated 11/25/15 at 3:00 PM revealed that the orders were faxed to the Nurse Practitioner (NP) for verification. Record review of the nurses ' notes dated 11/25/15 at 10:00 PM revealed that the NP	F 425	This plan of correction constitutes a written allegation of substantial compliance with Federal and Medicaid requirements. Preparation and/or execution of this correction do not constitute admission or agreement by the provider of the truth of items alleged or conclusions set forth for the alleged deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provision of the state and federal law in order to remove the immediate jeopardy. It also demonstrates our good faith and desire to continue to improve the quality of care and services to our residents. Immediate Corrective Actions 1.Resident 1 was transferred to hospital for antibiotic administration on 11/26/15. METHODS TO IDENTIFY ANY OTHER RESIDENTS WHO MIGHT BE AFFECTED 1.Licensed Nurse Supervisor completed a daily MAR review of antibiotic administration 12/1/2015.	

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F 425	Continued From page 4 confirmed the orders and MAR was sent to the pharmacy. Record review of the nurses ' notes dated 11/26/15 at 9 PM indicated that the Assistant of Director of Nursing was notified that there was no ampicillin available. Record review of the situation background assessment recommendation (SBAR) report dated 11/26/15 revealed an order at 9:00 PM to send Resident #31 to the hospital since the facility was unable to give ampicillin 2000 mg every six hours as ordered. During an interview on 1/11/16 at 2:55 PM, Nurse #7 stated that he called the pharmacy on 11/26/15 at 3:00 PM to inquire about the status of the ampicillin. The pharmacy staff promised to call the facility when the antibiotic was ready. During an interview on 1/13/16 at 3:20 PM, the Nurse Supervisor stated that on 11/25/15 he faxed the order for ampicillin to the pharmacy more than once, but did not receive this antibiotic during his shift. During an interview on 1/13/16 at 3:30 PM, the administrator stated that resident #31 missed five doses of ampicillin between 11/25/15 and 11/26/15.	F 425	SYSTEMIC CHANGES 1. Director of Health Service or Licensed Nurse Manager provided education of licensed nursing staff on policy regarding missing antibiotic delivery for new orders. 2. Director of Health Service or Licensed Nurse Manager provided education of all new nurses on policy regarding new orders and procedure if new orders do not arrive from pharmacy. MONITORING Director of Health Services will bring analysis of tracking and trending of antibiotic availability and administration as ordered to monthly QAPI for review and revision as needed.	