STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345538	A. BUILDING _____ B. WING _____	C 07/07/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEALTH-RALEIGH	2420 LAKE WHEELER ROAD RALEIGH, NC 27603

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F 000	INITIAL COMMENTS A complaint investigation was conducted from 7/6/22 to 7/7/22. Event ID# QEW211 One of the seven complaint allegations was substantiated. NC 189927 and NC 189695	F 000		
F 692 SS=E	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 observation, record review, resident interview, and staff interview the facility failed to assure accurate weights were obtained for two (Resident # 3 and # 6) of three sampled residents who received enteral (liquid tube) feedings. The	F 692	This plan of correction constitutes a written Allegation of Compliance with federal and state requirements. Preparation and submission of this Allegation of Compliance does not	7/21/22

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

Electronically Signed | 07/14/2022

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F 692	Continued From page 1 findings included: 1. Resident # 3 was admitted to the facility on 4/29/22 with a gastrostomy tube secondary to having a diagnosis of dysphagia. Resident # 3's admission Minimum Data Set assessment, dated 4/29/22, coded Resident # 3 as being cognitively intact. Resident # 3 was also assessed as having a tube feeding by which she received 51% or more of her caloric needs through. The MDS coded Resident # 3's weight and height as 61 inches and 146 pounds. Resident # 3's nutritional care plan, last revised on 6/6/22, included the information that Resident # 3 received both an oral diet and an enteral feeding. The care plan noted that the resident's enteral feeding would be adjusted with her oral intake. One of the goals for the resident was that her weight would remain within three pounds of her current weight. Staff were directed on the care plan to weigh and monitor the weight results "on admission weekly X 4." Review of Resident # 3's weights revealed the following values. 6/2/22-136 pounds 6/8/22-159 pounds 6/10/22-159 pounds 6/14/22-136.2 pounds. On 6/8/22 at 1:11 PM the RD (Registered Dietician) documented the following note, "5/5 146 # (pounds), 6/2/22 136 #, 6/8/22 159 #-reviewed weight fluctuations with nursing. For reweight to check accuracy. Resident is observed today, up in bed, with fair appetite."	F 692	constitute an admission or agreement by the provider of truth of the facts alleged or the corrections of the conclusions set forth on the statement of deficiencies. The plan of correction is prepared and submitted solely because of requirements under state and federal law. 1. Resident #3 was weighed on July 6, her weight was 155.2. Resident #3 will be weighed once per week, per her plan of care. Resident #6 was weighed on July 6, his weight was 145.00. Resident #6 will be weighed once per week, per his plan of care. 2. The facility has 4 residents who receive enteral feedings, in addition to PO intake, who could be affected by the facility process for obtaining resident weights. Two of these residents have stable weights and two have a desired weight increase. 3. The DHS and Clinical Competency Coordinator provided facility RD, licensed staff and nursing assistants re-education related to the policy and procedure for obtaining weights in accordance with the plan of care, including obtaining re-weights per the facility policy, which includes obtaining admission weights within 24 hours of admission, weekly weights for 4 weeks, or until weight is stable. The policy requires a re-weigh for weight discrepancies of 3# for weekly	

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F 692	Continued From page 2 On 6/13/22 at 1:05 PM the RD documented, "6/10 weight 159#. weight 5/5 146 #. Resident with 13 #/8.9 % weight gain X 36 days. On tube feeding for 100% nutritional needs. Resident does receive a meal tray with minimal oral intake." The RD further documented Resident # 3 was receiving 1500 calories/day per her enteral feeding. As of a record review conducted on 7/6/22 at 12:20 PM, there was no documentation of any further weights following 6/14/22. The facility's RD was interviewed on 7/6/22 at 12:20 PM and verified there had been no further weights since 6/14/22 and the resident's weight should have been rechecked since there was a significant difference. The RD stated the facility had protocols to follow regarding weighing residents On 7/6/22 at 1:05 PM the RD presented the facility's protocols for weight monitoring. A review of the protocol revealed that if weights varied by three pounds from a previous weight, then a re-weight was to be done within 24 hours. For residents who had significant weight loss, the residents were to be weighed and reviewed weekly for a minimum of four weeks until their weight was stable or increasing. The RD was further interviewed on 7/6/22 at 1:25 PM and again on 7/7/22 at 10 AM and reported the following. The staff had weighed Resident # 3 on the afternoon of 7/6/22 and her weight registered 155.2 pounds. According to the RD, she felt the times when the resident weighed 136 and 136.2 in June, 2022 were not valid weights. The RD reported visually the resident never appeared to have lost weight to the point of	F 692	weights, or a 5# weight change on a monthly weight. All re-weights are to be obtained within 24 hours. Staff who have not completed training by 7/20/22 will not be permitted to work until the training has been completed. Training will be included with general orientation for all new Licensed staff and Nursing Assistants hired after 7/20/22. Licensed staff and nursing assistants were provided education on the correct procedure to weigh residents, on all scales, to improve weight accuracy, by AAA Scale Company, the vendor who completes the monthly scale calibration, on 7/13/22. All scales were calibrated by AAA Scale Company on 7/13/22. The RD, or designee, will audit weights daily, for 30 days, to ensure weights are completed per the plan of care, and that re-weights are obtained in accordance with the facility policy and procedure. Following 30 days, the RD will audit weights weekly, for 60 days, to ensure weights are completed per the plan of care, and that re-weights are obtained in accordance with the facility policy and procedure. Audits will continue until sustained compliance is observed, for a minimum of 90 days. 4. The RD will present the analysis of the weight monitoring compliance percentage to the Nursing Home Administrator at the Quality Assurance and Performance	

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F 692	Continued From page 3 weighing 136 pounds. The RD was interviewed regarding how she adjusted enteral feeding needs when the weights were not consistent, and she replied that she made a lot of observations. She noted she looked at the resident and observed what they were eating also. The RD also reported that sometimes the scales did not give consistent readings, and she had talked to the Maintenance Director but he said they were calibrated correctly. According to the RD, the facility used both a chair scale and the scales on the mechanical lifts. Interview with NA (Nurse Aide # 1) on 7/6/22 at 1:30 PM revealed there were things that must be done correctly in order to obtain an accurate weight when using the scale on the mechanical lift. NA # 1 reported the resident's feet must be totally clear of the bed, the scale must be zeroed out, and all sling ties must be colored the same. The Maintenance Director was interviewed on 7/7/22 at 10:30 AM and reported he had a service provider who checked all the scales monthly to assure all facility scales were calibrated correctly. The Maintenance Director reported he did not think the problem of having inconsistent weights was with the scales but with the weighing techniques of the staff. The Maintenance Director reported that the staff must also do things correctly with the chair scale. He noted residents could not be bearing any of their weight on rails or nearby objects while being weighed and the staff person must not hold onto the back of the chair. The Administrator was interviewed on 7/6/22 at 5:00 PM and Resident # 3's weights were reviewed at that time with her. According to the	F 692	Improvement Committee meeting monthly until three consecutive months of compliance is maintained and then quarterly thereafter. 5. Completion Date: 7/21/22	

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Administrator the weights which varied significantly should have been redone to establish the correct weight.

Resident # 3 was interviewed on 7/7/22 at 8:55 AM and did not appear under nourished. The resident reported prior to being sick and admitted to the facility, she generally weighed between 160 and 170 pounds. She reported the staff had weighed her on 7/6/22 and she weighed 155 pounds. The resident did not feel as if that weight was inaccurate and she was pleased with that weight.

2. Resident # 6 was admitted to the facility on 4/29/22. Resident # 6 had a gastrostomy tube secondary to a diagnosis of dysphagia.

Review of Resident # 6's MDS, dated 5/3/22, revealed the resident was cognitively impaired. Resident # 6 was also assessed as having a tube feeding by which he received 51% or more of her caloric needs through. The MDS coded Resident # 6's weight and height as 67 inches and 128 pounds.

Resident # 6's nutritional care plan, last revised on 7/5/22, revealed the resident received an enteral feeding to meet 100 % of his needs up until 6/27/22. On that date the resident was started on an oral diet in conjunction with the enteral feeding. On 7/5/22 the resident was started on a trial of oral food only and his enteral feeding discontinued. One of Resident # 6's nutritional goals was for him to have gradual weight gain. The staff were directed on the care plan to weigh and monitor results "on admission weekly X 4."

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Review of Resident # 6's weights revealed the following values.
6/2/22-131 pounds
6/7/22-125 pounds
6/16/22-135.2 pounds
7/4/22-144.4 pounds

The RD was interviewed on 7/6/22 at 12:20 PM and stated that weights should be rechecked when there was a significant difference. The RD stated the facility had protocols to follow regarding weighing residents and when reweights were to be done.

On 7/6/22 at 1:05 PM the RD presented the facility's protocols for weight monitoring. A review of the protocol revealed that if weights varied by three pounds from a previous weight, then a re-weight was to be done within 24 hours. For residents who had significant weight loss, the residents were to be weighed and reviewed weekly for a minimum of four weeks until their weight was stable or increasing.

During a follow up interview with the RD on 7/6/22 at 3:30 PM, the RD reported the following. She doubted the validity of the 6/7/22 weight because it was an outlier. The resident had been on a 2 calorie/ milliliter enteral formula with the goal of gaining weight during June 2022. Excluding the 6/7/22 weight, the weights showed he was gaining a reasonable and expected amount of weight per time period. She did not believe that the resident had lost 6 pounds between 6/2/22 and 6/7/22 while receiving the enteral feeding. She thought the problem was with the accuracy of the weights.

Interview with NA (Nurse Aide # 1) on 7/6/22 at

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F 692	Continued From page 6	F 692		

1:30 PM revealed there were things that must be done correctly in order to obtain an accurate weight when using the scale on the mechanical lift. NA # 1 reported the resident's feet must be totally clear of the bed, the scale must be zeroed out, and all sling ties must be colored the same.

The Maintenance Director was interviewed on 7/7/22 at 10:30 AM and reported he had a service provider who checked all the scales monthly to assure all facility scales were calibrated correctly. This included both the scales on the mechanical lifts and the chair scales. The Maintenance Director reported he did not think the problem of having inconsistent weights was with the scales but with the weighing techniques of the staff. The Maintenance Director reported that the staff must also do things correctly when weighing residents. He noted residents could not be bearing any of their weight on rails or nearby objects while being weighed. When the chair scale was being utilized the staff person could not hold onto the back of the chair or it would give an erroneous value.

The Administrator was interviewed on 7/6/22 at 5:00 PM and Resident # 6's weights were reviewed at that time with her. According to the Administrator the weight which varied significantly should have been redone to establish the correct weight.

Resident # 6 was observed on 7/7/22 at 12:35 PM. Resident # 6's face was observed to be fuller and healthier when compared to his admission photograph located in his electronic record.