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 _____	02/08/2018

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 582 SS=B	Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v) §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section. §483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any	F 582		3/8/18

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

Electronically Signed | 03/01/2018

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 582	Continued From page 1 deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. (v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. This REQUIREMENT is not met as evidenced by: Based on staff interviews and medical record review, the facility failed to provide a CMS-10055 (Centers for Medicare and Medicaid Services) Skilled Nursing Facility Advanced Beneficiary Notice (SNF ABN) prior to discharge from Medicare part A services to two of three residents (Residents #77 and 245) reviewed for SNF Beneficiary Protection Notification Review. Findings included: 1. Resident #77 was admitted to the facility under part A Medicare services on 1/8/18. A review of the medical record revealed a CMS-10123 Notice of Medicare Non-Coverage letter (NOMNC) was signed by Resident #77's responsible party on 1/25/18. The notice indicated that Medicare coverage for skilled services were to end 1/28/18 and the resident would remain in the facility. A review of the medical record revealed a CMS-10055 SNF ABN was not provided to the	F 582	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. Process that lead to the deficiency Facility was not aware of the necessity to complete the ABN letter (CMS 10055SNF ABN) or residents who remained in the facility.	

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F 582	Continued From page 2 resident or responsible party. An interview was completed with the Nurse Navigator on 2/8/18 at 3:35 PM. She stated she issued the non-coverage notices after the inter-disciplinary team decided on the last covered day of Medicare. She said she gave at least a 48 hour notice to residents and families when part A Medicare services ended and assisted with discharge planning. She said she was unaware that if a resident remained in the facility an ABN notice was required to be given to the resident and/or family. An interview was completed with the Administrator on 2/8/18 at 4:12 PM. She stated she did not know the ABN notice was a requirement for part A Medicare. She said she expected the ABN notice be issued when a resident remained in the facility. 2. Resident #245 was admitted to the facility under part A Medicare services on 10/16/17. A review of the medical record revealed a CMS-10123 Notice of Medicare Non-Coverage letter (NOMNC) was signed by Resident #245 on 12/1/17. The notice indicated that Medicare coverage for skilled services were to end 12/4/17 and the resident would remain in the facility. A review of the medical record revealed a CMS-10055 SNF ABN was not provided to the resident. An interview was completed with the Nurse Navigator on 2/8/18 at 3:35 PM. She stated she issued the non-coverage notices after the inter-disciplinary team decided on the last	F 582	Process for implementing a plan of correction for specific deficiency The Administrator reviewed the Federal Regulation regarding CMS 10055 ABN, the Administrator educated the Senior Nurse Navigator, Social Worker and Financial Counselor on the requirements of the CMS guidelines. This was completed on 2/8/2018 The Senior Nurse Navigate and/or Social Worker began issuing the CMS 10055 ABN letters to residents who remained in the facility with Medicare days still available on 2/8/2018. Monitoring to ensure effectiveness of POC The Administrator reviews the CMS 10055 to ensure it is completed in a timely manner. The Administrator will present the analysis of the trending related to the CMS 10055 to the Quality Assurance Committee monthly until 3 months of continued compliance is maintained, then quarterly. Title of person responsible for implementing the POC Administrator is responsible for implementing the plan of correction. Compliance date 3/8/18	

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F 582	Continued From page 3 covered day of Medicare. She said she gave at least a 48 hour notice to residents and families when part A Medicare services ended and assisted with discharge planning. She said she was unaware that if a resident remained in the facility an ABN notice was required to be given to the resident and/or family. An interview was completed with the Administrator on 2/8/18 at 4:12 PM. She stated she did not know the ABN notice was a requirement for part A Medicare. She said she expected the ABN notice be issued when a resident remained in the facility.	F 582		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized	F 656		3/8/18

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F 656	Continued From page 4 rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews, the facility failed to follow the care plan for fluid restriction for 1 of 1 (Resident #294) reviewed for Dialysis. Findings included: Resident #294 was admitted to the facility on 1/14/18 with diagnosis of Hypertension, End Stage Renal Disease and Diabetes. On 2/6/18 at 4:26 PM, a record review of the Admission Minimum Data Set assessment dated 1/21/8 revealed the resident had impaired cognition. The resident required extensive assistance with all of her Activities of Daily Living, including feeding.	F 656	Process that lead to the deficiency The Nurse forgot to update the ADL Care Guide in the resident□s room when they received the order for the fluid restrictions. Process for implementing a plan of correction for specific deficiency The Director of Health Services, Clinical Competency Coordinator and/or Nurse Managers began educating the Licensed Nurses on updating the ADL care guides when they receive a new order on 2/8/2018. This education will be completed by 3/7/2017. The Director of Nursing and/or Nurse Managers are correlating the new Physician orders with	

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F 656	Continued From page 5 On 2/6/18 at 4:26 PM, a record review of the care plan dated 1/21/18 revealed a problem of: Alteration in kidney function related to diagnosis of End Stage Renal Disease requiring dialysis with fluid restriction. An intervention was reviewed for: Fluid Restriction 900 milliliters from dietary and 600 millimeters from nursing. On 2/6/18 at 4:26 PM, a record review of the dietary note dated 1/2/18 revealed no significant weight change. On 2/8/18 at 9:58 AM, an interview was conducted with NA #2 that revealed she pretty much gives the resident what she asks for. She revealed that if the resident was on a fluid restriction, she was unaware of it, the nurse had not told her. On 2/8/18 at 10:02 AM, an interview with Nurse #3 revealed the resident is on a 1500 milliliter per day fluid restriction and nursing gives 600 milliliters that is broken down between the three shifts with each shift giving 200 milliliters. She revealed the NA's get this information from the care guide that is in each resident's room. On 2/8/18 at 3:35 PM, an interview was conducted with NA #3 who was assigned to give showers but had worked with the resident frequently. She revealed if the resident was on a fluid restriction, she was unaware of it. On 2/8/18 at 5:23 PM, and interview with the Director of Nursing Services revealed that the admission nurse is responsible for putting information on the care guides. She said it got missed. She did not know who the admission nurse was, but she was going to find out and	F 656	the ADL care guides for accuracy daily. Monitoring to ensure effectiveness of POC The Director of Health Services will correlate the data received from the review of the physician orders to the ADL care guide and present at Quality Assurance / Performance Improvement monthly until 3 consecutive months of compliance is maintained then quarterly. Title of person responsible for implementing the POC Director of Health Services is responsible for implementing the plan of correction. Compliance date 3/8/18	

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F 656	Continued From page 6 educate her as well as educate other nurses. She revealed it was her expectation that the care plan be followed.	F 656		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews the facility failed to update a care plan for a. actual weight loss and b. multiple bruising	F 657	Process that lead to the deficiency The facility did not update the care plans	3/8/18

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F 657	Continued From page 7 for one of 31 sampled residents with care plans reviewed. (Resident #64) The findings included: Resident # 64 was admitted to the facility on 1/4/18 with diagnosis including pneumonia, stroke and diabetes. The admission Minimum Data Set (MDS) dated 1/11/18 indicated Resident#69 had mild impairment with her memory, required extensive assistance of two staff with bed mobility, toileting and transfers, required extensive assistance of one staff for personal hygiene, dressing and eating. This MDS indicated Resident #69 had a weight of 176 pounds with no loss of 5% or more in the last month. a. The care plan dated 1/18/18 for included a problem for a potential for weight loss related to the resident would leave 25% or more of meals uneaten. Review of the documented weights included the following: 1/4/18 176 pounds; 1/18/18 164.5 pounds; 1/26/18 160.6 pounds; and 1/30/18 159 pounds. Review of a dietary note dated 1/29/18 indicated a review of the weights had been completed with the resident weighing 160.6 pounds. The note indicated this was a 9.7% loss in one month. The dietary manager documented the weight loss was addressed by dietary, and she was on a supplement three times a day, fed by staff, had wounds, and a poor appetite. Interview with the MDS nurse on 2/8/18 at 10:02 AM revealed if a resident had excessive weight	F 657	timely to accurately reflect the resident current status. Process for implementing a plan of correction for specific deficiency The Director of Health Services, Clinical Competency Coordinator and Nurse Managers began education all Licensed Nurses on 2/8/18 regarding updating care plans with any resident change in status. The Director of Nursing and/or Nurse Manager is reviewing the 24 hour nursing report, event reports, weekly weight sheets, and completing Nurse Huddles for resident status changes. The Director of Nursing and/or Nurses Manager then reviews the Residents care plan to ensure the care plan has been updated to reflect the residents change in status. Monitoring to ensure effectiveness of POC The Director of Nursing is tracking and trending the care plan updates per resident change is status and presenting the analysis at the Quality Assurance and Performance Committee meeting monthly until 3 months of substantial compliance is sustained then quarterly. Title of person responsible for implementing the POC Director of Health Services is responsible for implementing the plan of correction. Compliance date 3/8/18	

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F 657	Continued From page 8	F 657		

loss, an update would be made to the care plan. In reviewing the care plan, the problem and the goal hand not been changed with the weight loss that occurred over a month. The MDS nurse explained the problem and goal should have been updated to reflect the resident ' s change in weight status.

Interview with the Director of Nursing on 2/8/18 at 11:16 AM revealed the care plan update may have been missed due to our communication break down over the past week. She further explained the MDS nurse may not have been communicated with, as she should have been, to update the MDS nurse.

b. Review of the care plan for bruising revealed a care plan had not been initiated.

Observations on 02/05/18 at 12:25 PM revealed Resident #69 had a large bruise the size of a grapefruit on the outside of her left leg at the calf area.

Interview with the resident at the time of the observation revealed she did not know how it happened.

Interview with the MDS nurse on 2/8/18 at 10:02 AM revealed care plans were updated daily, by the MDS nurses. She explained other disciplines updated care plans also. She did not typically care plan for the use of Plavix and Aspirin and the potential for bruising. She further explained she would not add it to the care plan unless they had a lot of bruising. She was informed by the treatment nurse Resident #69 had a bruise on

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F 657	Continued From page 9 the right leg and buttocks. She was not aware of the large bruise on Resident #69 ' s out left leg. The MDS nurse explained information is provided to the departments during morning meetings. Interview with the treatment nurse on 2/8/18 at 10:55 AM revealed she had a skin assessment on her admission note dated 1/4/18. The skin assessment included bruising on several areas, but not the left outer calf. Observations were made with the treatment nurse of Resident #69's leg on 2/8/18 at 11:00 AM. The treatment nurse confirmed the bruise on the left calf was not present on admission. She did not know how it happened. Interview with the Director of Nursing on 2/8/18 at 11:16 AM revealed the care plan update may have been missed due to our communication break down over the past week. She further explained the MDS nurse may not have been communicated with, as she should have been, to update the MDS nurse. Interview with the Director of Nursing on 2/8/18 at 1:38 PM revealed the resident was being transferred last week by her, another nurse and an aide. The resident hit her leg on the side of the bed. There was no redness or bruising at the time of transfer.	F 657		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive	F 684		3/8/18

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F 684	Continued From page 10 assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on record review, staff and physician interviews the facility failed to transcribe orders correctly for one of two sampled residents on Coumadin. The orders failed to a. include the dose, route and frequency for Vitamin K and to b. include the diet restrictions for Resident #87. The findings included: Resident #87 was admitted to the facility on 11/24/17 with a diagnosis including atrial fibrillation. a. Record review revealed an order dated 1/3/18 for Vitamin K (no dose, route or frequency), hold Coumadin (blood thinner used to treat atrial fibrillation) and recheck the PT/INR (clotting time) the next morning. Review of the Medication Administration Record (MAR) for 1/3/18 revealed Vitamin K was written as Vitamin K 5 milligrams (mg) IM (intramuscular) now. Interview with the Director of Nursing (DON) on 2/18/18 at 8:30 AM revealed the order was not complete and should have the dose, route and frequency. Observation with the DON of the medication in the computerized back up medications revealed the medication was identified as Vitamin K 10 milligrams in 1 milliliter.	F 684	Process that lead to the deficiency The Licensed Nurse did not adequately transcribe physicians order due to not paying attention to the fine details of the physician order. Process for implementing a plan of correction for specific deficiency The Director of Health Services, Clinical Competency Coordinator and/or Nurse Manager began educating on 2/9/2018 the Licensed Nurses on writing complete detailed physician orders. The Director of Health Services and/or Nurse Manger are reviewing physician orders within 24 hours to validate the order is detailed and complete for 7 days then weekly thereafter. Orders identified as not complete will be clarified and corrected by the Licensed Nurse who completed the initial order. Monitoring to ensure effectiveness of POC The Director of Health Services will track and trend the physician order review and present the findings to the Quality Assurance and Performance Improvement Committee monthly until 3	

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F 684	Continued From page 11 The nurse who wrote the telephone order was not available for interview. b. Record review revealed a lab flowsheet dated 2/1/18 with the INR of 1.1 (below therapeutic range) and the current dose of Coumadin was 3.5 mg. The flowsheet included hand written orders dated 2/1/18 by the primary physician that included in part : 1. Make sure she is not receiving any Vitamin K in her diet, vitamin supplement or other sources. The word diet was underlined twice. 2. Increase (coumadin) to 5 mg orally every day Review of the telephone order transcribed with a date of 2/1/18 the resident was to receive no Vitamin K. Review of the dietary note dated 2/6/18 revealed Resident #87 was on a regular NAS (no added salt) liberalized diabetic diet. Interview with dietary manager on 2/7/18 at 12:00 PM revealed she had no notification of deleting leafy green vegetables from the resident's diet. She only had one resident with these restrictions and it was not Resident #87. Interview with Nurse # 2 on 2/8/18 at 10:36 AM revealed she wrote the order and wrote it as not to use Vitamin K. She explained she did not include dietary to restrict foods with vitamin K. On 2/7/18 at 1:26 PM an interview was conducted with the primary physician. He explained he did intend for the resident to not have any type of foods or supplement that would interfere with the coumadin.	F 684	months of substantial compliance is maintained then quarterly. Title of person responsible for implementing the POC Director of Health Services is responsible for implementing the plan of correction. Compliance date 3/8/18	

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F 684	Continued From page 12 Interview with the Administrator on 2/7/18 at 1:30 PM revealed the order was not carried out correctly and she would write a clarification order to include dietary and supplements. Review of the menus for the week of 2/5/18 revealed spinach was served one meal and should have been restricted from her diet.	F 684		
F 757 SS=D	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: Based on record review, staff and physician interviews the facility prescribed and administered antibiotics prior to results of the urine cultures and sensitivity results were reported to treat possible	F 757	Process that lead to the deficiency The Licensed Nurse requested a broad spectrum antibiotic prior to the culture	3/8/18

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F 757	Continued From page 13	F 757		

urinary tract infections for one of six sampled residents for unnecessary medication reviews. (Resident #69)

The findings included:

Resident #69 was admitted to the facility on 1/4/18 with diagnosis of pneumonia.

Record review revealed a communication form dated 1/17/18 from Nurse #2 to Physician #1. It read "Resident noted to have frequent urination with strong, foul smelling urine. Resident denies any burning/discomfort when voiding. Vital signs included Temperature 97.4 degrees, pulse 68 and respirations 20. The blood pressure was 134/76 and the oxygen saturation was 95% on 1 liter/minute of oxygen. May we obtain a urinalysis with culture and sensitivity. Also, would you like to start a broad spectrum antibiotic until culture results are received?" Physician #1 replied on 1/18/18 with orders for a urinalysis with culture and sensitivity, Cipro (broad spectrum antibiotic) 500 milligrams (mg) twice a day by mouth.

Review of the urinalysis with a collection date of 1/20/18 included results of 4+ urine bacteria. Physician #1 reviewed the results and noted to continue Cipro pending culture on 1/22/18. Review of the culture and sensitivity analysis dated 1/23/18 indicated Escherichia coli (E. coli) that was greater than 100,00 colonies per milliliter grew from the urine culture. The organism was resistant to the antibiotic Cipro. The faxed lab results had a time and date stamp of 1/23/18 at 10:30 AM.

Review of the Medication Administration Record (MAR) revealed Cipro was administered twice a

result being received.

Process for implementing a plan of correction for specific deficiency

The Director of Health Services, Clinical Competency Coordinator and/or Nurse Managers began educating the Licensed Nurses on 2/9/2018 on reporting signs and symptoms of infection to the physician. If the Physician orders an antibiotic prior to the culture and sensitivity returns the Licensed Nurse will question the Physician about the appropriateness of starting an antibiotic prior to culture and sensitivity is completed and document conversation in the nursing notes.
The Director of Health Services, Clinical Competency Coordinator and/or Nurse Manager will review the physician orders daily to verify the antibiotic with the culture and sensitivity report to validate the susceptibility of the organism. The Director of Health Services will report the outcome of the physician order versus antibiotic review to the Infection Control Preventionist for validation and review.

Monitoring to ensure effectiveness of POC

The Infection Control Preventionist will present the findings of the antibiotic orders versus the culture and sensitivity results and/or presence of signs and symptoms review to the Quality Assurance and Performance Improvement Committee monthly until 3

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F 757	Continued From page 14 day on 1/19/18, 1/20/18, 1/21/18, 1/22/18 and one dose was administered on 1/23/18. An order was obtained on 1/25/18 for a different antibiotic that the E. Coli was sensitive to and was administered beginning 1/26/18 two times a day for 10 days. Review of a physician ' s progress note dated 1/25/18 indicated Resident #69 had diagnoses of dehydration and urinary tract infection (UTI). Interview on 2/8/18 at 4:05 PM with the Infection Preventionist (IP) revealed she had not included the use of the Cipro in her infection control report for January. The resident did not meet the criteria for an infection.	F 757	months of sustained compliance is maintained then quarterly. Title of person responsible for implementing the POC The Infection Control Preventionist is responsible for implementation of the plan of correction.	
F 867 SS=F	QAPI/QAA Improvement Activities CFR(s): 483.75(g)(2)(ii) §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; This REQUIREMENT is not met as evidenced by: Based on staff interviews and record review, the facility's Quality Assurance Performance Improvement Committee (QAPI) failed to maintain implemented procedures and monitor interventions that the committee put into place following the 1/21/17 recertification and complaint investigation survey. This was for a recited deficiency in the area of infection control. This deficiency was cited again on the current recertification survey on 2/8/18. The continued failure of the facility during two federal surveys of	F 867	Process that lead to the deficiency The Quality Assurance Committee did not maintain implemented procedures and monitor their interventions after 3 consecutive months of compliance. Process for implementing a plan of correction for specific deficiency The QAPI team will be re-educated via	3/8/18

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F 867	Continued From page 15 record shows a pattern of the facility's inability to sustain an effective QAPI Program. Findings included: This tag is cross referenced to: 1. 483.80 (a) Infection Prevention and Control: Based on observations, staff interviews and record review, the facility failed to follow ordered isolation precautions for 1 of 11 residents (Resident #34) on isolation precautions. During the recertification and complaint investigation survey of 1/21/17 the facility was cited at 483.80 (a) because they failed to post accurate isolation precaution signs and failed to keep isolation precaution signs posted on the carts. On the current recertification survey of 2/8/18, the facility failed to follow the ordered isolation precautions. An interview was conducted with the Administrator on 2/8/18 at 4:22 PM. She stated the QAPI Committee met monthly and committee members included the Medical Director, Administrator and department managers. The Administrator reported that the management team talked about infection control issues daily and made rounds to ensure the correct isolation precaution signs were posted. She further stated they had worked on consistent communication among staff regarding infection control and had completed ongoing inservicing of the nurse aides with regards to infection control procedures.	F 867	watching QAPI Root Cause Analysis & PIP Development for SNF via Relias. Quality Assurance and Performance Improvement Committee meets monthly to review the tracking and trending analysis of each department□s performance improvement plan. The agenda will include the developing of a retrospective effort to examine certain facility standards and determine the reasons for failure to meet any standards. The Quality Assurance and Performance Improvement Committee will develop systemic procedures and new approaches to repair causes of failed procedures. The Quality Assurance and Performance Improvement Committee will continually monitor implemented procedures and monitor the interventions put into place monthly until 3 consecutive months of compliance is maintained then quarterly thereafter. Monitoring to ensure effectiveness of POC The Regional Team (Area Vice President and/or Senior Nurse Consultant) will attend and review the Quality Assurance and Performance Improvement Committee progress with continued implementation of procedures and monitor the interventions put into place. The Regional Team will make changes to the committee□s approach as deemed necessary. Title of person responsible for implementing the POC	

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F 867	Continued From page 16	F 867	The Administrator is responsible for implementation of the plan of correction with oversight by the Regional Team.	
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(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: §483.80(a)(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; §483.80(a)(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	F 880		3/8/18

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F 880	Continued From page 17 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 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. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(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 observations, staff interviews and record review, the facility failed to follow ordered isolation precautions for 1 of 11 residents (Resident #34) on isolation precautions.	F 880	Process that lead to the deficiency The Certified Nursing Assist forgot to replace the gown that she removed when she exited the room to obtain an item for	

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F 880	Continued From page 18 Findings included: A review of the facility's policy dated 5/12/17 and titled "Droplet Precautions" revealed conditions that required droplet precautions included seasonal influenza. The policy indicated the precautionary period for droplet precautions was for "five days after onset of signs and symptoms or for the duration of illness in immunocompromised patients." Implementation of droplet precautions included the following: "Put a droplet precautions sign at the patient's door to notify anyone entering the room of the situation. Perform hand hygiene. Put on a gown if necessary to comply with standard precautions. Just before entering the patient's room, put on a mask. Put on gloves if necessary to comply with standard precautions." 1. Resident # 34 was admitted to the facility 9/10/15 with diagnoses that included, in part, of dementia. A review of a flu care plan updated 1/31/18 revealed interventions included droplet and contact isolation per physician's order. A review of physician's order dated 1/31/18 revealed Resident #34 was placed on droplet and contact precautions for a positive flu test. On 2/5/18 at 1:28 PM an observation was made of droplet and contact isolation signs posted on the wall next to Resident #34's door. Further observation of the room revealed Nurse Aide #1 was in the room with Resident #34, seated in a chair next to the resident while she fed her lunch. NA #1 had on gloves and a mask but no gown.	F 880	the resident. Process for implementing a plan of correction for specific deficiency The Infection Control Preventionist and/or Nurse Managers began educating all staff on 2/9/18 on the utilization of Personnel Protection Equipment when entering an isolation room. The Staff is to read each posted isolation sign and follow the dedicated PPE for the isolation. The Infection Control Preventionist and Department Managers will observe staff members entering isolation rooms daily for 7 days then weekly for 4 weeks then monthly thereafter. Monitoring to ensure effectiveness of POC The Infection Control Preventionist will analyze the isolation observation data and report findings to the Quality Assurance and Performance Improvement Committee monthly until 3 months of compliance is sustained then quarterly. Title of person responsible for implementing the POC Infection Control Preventionist is responsible for implementation of the plan of correction.	

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F 880	Continued From page 19 On 2/5/18 at 1:29 PM an interview was completed with Nurse #1. She stated if a resident was on contact precautions, staff should have worn a gown when in the room. She further said staff were supposed to wear a gown, gloves and a mask due to the droplet and contact isolation precautions that were ordered. On 2/5/18 at 1:30 PM an interview was completed with Nurse Aide (NA) #1. She said she was supposed to wear a gown, gloves and mask when in Resident #34's room since the resident was on contact and droplet precautions. NA #1 stated she forgot to put on the gown before she entered the resident's room. On 2/8/18 at 8:52 AM an interview was completed with the Infection Control Nurse. She stated the facility used both droplet and contact precautions for residents who tested positive for the flu. She said that droplet precautions did not include wearing a gown but that contact precautions indicated staff should wear a gown and the facility wanted staff to wear gowns when they were in direct contact with residents. She said she expected NA #1 would have followed the isolation precautions that were posted and worn a gown, gloves and mask when she fed Resident #34 because of the close proximity and contact she had with the resident when she fed her.	F 880		
F 881 SS=F	Antibiotic Stewardship Program CFR(s): 483.80(a)(3) §483.80(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 881		3/8/18

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F 881	Continued From page 20 §483.80(a)(3) An antibiotic stewardship program that includes antibiotic use protocols and a system to monitor antibiotic use. This REQUIREMENT is not met as evidenced by: Based on record review, staff, pharmacy consultant and physician interviews the facility failed to initiate the facility wide antibiotic stewardship program. This was evidenced by one of three sampled residents reviewed for unnecessary antibiotic use (Residents #69). The findings included: Review of the "Antibiotic Stewardship Program" (ASP) revised 11/28/17 indicated the goal of the program was to promote appropriate use of antimicrobials to treat infections and reduce possible adverse events associated with antibiotic use. The components of the program included in part: 1. Leadership: The "Procedure" included the Director of Health Services would communicate the facility ' s expectations for antibiotic use to prescribing clinicians and all partners. 2. Accountability: The team would consist of the Director of Health Services, Infection Preventionist (IP), Consultant Licensed Pharmacist, and Prescribing Physician/Provider. Include a separate report for the number of residents on antibiotics that did not meet criteria for active infection. 3. Drug Expertise: Each month the Antibiotic Stewardship Pharmacist will provide assessment, monitoring and written communication of antibiotic use to the ASP Team. 4. Action: All Pruitt Health facilities will implement evidence-based ASP protocols to help	F 881	Process that lead to the deficiency The Infection Control Preventionist had conducted 1:1 education with facility staff and physicians but did not formally document the education. Process for implementing a plan of correction for specific deficiency The Director of Health Services, Nurse Managers and/or Infection Control Preventionist began a formal education on 2/12/18 with the facility staff, Pharmacist and physicians on the Antibiotic Stewardship Program and Pruitt Policy. Per Pruitt Policy the Infection Control Preventionist began separating the resident with antibiotics, that did not meet the criteria of an infection, on a separate report that they present to Quality Assurance Performance Improvement Committee monthly meeting. The Licensed Pharmacist, Medical Director and the Infection Control Preventionist will review the residents that have received ABT in the past month to ensure they meet the intent of the Antibiotic stewardship policy. Monitoring to ensure effectiveness of POC	

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F 881	Continued From page 21 guide optimal decisions for therapy and to ensure appropriate antibiotic selection. 5. Tracking: The IP along with the prescribing practitioner, will collect and review the following data such as: " ... Number of residents on antibiotics that did not meet criteria for active infection ....Provider documentation of indication for antibiotic use, dosage and duration ..." Resident #69 was admitted to the facility on 1/4/18 with diagnosis of pneumonia. Record review revealed a communication form dated 1/17/18 from Nurse #2 to Physician #1. It read "Resident noted to have frequent urination with strong, foul smelling urine. Resident denies any burning/discomfort when voiding. Vital signs included Temperature 97.4 degrees, pulse 68 and respirations 20. The blood pressure was 134/76 and the oxygen saturation was 95% on 1 liter/minute of oxygen. May we obtain a urinalysis with culture and sensitivity. Also, would you like to start a broad spectrum antibiotic until culture results are received?" Physician #1 replied on 1/18/18 with orders for a urinalysis with culture and sensitivity, Cipro (broad spectrum antibiotic) 500 milligrams (mg) twice a day by mouth. Review of the urinalysis with a collection date of 1/20/18 included results of 4+ urine bacteria. Physician #1 reviewed the results and noted to continue Cipro pending culture on 1/22/18. Review of the culture and sensitivity analysis, dated 1/23/18, indicated Escherichia coli (E. coli) grew in the urine culture at greater than 100,000 colonies per milliliter. The organism was resistant to the antibiotic Cipro. The faxed lab results had a time and date stamp of 1/23/18 at 10:30 AM. Review of the Medication Administration Record	F 881	The Infection Control Preventionist will present the findings of the monthly antibiotic monitoring reports to the Quality Assurance and Performance Improvement Committee monthly until 3 consecutive months of sustained compliance is maintained and then quarterly. Title of person responsible for implementing the POC Infection Control Preventionist is responsible for implementation of the plan of correction.	

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F 881	Continued From page 22	F 881		

(MAR) revealed Cipro was administered twice a day on 1/19/18, 1/20/18, 1/21/18, 1/22/18 and one dose was administered on 1/23/18.
An order was obtained on 1/25/18 for a different antibiotic that the E. Coli was sensitive to and was administered beginning 1/26/18 two times a day for 10 days.
Review of a physician's progress note dated 1/25/18 indicated Resident #69 had diagnoses of dehydration and urinary tract infection (UTI).

Interview with Nurse #2 on 2/8/18 at 9:25 AM revealed she had requested an antibiotic for treatment before the results of the urine culture and sensitivity results returned due to family request. The family did not want to wait for the report to come back before treating a possible infection. Nurse #2 explained a family member insisted on the antibiotic being given due to previous UTI's with hospitalization. Nurse #2 further explained the family member was informed it would be the physician's decision to order an antibiotic.

Interview with Physician #1 on 2/8/18 at 12:00 PM revealed the resident had chronic UTIs with frequent hospitalizations. The family was hyper vigilant about treating the possible infections to prevent hospitalizations. When the culture results returned, the antibiotic was changed to the drug that the bacteria was sensitive to.

Interview with the pharmacy consultant on 2/8/18 at 1:15 PM revealed For Resident #69 he did not recommend any changes for Resident # 69 as the resident had already received the antibiotic and was started on the appropriate antibiotic when the review was completed. Further interview revealed he had not attended a meeting

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F 881	Continued From page 23	F 881		

at the facility to review the use of antibiotics.

Interview on 2/8/18 at 4:10 PM with the IP revealed Resident #69 had a urine test obtained due to having dark urine with a foul smell. She explained the resident had a culture that grew greater than 100,000 colonies of E Coli. Criteria for treating a urinary tract infection included a fever with this type of culture. Resident #69 did not have a fever.

Interview on 2/8/18 at 4:05 PM with the Infection Preventionist (IP) revealed she had not implemented the Antibiotic Stewardship Program. She explained it was something I'm she was learning. Further interview revealed she currently did not have any type of tracking system in place for antibiotic stewardship. The IP explained her plan was to begin tracking in January, but due to the flu outbreak she hadn't had time. During the interview, the IP revealed that the facility did not conduct inservices with staff on antibiotic stewardship, did not inform the doctors/practitioners about the program, and did not do reviews for unnecessary antibiotic use The IP explained she had talked with some of the doctors about not ordering antibiotics if the residents don't really need it.

Interview with the pharmacy consultant on 2/8/18 at 1:15 PM revealed he had given the facility information about antibiotic stewardship, but did not hold any inservices. He reviewed for unnecessary antibiotics each month, but had not compiled a report.

Interview with the Medical Director on 2/8/18 at 5:22 PM revealed the facility had started the ASP program. During this interview the Administrator,

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 _____	02/08/2018

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 881	Continued From page 24 Director of Nursing and the IP were in attendance. The corporate policy for ASP was reviewed with the group. It was confirmed a separate report for the number of residents on antibiotics that did not meet criteria for active infections had not been compiled, the pharmacy consultant had not provided a report on antibiotic use, and prescribers had not been educated on the use of antibiotics prior to obtaining culture and sensitivity results, or use of antibiotics with no stop date. Interview revealed the IP had not provided education to the prescribing providers, clinical staff, residents and their families on the appropriate use of antibiotics. The IP further explained she used the urine culture as determining that Resident #69 had a UTI and there were no other symptoms exhibited by the resident.	F 881		