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 09/08/2018

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 000	INITIAL COMMENTS A complaint investigation was conducted from 09/04/18-09/08/18. Immediate jeopardy was identified at: CFR 483.25 at tag F-689 at a scope and severity of (J). CFR 483.70 at tag F-835 at a scope and severity of (J). Tags F-689 constituted Substandard Quality of Care. A partial extended survey was completed.	F 000		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interview, the facility failed to provide showers, nail care and shampoo the resident ' s hair for one of three sampled dependent residents reviewed for assistance with Activities of Daily Living (Resident #1). The findings included: Resident #1 was initially admitted to the facility on 2/7/14 with diagnoses that included severe dementia, seizure disorder and diabetes type 2. Review of the Minimum Data Set (MDS) dated 8/11/18 indicated Resident #1 had severe impairment with short and long-term memory, no behaviors of rejecting care were indicated,	F 677	This plan of correction constitutes a written allegation of substantial compliance with Federal and Medicaid requirements. Preparation and/or execution of this correction does 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. 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	10/3/18

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — Electronically Signed | TITLE | (X6) DATE 09/29/2018

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.

F 677 Continued From page 1

extensive assistance was required for bed mobility and total dependence on staff for transfer, and bathing.

The resident was sent to the hospital on 8/11/18 and returned 8/16/18 with diagnoses that included resolved sepsis and moderate dehydration. Resident #1 returned with treatment for Clostridium dificile (bowel infection) and was on contact isolation upon return to the facility and until 8/29/18.

Review of the updated care plan dated 8/30/18 included problems of dementia with memory impairment, impaired communication related to cognitive deficits due to Alzheimer ' s and the resident was unable to make needs known, and self- care deficits related to impaired mobility and cognitive deficits due to Alzheimer ' s. The approaches for staff included to ask the resident yes/no questions, anticipate her needs, and meet her physical needs.

Review of the "Shower Schedule" notebook for the Nursing Assistants (NA) indicated Resident #1 was scheduled to have a shower on Monday, Wednesday and Friday, by the 11-7 shift NA ' s.

Review of documentation on the "ADL Dressing and Personal Hygiene" electronic sheet by the NA ' s, for the dates of 8/17/18 to 9/5/18, revealed bathing (shower) was documented as an activity that did not occur on the scheduled shower days (no showers were provided). The documentation indicated she had been provided a partial or bed bath daily during this timeframe.

Observations of Resident #1 on 9/5/18 at 1:00 PM, 9/6/18 at 10:30 AM and 9/7/18 at 12:00 PM

F 677

The Certified Nursing Assistants were unaware that an isolation resident was able to go to the shower room for bathing. The Certified Nursing Assistants were not educated by the Nursing Administration that isolation resident could utilize the shower room as long as the shower room was disinfected after use.

Process for implementing a plan of correction for specific deficiency

The Clinical Competency Coordinator, Director of Health Services and/or Nurse Managers began education of the Licensed Nurses and Certified Nursing Assistants regarding showers are to be given to isolation residents with disinfection practices of the shower surface areas when completed. The Licensed Nurses and Certified Nursing Assistants that are not educated by 10/03/2018 will be removed from the schedule until education is completed. This education has been incorporated into the general orientation for newly hired Licensed Nurses and Certified Nursing Assistants.
The Clinical Competency Coordinator, Director of Health Services and/or Nurse Managers began education of the Licensed Nurses and Certified Nursing Assistants regarding providing activities of daily living (grooming and personal hygiene) to residents who are unable to carry out these functions themselves. The Licensed Nurses and Certified Nursing Assistants that are not educated by

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 09/08/2018

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 677

Continued From page 2

revealed she had a black substance under her fingernails on both hands. Resident #1 had her hair braided in sections, and it was coming out of the braids.

Interview with NA #1 on 9/5/18 at 1:28 PM revealed she provided a partial bath on her shift when she worked. NA #1 explained Resident #1 had showers on the 11-7 shift and nail care would be provided on shower days.

Interview with NA #2 on 9/6/18 at 3:15 PM revealed she worked on the 11-7 shift and had provided care for Resident #1. NA #2 explained Resident #1 would receive showers on her shift on Monday, Wednesday and Friday. She had provided a bed bath because the resident had been sick and was on isolation. Review of the ADL documentation by NA #2 revealed she had provided care for the resident after contact isolation had been discontinued. NA #2 further explained no one had instructed her to do a bed bath due to her being "sick."

Interview with NA #3 on 9/6/18 at 4:09 PM revealed she worked on the 11-7 shift and had provided care for Resident #1. NA #3 explained she provided a bed bath for the resident. Further interview revealed shampooing the resident ' s hair and nail care was not provided during a bed bath. NA #3 explained that would be done when she had a shower. During the interview, NA #3 was asked if she had provided a shower on 9/5/18, and she replied "No." NA #3 explained it was not done due to the resident "did not feel good."

Interview with the Director of Nursing on 9/7/18 at 10:15 AM revealed the NA ' s have a shower

F 677

10/03/2018 will be removed from the schedule until education is completed. This education has been incorporated into the general orientation for newly hired Licensed Nurses and Certified Nursing Assistants.
The Licensed Nurse will visualize each resident daily to ensure grooming and personal hygiene needs are being met. The Licenses nurse will validate the shower schedule by the visual appearance of the resident and sign off on the shower sheet as complete and /or document reason not completed in the resident□s medical record. The Shower sheets will be reviewed and validated for completion by the Director of Nursing and/or Nurse Managers.

Monitoring to ensure effectiveness of POC

The Director of Nursing and/or Nurse Manager will validate the residents grooming and shower completion by visual observation of nails, hair and showers daily for thirty days, then weekly for four weeks, then monthly thereafter until six consecutive months of compliance is maintained then quarterly thereafter. The Director of Nursing will track and trend the data from the grooming observations and report the analysis of findings to the Quality Assurance and Performance Improvement Committee monthly until six months of continued compliance is maintained then quarterly thereafter.

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 09/08/2018

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 677	Continued From page 3 schedule according to their shift and the days of the week. The NA ' s were expected to initial the shower schedule sheet the shower was given, the nurse then signed to confirm it was given. He explained if a resident refused a shower, the nurse was to ask the resident and attempt to have the shower given. If the resident still refused, the nurse was expected to document in the nurse ' s notes the refusal. During the interview, he was asked if he was aware Resident #1 had not had a shower in the past two weeks and he replied "No." When asked if the resident could have a shower while on contact isolation for C. diff, he explained yes, in the shower stall and the staff would disinfect the shower stall and the shower chair.	F 677	Title of person responsible for implementing the POC The Administrator and Director of Nursing is responsible to implement the Plan of Correction.	
F 689 SS=J	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observations, record review, interviews with the Nurse Practitioner (NP), the ombudsman, dialysis center staff, representative from the resident's transportation company, and facility staff, the facility failed to provide supervision to a cognitively impaired resident with wandering behaviors during transportation to and from dialysis in a non-medical taxi like service for 1 of 1 (Resident #5) residents reviewed for	F 689	Process that lead to the deficiency On 5/22/2018 Resident #5 was scheduled for transportation to their dialysis center by their insurance company who contracted with Care Navigation Unit who sent an UBER driver to transport the resident to the dialysis center. The facility allowed the resident to enter the vehicle	10/3/18

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 09/08/2018

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 689 Continued From page 4

transportation. The resident was transported back to the facility, but due to the resident's severe cognitive impairment and wandering tendencies, the lack of staff supervision during transport to and from the dialysis center in a non-medical mode of transportation could have resulted in an adverse outcome to the resident.

Immediate jeopardy began on 5/22/18 when the facility staff failed to supervise Resident #5 who was cognitively impaired with wandering behaviors during transportation via a non-medical taxi like service to and from his dialysis appointment. The immediate jeopardy was removed on 9/8/18 when the facility provided an acceptable credible allegation of Immediate Jeopardy removal. The facility will remain out of compliance at a scope and severity of D (not actual harm with potential for more than minimal harm that is not immediate jeopardy) to ensure monitoring and that all staff have been in-serviced.

Findings included:

Resident #5 was admitted to the facility on 5/14/18 with the diagnoses of Alzheimer's disease, dementia with behavioral disturbances, and end stage renal disease (ESRD).

Review of Resident #5's admission assessment for Fall Risk of 5/15/18 the resident was at high risk for falls. The Elopement Risk Observation Form documented that the resident needed to be admitted to the locked unit after 3-days of behavior monitoring.

Review of Nurse's Notes from 5/16/18 revealed Resident #5 was noted to wander the unit and his

F 689

without assisting the resident to and from the scheduled dialysis appointment or validating the driver□s qualifications.
Root cause analysis:
The facility made an assumption that the Insurance company would send a medically qualified driver. The facility did not brainstorm to figure out how the facility could transport this resident our self, i.e. utilizing outside resources such as a qualified transportation company and/or sister facility.

Process for implementing a plan of correction for specific deficiency

On 9/6/2018 the Director of Nursing and Administrator utilized the appointment schedule to review resident with appointments through September 8, 2018 for mobility (ambulatory status) and cognitive status utilizing the resident□s behaviors, hospital history and physical.
There are currently 8 residents scheduled for appointments requiring transportation for the week ending September 8, 2018.
Transportation for the 8 residents include 7 residents by the Facility van and 1 resident by Life Star transportation stretcher.
All current residents have been reviewed by the Director of Nursing and/or Licensed Nurse on 9/7/2018 to identify their current mode of transportation requirements and if an escort is needed when a future appointment may be scheduled. Prior to scheduling any new transportation, for current and/or new residents, the scheduler will notify the Director of

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 09/08/2018

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 689

Continued From page 5

dialysis treatments were set for Tuesday, Thursday, and Saturday Resident noted to be pleasant one minute and then aggressive and confused the next.

Review of Physician Orders revealed an order placed on 5/19/18 for Resident #5 to receive hemodialysis on Tuesday, Thursday, and Saturday.

Review of the resident's Admission minimum data set (MDS) dated for 5/25/18, with a look back period from 5/19/18 through 5/25/18, documented that the resident had severe cognitive impairment, wandered 1 to 3 days during that assessment period. Resident #5 required the supervision of one person for ambulation and for locomotion on/off unit. The resident did not have impaired functional limitation in range of motion (ROM) and did not require mobility devices.

Review of Resident #5's insurance company transportation department (ICTD) notes from 5/21/18 by the Insurance Navigation Coordinator (INC) #1 revealed an outbound call was placed to the Facility Receptionist/Scheduler. The INC informed Facility Receptionist/Scheduler that a vendor was found that could possibly help with the resident transportation from the facility to the dialysis center. While the Facility Receptionist/Scheduler was on the phone, the INC booked a reservation through circulation. The Facility Receptionist/Scheduler was informed of the details of the transportation arrangements and she then requested that transport be scheduled for the resident for Tuesday, Thursday, and Saturday through 6/2/18.

Review of ICTD notes from 5/22/18 by Insurance

F 689

Nursing of new appointment and Director of Nursing and/or Licensed nurse will evaluate resident to ensure the mode of transportation continues to meet their physical and psychological needs.

On 9/7/2018 New resident referrals will be reviewed by the Admissions Director and/or Registered Nurse prior to admissions to ensure that the facility can safely meet their physical and psychological transportation needs. Upon admissions to the facility the resident will be assessed by a Licensed Nurse within 24 hours of admission to determine the safest mode of transportation for their physical and psychological needs.

On 9/6/2018 the Director of Nurses and/or Nurse Managers began education to the RN□s, LPN□s, C.N. A□s, Receptionist, Schedulers, Transport Drivers, Admissions and Senior Nurse Navigator(external pre admission evaluator) on all residents must be assessed prior to scheduling transportation to ensure the correct mode of transportation will be used to meet the residents physical and psychological needs and that all scheduling of transportation for the residents will be done by facility staff only. No staff will be allowed to work until education is complete.

On 9/6/2018 the Director of Nursing and/ or Licensed Nurse educated the clinical staff that when a resident has an appointment, the transportation company will come into the facility and identify themselves to the Licensed Nurse on duty by showing the facility staff their employee

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 09/08/2018

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 689	Continued From page 6 Navigation Coordinator (INC) #2 revealed an inbound call was received from the Dialysis Clinic Manager (DCM) #1 stating the resident had not shown up for his dialysis treatment yet. INC #2 checked the records and found that the earlier transport had been cancelled. INC #2 rescheduled for 7:15 AM on 5/22/18. The DCM #1 stated that the resident required door to door service due to dementia. INC #2 attempted to call the assigned driver to communicate this information, but the outbound call to the driver was not answered. INC #2 called DCM #1 to inform her that the driver had not been reached and the resident was already in route to the dialysis center from the facility. The DCM #1 requested that Resident #5 be provided ambulatory transportation for future treatments and not the non-medical taxi like service being used. A driver was reserved for the return trip from the dialysis center to the facility and was provided instructions by INC #2 per DCM #1's request at that time. Review of the Dialysis Center Records from 5/22/18 revealed that Resident #5's dialysis treatment began at 7:26 AM and ended at 10:55 AM. Review of the facility records revealed a nurse's note from 5/22/18 that documented the resident had returned from dialysis with vital signs of 126/68 Blood Pressure (BP); 86 Pulse Rate (PR); 20 Respiratory Rate (RR); and 97.7 Temperature (T). Review of Dialysis Center Records revealed a note from 5/23/18 at 10:03 AM by Dialysis Nurse (DN) #1 stated that her and the Dialysis Clinic Manager (DCM) #1 were concerned that the	F 689	ID badge and/or uniform, prior to the resident being transported out of the facility. All new hires will be educated during their general orientation to the facility On 9/7/2018 the Director of Nursing and or Licensed Nurses within the facility are utilizing the Pre / New / reevaluate transportation audit to review the mobility status, cognitive status (behaviors/dementia) to determine the safest mode of transportation for resident. Effective 5/24/18 the facilities only utilized a contracted transportation agency which supplements the facilities transportation van to accommodate residents appointment needs in a timely. Monitoring to ensure effectiveness of POC On 9/6/2018 the Administrator, Director of Health Services or Nurse Manager began to review, and audit the pre/new /reevaluation transport audit and daily/weekly scheduled transportation and new admissions for assessment of the resident for the appropriate mode of transportation to meet their physical and psychological needs to ensure safe transportation. This will be done daily for 2 weeks, then 3 times a week for 6 weeks and then weekly for 1 month then monthly until 6 months of continued compliance is sustained then quarterly thereafter. On 9/6/2018 the Administrator presented the initial safe mode of transportation audit to the Quality Assurance and	

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 09/08/2018

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 689	Continued From page 7 resident was dropped off by a non-medical taxi like service [for 5/22/18 dialysis treatment] with his history of dementia. Transportation arrangements were made by the resident's insurance company, the hospital, and the facility. Review of Resident #5's ICTD notes from 5/23/18 revealed an inbound call from the Dialysis Social Worker (DSW) was placed to inform them that the resident had dementia and that due to safety concerns other transport arrangements needed to be made. Review of Dialysis Center Records revealed a note from 5/23/18 at 2:51 PM from the Dialysis Social Worker (DSW) spoke with the Facility Social Worker (FSW) to discuss concerns about transportation to and from dialysis and the FSW indicated no knowledge of any problems. The DSW spoke with Facility's Receptionist/Scheduler and confirmed that the resident's insurance had arranged a non-medical taxi like service to transport the resident to and from dialysis. The DSW informed the Facility Receptionist/Scheduler that she had shared concerns with ICTD related to the resident's mental status and requested more appropriate transport for Thursday and Saturday appointments, and was told that it would be worked on. On 9/5/18 at 11:00 AM Resident #5 was observed being escorted by a nurse assistant (NA) to the facility van for transportation to the dialysis center. During an interview on 9/5/18 at 3:27 PM with the Facility Transport Coordinator, she stated that the resident had an initial appointment with the kidney	F 689	Performance Improvement Committee. The Administrator/ Director of Nursing will continue to track and trend the appropriate mode of transportation form and present the analysis to the Quality Assurance and Performance Improvement Committee monthly until 6 months of continued compliance is sustained then quarterly thereafter. Title of person responsible for implementing the POC The Administrator and Director of Nursing services are responsible for implementing the plan of correction. Date of Compliance 10/03/2018	

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 09/08/2018

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 689	Continued From page 8	F 689		

doctor prior to being able to start dialysis. She stated that to her knowledge the resident did not miss any appointments or dialysis treatments and safe transportation was provided. When asked if she recalled the resident being transported to dialysis on 5/22/18 by a non-medical taxi like service, she stated she did not.

During an interview on 9/5/18 at 3:40 PM with the Director of Health Services (DHS) he stated he was unaware that the resident was transported to the dialysis center by a non-medical taxi like service on 5/22/18 until the Ombudsman called and voiced his concerns about the resident's safety. He stated that once this was brought to his attention the facility made arrangements to transport the resident via their own transportation services. When asked if any staff member accompanied the resident the day non-medical taxi like service was used for transport, he stated that the resident went alone. When asked who escorted the resident from the locked unit to the car on 5/22/18, the DHS said he was unsure. When asked if the facility was responsible for the resident's safety he stated that they were and once they were aware of the situation, changes were made to transport the resident to dialysis with their van. When asked if an investigation was completed for the incident he stated that it happened one time, the resident returned to the facility unharmed, the moment they were aware of the situation, arrangements were made to transport Resident #5 using the facility transport service. He stated that an investigation was not done because they immediately fixed the problem. The DHS was unable to identify the staff member responsible for walking Resident #5 to the non-medical taxi like service driver's car on 5/22/18, so no interview was completed with this

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 09/08/2018

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 689	Continued From page 9 staff member. During an interview on 9/6/18 at 9:16 AM with Ombudsman #1 she stated she did not feel it was safe for the resident to be transported unsupervised by a non-medical taxi like service on 5/22/18 with his cognitive status, wandering tendency, and behaviors. During an interview on 9/6/18 at 9:54 AM with Dialysis Clinical Manager (DCM) #2 she stated that DN #1 and DCM #1 no longer worked at the center. She stated that she would attempt to contact them for possible interviews. Interviews were not obtained with DN #1 and DCM #1. During an interview with Insurance Navigation Coordinator (INC) on 9/6/18 at 12:07 PM she stated that she had several conversations with the Facility Transitional Nurse (FTN) about the transportation for Resident #5. The FTN told her that the facility was unable to arrange transportation for Tuesday, Thursday, and Saturday dialysis treatments and had asked this service through the resident's insurance to arrange transport for the resident because the facility only transported residents using their van on Monday, Wednesday, and Friday. She stated that she was only able to arrange transport with a non-medical taxi like service. She stated that facility staff were informed of this and that this was the only available transport service unless the facility could figure out a way to take him to his appointments using their own van. She stated that she did not understand why they elected to use the service if the resident's safety was an issue and assumed that a staff member would travel with the resident to and from his appointment.	F 689		

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 09/08/2018

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 689	Continued From page 10	F 689		

Continued From page 10

On 9/6/18 at 2:45 PM the facility DHS provided a telephone number for Facility Nurse #2 that was the nurse identified as the nurse assigned the Resident #5 at the time he was transported to dialysis via the non-medical taxi like service on 5/22/18. The facility DHS was unable to provide a name or contact information for the staff member who was responsible for walking Resident #5 from the locked unit and for who assisted him into the vehicle of the non-medical taxi like service on 5/22/18 for transport to his dialysis treatment.

During an interview on 9/6/18 at 2:51 PM with Facility Nurse #2 she stated that her coworkers had reported to her aggressive behaviors from Resident #5 on their shifts but that she had not seen it firsthand. When asked if she recalled an incident where Resident #5 was transported to dialysis via a non-medical taxi like service, she stated that she did not have any knowledge of this happening and stated that she would never have allowed him to go without supervision if she had known about it.

During an interview with the Facility Nurse Practitioner on 9/6/18 at 5:11 PM she stated she was not informed of any missed appointments or dialysis treatments and was not aware that there were problems with transportation. When asked if she thought Resident #5 was safe to travel to and from dialysis without facility staff with a non-medical taxi like service, she stated that the resident was not, due to his dementia, cognition, that he lived on a locked unit, and had wandering tendencies. She stated that she was not informed of the incident by anyone from the facility.

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 09/08/2018

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 689		F 689		

Continued From page 11

During an interview with the FTN on 9/7/18 at 11:41 AM she stated that the insurance helped arrange transportation so that the resident could leave the hospital earlier due to the facility not being able to accommodate his Tuesday, Thursday and Saturday dialysis schedule. The resident needed ten to twelve days until the dialysis center could switch him over to Monday, Wednesday and Friday treatments. At that point the facility transport service would be able to take over. When asked if the INC had informed her of the mode of transport that was arranged for the resident she stated she had called and confirmed that it was arranged. She stated she assumed that it would have been a medical transport and had no idea that a non-medical taxi like service was used to transport the resident on 5/22/18. She stated that she was shocked because she would never have approved that type of transport due to the resident's cognitive status, wandering tendencies, and the fact that he lived on the locked unit. She stated that he had a sitter in the hospital for those reasons as well. She stated that the resident required medically trained personnel to transport him to and from dialysis.

On 9/6/18 at 5:32 PM, the administrator was informed of the immediate jeopardy. The facility provided a credible allegation of Immediate Jeopardy removal on 9/7/18. The allegation of Immediate Jeopardy removal indicated:

Credible Allegation of Immediate Jeopardy removal:

This plan of correction constitutes a written allegation of substantial compliance with Federal and Medicaid requirements. Preparation and/or

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 09/08/2018

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 689	Continued From page 12	F 689		

execution of this correction does 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. It also demonstrates our good faith and desire to continue to improve the quality of care and services to our residents.

On 9/6/2018 the Director of Nursing and Administrator utilized the appointment schedule to review resident with appointments through September 8, 2018 for mobility (ambulatory status) and cognitive status utilizing the resident's behaviors, hospital history and physical. There are currently 8 residents scheduled for appointments requiring transportation for the week ending September 8, 2018. Transportation for the 8 residents include 7 residents by the Facility van and 1 resident by Life Star transportation stretcher.

All current residents have been reviewed by the Director of Nursing and/or Licensed Nurse on 9/7/2018 to identify their current mode of transportation requirements and if an escort is needed when a future appointment may be scheduled. Prior to scheduling any new transportation, for current and/or new residents, the scheduler will notify the Director of Nursing of new appointment and Director of Nursing and/or Licensed nurse will evaluate resident to ensure the mode of transportation continues to meet their physical and psychological needs.

On 9/7/2018 New resident referrals will be reviewed by the Admissions Director and/or Registered Nurse prior to admissions to ensure

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 09/08/2018

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 689	Continued From page 13	F 689		

that the facility can safely meet their physical and psychological transportation needs. Upon admissions to the facility the resident will be assessed by a Licensed Nurse within 24 hours of admission to determine the safest mode of transportation for their physical and psychological needs.

On 9/6/2018 the Director of Nurses and/or Nurse Managers began education to the RN's, LPN's, C.N. A's, Receptionist, Schedulers, Transport Drivers, Admissions and Senior Nurse Navigator (external pre admission evaluator) on all residents must be assessed prior to scheduling transportation to ensure the correct mode of transportation will be used to meet the residents physical and psychological needs and that all scheduling of transportation for the residents will be done by facility staff only. No staff will be allowed to work until education is complete.
On 9/6/2018 the Director of Nursing and/ or Licensed Nurse educated the clinical staff that when a resident has an appointment, the transportation company will come into the facility and identify themselves to the Licensed Nurse on duty by showing the facility staff their employee ID badge and/or uniform, prior to the resident being transported out of the facility.

All new hires will be educated during their general orientation to the facility.

On 9/7/2018 the Director of Nursing and or Licensed Nurses within the facility are utilizing the "Pre / New / reevaluate transportation audit" to review the mobility status, cognitive status (behaviors/dementia) to determine the safest mode of transportation for resident.

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 09/08/2018

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 689	Continued From page 14	F 689		

Effective 5/24/18 the facilities only utilized a contracted transportation agency which supplements the facilities transportation van to accommodate residents appointment needs in a timely manner.

On 9/6/2018 the Administrator, Director of Health Services or Nurse Manager began to review and audit the "pre/new /reevaluation transport audit" and daily/weekly scheduled transportation and new admissions for assessment of the resident for the appropriate mode of transportation to meet their physical and psychological needs to ensure safe transportation. This will be done daily for 2 weeks, then 3 times a week for 6 weeks and then weekly for 1 month then monthly until 6 months of continued compliance is sustained then quarterly thereafter.
On 9/6/2018 the Administrator presented the initial safe mode of transportation audit to the Quality Assurance and Performance Improvement Committee. The Administrator/ Director of Nursing will continue to track and trend the appropriate mode of transportation form and present the analysis to the Quality Assurance and Performance Improvement Committee monthly until 6 months of continued compliance is sustained then quarterly thereafter.

The Administrator and Director of Nursing services are responsible for implementing the plan of correction.

The credible allegation of Immediate Jeopardy removal was verified 9/8/18 at 12:00 PM as evidenced by:

During an observation on 9/8/18 at 10:40 AM six residents were observed boarding the facility van

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 09/08/2018

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 689	Continued From page 15 with the Facility Transportation Coordinator and NA #4 for a shopping trip. All residents were signed out and verified to have been assessed for safe modes of transportation in the facility's audit log that was started on 9/7/18 per the facility's new transportation policies. Review of facility's records revealed the following in-services were completed with all active facility staff on 9/6/18 through 9/8/18: - In-service by Nurse #3 was completed to educate staff about new policies in place to sign-out residents going to appointments by the driver/person accompanying them. They were also educated to verify the employee identification/uniform of the driver before departure and to sign the resident back in upon return to the facility. A list of approved transportation services was added to the front of every transport binder located on every unit. - In-service was completed to educate staff about new policies to assess newly admitted residents for safe modes of transport. Each resident would also be reviewed prior to admission to make sure needs would be met. - In-service was completed to educate staff that all transportation arrangements would be made by the facility. No insurance company would have the authority to arrange transportation for any resident. - An in-service was completed on 9/6/18 by the Facility Vice President of Operations to educate the Administrator and the DHS about efficient investigations being done for all incidents that affect resident safety. A power-point and	F 689		

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 09/08/2018

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 689	Continued From page 16	F 689		

check-list for handling immediate jeopardy situations efficiently.

Review of facility records revealed that audits were completed starting on 9/7/18 of:

- Current residents were reviewed for transportation needs, the mode used, and their schedules
- Current and new residents were reviewed/assessed for safe modes of transportation required
  - Three new admissions on 9/7/18 - all were reviewed/assessed upon admission to the facility

During an interview on 9/8/18 at 11:20 PM with the Weekend Receptionist revealed that she was educated on the new policies of resident transport. She stated that she would verify the driver was an approved vendor, check their identification, and have them sign in and out for appointment transportation.

During an interview on 9/8/18 at 11:26 PM with Nurse #4 she stated that any newly admitted resident would be assessed for their safe mode of transport. She would also verify on the day of appointments that the driver/service was an approved vendor, check their identification, and have them sign in and out for appointment transportation.

During an interview on 9/8/18 at 11:36 PM with Nurse #5 she stated that any newly admitted resident would be assessed for their safe mode of transport. She would also verify on the day of appointments that the driver/service was an

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 09/08/2018

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 689	Continued From page 17 approved vendor, check their identification, and have them sign in and out for appointment transportation.	F 689		
F 692 SS=G	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on record review, staff and Nurse Practitioner interviews, the facility failed to provide the daily caloric intake by feeding tube as assessed by the registered dietitian for one of one sampled residents receiving total nutrition by tube feeding (Resident #4). The resident experienced a significant unplanned weight loss of 6.4 percent in one month.	F 692	Process that lead to the deficiency The Nurse Practitioner changed a tube feeding order believing they were increasing the feeding when they decreased the total amount of nutrition. The facility did not notify the Registered Dietitian of the order change when it occurred as per protocol. Therefore, the	10/3/18

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 09/08/2018

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 692 Continued From page 18

The findings included:

Resident #4 was admitted to the facility on 11/15/17 with diagnoses including cancer of the mouth, dysphagia, total nutrition by a feeding tube and failure to thrive.

The physician ' s monthly orders for April 2018 included tube feeding of Glucerna 1.5 to be provided at 80 milliliters (ml) per hour for 20 hours of continuous feeding. The feeding was to begin at 12:00 PM and continue until 8:00 AM.

Review of the "Enteral Feeding Progress Notes" dated 4/16/18 by the Registered Dietician (RD) revealed Resident #4 ' s current weight was 157 pounds, was NPO (nothing by mouth), received total nutrition by a feeding tube of Glucerna 1.5, and required 2400 calories in a 24 hour period with protein provided of 132 grams. The tube feeding rate was calculated for 80 milliliters (ml) per hour for 20 hours of continuous feeding.

Review of the resident ' s care plan revealed it was reviewed by staff on 4/23/18 and included a problem the resident was NPO and received nutrition via tube feeding. The approaches for the stated problem included the tube feeding to be administered as ordered, water flushes as ordered, monitor weights and labs and check residual per protocol.

Review of a nurse practitioner ' s progress note dated 5/4/18 included the diagnoses of urinary tract infection (UTI), severe protein calorie malnutrition and dysphagia. The plan included an antibiotic to be administered via intravenous every day for 7 days, change tube feeding time to start at 5:00 pm and continue until 8:00 AM (with

F 692

Registered Dietitians could not complete there review and recommendation to the facility.

Process for implementing a plan of correction for specific deficiency

The Clinical Competency Coordinator and/or Nurse Managers have educated the Licensed Nurses on the protocol regarding notification to the Register Dietician related to any tube feeding changes. The Licensed Nurses that have not been educated by 10/03/2018 will be removed from the schedule until the education is completed. This education has been added to the general orientation for newly hired Licensed Nurses.
When a tube feeding order is changes by a health care professional the facility Licensed Nurse will send the Registered Dietitians a fax
The Director of Nursing and/or Nurse Managers will review all tube feeding order changes to ensure the Licensed Nurses have notified the Registered Dietitian of the Tube Feeding order change and recommendation have been completed.

Monitoring to ensure effectiveness of POC

The Director of Nursing and/or Nurse Manager will validate the new and/or changes tube feeding orders daily as they occur to validate Registered Dietitian notification and completion of recommendation. This will occur daily for

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 09/08/2018

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 692 Continued From page 19

no change made to the rate the tube feeding would be administered each hour).

A telephone order, dated 5/4/18, written by the NP indicated the tube feeding of Glucerna 1.5 hours of administration was changed to 5:00 PM start the feeding and continue to 8:00 AM (a total of 15 hours of administration per day).

Review of the Medication Administration Record (MAR) for May 2018 revealed beginning on 5/4/18 the start time for the tube feeding was changed from 12:00 PM to 5:00 PM and 8:00 AM remained the time the feeding was stopped each day. The MAR documentation indicated the tube feeding continued for the month of May as changed on 5/4/18. There were no days the resident did not receive the tube feeding.

Review of the Minimum Data Set (MDS) dated 5/25/18 indicated Resident #4 had moderate impairment with cognition with short and long term memory impairment. He had no change in his ADL activity and continued to require extensive assistance with ADLs. Nutrition was provided by enteral feedings 51% or greater and his weight was documented as 156 pounds.

Review of Resident #4 ' s monthly Medication Administration Record (MAR) for June 2018 revealed from 06/01/18 to 06/14/15 the resident continued to receive the tube feeding according to the April 2018 order at 80 ml per hour from 12:00 PM to 8:00 AM.

Review of the monthly weights for Resident #4 revealed the following significant weight loss from May 2018 to June 2018:
4/2/18: 157 pounds,

F 692

thirty days then weekly for four weeks, then monthly until six months of continued compliance is maintained, then quarterly thereafter.
The Director of Nursing will track and trend the tube feeding order changes in relation to the notification to the Registered Dietitian and completeness of the Registered Dietitians recommendation and report the analysis to the Quality Assurance and Performance Improvement Committee monthly until six consecutive months of compliance is maintained then quarterly.

Title of person responsible for implementing the POC
The Administrator and the Director of Nursing is responsible for implementation for the Plan of Correction.

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 09/08/2018

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 692	Continued From page 20 5/8/18: 156 pounds 6/8/18: 146 pounds (which equates into a 10 pound or 6.4 percent significant weight loss in one month). Review of the consult dated 6/12/18 at a local cancer center recorded the resident ' s as losing 15 pounds in 5 weeks. The note included instructions "please ensure he gets proper nutrition through his G-tube (feeding tube). Recommendations included "Continue feeding through G-tube until he is cleared to swallow (and take nutrition by mouth). Please ensure he gets at least 5-6 cans (of the tube feeding) a day." Review of the RD "Enteral Feeding Progress Notes" dated 6/15/18 included a weight of 146 pounds on 6/8/18 with a significant weight loss of 6.4% in one month. The diet order was Glucerna 1.5 and the resident remained NPO. The rate of the feeding and the calories required in 24 hours remained as 80 ml per hour for 20 hours to provide 2400 calories and 132 grams of protein. The RD documented in the notes of the order change in the amount of time the resident received the tube feeding. The resident had a decrease of 5 hours of feeding per day due to the order change. The RD indicated she had not been notified of the order change and received the consult report from 6/12/18 on 6/14/18. Reasons for possible weight loss documented in the RD notes included on antibiotic in May for UTI which may have possibly contributed to the weight change, along with the G tube pulled out. Interview with the nurse practitioner on 9/6/18 at 5:15 PM revealed she saw the resident on 5/4/18. She explained she thought she was increasing the tube feeding and actually had decreased the	F 692		

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 09/08/2018

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 692	Continued From page 21 total feeding he received. She had mistaken the time frame for the feeding as 8:00 PM and changed the time to 5:00 PM for an additional 3 hours of tube feeding. During the interview she explained she had meant to increase the feeding because the resident had complained of being hungry in the evening. Further interview revealed the resident had not refused his tube feedings. Interview with the Director of Nursing (DON) on 9/7/18 at 10:15 AM revealed the process for notification of the RD of changes in tube feeding orders included the nurse taking the changed order would fax the RD of the order change. The DON could not explain why the RD had not been notified of the 5/4/18 tube feeding order change for Resident #4. Interview with the Dietary Manager on 9/7/18 at 10:40 AM revealed he was not involved in orders for tube feedings. He explained the RD would be notified of a resident receiving a tube feeding. The RD would do the calorie calculations. He explained if there were changes in orders, the nurse would fax the RD the information.	F 692		
F 698 SS=D	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on record review, staff interview, dialysis staff interview, the facility failed to ensure a	F 698	Process that lead to the deficiency	10/3/18

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 09/08/2018

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 698

Continued From page 22

resident was transported to kidney provider and dialysis appointments at scheduled days and times, for 1 of 1 residents (Resident #5) reviewed for hemodialysis.

Findings included:

Resident #5 was admitted to the facility on 5/14/18 with the diagnoses of Alzheimer's disease, dementia with behavioral disturbances, and end stage renal disease (ESRD).

Review of Dialysis Center Records from 5/15/18 revealed a note from 10:34 AM documented by Dialysis Clinical Manager (DCM) #1 stated that she spoke with the Facility Receptionist/Scheduler regarding the 5/16/18 appointment at 10:45 AM. The driver stated that they had a full schedule and did not think she would be able to bring him to his appointment. Facility Receptionist/Scheduler was also informed of the resident's appointment on 5/17/18 with arrival time of 5:30 AM for dialysis and she stated that the facility only brings residents to dialysis on Monday, Wednesday, Friday and was not sure she could accommodate this.

Review of Insurance Company Transportation Department (ICTD) notes from 5/16/18 at 3:23 PM revealed an initial note from an inbound call from the Facility Transitional Nurse (FTN) to the ICTD. The FTN stated she had spoken to someone the previous day regarding obtaining transportation through that service for Resident #5. The FTN stated that the resident had his dialysis treatment days changed to Tuesday, Thursdays, and Saturday and needed roughly six trips of transportation. The treatments were going to be changed back to Monday,

F 698

On 5/17/18 resident number 5 was not picked up by his insurance pre arranged transportation. The facility did not ensure alternative transportation was provided to resident #5 to dialysis when the pre-arranged transportation did not arrive as scheduled to transport the resident to dialysis in a timely manner. The facility did not brainstorm to figure out how the facility could transport this resident our self, i.e. utilizing outside resources such as a qualified transportation company and/or sister facility to ensure the resident arrived at the dialysis center on time.

Process for implementing a plan of correction for specific deficiency

The Clinical Competency Coordinator and/or Nurse Manager began educating the Licensed Nurses, Admission Coordinator, Scheduler, Social Worker on 09/06/2018 regarding the facility scheduling appointments utilizing the facility transportation van and/or a facility contracted medical transport agency. This education has been added to the general orientation for newly hired, Licensed Nurses, Admission Coordinators, Scheduler, and Social Workers.
The facility will ensure that all dialysis appointments transportation will be scheduled by the facility and not an outside source, for dialysis transportation to be received in a timely manner.

On 9/6/2018 the Director of Nursing and/or Nurse Managers utilized the appointment schedule to review resident

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 09/08/2018

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 698 Continued From page 23

Wednesday, and Friday in about two weeks. The FTN had called earlier in the day and was told that the ICTD could not set up transport and that it was for emergency transport only. The dates of service the FTN was requesting were 5/17/18, 5/19/18, 5/22/18, 5/24/18, and 5/26/18 for a chair time of 6:30 AM to the dialysis center one way and the facility van would transport the resident back to the facility after treatment.

Review of ICTD notes from 5/16/18 revealed that the ICTD attempted to arrange transport for Resident #5 but was not successful. The notes showed that several more calls were made to other transportation companies in that area but none were able to facilitate transport for the resident.

Review of Dialysis Center Records revealed a note from 5/16/18 at 1:14 PM documented by DCM #1 stated that the Physician Assistant #1 called to inform the dialysis center that the resident did not show up for his appointment with his kidney provider.

Review of Dialysis Center Records revealed a note from 5/16/18 at 1:17 PM documented by DCM #1 and spoke with the Facility Receptionist/Scheduler and was told that they had arranged transport with his insurance, but they had not shown up to take the resident to dialysis. She was told that the facility would get him there the next day.

Review of Dialysis Center Records revealed a note from 5/16/18 at 4:03 PM documented by DCM #1 stated that she had spoken to the Director of Health Services (DHS) in regards to transportation and he stated that he was reaching

F 698

with appointments through September 8, 2018 to validate the residents arrived for dialysis treatment on time.
Effective 9/6/18 the facility will only utilize a contracted transportation agency which supplements the facilities transportation van to accommodate residents appointment needs in a timely manner. The Director of Nursing and/or Nurse Manager will review the transportation logs daily for 30 days, weekly for four weeks then monthly thereafter, to ensure the residents arrived to their dialysis appointments in a timely manner to receive services required.

Monitoring to ensure effectiveness of POC

The director of nursing and nurse manager will review that all dialysis residents are transported to their appointments and receive their desired course of treatment, this will be completed daily for 30 days, weekly for four weeks, then monthly until continued compliance is sustained, then quarterly thereafter. The administration and Director of Nursing will continue to track and trend the dialysis form and report the analysis to the Quality Assurance and Performance Improvement committee monthly until six consecutive months of compliance is maintained then quarterly

Title of person responsible for implementing the POC

The Administrator and the Director of

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 09/08/2018

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 698	Continued From page 24 out to the transportation navigation team to make sure transport was set-up for the resident's dialysis treatment on 5/17/18 at 6:00 AM and to see his kidney provider at 2:30 PM the same day. Review of Dialysis Center Records revealed a note from 5/17/18 at 7:01 AM by DCM #1 that stated the resident did not show up for treatment (dialysis) and that facility was called and she unable to reach anyone. Review of Dialysis Center Records revealed a note from 5/17/18 at 11:54 AM by DCM #1 that stated she spoke with the Facility's Receptionist/Scheduler and she was informed that the resident's transportation did not pick resident up for dialysis. The dialysis treatment was rescheduled for 5/18/18. Review of Physician Orders revealed an order placed on 5/19/18 for Resident #5 to receive hemodialysis on Tuesday, Thursday, and Saturday. Review of the resident's Admission minimum data set (MDS) dated for 5/25/18, with a look back period from 5/19/18 through 5/25/18, documented that the resident had severe cognitive impairment, wandered 1 to 3 days during that assessment period. Resident #5 required the supervision of one person for ambulation and for locomotion on/off unit. The resident did not have impaired functional limitation in range of motion (ROM) and did not require mobility devices. Review of Resident #5's insurance company transportation department (ICTD) notes from 5/21/18 by the Insurance Navigation Coordinator	F 698	Nursing is responsible for implementing the Plan of Correction.	

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 09/08/2018

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 698	Continued From page 25 (INC) #1 revealed an outbound call was placed to the Facility Receptionist/Scheduler. The INC informed Facility Receptionist/Scheduler that a vendor was found that could possibly help with the resident transportation from the facility to the dialysis center. While the Facility Receptionist/Scheduler was on the phone, the INC booked a reservation through circulation. The Facility Receptionist/Scheduler was informed of the details of the transportation arrangements and she then requested that transport be scheduled for the resident for Tuesday, Thursday, and Saturday through 6/2/18. Review of ICTD notes from 5/22/18 by Insurance Navigation Coordinator (INC) #2 revealed an inbound call was received from the Dialysis Clinic Manager (DCM) #1 stating the resident had not shown up for his dialysis treatment yet. INC #2 checked the records and found that the earlier transport had been cancelled. INC #2 rescheduled for 7:15 AM on 5/22/18. The DCM #1 stated that the resident required door to door service due to dementia. INC #2 attempted to call the assigned driver to communicate this information, but the outbound call to the driver was not answered. INC #2 called DCM #1 to inform her that the driver had not been reached and the resident was already in route to the dialysis center from the facility. The DCM #1 requested that Resident #5 be provided ambulatory transportation for future treatments and not the non-medical taxi like service being used. A driver was reserved for the return trip from the dialysis center to the facility and was provided instructions by INC #2 per DCM #1's request at that time. Review of the Dialysis Center Records from	F 698		

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 09/08/2018

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 698	Continued From page 26	F 698		

5/22/18 revealed that Resident #5's dialysis treatment began at 7:26 AM and ended at 10:55 AM.

Review of Dialysis Center Records revealed a note from 5/24/18 at 6:21 AM documented that the DCM #1 called the facility and spoke to the resident's nurse and was told that when she called transportation the nurse was told that they would not be at the facility until 7:15 AM. The nurse was made aware that the resident was supposed to be at the dialysis center at 6:00 AM.

Review of Dialysis Center Records revealed a note from 5/24/18 at 8:24 AM documented that the Dialysis Social Worker (DSW) notified the Facility Social Worker (FSW) that the resident did not show up for his 6:00 AM dialysis appointment until 7:45 AM. They discussed Resident #5's Saturday appointment and that the resident would be starting a Monday, Wednesday, Friday schedule starting Monday, May 28, 2018.

During an interview on 9/5/18 at 3:27 PM with the Facility Transport Coordinator, she stated that the resident had an initial appointment with the kidney doctor prior to being able to start dialysis. She stated that to her knowledge the resident did not miss any appointments or dialysis treatments and safe transportation was provided. When asked if she recalled the resident being transported to dialysis on 5/22/18 by a non-medical taxi like service, she stated she did not.

During an interview on 9/6/18 at 9:16 AM with Ombudsman #2 contacted the dialysis center on 5/25/18. A staff member confirmed the resident`s appointment was for 6:00am, but the resident did not arrive until around 8:00 AM. As a result, this

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 09/08/2018

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 698	Continued From page 27	F 698		

dramatically reduced the duration of the session and the resident required another treatment the following day on 5/26/28 at 6:00 AM. Later, Ombudsman #2 visited the facility and spoke with the DHS and he admitted the mistake and stated there was some confusion about his mode of transportation on the day of the appointment.

During an interview with Insurance Navigation Coordinator (INC) on 9/6/18 at 12:07 PM she stated that she had several conversations with the Facility Transitional Nurse (FTN) about the transportation for Resident #5. The FTN told her that the facility was unable to arrange transportation for Tuesday, Thursday, and Saturday dialysis treatments and had asked this service through the resident's insurance to arrange transport for the resident because the facility only transported residents using their van on Monday, Wednesday, and Friday.

During an interview with the FTN on 9/7/18 at 11:41 AM she stated that the insurance helped arrange transportation so that the resident could leave the hospital earlier due to the facility not being able to accommodate his Tuesday, Thursday and Saturday dialysis schedule. The resident needed ten to twelve days until the dialysis center could switch him over to Monday, Wednesday and Friday treatments. At that point the facility transport service would be able to take over.

During an interview on 9/5/18 at 3:40 PM with the Director of Health Services (DHS) he stated that transportation services had been arranged by Resident #5's insurance company prior to his admission. He stated that the facility would not have admitted the resident unless this was

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 09/08/2018

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 698	Continued From page 28 already arranged by them due to conflicts with the resident's dialysis treatment schedule and the facility's transportation/driver's schedule. He stated that once the transportation issues were brought to his attention the facility made arrangements to transport the resident via their own transportation services.	F 698		
F 835 SS=J	Administration CFR(s): 483.70 §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 observations, record review, interviews with the Nurse Practitioner (NP), the ombudsman, dialysis center staff, representative from the resident's transportation company, and facility staff, the administration failed to provide oversight and leadership to facility staff to maintain safe transportation and analyze an incident for 1 of 1 (Resident #5) residents reviewed for transportation. Resident #5, who was cognitively impaired with wandering behaviors, was transported to and from dialysis by a non-medical taxi like service without supervision. Immediate jeopardy began on 5/22/18 when the facility staff failed to supervise Resident #5 who was cognitively impaired with wandering behaviors during transportation via a non-medical taxi like service to and from his dialysis appointment. The facility administration failed to	F 835	Process that lead to the deficiency On 5/22/2018 Resident #5 was scheduled for transportation to their dialysis center by their insurance company who contracted with Care Navigation Unit who sent an UBER driver to transport the resident to the dialysis center. The facility allowed the resident to enter the vehicle without assisting the resident to and from the scheduled dialysis appointment or validating the driver□s qualifications. Administration failed to provide safe transportation for resident. The facility did not have adequate resources to transport resident to dialysis at 6am and the contracted transportation could not accommodate the 6am time either. This was resolved by changing the residents time for Dialysis.	10/3/18

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 09/08/2018

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 835

Continued From page 29

conduct a timely and thorough analysis to identify a causative factor that directly led to the incident, which left Resident #5 and other residents at risk for a repeat incident. The immediate jeopardy was removed on 9/8/18 when the facility provided an acceptable credible allegation of Immediate Jeopardy removal. The facility will remain out of compliance at a scope and severity of D (not actual harm with potential for more than minimal harm that is not immediate jeopardy) to ensure monitoring and that all staff have been in-serviced.

The findings included:

Cross Reference to F689:
Based on observations, record review, interviews with the Nurse Practitioner (NP), the ombudsman, dialysis center staff, representative from the resident's transportation company, and facility staff, the facility failed to provide supervision to a cognitively impaired resident with wandering behaviors during transportation to and from dialysis in a non-medical taxi like service for 1 of 1 (Resident #5) residents reviewed for transportation. The resident was transported back to the facility, but due to the resident's severe cognitive impairment and wandering tendencies, the lack of staff supervision during transport to and from the dialysis center in a non-medical mode of transportation could have resulted in an adverse outcome to the resident.

On 9/6/18 at 5:32 PM, the administrator was informed of the immediate jeopardy.

The facility provided a credible allegation of Immediate Jeopardy removal on 9/7/18. The allegation of Immediate Jeopardy removal

F 835

Facility did not conduct an investigation to determine why this occurred to prevent this event from happening again, as the Director of Health Services assumed that is was an isolated issue and not a systemic issue and had been resolved. The facility did not brainstorm to figure out how the facility could transport this resident, i.e. utilizing outside resources such as a qualified transportation company and/or sister facility.

Process for implementing a plan of correction for specific deficiency

The Director of Health Services should have conducted a thorough investigation to determine if this issue could or would affect other residents.
On 9/7/2018 the facility Administration and Director of Health Services was in-serviced by the Pruitt Health Area Vice President on the company policy regarding investigating any potential issues regarding potential harm to residents.
On 9/6/2018 the facility began educating nursing clinical staff on proper procedures for scheduling transportation to ensure resident safety. Clinical nursing staff who have not completed education will be removed from the schedule until education is completed.
Beginning on 9/6/2018 all transportation must be scheduled by facility rather than outside agency and approved by Administrator or Director of Health Services for safety. If the facility is unable to transport the volume of residents, they

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 09/08/2018

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 835 Continued From page 30
indicated:

Credible Allegation of Immediate Jeopardy removal:

This plan of correction constitutes a written allegation of substantial compliance with Federal and Medicaid requirements. Preparation and/or execution of this correction does 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. It also demonstrates our good faith and desire to continue to improve the quality of care and services to our residents.

Resident #5 was admitted on May 15, 2018 at 4:15pm from the hospital with diagnosis of End Stage Renal Dialysis and Dementia with behavior disturbance.
On 5/22/2018 Resident #5 was scheduled for transportation to their dialysis center by their insurance company who contracted with Care Navigation Unit who sent a non-medical taxi like service driver to transport the resident to the dialysis center. The facility allowed the resident to enter the vehicle without assisting the resident to and from the scheduled dialysis appointment or validating the driver's qualifications.

Root cause analysis:
The facility made an assumption that the Insurance company would send a medically qualified driver. The facility did not brainstorm to figure out how the facility could transport this resident our self, i.e. utilizing outside resources such as a qualified transportation company

F 835

will utilize their contracted transportation agency to handle high volume transportation.
On 9/7/2018 the Administration began reviewing the grievance log and daily operations report to identify any potential areas that may cause harm. Areas that are deemed with potential for harm will be placed on the Potential for Harm form and investigation will be completed by the facility Administration.
The Administration will track, trend and analyze the potential for harm form and submit findings to the Quality Assurance and Performance Improvement Committee monthly for 3 months then quarterly thereafter.

On 9/6/2018 the Director of Health Services and Administrator utilized the appointment schedule to review resident with appointments through September 8, 2018 for mobility (ambulatory status) and cognitive status utilizing the resident□s behaviors, hospital history and physical. There are currently 8 residents scheduled for appointments requiring transportation for the week ending September 8, 2018. Transportation for the 8 residents include 7 residents by the Facility van and 1 resident by Life Star transportation stretcher.
All current residents have been reviewed by the Director of Health Services and/or Licensed Nurse on 9/7/2018 to identify their current mode of transportation requirements and if an escort is needed when a future appointment may be scheduled. Prior to scheduling any new

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 09/08/2018

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 835

Continued From page 31

and/or sister facility.

On 9/6/2018 the Director of Nursing and Administrator utilized the appointment schedule to review resident with appointments through September 8, 2018 for mobility (ambulatory status) and cognitive status utilizing the resident's behaviors, hospital history and physical. There are currently 8 residents scheduled for appointments requiring transportation for the week ending September 8, 2018. Transportation for the 8 residents include 7 residents by the Facility van and 1 resident by Life Star transportation stretcher.

All current residents have been reviewed by the Director of Nursing and/or Licensed Nurse on 9/7/2018 to identify their current mode of transportation requirements and if an escort is needed when a future appointment may be scheduled. Prior to scheduling any new transportation, for current and/or new residents, the scheduler will notify the Director of Nursing of new appointment and Director of Nursing and/or Licensed nurse will evaluate resident to ensure the mode of transportation continues to meet their physical and psychological needs.

On 9/7/2018 New resident referrals will be reviewed by the Admissions Director and/or Registered Nurse prior to admissions to ensure that the facility can safely meet their physical and psychological transportation needs. Upon admissions to the facility the resident will be assessed by a Licensed Nurse within 24 hours of admission to determine the safest mode of transportation for their physical and psychological needs.

F 835

transportation, for current and/or new residents, the scheduler will notify the Director of Health Services of new appointment and Director of Health Services and/or Licensed nurse will evaluate resident to ensure the mode of transportation continues to meet their physical and psychological needs.

On 9/7/2018 New resident referrals will be reviewed by the Admissions Director and/or Registered Nurse prior to admissions to ensure that the facility can safely meet their physical and psychological transportation needs. Upon admissions to the facility the resident will be assessed by a Licensed Nurse within 24 hours of admission to determine the safest mode of transportation for their physical and psychological needs.

On 9/6/2018 the Director of Health Services and/or Nurse Managers began education to the RN□s, LPN□s, C.N. A□s, Receptionist, Schedulers, Transport Drivers, Admissions and Senior Nurse Navigator (external pre admission evaluator) on all residents must be assessed prior to scheduling transportation to ensure the correct mode of transportation will be used to meet the residents physical and psychological needs and that all scheduling of transportation for the residents will be done by facility staff only. No staff will be allowed to work until education is complete.

On 9/6/2018 the Director of Health Services and/ or Licensed Nurse educated the clinical staff that when a resident has an appointment, the

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 09/08/2018

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 835

Continued From page 32

On 9/6/2018 the Director of Nurses and/or Nurse Managers began education to the RN's, LPN's, C.N. A's, Receptionist, Schedulers, Transport Drivers, Admissions and Senior Nurse Navigator (external pre admission evaluator) on all residents must be assessed prior to scheduling transportation to ensure the correct mode of transportation will be used to meet the residents physical and psychological needs and that all scheduling of transportation for the residents will be done by facility staff only. No staff will be allowed to work until education is complete.
On 9/6/2018 the Director of Nursing and/ or Licensed Nurse educated the clinical staff that when a resident has an appointment, the transportation company will come into the facility and identify themselves to the Licensed Nurse on duty by showing the facility staff their employee ID badge and/or uniform, prior to the resident being transported out of the facility.
All new hires will be educated during their general orientation to the facility

On 9/7/2018 the Director of Nursing and or Licensed Nurses within the facility are utilizing the "Pre / New / reevaluate transportation audit" to review the mobility status, cognitive status (behaviors/dementia) to determine the safest mode of transportation for resident.

Effective 5/24/18 the facilities only utilized a contracted transportation agency which supplements the facilities transportation van to accommodate residents appointment needs in a timely manner.

On 9/6/2018 the Administrator, Director of Health Services or Nurse Manager began to review and audit the "pre/new /reevaluation transport audit"

F 835

transportation company will come into the facility and identify themselves to the Licensed Nurse on duty by showing the facility staff their employee ID badge and/or uniform, prior to the resident being transported out of the facility.
All new hires will be educated during their general orientation to the facility
On 9/7/2018 the Director of Health Services and or Licensed Nurses within the facility are utilizing the Pre / New / reevaluate transportation audit to review the mobility status, cognitive status (behaviors/dementia) to determine the safest mode of transportation for resident.
Effective 5/24/18 the facilities only utilized a contracted transportation agency which supplements the facilities transportation van to accommodate residents appointment needs in a timely.

Monitoring to ensure effectiveness of POC

On 9/7/2018 the Regional Area Vice President attended the ad-hoc Quality Assurance and Performance Improvement committee meeting related to policy and procedure regarding safe transportation.
The Corporate representative will review any incidents related to transportation monthly and report trends / analysis to the corporate Quality Assurance and Performance Improvement team.
The Regional Area Vice President will review the potential for harm form and attend the Quality Assurance and Performance Improvement committee

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 09/08/2018

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 835 Continued From page 33

and daily/weekly scheduled transportation and new admissions for assessment of the resident for the appropriate mode of transportation to meet their physical and psychological needs to ensure safe transportation. Th.is will be done daily for 2 weeks, then 3 times a week for 6 weeks and then weekly for 1 month then monthly until 6 months of continued compliance is sustained then quarterly thereafter.

On 9/6/2018 the Administrator presented the initial safe mode of transportation audit to the Quality Assurance and Performance Improvement Committee. The Administrator/ Director of Nursing will continue to track and trend the appropriate mode of transportation form and present the analysis to the Quality Assurance and Performance Improvement Committee monthly until 6 months of continued compliance is sustained then quarterly thereafter.

The Administrator and Director of Nursing services are responsible for implementing the plan of correction.

The credible allegation of Immediate Jeopardy removal was verified 9/8/18 at 12:00 PM as evidenced by:

During an observation on 9/8/18 at 10:40 AM six residents were observed boarding the facility van with the Facility Transportation Coordinator and NA #4 for a shopping trip. All residents were signed out and verified to have been assessed for safe modes of transportation in the facility's audit log that was started on 9/7/18 per the facility's new transportation policies.

Review of facility's records revealed the following

F 835

meetings to ensure the facility Administration is identifying, trending and analyzing and reporting the areas with potential for harm monthly for 3 months then quarterly thereafter.

Title of person responsible for implementing the POC

The Administrator is responsible for implementing the plan of correction.

Date of Compliance 10/03/2018

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 09/08/2018

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 835	Continued From page 34	F 835		

in-services were completed with all active facility staff on 9/6/18 through 9/8/18:

- In-service by Nurse #3 was completed to educate staff about new policies in place to sign-out residents going to appointments by the driver/person accompanying them. They were also educated to verify the employee identification/uniform of the driver before departure and to sign the resident back in upon return to the facility. A list of approved transportation services was added to the front of every transport binder located on every unit.

- In-service was completed to educate staff about new policies to assess newly admitted residents for safe modes of transport. Each resident would also be reviewed prior to admission to make sure needs would be met.

- In-service was completed to educate staff that all transportation arrangements would be made by the facility. No insurance company would have the authority to arrange transportation for any resident.

- An in-service was completed on 9/6/18 by the Facility Vice President of Operations to educate the Administrator and the DHS about efficient investigations being done for all incidents that affect resident safety. A power-point and check-list for handling immediate jeopardy situations efficiently.

Review of facility records revealed that audits were completed starting on 9/7/18 of:

- Current residents were reviewed for transportation needs, the mode used, and their

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 09/08/2018

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 835	Continued From page 35	F 835		

schedules
- Current and new residents were reviewed/assessed for safe modes of transportation required
  - Three new admissions on 9/7/18 - all were reviewed/assessed upon admission to the facility

During an interview on 9/8/18 at 11:20 PM with the Weekend Receptionist revealed that she was educated on the new policies of resident transport. She stated that she would verify the driver was an approved vendor, check their identification, and have them sign in and out for appointment transportation.

During an interview on 9/8/18 at 11:26 PM with Nurse #4 she stated that any newly admitted resident would be assessed for their safe mode of transport. She would also verify on the day of appointments that the driver/service was an approved vendor, check their identification, and have them sign in and out for appointment transportation.

During an interview on 9/8/18 at 11:36 PM with Nurse #5 she stated that any newly admitted resident would be assessed for their safe mode of transport. She would also verify on the day of appointments that the driver/service was an approved vendor, check their identification, and have them sign in and out for appointment transportation.