STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345371	A. BUILDING _____ B. WING _____	C 08/03/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEALTH-TRENT	836 HOSPITAL DRIVE NEW BERN, NC 28560

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F 204 SS=D	483.15(c)(7) PREPARATION FOR SAFE/ORDERLY TRANSFER/DISCHRG (c)(7) Orientation for Transfer or Discharge A facility must provide and document sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility. This orientation must be provided in a form and manner that the resident can understand. This REQUIREMENT is not met as evidenced by: Based on record reviews, and staff interviews, the facility failed to assist in a safe and orderly discharge for a resident with a diagnosis of paranoid schizophrenia and a history of refusing medications. The resident left the building and upon return was advised that the facility had signed him out against medical advice for 1 of 1 (98) residents. Findings included: Resident # 98 was admitted to the facility on 6/29/2017 with diagnosis of hypertension, coronary artery disease, nicotine addiction, Noncompliance, paranoid schizophrenia, peripheral vascular disease, physical debility and elevation myocardial infarction. The resident's Minimum Data Set (MDS) date 7/6/2017 indicated the resident's cognition was intact, rejected care 1 to 3 days in a week, required supervision with one person assist with bed mobility, limited assist with one person for transfer, walk in room independently with no setup help and supervision with one person assist when walking in the corridor. Resident # 98 was care planned on 6/29/2017 for "potential for side effects and/or adverse reaction	F 204	This plan of correction constitutes a written allegation of compliance. Preparation and submission of this plan of correction does not constitute an admission or agreement by the provider of truth of the facts alleged or the corrections of the conclusions set forth on the statement of deficiencies. The plan of correction is prepared and submitted solely because of requirements under state and federal law. What Corrective action will be accomplished for the deficient practice? Resident #98 voluntarily discharged AMA on 7/14/17. He then returned to the facility and verbally and physically assaulted the staff while trying to enter the facility which had been placed on lockdown. Resident became calm when the New Bern City Police arrived and verbalized multiple times that he did not want to return to the facility. He wanted his personal belongings which were given to him and he left on his own accord. How will you identify other areas having	8/22/17

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

Electronically Signed | 08/23/2017

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F 204	Continued From page 1 due to use of psychotropic medications, mood disorder, anxiety/ agitation paranoid schizophrenia reported history on noncompliance with medication and treated, Consistent refusal of medical treatment, he was admitted to facility post hospital stay stent placement for rehabilitation and medical care. He is consistently refusing therapy services and medical care as well as medications he has diagnosis of paranoid Schizophrenia and was reported to be homeless prior to hospital admit refusing medication places him at risk for a psychotic/ schizophrenic break episode. He is being followed by the mental health services for his altered perception of reality. His schizophrenia is expected to have psychotic break if not compliant with current medication regiment treatment." The goals included " Do not criticize or argue with patient if he refuses accepts his answer/ refusal return at later time frame if appropriate to ask again- document refusals, Discuss with patient implications of not complying with therapeutic regime encourage him to express his concerns and why he does not want to take medication or remain in compliance." Review of the resident's Medication Administration Record(MAR) dated for June 2017 and July 2017 revealed the physician prescribed the following medication: Seroquel 200 mg daily, Depakote 250 mg two times per day. Review of the nurse's note dated 6/30/2017 revealed the resident refused to take Seroquel medication. Review of the nurse's note dated 7/1/2017revealed the resident was talking to self and asking for someone to contact a famous	F 204	the potential to be affected by the same deficient practice and what corrective action will be taken? Any resident that is cognitively intact and can make decisions regarding their personal care and who have a diagnosis of paranoid schizophrenia. Per our policy, If a resident refuses medications twice, the Medical Director/Physician□s Assistant is notified as well as Psychiatric services. What measures will be put in place or what systemic changes will be made to ensure that the deficient practice will not reoccur? Any resident that is cognitively intact and can make decisions regarding their personal care and who have a diagnosis of paranoid schizophrenia and choose to leave the facility AMA will be referred to the Adult Protective Services Department. How will the corrective action be monitored to assure that the deficient practice will not reoccur, i.e., what quality assurance program will be put in place for monitoring to assure continued compliance. All residents that are cognitively intact and can make decisions regarding their personal care and who have a diagnosis of paranoid schizophrenia and choose to leave AMA will be reviewed during QAPI x 3 months.	

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musician for him write away.

Review of the nurse's note dated 7/2/2017 revealed the resident refused to take Depakote medication and was overheard talking to self-saying someone better call the studio so he can go ahead and produce the record.

Review of the nurse's note dated 7/3/2017 revealed the resident had to be redirected and reoriented due to his disorganized thoughts.

Review of the nurse's note dated 7//4/2017 revealed the resident refused to take most of his medication.

Review of the doctor's note dated 7/4/2017 noted the resident was at the facility for physical rehabilitation and management in the setting of underlying schizophrenia, hypertension. The resident was ambulating and also was using a wheel chair.

Review of the nurse's medication dated 7/5/2017 revealed the resident refused to take Depakote medication.

Review of behavior monitoring sheet for the month of July 2017 revealed the resident refused to take his medications on the following dates: "July 4th, July 8th, July 9th, July10th, July 11th, July 12, July 13, and July 14."

The behavioral monitoring sheet also revealed the resident exhibited paranoia and delusion behavior on July 14th.

Review of the form with headline "Release of responsibility for discharge Against Medical

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Advice (AMA)" dated 7/14/2017 revealed the resident did not sign the form. The facility staff documented on the form the resident refused to sign.

Facility incident report dated 7/14/2017 revealed the Administrator arrived at work at 8:00am and proceeded to do rounds. She found Resident # 98 in another resident's room eating breakfast. She knocked on the door and the other resident was in bed. She asked Resident # 98 why he was eating other resident's breakfast and he stated she gave it to him. She asked Resident 98 if the statement was true and she shook her head. The other resident appeared to be uncomfortable and asked Resident # 98 if he would wheel out of the room. He became angry and belligerent. He started yelling at the Administrator and calling her the "head blond b---." He yelled that she was up in his business and he was going to take her out. He proceeded to wheel towards her at which point she sidestepped out of his way. He continued to verbally threaten her and went out the front door. She asked him where he was going and he repeatedly told her he was leaving.

The staff had called the police and they arrived in the parking lot. She met with the police and Resident # 98 in another street outside the facility. Resident # 98 continued to verbally assault and threaten. EMS (Emergency services) arrives and tried to take him to the hospital for evaluation and involuntary commitment. Resident # 98 refused to go and answered all of EMS questions appropriately. He signed the refusal to go to the hospital and EMS left. The police continued to talk with him. The Administrator advised the resident that he had left the property without signing out. She advised him he would be

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leaving AMA and he continued to verbally assault her and wheeled off down the street. The police left. Approximately 1 hour later, the Administrator was advised that Resident # 98 was coming down the street towards the building. The Administrator instructed the staff to go on Code Gray (lockdown). Director of Nursing (DON) and Administrator went out to meet Resident # 98. The DON explained to the resident that he was AMA. He stated he understood that but wanted his personal belongings. She told him she would get them and bring them out to the street for him. The resident then started rapidly wheeling his chair towards the front entrance and then jumps up and starts running. She proceeded to run behind him. A Nurse assistant was also running trying to catch him. The admissions director ran in through the back door to assist in getting the building locked down. The DON was running behind her calling 911 for assistance. As they reach the front porch, the resident busted through the front sliding doors at the same time the staff was closing them. He cornered the Admission director and drew his fists back. He was kicking the doors and trying to break in while screaming and cursing. He pulled his arm back to punch admission director. Administrator screamed at Admission director to drop to the ground as he was swinging. NA # 1 grabbed his shirt and was yelling at him to stop. Administrator tried to block him from hitting her and he pushed her. Admission dropped to the ground and got away. At the same time, DON jumped in from of a police car and flagged down the sheriff who approached Resident # 98 and kept him at bay until the police arrived. The police arrived and investigated the incident. They explained that he was AMA and he agreed that he did not want to go back in the facility and left with his personal

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belongings.

The interview on 8/2/2017 at 10:30 AM with the physical therapy assistant revealed the resident refused to participate in physical therapy during the time he was admitted to the facility.

During the interview on 8/3/2017 at 9:30 AM, the Nurse Assistant (NA) # 1 reported on 7/14/2017 she saw the resident getting ready to get back into the facility while kicking the door. She stated she held the resident's hand back to prevent him from hitting another staff who was in front of him.

During the interviews on 8/3/2017 at 9:45 AM, Nurse Aide # 2 and Nurse Aide # 3 reported they did not observe any behavioral symptoms exhibited by Resident # 98 during the time he was admitted to the facility.

During the interview on 8/3/2017 at 9:50 AM, Nurse # 1 reported she did not observe any behavioral symptoms exhibited by the resident except refusing his medications at times from the staff.

During the Interview on 8/3/2017 at 10:00 AM, The Director of Nursing (DON) reported on 7/14/2017, the resident became belligerent and stated he was leaving the facility. The resident was asked to sign the discharge paper work because he had stated to them that he was not coming back to the facility once he leaves. The resident refused to sign the paperwork and was advice that if he leaves the facility without signing the paperwork it was considered Against Medical advice (AMA). The DON stated the resident left the facility without signing the discharge paperwork. She added later after 45 minutes, the

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resident tried to come back to the facility but he was asked not to come back in and the police was called due to the resident was trespassing. DON was asked why the facility did not intervene when the resident consistently refused taking his medication. DON indicated they did not seek involuntary commitment or intervened when the resident refused his medication because they were letting the resident make his own decisions.

During the interview on 8/3/2017 at 11:00 AM the Administrator reported on 7/14/2017 she arrived at 8:00am at the facility and proceeded to do rounds. She saw the resident eating another resident's breakfast and asked the resident if he needed additional breakfast instead of eating another resident's breakfast. The resident became belligerent stating he was leaving because he was tired of the staff getting in his business. The Administrator also indicated the facility did not intervene in deescalating the resident's behavior on 8/14/2017 because they felt the resident was a threat to the staff. She further reported the resident refused to sign discharge paperwork and was asked to sign out Against Medical advice (AMA) paperwork. The resident refused and walked out. The resident was stopped from coming back in after he left the facility for 45 minutes and the police was notified as it was considered the resident was trespassing. The Administrator also reported even though the resident was refusing his medication, the facility did not seek involuntary commitment at the court house because they felt the resident could make his own decisions. She stated the resident was a threat to the staff at the facility and that was the reason he was not allowed to come back into the facility.