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 06/14/2017

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 274 SS=D	483.20(b)(2)(ii) COMPREHENSIVE ASSESS AFTER SIGNIFICANT CHANGE (b)(2)(ii) Within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a "significant change" means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on record review, and staff interview, the facility failed to complete a significant change in condition assessment for 1 of 5 sampled residents (Resident #4). The finding included: Resident #4's diagnoses included dementia and history of a cerebrovascular accident. The annual Minimum Data Set (MDS) dated 2/2/17, specified Resident #4 required limited assistance for bed mobility, eating and walking in the room. The resident was also assessed to be moderately cognitively impaired. The quarterly MDS dated 5/15/17, specified Resident #4 required extensive assistance for bed mobility, eating, and walking in the room. This MDS indicated the resident was severely cognitively impaired.	F 274	This plan of Correction constitutes the facilities written allegation of compliance for the deficiencies cited. However, submission of this plan of correction is not an admission that deficiencies exist or that one was cited correctly. This plan of correction is submitted to meet requirements established by federal and state law. 1.Resident affected Resident #4 had significant change completed 6/16 and transmitted 6/19. 2.Residents with the potential to be affected a.All residents have the potential to be affected b.An audit of all residents with a Quarterly,	7/7/17

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

Electronically Signed | 06/28/2017

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F 274	Continued From page 1 MDS Coordinator #1 was interviewed on 6/7/17 at 3:40 PM, about this resident's significant change in activities of daily living and cognition. MDS Coordinator #1 agreed the 5/15/17 assessment should have triggered a Significant Change in Condition assessment, but it had been missed. On 6/8/17 at 10:28 AM, the Director of Nursing said he had been made aware a Significant Change in Condition assessment should have been done for this resident. He stated they had been trying very hard to hire another MDS Coordinator but to date, had been unsuccessful. The Administrator was interviewed on 6/8/17 at 10:55 AM. The Administrator stated they were trying to find someone for MDS but until this survey she felt the facility was in substantial compliance with regard to significant change in status assessments.	F 274	Annual, Significant Change OBRA assessment will be completed by the Interdisciplinary Team (comprised of the Case Mix Director, the Social Services Director, the Dietary Manager, the Skin Integrity Coordinator, the Activities Director, and the Director of Health Services) to identify any significant change in status from the prior OBRA assessment. The audit will be conducted as follows: 25% of all current patients with a completed Quarterly or Annual assessment will be reviewed by the Interdisciplinary team weekly to identify any change that would warrant the completion of a Significant Change in Status Assessment. The weekly audits will occur weekly until 100% complete. The findings will be placed on the Significant Change in status audit tool and will be reviewed by the Administrator weekly and reported to the Quality Assurance and Performance Improvement Committee to ensure compliance. 3.Systematic Change/Intervention a.Competency education for RAI 3.0-OBRA completion requirements was completed 6/20/17 by Case Mix Director, the Social Services Director, the Dietary Manager, the Skin Integrity Coordinator, the Activities Director, and the Director of Health Services electronically via Assessment Intelligence Systems (AIS). A post-test was completed and certificate granted as proof of competency. b.Education provided to Interdisciplinary	

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F 274	Continued From page 2	F 274	team (comprised of the Case Mix Director, the Social Services Director, the Dietary Manager, the Skin Integrity Coordinator, and the Director of Health Services) on the utilization of the RUGS Analysis Tool (AHT system summary of MDS coding) to assist with identifying Significant Change in status by the Director of Clinical Reimbursement and Clinical Reimbursement Consultant. c.The Case Mix Director will review the RUGs Analysis for changes that may warrant a significant change in status assessment with the completion of each new assessment and bring forward to the Interdisciplinary team to make the determination if Significant Change Assessment is needed and document on Significant Change Audit Tool until substantial compliance determined through QAPI. d.The Financial Counselor will notify the Interdisciplinary team of Hospice Admission and Discharge dates during Weekly Case Mix Meeting. e.The Administrator will verify the results of the reviews and Significant Change Assessment completion utilizing the Significant Change audit tool 1 X weekly for 3 weeks, and then 1 X monthly for 3 months or until substantial compliance is determined and report findings to QAPI. 4. Monitoring a.The Administrator will review and trend	

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F 274	Continued From page 3	F 274	the findings the findings from the Significant Change audit tool. The Administrator will bring the finds from the audit to the Quality Assurance Performance Improvement Committee for meetings x 3 months or until substantial compliance is achieved. Changes will be made to the plan by the committee as indicated to include re-education and/or immediate corrective action.	
F 490 SS=D	483.70 EFFECTIVE ADMINISTRATION/RESIDENT WELL-BEING 483.70 Administration. A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility's administration failed to utilize its resources effectively to ensure the facility recognized and completed assessments for residents with a significant change in status. The findings included: This tag is cross referenced to: F274: Based on record review, and staff interview, the facility failed to complete a significant change in condition assessment for 1 of 5 sampled residents (Resident #4). The facility was recited for F274 on the current complaint investigation survey for failing to complete a significant change in status assessment for a resident with declines in	F 490	Resident affected a.Resident # 4 had significant change completed on 6/16/2017 and was transmitted on 6/19/2017 2. Residents with the potential to be affected. a.All residents have the potential to be affected b.An audit of all residents with a Quarterly, Annual, and Significant change OBRA assessment will be completed by the interdisciplinary team (Comprised of the Case Mix Director, the Social Services	7/7/17

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F 490	Continued From page 4 activities of daily living and cognition. F274 was originally cited during the January 2017 recertification survey for failing to complete a significant change in status assessment for a resident who had elected the hospice benefit on 12/13/16. On 6/14/17 at 1:13 PM, the Administrator stated they had been unable to hire a second MDS Coordinator and after the January survey, had received assistance for a while from the corporate office. The Administrator indicated assessments needed to be done and said, "Hopefully we can get more help."	F 490	Director, the Dietary Manager, the Skin Integrity Coordinator, the Activities Director, and the Director of Health Services to identify any significant change in the status from the prior OBRA assessment. The audit will be conducted as follows: 25% of all current patients with a completed Quarterly or Annual assessment will be reviewed by the interdisciplinary team weekly to identify any change that would warrant the completion of a significant change in status assessment. The weekly audits will occur weekly until 100% complete. The findings will be placed on the significant change in status audit tool and will be reviewed by the Administrator weekly and reported to the Quality Assurance and Performance Improvement Committee to ensure compliance. 3.Systematic Change/Intervention a. Competency education for RAI 3.0 OBRA completion requirements was completed 06/20/17 by Case Mix Director, the Social Services Director, the Dietary Manager, the Skin Integrity Coordinator, the Activities Director, the Director of Health Services and the Administrator electronically via Assessment Intelligence Systems (AIS). A posttest was completed and certificate granted as proof of competency. b.Education provided to the interdisciplinary team (comprised of the Case Mix Director, the Social Services	

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F 490	Continued From page 5	F 490	Director, the Dietary Manager, the Skin Integrity Coordinator, the Director of Health Services and the Administrator) on the utilization of the RUGS analysis tool (AHT system summary of MDS coding) to assist with identifying significant change in status by the Director of Clinical Reimbursement and clinical Reimbursement Consultant. c.The Case Mix Director will review the RUGS Analysis for changes that may warrant a significant change in status assessment with the completion of each new assessment and bring forward to the interdisciplinary team to make the determination if significant change assessment is needed and document on significant change audit tool until substantial compliance determined through QAPI. d.Administrator participated in QAPI Process training with Pruitt Vice President of Quality Services on June 22, 2017 and proof of attendance acquired. e.The Financial Counselor will notify the interdisciplinary team of Hospice admission and discharge dates during weekly Case Mix meeting. The Case Mix Director will then schedule a significant change to be completed. f.The Administrator will verify the results of the reviews and significant change assessment completion utilizing the significant change audit tool weekly for 3 weeks, and then monthly for 3 months or	

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F 490	Continued From page 6	F 490	until substantial compliance is determined and report findings to QAPI. g. A Regional Team member (Area Vice President, Clinical Reimbursement Consultant, Senior Nurse Consultant, etc. Clinical Nurse Consultant will participate in the QAPI process for three months with their findings reviewed with the Pruitt Quality Assurance and Performance Improvement Committee. h.CMD will complete assessments no later than 2-3 days after ARD date of by due date, whichever comes first. MDS schedule for all OBRA assessments will be completed by the third week of previous month for all OBRA assessments and distributed to all members of the interdisciplinary team. I. RN will sign MDS□s as completed daily. j.A list of completed assessments will be given by the Case Mix Director to the Administrator at the end of each work day. 4. Monitoring a.The Administrator will review and trend the findings the findings from the Significant Change audit tool. The Administrator will bring the finds from the audit to the Quality Assurance Performance Improvement Committee for meetings x 3 months or until substantial compliance is achieved. Changes will be made to the plan by the committee as indicated to include re-education and/or	

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F 490	Continued From page 7	F 490	immediate corrective action. b.The Administrator will bring results of all open PI Plans to the Monthly Quality Assurance Performance Improvement Committee meetings x 3 months or until substantial compliance is achieved to ensure we have appropriate corrective action. Changes will be made to the plan by the committee as indicated to include re-education and/or immediate corrective action c.The Regional Leadership team will review performance improvement plans for the facility monthly X 6 months to ensure effectiveness. Any negative findings will be reviewed at the Regional Leadership team at the quarterly Quality Assurance/Performance Improvement meeting for opportunities for re-education or correction.	
F 520 SS=D	483.75(g)(1)(i)-(iii)(2)(i)(ii)(h)(i) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS (g) Quality assessment and assurance. (1) A facility must maintain a quality assessment and assurance committee consisting at a minimum of: (i) The director of nursing services; (ii) The Medical Director or his/her designee; (iii) At least three other members of the facility's staff, at least one of who must be the	F 520		7/7/17

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F 520	Continued From page 8 administrator, owner, a board member or other individual in a leadership role; and (g)(2) The quality assessment and assurance committee must : (i) Meet at least quarterly and as needed to coordinate and evaluate activities such as identifying issues with respect to which quality assessment and assurance activities are necessary; and (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (h) Disclosure of information. A State or the Secretary may not require disclosure of the records of such committee except in so far as such disclosure is related to the compliance of such committee with the requirements of this section. (i) Sanctions. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on record reviews, and staff interviews, the facility's Quality Assessment and Assurance Committee failed to maintain implemented procedures and monitor interventions the committee put into place for one recited deficiency that was originally cited in the recertification survey in January of 2017, and was subsequently cited on this current complaint survey in June of 2017. The repeated deficiency was in the area of resident assessment. The continued failure of the facility during two federal	F 520	1.Resident affected a.No resident was negatively impacted by this concern. 2.Residents with potential to be affected a.All residents in the facility have the ability to be impacted by this practice. There were no adverse outcomes related to this concern.	

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F 520	Continued From page 9 surveys of record show a pattern of the facility's inability to sustain an effective Quality Assurance Program. The findings included: This tag is cross referenced to: F274: Based on record review, and staff interview, the facility failed to complete a significant change in condition assessment for 1 of 5 sampled residents (Resident #4). The facility was recited for F274 on the current complaint investigation survey for failing to complete a significant change in status assessment for a resident with declines in activities of daily living and cognition. F274 was originally cited during the January 2017 recertification survey for failing to complete a significant change in status assessment for a resident who had elected the hospice benefit on 12/13/16. The Administrator was interviewed on 6/8/17 at 10:55 AM. The Administrator indicated that after the recertification survey, corrective action was put in place and until this survey, she felt the facility was in substantial compliance with regard to significant change in status assessments.	F 520	b.On 6/22/17, the Administrator will be re-educated by the Vice President of Quality Assurance and Performance Improvement on the quality assurance process. 3.Systemic Change/Interventions a.Re-education began on 6/20/17 provided via Pruitt U class to all members of the Quality Assurance and Performance Improvement (QAPI) Committee, which is comprised of the Administrator , Director of Health Services, Clinical Competency Coordinator, Dietary Manager, Maintenance Director, Housekeeping Supervisor, Financial Counselor, Social Services Director, Activity Director, Case Mix Coordinator, Admissions Director and Medical Records Coordinator. Assigned class on Pruitt U included PruittHealth QAPI Developing and Sustaining a Quality Culture, and QAPI Root Cause Analysis and PIP Development for SNF All employees that are on the QAPI committee are full time. There are no PRN or weekend staff on this committee. b.The Area Vice President of Operations will designate a member of the Regional Leadership team to participate in the Quality Assurance/Performance Improvement meetings for the facility monthly X 6 months. c.The Regional Leadership team will review performance improvement plans	

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F 520	Continued From page 10	F 520	for the facility monthly X 6 months to ensure effectiveness. Any negative findings will be reviewed at the Regional Leadership team at the quarterly Quality Assurance/Performance Improvement meeting for opportunities for re-education or correction. 4.Plan to Monitor a.The Administrator will bring results of all open PI Plans to the Monthly Quality Assurance Performance Improvement Committee meetings x 3 months or until substantial compliance is achieved to ensure we have appropriate corrective action. Changes will be made to the plan by the committee as indicated to include re-education and/or immediate corrective action b.The Regional Leadership team will review performance improvement plans for the facility monthly X 6 months to ensure effectiveness. Any negative findings will be reviewed at the Regional Leadership team at the quarterly Quality Assurance/Performance Improvement meeting for opportunities for re-education or correction.	