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 _____	01/14/2016

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

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F 272 SS=D	483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment.	F 272	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. It also demonstrates our good faith and desire to continue to improve the quality of care and services to our residents. Resident #43 annual assessment of 3-11-15 had item correction done on 1-13-16 revealing his PASRR Level II status. Resident # 116 annual assessment date of 9-10-15 had item correction done on 1-13-16 revealing his PASRR Level II status. Resident #6 comprehensive assessment of 4-25-15 had item correction done to	

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

Linda Price RN, LNHA 2-11-16

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 272	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to accurately code sections A1500, A1510 and A 1550 of the Minimum Data Set (MDS) to reflect the Level II Preadmission Screening and Resident Review (PASRR) determination of 3 of 3 residents reviewed as Level II PASRR residents. The findings included: 1. Resident # 43 was admitted to the facility on 7/23/2014 with a diagnosis of depression. A review of Resident # 43 ' s annual MDS section A 1500 dated 3/11/2015 revealed the MDS was not coded as having a Level II PASRR. A Level II PASRR was not indicated on the face sheet of Resident #43 ' s medical record. The review of this screening is used to determine care needs, appropriate care setting to meet those needs and a set of recommendations for services to help develop an individual ' s plan of care. 2. Resident # 116 was admitted on 5/20/2015 to the facility with a diagnosis of schizophrenia and schizoaffective disorder. A review of Resident # 116 ' s annual MDS section A 1500 dated 9/10/2015 revealed the MDS was not coded as having a level II PASRR. A Level II PASRR was not indicated on the resident face sheet in the chart of Resident # 116. The review of this screening is used to determine resident needs, appropriate care setting and a set of recommendations for services to help develop an individual ' s plan of care. 3. Resident #6 was initially admitted to the facility on 5/20/2013 with a diagnosis which included intellectual disability. A review of Resident # 6 ' s comprehensive MDS section A1500 dated 4/25/2015 was coded as	F 272	Reveal his diagnosis of intellectual disability on 1-13-16. Review of all current residents to establish current list of Level II PASRRS. Establish system to ensure PASRRS are current and Level II PASRRS will be kept in separate section of binder along with current admitting FL2 will be placed in resident chart behind admission record tab. Appropriate staff in serviced on new procedure All Findings taken to PI committee monthly times 3 then quarterly.	1-13-16 1-13-16 1-21-16 1-21-16

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F 272	Continued From page 2 having a Level II PASRR. A further evaluation determined Resident #6 was not coded on section A1510 or section A1550 as having a diagnosis of intellectual disability. The review of this screening should be used to determine needs, appropriate care setting and a set of recommendations for services to help develop an individual ' s plan of care. During the entrance conference with the administrator on 1/11/2016, at 10:00AM, it was revealed that there were no residents residing in the facility with a Level II PASRR. Also revealed was that Level II PASRR numbers were recorded at the bottom of each resident ' s face sheet set by the computer program. On 1/13/2016 at 10:36 AM, the Financial Counsel Officer confirmed that there were no Level II PASRR residents present in the facility. The Financial Counsel Officer then verified the PASRR levels of all residents currently residing in the facility and discovered that Resident # 43, resident # 116 and Resident # 6 did have Level II PASRR. An interview on 1/13/2016 at 1:59 PM with the MDS Coordinator revealed that the PASRR status of each resident was indicated on the resident ' s face sheet and that this was where the information was reviewed for coding of the comprehensive MDS ' s. The MDS Coordinator revealed that the Financial Counsel Officer prepared the face sheets and that the MDS Coordinator was responsible for coding this status on sections A1500, A 1510 and A1550 of the MDS. The MDS Coordinator stated that she was not aware of the Level II PASRRs for Residents # 43 and #116. The MDS Coordinator also confirmed that the diagnosis for Resident # 6 had been overlooked when coding the previous comprehensive assessment dated 4/25/2015.	F 272		

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F 272	Continued From page 3 The MDS Coordinator indicated that she would correct the Comprehensive assessments for Residents # 43, # 116, and #6 and that the Financial Counsel Officer or the Administrator would confirm all current and new admission resident ' s PASRR status and communicate any Level II PASRR residents to the MDS Coordinator and also to verify that the correct PASRR information was recorded on each resident ' s medical record.	F 272		
F 463 SS=D	483.70(f) RESIDENT CALL SYSTEM - ROOMS/TOILET/BATH The nurses' station must be equipped to receive resident calls through a communication system from resident rooms; and toilet and bathing facilities. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and resident interview the facility failed to maintain a properly working call bell system for 1 out of 40 residents, Resident #193. Findings included: During resident interview and observation on 01/11/2016 at 11:56 am Resident #193 ' s call bell cord was found to be frayed near the button end of the call bell. The call light would not activate the light outside the room or ring at the desk. The bathroom call bell was checked and was found to work properly. The roommate ' s call bell was checked and was found to work properly. Resident explained that she did not know that her call bell was not working. Nurse #1 was interviewed on 01/11/2016 at 1:34	F 463	Maintenance Director immediately replaced the broken call bell cord in room 415-A for resident #193 at approximately 1:50 PM. Maintenance Director checked all other resident rooms to ensure call bells were working properly. Direct care staff inserviced on when providing care to monitor call bell for proper functioning and to notify maintenance immediately of any concerns. Findings will be taken to PI committee monthly times 3	1-11-16 1-11-16 2-2-16 1-21-16

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F 463	Continued From page 4	F 463		

pm. When notified of the frayed call bell cord and the fact that it was not working, she explained that she did not know that the call light was not working. She indicated that she would call maintenance right away.

The Maintenance Director was interviewed on 1/13/2016 at 10:38 am. He described his process to check the call bell system. The rooms are checked for many maintenance items quarterly and are scheduled on our computer system. He indicated that he rarely finds any problems with the system, but when there are problems, they are addressed right away.

Nurse Aide # 1 was interviewed on 1/13/2016 at 11:18 am. She explained that the resident would need to use her call light some. She needs limited assistance with one staff member. She does get up on her own some as she has dementia, but she should have staff assistance.

Nurse Aide #2 was interviewed on 11/14/2016 at 11:17 am. She described the process she would follow if she noted a call bell that did not work. She explained that she would check to make sure the cord was plugged in correctly. If that didn ' t help she would notify maintenance. She also explained that she would monitor the resident frequently until the problem was corrected.

On 1/14/2016 at 11:30 am the administrator was interviewed. She indicated that staff had made her aware of the problem when it was discovered and that they had addressed the issue promptly as she expected them too.