| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| PRUITTHEATH-FARMVILLE | 4351 SOUTH MAIN STREET FARMVILLE, NC 27828 |

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| E 000 | Initial Comments<br><br>An unannounced Recertification survey was conducted on 8/13/19 through 8/16/19. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #X75Q11. | E 000 | | |
| F 000 | INITIAL COMMENTS<br><br>A recertificant and complaint investigation survey was conducted from 8/13/19 through 8/16/19. All 5 alligations were unsubstantiated. Event ID X75Q11. | F 000 | | |
| F 637 SS=D | Comprehensive Assessment After Signifcant Chg CFR(s): 483.20(b)(2)(ii)<br><br>§483.20(b)(2)(ii) Within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a "significant change" means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.)<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review and staff interviews the facility failed to complete a significant change in status Minimum Data Set (MDS) assessment within 14 days following hospice election for 1 of 1 resident reviewed for hospice. (Resident #26)<br><br>Findings included: | F 637 | This plan of Correction constitutes the facilities written allegation of compliance for the deficiencies cited. However, submission of this plan of correction is not an admission that deficiencies exist or that one was cited correctly. This plan of correction is submitted to meet requirements established by federal and | 9/5/19 |

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

Electronically Signed | 09/06/2019

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| F 637 | Continued From page 1<br>Resident #26 was admitted to the facility on 9/20/18. Her active diagnoses included hypertension and dementia.<br><br>Review of Resident #26's orders revealed on 3/14/19 the resident was ordered to have a hospice referral per family request.<br><br>Review of Resident #26's hospice notice of election and informed consent revealed the effective date of hospice election was on 3/15/19 and was signed 3/15/19.<br><br>Review of Resident #26's notification of admission to hospice revealed she had been admitted to hospice on 3/15/19.<br><br>Review of Resident #26's minimum data set assessments revealed a significant change is status minimum data set assessment was completed with an Assessment Reference Date (ARD) of 4/10/19.<br><br>During an interview on 08/14/19 at 11:39 AM MDS Nurse #1 stated Resident #26's significant change in status for hospice election was performed on 4/10/19. She further stated 4/10/19 was the date of the ARD. MDS Nurse #1 stated Resident #26 had elected hospice on 3/14/19 and the ARD should have been within 14 days of hospice election. She further stated the reason the significant change in status assessment was not done timely was due to communication issues between herself and the staff.<br><br>During an interview on 8/14/19 at 11:45 AM the Administrator stated he was not aware a significant change in status minimum data set assessment was late for Resident #26 and there | F 637 | state law.<br><br>"Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice; Assessment for significant change related to Resident # 26 to hospice election was completed on 4/10/2019.<br><br>"Address how the facility will identify other residents having the potential to be affected by the same deficient practice; Case Mix Director and Assistant Director of Nursing completed 100% audit of current resident□s with 0 residents identified with needed status changes completed on 9/5/2019 to identify significant changes and complete assessments as needed.<br><br>"Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur; The Case Mix Director and Interdisciplinary team will complete the Relias Couse for identification of Significant changes by 9/9/2019.<br><br>Facility Case Mix Coordinator nurse will review orders daily with nursing management during morning clinical meeting. Status changes will be discussed with interdisciplinary team daily during morning meeting. The Case Mix coordinator will review the RUGs analysis for changes that may warrant a significant change in status assessment with the completion of each new assessment and | |

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| F 637 | Continued From page 2<br>had been no quality assurance and performance improvement plan to correct this. He further stated significant change in status minimum data set assessments should be completed within 14 days of the hospice election date of residents. | F 637 | bring forward to the interdisciplinary team to make the determination if significant change assessment is needed and document on significant change audit tool until substantial compliance through QAPI.<br><br>"Indicate how the facility plans to monitor its performance to make sure that solutions are sustained; and The Interdisciplinary Team will maintain a significant change audit tool identifying residents discussed and significant changes needed.<br><br>The administrator will review and trend the findings from the significant change audit tool. The administrator will bring the findings from the audit to the quality assurance performance improvement committee meetings monthly until substantial compliance is achieved then quarterly thereafter. Changes will be made to the plan by the committee as indicated to include re-education and/or immediate corrective action.<br><br>"Include dates when corrective action will be completed.<br>Date of Compliance: 9/9/2019 | |
| F 657 SS=D | Care Plan Timing and Revision<br>CFR(s): 483.21(b)(2)(i)-(iii)<br><br>§483.21(b) Comprehensive Care Plans<br>§483.21(b)(2) A comprehensive care plan must be- | F 657 | | 9/5/19 |

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| F 657 | Continued From page 3<br>(i) Developed within 7 days after completion of the comprehensive assessment.<br>(ii) Prepared by an interdisciplinary team, that includes but is not limited to--<br>(A) The attending physician.<br>(B) A registered nurse with responsibility for the resident.<br>(C) A nurse aide with responsibility for the resident.<br>(D) A member of food and nutrition services staff.<br>(E) To the extent practicable, the participation of the resident and the resident's representative(s).<br>An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan.<br>(F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident.<br>(iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review and staff interview the facility failed to update the care plan to reflect the resident was not able to ambulate and did not use bed rails for 1 of 12 resident care plans reviewed. (Resident #6)<br><br>Findings included:<br><br>Resident #6 was admitted to the facility on 5/16/17 with diagnoses including osteoarthritis, osteoporosis and dementia.<br><br>Review of the Minimum Data Set assessment | F 657 | "Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;<br>The plan of care of resident #6 was revised on 8/16/19 to accurately reflect resident #6□s status for mobility and bed rail use.<br><br>"Address how the facility will identify other residents having the potential to be affected by the same deficient practice; | |

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| F 657 | Continued From page 4<br>(MDS) for Resident #6 dated 5/21/19 and coded as an annual assessment indicated she was severely impaired for daily decision making. She was coded as requiring total assistance of one person for bed mobility and total assist of two people for transfers. She was coded as using a wheelchair for mobility. Walking was coded as did not occur. Bedrails were coded as not used. Resident #6 was further coded as having functional impairment of her upper and lower extremities (arms and legs) on both sides.<br><br>Review of a care plan for Resident #6 dated 5/21/19 and initialed as reviewed by the facility MDS Nurse revealed a focus area of at risk for falls related to muscle weakness and dementia. The goal was that the resident would not experience any injuries related to falls thru next review. The interventions included to assist resident with one staff member for all ambulation (walking) and remind resident to ask for assistance with all ambulation. A second focus area included self-care deficit related to muscle weakness with a goal of needs are met through next review. The interventions included ½ side rails head of bed to assist with bed mobility.<br><br>On 8/15/19 at 11:19 AM in an interview, the MDS Nurse indicated she was responsible for updating resident's care plans. She further indicated if Resident #6 did not have an assessment for bedrails it should not appear on her care plan. She went on to say that Resident #6 did not ambulate and the intervention to assist her with walking should have been removed from her care plan.<br><br>On 8/16/19 at 9:17 AM an interview with the facility Director of Nursing revealed the current | F 657 | The Interdisciplinary Team completed an audit of 100% of the resident plans of care to ensure accuracy completed on 9/5/19 and make corrections as needed.<br><br>"Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;<br><br>On 9/5/2019 the Director of nursing, assistant director of nursing, and MDS Coordinator were educated on updating/revising the residents plans of care. Education relating to review and revision of care plans has been added to the new hire Licensed Nurse orientation. The Director of Nursing and or nurse management will review 24- hour reports for resident changes and ensure the plan of care is updated to accurately reflect resident status. The MDS Coordinator will visually observe the resident prior to completing MDS assessments to ensure the resident plan of care matches the resident status.<br><br>"Indicate how the facility plans to monitor its performance to make sure that solutions are sustained; and The Director of Nursing/Nurse management will review all residents with changes during clinical meeting and/or stand up meeting and ensure that the plans of care are completed and updated as necessary. The review will be conducted weekly for 2 weeks then monthly until six months of substantial compliance is maintained then | |

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| F 657 | Continued From page 5<br>care plan for Resident #6 did not accurately reflect her status for mobility and bed rail use. She further indicated it was important for resident's care plans to accurately reflect their status, so staff knew how to provide care for the resident.<br><br>On 8/16/19 at 9:28 AM an interview with the facility's Assistant Director of Nursing revealed the MDS assessment dated 5/21/19 accurately reflected Resident #6's status at the time of the assessment. She went on to say the care plan dated 5/21/19 and currently in use was not accurate as Resident #6 had not been able to walk, had been totally dependent on staff for bed mobility and was not appropriate for the use of bedrails since her return to the facility from the hospital on 8/15/18. | F 657 | quarterly thereafter.<br>Any areas of non-compliance will be reported by the Administrator and/or Director of Health Services to the Quality Assurance / Performance Improvement Committee quarterly for recommendations as needed.<br><br>Include dates when corrective action will be completed<br>Date of compliance: 9/5/19 | |
| F 700 SS=D | Bedrails<br>CFR(s): 483.25(n)(1)-(4)<br><br>§483.25(n) Bed Rails.<br>The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements.<br><br>§483.25(n)(1) Assess the resident for risk of entrapment from bed rails prior to installation.<br><br>§483.25(n)(2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation.<br><br>§483.25(n)(3) Ensure that the bed's dimensions | F 700 | | 8/19/19 |

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| F 700 | Continued From page 6<br>are appropriate for the resident's size and weight.<br><br>§483.25(n)(4) Follow the manufacturers' recommendations and specifications for installing and maintaining bed rails.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observations, staff interviews and record review, the facility failed to assess the use of side rails before maintaining the bedrails in the upright position for 1 of 1 Resident (Resident #6) reviewed for bedrails.<br><br>Findings included:<br><br>Resident #6 was admitted to the facility on 5/16/17 with diagnoses including osteoarthritis, osteoporosis and dementia.<br><br>Review of Resident # 6's Minimum Data Set assessment (MDS) dated 5/21/19 and coded as an annual assessment indicated she was severely impaired for daily decision making. She was further coded as requiring total assistance of one person for bed mobility and total assistance of two people for transfers.<br><br>Review of Resident #6's medical record revealed she was not assessed for the use of bedrails.<br><br>Review of a document titled, "CNA Care Interventions Record Form" for Resident #6 dated 8/21/18 and currently in use by facility staff indicated Resident #6 used no safety devices or restraints including bedrails.<br><br>On 08/13/19 at 12:42 PM Resident #6 was observed in bed with her meal tray on her bedside table. The half rails on either side of the | F 700 | "Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;<br>Based on nursing observations and ADL reporting it was determined that resident #6 does not use the bed rails for mobility. The bed rails for #6 were lowered on 8/16/19 and the plan of care was updated to accurately reflect the changes.<br><br>"Address how the facility will identify other residents having the potential to be affected by the same deficient practice;<br><br>Assistant Director of nursing completed 100% audit of bed rail utilization by 9/5/19. Nursing management ensured that any residents that had bed rails in the upright position used the rails for bed mobility and that the plans of care accurately reflected the resident□s status for bed mobility and bed rail use including the assistive device assessment form.<br><br>"Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;<br><br>The Director of nursing and Assistant | |

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| F 700 | Continued From page 7<br>head of her bed were observed to be in the upright position.<br><br>On 08/14/19 at 12:40 PM Resident #6 was observed to be in bed with the half rails on either side of the head of her bed in the upright position.<br><br>On 08/15/19 at 08:10 AM Resident #6 was observed in her bed with the half rails on either side of the head of her bed in the upright position.<br><br>On 08/15/19 at 10:20 AM during an observation of Resident #6, the facility Assistant Director of Nursing (ADON) confirmed that Resident #6 was in her bed with the half rails on either side of the head of her bed in the upright position.<br><br>On 08/15/19 at 10:44 AM in an interview, the ADON indicated Resident #6 had been assessed as not appropriate for the use of bedrails. She further indicated Resident #6 was dependent on staff for bed mobility and could not use bed rails to assist herself. She went on to say that Resident #6 should not have her bedrails in the upright position.<br><br>On 8/15/19 at 10:52 AM an interview with NA #3 revealed she was responsible for the care of Resident #6. She further indicated she knew Resident #6 was not supposed to have her bed rails up.<br>She went on to say she did not know how the rails got into the upright position, she had been busy providing care to other residents in the room that day and had not noticed the rails were up.<br>She further indicated she thought maybe Resident #6's family had put the bedrails up when they visited. | F 700 | director of nursing educated on utilization of assistive device assessment tool an updating plan of care based on findings on 9/5/19.<br><br>Upon admission, nursing will complete observations and interviews to identify if bed rails are appropriate for the resident. Once determined if the bed rails are an appropriate assistive device the resident□s care plan will be updated to reflect the bed mobility status and bed rail usage. The interdisciplinary team will review resident□s care plans with each new assessment and as needed based on resident status changes to ensure accuracy and appropriateness of interventions.<br><br>"Indicate how the facility plans to monitor its performance to make sure that solutions are sustained; and<br><br>The Director of Nursing and/or the Assistant Director of Nursing will present their findings of the bed rail utilization audit to the Quality Assurance and Performance Improvement Committee. Director of Health Services and/or Assistant Director of Health Services will complete bed rail utilization / plan of care audit monthly until 6 months of compliance and quarterly thereafter to ensure that bed rails are only in use for the residents that use them for bed mobility and that the care plans appropriately reflect the bed rail usage and patient status.<br>Findings will be brought the Quality | |

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| F 700 | Continued From page 8<br>On 8/15/19 at 10:53 AM interview with Nurse #2 indicated she was responsible for providing care for Resident #6. She further indicated she had been in Resident #6's room that day but had not noticed the bed rails were in the upright position.<br><br>On 8/15/19 at 10:56 AM interview with the facility Administrator revealed all facility beds came from the manufacturer with bedrails. He further indicated the rails could be raised and lowered as appropriate. He went on to say staff should be providing care to residents in accordance with their CNA Care Interventions Record guide. | F 700 | Assessment Performance Improvement committee monthly for 3 months and quarterly thereafter.<br><br>Include dates when corrective action will be completed<br>Date of compliance: 8/19/19 | |
| F 867 SS=D | QAPI/QAA Improvement Activities<br>CFR(s): 483.75(g)(2)(ii)<br><br>§483.75(g) Quality assessment and assurance.<br><br>§483.75(g)(2) The quality assessment and assurance committee must:<br>(ii) Develop and implement appropriate plans of action to correct identified quality deficiencies;<br>This REQUIREMENT is not met as evidenced by:<br>Based on observations, resident and staff interviews and record review, the facility's quality assurance (QA) process failed to implement, monitor and revise as needed the action plan developed for the recertification survey dated 8/3/18 in order to achieve and sustain compliance. This was for a recited deficiency on recertification survey on 8/16/19. The deficiencies were in the area of comprehensive assessment after significant change at regulatory grouping 483.20. The continued failure during two federal surveys of record showed a pattern of the facility's inability to sustain an effective quality assurance program. | F 867 | "Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;<br><br>Assessment for significant change related to hospice election was completed on 4/10/2019.<br><br>"Address how the facility will identify other residents having the potential to be affected by the same deficient practice; | 9/5/19 |

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| F 867 | Continued From page 9<br><br>The findings included:<br><br>This tag is cross-referenced to:<br><br>CFR 483.20 (F637) - Based on record review and staff interviews the facility failed to complete a significant change in status Minimum Data Set (MDS) assessment within 14 days following hospice election for 1 of 1 resident reviewed for hospice. (Resident #26)<br><br>During the recertification survey on 8/3/18 the facility was cited for failure to complete a significant change in status minimum data assessment within 14 days of the significant change being identified.<br><br>During an interview with the Administrator on 8/16/19 at 10:15 AM he stated a new process had been implemented by the facility where a new nurse practitioner was seeing the resident who's MDS was late. He further stated upon being made aware of the concern he found the issue stemmed from floor nursing having a breakdown in communication with MDS Nurse #1 which led to the late MDS. | F 867 | The Administrator and the Director of Health Services educated on the Quality Assurance and Performance Improvement policy/process for members of the QA Committee with emphasis on identifying areas that may lead to deficient practice. Education will be completed by 9/5/2019. Administrator will lead Quality Assurance and Performance Improvement meetings with emphasis and focus on ensuring that any areas on non-compliance are addressed to prevent further deficient practices related completing significant change assessments. At least a member of the regional team that includes senior nurse consultant, clinical reimbursement consultant or area vice president will attend QAPI meetings for 3 quarters.<br><br>"Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;<br><br>The Quality Assurance and Performance Improvement committee will continually monitor implemented procedures and monitor the plan of correction (POC) put in place for Tag F637 monthly until 3 consecutive months of compliance is maintained then quarterly thereafter. The Quality Assurance and Performance Improvement committee will meet monthly to review the tracking and trending analysis of areas that led to a repeat tag/deficiency. | |

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| F 867 | Continued From page 10 | F 867 | "Indicate how the facility plans to monitor its performance to make sure that solutions are sustained; and<br><br>Administrator will lead Quality Assurance and Performance Improvement meetings monthly with emphasis and focus on areas that have led to repeated deficiency (Tag F637). This will ensure the facility is identifying areas on non-compliance and addressing them as needed to prevent further deficient practice related to significant change assessments. A member of the regional team that includes the senior nurse consultant, clinical reimbursement consultant or Area Vice President will attend QAPI meetings for the next 3 months and then quarterly for 3 quarters to ensure the QAPI process is effective. The administrator will report to the Quality Assurance and Performance Improvement Committee any areas of non-compliance monthly for 3 months and then quarterly and/or as needed for 3 quarters for further recommendations until compliance is sustained.<br><br>Include dates when corrective action will be completed<br>Date of Compliance: 9/5/2019 | |