STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345384	A. BUILDING _____ B. WING _____	C 01/04/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEATH-FARMVILLE	4351 SOUTH MAIN STREET FARMVILLE, NC 27828

(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 survey was conducted on 1/4/2023. Event ID# 9ZOC11. The following intakes were investigated: NC00196376 and NC00195907. 2 of the 10 complaint allegations were substantiated resulting in deficiencies.	F 000		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any,	F 580		1/23/23

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

Electronically Signed | 01/19/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345384	A. BUILDING _____ B. WING _____	C 01/04/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEATH-FARMVILLE	4351 SOUTH MAIN STREET FARMVILLE, NC 27828

(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 580	Continued From page 1 when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on record review and staff, Responsible Party (RP), and physician interviews the facility failed to notify the physician when a new onset stage 2 (an open wound with skin loss) pressure ulcer requiring treatment orders was identified (Resident #1) and failed to notify the RP of the initiation of a new medication (Resident #2). This was for 2 of 3 residents reviewed for notification of change. Findings included: 1. Resident #1 was admitted to the facility on 11/9/22 A review of the admission Minimum Data Set (MDS) assessment for Resident #1 dated	F 580	Preparation and/or execution of this plan does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because the provisions of federal and state law require it. Corrective action for the residents found to be affected by the deficient practice. Resident #1 no longer resides in the facility. Resident #2 had an Interdisciplinary care plan meeting, including the Ombudsman on 1/19/23. During this meeting a list of all	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345384	A. BUILDING _____ B. WING _____	C 01/04/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEATH-FARMVILLE	4351 SOUTH MAIN STREET FARMVILLE, NC 27828

(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 580	Continued From page 2 11/12/22 revealed she was moderately cognitively impaired. She was at risk for pressure ulcers. She had no unhealed pressure ulcers. A nursing progress note dated 12/7/22 at 12:15 PM written by Nurse #1 revealed Resident #1 had a new 2-inch area of skin breakdown to her sacral (bottom of spine) area. A physician's order for Resident #1 dated 12/10/22 revealed Wound Dressing for Sacral Area: Cleanse area with normal saline. Apply skin prep to surrounding intact tissue. Apply a hydrocolloid (a gel forming moisture retentive wound dressing) dressing to open area, cut to fit. Change every 72 hours or PRN (as needed) for soiling. Change Saturday, Monday, Thursday. Once A Day; 07:00 AM - 03:00 PM. On 1/4/23 at 3:17 PM a telephone interview with Nurse #1 indicated when she discovered the new open area of skin breakdown on Resident #1's sacrum on 12/7/22 she did not think to notify a provider or get treatment orders for the wound. She stated she covered it with a "sacral heart". She further indicated a sacral heart was a foam protective dressing in the shape of a heart. She explained she just thought she was supposed to notify Nurse #2 who was the facility's wound treatment nurse. She went on to say she thought this nurse would take care of the rest. On 1/4/23 at 1:51 PM an interview with Nurse #2 indicated she was the facility's wound treatment nurse. She stated on 12/7/22 she received a text message from Nurse #1 informing her Resident #1 had a new pressure ulcer on her sacrum. She went on to say she had not been in the facility at the time. She further indicated when she returned	F 580	active medications were reviewed with the Responsible Party (RP). Corrective action for other residents having the potential to be affected by the same deficient practice. All residents have the potential to be affected by the alleged deficient practice. The Director of Health Services (DHS) audited the wound report in its entirety on 1/19/23. The audit was completed on 1/19/23. There were 9 residents noted with skin impairment. Of the 9 with a skin impairment, 5 were pressure ulcers. All residents with a skin impairment and/or pressure ulcer have been reported to the physician. The Skin Integrity Coordinator gave the physician a copy of the wound management report on 1/19/23. The Director of Health Services (DHS) and the Case Mix Coordinator audited all new orders from 1/4/23 through 1/17/23 for Responsible Party (RP) notification of new medications. This audit was completed on 1/17/23. There were 37 residents noted with a new, change or discontinued medication order. All residents if alert and oriented and/or Responsible Party (RP) were notified of the medication orders/changes/discontinuation on 1/18/23. The Director of Health Services (DHS) and/or Interim Administrator began education to the Licensed Nurses on	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345384	A. BUILDING _____ B. WING _____	C 01/04/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEATH-FARMVILLE	4351 SOUTH MAIN STREET FARMVILLE, NC 27828

(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 580	Continued From page 3 to work on 12/8/22 she did an assessment of Resident #1's sacral wound. She stated she had not notified a medical provider of Resident #1's new pressure ulcer or obtained any treatment orders for the wound that day. She went on to say she could have called a provider to get treatment orders for the wound, but she knew the Wound Care Nurse Practitioner (NP) was coming on Monday 12/12/22, so she just covered the area to keep it clean and dry. Nurse #2 went on to say she thought it would be okay to keep the wound clean and dry until the wound NP saw Resident #1 on Monday 12/12/22. On 1/4/23 at 2:14 PM a telephone interview with Physician (MD) #1 indicated she was Resident #1's facility physician. She stated she would have expected a medical provider to be notified when Resident #1's new pressure ulcer was first identified on 12/7/22. She stated a provider was available 24 hours a day. She went on to say this would have enabled treatment orders to be put in place in a timely manner to address Resident #1's wound care needs. She went on to say based on her knowledge of Resident #1's medical history she felt her sacral wound was not avoidable. MD #1 further indicated she didn't feel the delay in getting treatment orders caused any harm to Resident #1 or caused her sacral wound to worsen. On 1/4/22 at 2:42 PM an interview with the Director of Nursing (DON) indicated she was called to Resident #1's room on 12/9/22 by her RP. She stated when she observed Resident #1's sacral pressure ulcer that day there was no dressing in place. She went on to say there had been no treatment orders in place for this wound. She further indicated she had not been made	F 580	1/17/23 regarding new onset of skin impairments and physician notification. When a new skin impairment is noted, the Nurse identifying the new skin impairment will be responsible for physician/physician extender notification of the newly identified skin impairment. The nurse will document such notification in the patient□s electronic medical record. Any Licensed Nurses not receiving the education due to scheduled time off or FMLA will be educated prior to next scheduled shift. Education has been added to licensed nurse orientation conducted by the Director of Health services and/or the staff educator. The Director of Health Services (DHS) and/or Interim Administrator began education to the Licensed Nurses on 1/17/23 regarding notification of a new medication to the Responsible Party (RP). When a new medication order is written, the Nurse taking off the physician□s order will be responsible for notifying the Responsible Party (RP). Any Licensed Nurses not receiving the education due to scheduled time off or FMLA will be educated prior to next scheduled shift. Education has been added to licensed nurse orientation conducted by the Director of Health services and/or the staff educator. The Director of Health Services (DHS) was notified on 1/17/23 by the Interim Licensed Nursing Home Administrator (LNHA), to add the education regarding the notification of Responsible Party (RP)	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345384	A. BUILDING _____ B. WING _____	C 01/04/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEATH-FARMVILLE	4351 SOUTH MAIN STREET FARMVILLE, NC 27828

(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 580	Continued From page 4	F 580		

aware of the wound prior to that day. The DON stated Resident #1's RP had been very upset and insisted Resident #1 go out to the hospital to have her wound evaluated even after she offered him a telehealth visit with a medical provider. She went on to say she notified NP #1 of the wound and Resident #1's RP's request she be sent to the hospital on 12/9/22 but did not obtain treatment orders for the wound at that time. She stated there was really no point in getting treatment orders if Resident #1 was going to the hospital. The DON stated when Resident #1 returned from the hospital on 12/10/22 she did contact a provider to obtain treatment orders for the wound. She went on to say she was not aware of any facility standing wound treatment orders that could have been put in place. She further indicated she would have expected a medical provider to be contacted to obtain wound treatment orders immediately when Resident #1's new sacral pressure ulcer was first identified. The DON stated a lack of timely initiation of proper treatment orders for her sacral pressure ulcer could have put Resident #1 at risk for wound deterioration.

2. Resident #2 was admitted to the facility on 10/27/2020 with a diagnosis of dementia.

A review of the annual Minimum Data Set (MDS) assessment for Resident #2 dated 9/29/22 revealed she was severely cognitively impaired.

A physician's order for Resident #2 dated 9/28/22 revealed Melatonin (a hormone to promote sleep) 3 milligrams (mg) at bedtime for insomnia (difficulty sleeping). The order was entered into Resident #2's medical record by the Director of Nursing (DON).

for new medication orders to the general orientation for all licensed nurses.

Systemic changes made to ensure that the deficient practice will not recur.

On 1/17/23 the Interim Licensed Nursing Home Administrator (LNHA) notified the Director of Health Services (DHS) and/or Nursing Leadership to review the daily activity report in MatrixCare (electronic health record system) to validate new skin impairments identified have physician/physician extender notification as well as the notification of the Responsible Party (RP) for any new medication orders, changes and/or discontinuation. The daily activity report via Matrix Care will be monitored daily for physician/physician extender and/or Responsible Party (RP) notification. The Director of Health Services (DHS) will audit the daily activity report and the facility wound manager report daily for two weeks, then three times weekly for two weeks and then monthly times two months to ensure the physician has been notified of any new skin impairment and Responsible Party (RP) have been notified of new medication orders.

The Director of Health Services (DHS) was notified on 1/17/23 by the Interim Licensed Nursing Home Administrator (LNHA) that the review of the daily activity report in MatrixCare to validate new skin impairments identified have physician/physician extender notification as well as notification of the Responsible

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345384	A. BUILDING _____ B. WING _____	C 01/04/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEATH-FARMVILLE	4351 SOUTH MAIN STREET FARMVILLE, NC 27828

(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 580	Continued From page 5 A review of the September 2022 Medication Administration Record (MAR) for Resident #2 revealed documentation indicating Melatonin 3mg was first administered to her on 9/28/22 at 9:00 PM by Nurse #3. On 1/4/22 at 7:02 PM a telephone interview with Resident #2's RP indicated Resident #2 was not capable of understanding information about new medications. She stated Resident #2 was not capable of understanding the risks or the benefits of any medications. She went on to say she was Resident #2's RP and she expected to be made aware if the facility was going to be changing medication or starting any new medications so she could make an informed decision about whether she wanted Resident #2 to be getting them. The RP stated she had not been made aware of the new order for Melatonin by anyone at the facility. On 1/4/23 at 1:41 PM an interview with the DON indicated she entered the new physician's order for Resident #2's Melatonin on 9/28/22. She stated she had not been aware at the time this was something she needed to notify Resident #2's RP about. She stated she had not been aware of any system in place for notifying a resident or their RP of a new medication order. She went on to say Resident #2's RP had made it very clear since then that she wanted to be notified of any change in Resident #2's treatment orders. On 1/4/23 at 3:41 PM in a telephone interview Nurse #3 stated she had not entered the physician's order for Resident #2's Melatonin into her medical record. She went on to say while she	F 580	Party (RP) for all new medications are added to the general orientation for Nurses and/or the Director of Health Services (DHS) upon hire. Emphasis will be placed on the nurse who identifies the new skin integrity issue provides the physician notification and the nurse that takes off the new medication order will be responsible for notifying the Responsible Party (RP). Plans to monitor its performance to make sure that the solutions are sustained. The findings of the daily facility activity report will be brought to the monthly Quality Assurance Performance Improvement (QAPI) Committee meeting by the Director of Health Services (DHS) for review of physician notification of new skin impairments and Responsible Party (RP) notification of new medication orders monthly x 3 months or until substantial compliance is achieved. Date of compliance: 1/23/23	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345384	A. BUILDING _____ B. WING _____	C 01/04/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEATH-FARMVILLE	4351 SOUTH MAIN STREET FARMVILLE, NC 27828

(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 580	Continued From page 6 had administered it to her on 9/28/22 at 9:00 PM, she had not notified Resident #2's RP of the new medication because she had no way of knowing it was a new order. She further indicated it was her understanding that the nurse entering a new physician's medication order into a resident's record would be responsible for notifying either the resident or their RP of the new order. Nurse #3 stated if the nurse who entered the order had not been able to notify Resident #2's RP, she would have expected this to have been communicated to her in report so she could have done so. On 1/4/23 at 5:18 PM an interview with the Administrator indicated there was no facility protocol for notification of changes in medications. She stated either the resident, if they were capable of understanding, or the resident's RP should be made aware of any changes in treatment including a new medication order. She went on to say this would be a shared responsibility and she would expect the nurses to communicate amongst themselves to determine who would be responsible for making the notification.	F 580		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and	F 686		1/23/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345384	A. BUILDING _____ B. WING _____	C 01/04/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEATH-FARMVILLE	4351 SOUTH MAIN STREET FARMVILLE, NC 27828

(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 686	Continued From page 7 (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on record review and staff, Resident Representative (RP) and physician interviews the facility failed to obtain a wound treatment order when a new onset stage 2 (an open wound with skin loss) pressure ulcer was identified. This was for 1 of 3 residents (Resident #1) reviewed for pressure ulcers. Findings included: Resident #1 was admitted to the facility on 11/9/22 with a diagnosis of left humerus (upper arm bone) fracture. A review of the admission Minimum Data Set (MDS) assessment for Resident #1 dated 11/12/22 revealed she was moderately cognitively impaired. She required the extensive assistance of 2 persons for bed mobility. She was always incontinent of bowel and bladder. She was at risk for pressure ulcers. She had no unhealed pressure ulcers. A review of the comprehensive care plan for Resident #1 revealed a focus area initiated on 11/9/22 of at risk for skin breakdown. The goal was for Resident #1's skin to remain intact through the next review. An intervention was to report any signs of skin breakdown (sore, tender, red or open areas). A nursing progress note dated 12/7/22 at 12:15	F 686	Corrective action for the residents found to be affected by the deficient practice. Resident #1 no longer resides in the facility. Corrective action for other residents having the potential to be affected by the same deficient practice. All residents have the potential to be affected by the alleged deficient practice. The Director of Health Services (DHS) and the Skin Integrity Coordinator completed a 100% audit of all residents noted with a skin impairment and/or pressure ulcer to ensure there is a treatment order in place. The audit was completed on 1/19/23. There were 9 residents noted with a skin impairment. Of the 9 with a skin impairment, 5 were pressure ulcers. All skin impairments and/or pressure ulcers have a current physicians order in place. The Director of Health Services (DHS) and/or Interim Administrator began education to the Licensed Nurses on 1/17/23 regarding new onset of a skin impairment and the initiation of a physician□s order at the time the skin	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345384	A. BUILDING _____ B. WING _____	C 01/04/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEATH-FARMVILLE	4351 SOUTH MAIN STREET FARMVILLE, NC 27828

(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 686	Continued From page 8 PM written by Nurse #1 revealed Resident #1 had a new 2 inch area of skin breakdown to her sacral (bottom of spine) area. Nurse #1 padded the area and covered it with a "sacral heart" (a foam dressing in the shape of a heart). The facility wound treatment nurse was notified. On 1/4/23 at 3:17 PM a telephone interview with Nurse #1 indicated when she discovered the new open area of skin breakdown on Resident #1's sacrum, she covered it with a "sacral heart". She stated a "sacral heart' was a foam protective dressing in the shape of a heart. She went on to say did not think to notify a provider or get treatment orders for the wound, she just though she was supposed to notify the facility's wound treatment nurse. She went on to say she thought this nurse would take care of the rest. A review of a Wound Management Detail Report completed by the facility wound treatment nurse dated 12/8/22 at 3:12 PM revealed Resident #1's sacral wound measured 4.5 centimeters (cm) in length by 3.5 cm in width. There was a light amount of serous (clear, amber, thin and watery) exudate (drainage). A nursing progress note dated 12/8/22 at 6:30 PM written by Nurse #2 revealed she performed a skin observation. It further revealed Resident #1 had a pressure ulcer on her sacrum with partial skin loss and minimal drainage. The area had no depth. Nurse #2 applied barrier cream and a sacral dressing. Resident #1's RP was notified of the pressure ulcer and informed that the wound care nurse practitioner (NP) would be present in the facility on Monday 12/12/22 to assess the area and provide treatment orders. Resident #1's RP indicated his understanding of the information	F 686	impairment is noted. When a new skin impairment is noted, the Nurse identifying the new skin impairment will be responsible for the initiation of a treatment order of the newly identified skin impairment per the facility□s wound care formulary. When in question, call the provider on-call for order clarification and proceed as directed by the provider. Any Licensed Nurses not receiving the education due to scheduled time off or FMLA will be educated prior to next scheduled shift. Education has been added to licensed nurse orientation conducted by the Director of Health services and/or the staff educator. The Director of Health Services (DHS) was notified on 1/17/23 by the Interim Licensed Nursing Home Administrator (LNHA), to add the education regarding the initiation of treatment orders per the wound care formulary of new skin impairments to the general orientation for all licensed nurses. Systemic changes made to ensure that the deficient practice will not recur. The Director of Health Services (DHS) and/or Interim Administrator began education to the Licensed Nurses on 1/17/23 regarding new onset of pressure ulcers and physician treatment orders. When a new skin impairment is noted, the Nurse identifying the new skin impairment will be responsible for notifying the physician/physician extender and the initiation of a wound treatment order per	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345384	A. BUILDING _____ B. WING _____	C 01/04/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEATH-FARMVILLE	4351 SOUTH MAIN STREET FARMVILLE, NC 27828

(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 686	Continued From page 9 and stated he would be present on Monday 12/12/22 to speak with the NP. On 1/4/23 at 1:51 PM an interview with Nurse #2 indicated she was the facility wound treatment nurse. She stated on 12/7/22 she received a text message from Nurse #1 informing her Resident #1 had a new pressure ulcer on her sacrum. She went on to say she had not been in the facility at the time. She further indicated when she returned to work on 12/8/22 she did an assessment of Resident #1's sacral wound and completed the Wound Management Detail Report. She further indicated she had not notified a medical provider of Resident #1's new pressure ulcer or obtained any treatment orders for the wound that day. Nurse #2 stated she placed a protective dressing on the wound. She went on to say she notified Resident #1's RP of the new wound that same day and let him know Resident #1 would be seen by the facility wound NP when she came to the facility on Monday 12/12/22. She further indicated initially he had been okay with that, and then he became upset and wanted Resident #1 sent to the hospital to have her wound evaluated sooner. In a follow up interview on 1/4/23 at 3:19 PM Nurse #2 stated the protective dressing she placed on Resident #1's sacral wound on 12/8/22 was called a "sacral heart". She stated this was a foam protective dressing. She went on to say she could have called a provider to get treatment orders for the wound, but she knew the wound care NP was coming on Monday, so she just covered the area to keep it clean and dry. She stated she was not aware of any facility standing wound treatment orders that could have been initiated. Nurse #2 went on to say she thought it would be okay to keep the wound clean and dry until the wound NP saw Resident #1 on Monday	F 686	the facility□s wound care formulary. The Medical Director has signed and approved the use of the facility□s wound care formulary. When in question, call the provider on-call for order clarification and proceed as directed by the provider. Any Licensed Nursed not receiving the education due to scheduled time off or FMLA will be educated prior to next scheduled shift. Education has been added to licensed nurse orientation conducted by the Director of Health services and/or the staff educator. On 1/17/23 the Interim Licensed Nursing Home Administrator (LNHA) notified the Director of Health Services (DHS) and/or Nursing Leadership to review the daily activity report in MatrixCare (electronic health record system) to validate new skin impairments identified have physician treatment orders written. The Director of Health Services (DHS) was notified on 1/17/23 by the Interim Licensed Nursing Home Administrator (LNHA) that the review of the daily activity report in MatrixCare will be reviewed daily to validate new skin impairments identified have physician treatment orders written is added to the general orientation for Nurses upon hire with emphasis that the nurse who identifies the skin integrity issue initiates the treatment/order per the facility wound care formulary. The Director of Health Services (DHS) will audit the daily activity report daily for two weeks, then three times weekly for two weeks and then monthly times two	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345384	A. BUILDING _____ B. WING _____	C 01/04/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEATH-FARMVILLE	4351 SOUTH MAIN STREET FARMVILLE, NC 27828

(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 686	Continued From page 10 12/12/22. A nursing progress note dated 12/9/22 at 3:49 PM written by the Director of Nursing (DON) revealed Resident #1's RP expressed concern over the pressure ulcer on Resident #1's sacrum. She assessed Resident #1. An approximately 2 cm by 1 cm area of skin breakdown was present on Resident #1's sacrum. There was no bleeding. The area appeared pink. It appeared to be a stage 2 pressure ulcer. Resident #1 was not complaining of any pain. Her RP was requesting Resident #1 be sent to the hospital for evaluation of the wound by a physician. The DON offered Resident #1's RP a telehealth (computer video) visit in the facility with a medical provider but he refused. She explained to Resident #1's RP an NP would be present in the facility on Monday 12/12/22 to evaluate Resident #1's pressure ulcer but he refused. The DON would transfer Resident #1 to the hospital per her RP's request. On 1/4/22 at 2:42 PM an interview with the DON indicated she was called to Resident #1's room on 12/9/22 by her RP. She stated when she observed Resident #1's sacral pressure ulcer that day there was no dressing in place. She went on to say there had been no treatment orders in place for this wound. She further indicated she had not been made aware of the wound prior to that day. The DON stated Resident #1's RP had been very upset and insisted Resident #1 go out to the hospital to have her wound evaluated even after she offered him a telehealth visit with a medical provider. She went on to say she notified NP #1 of the wound and Resident #1's request she be sent to the hospital on 12/9/22 but did not obtain treatment orders for the wound at that time. She stated there was really no point in	F 686	months to ensure new skin impairments have a physician treatment order. Plans to monitor its performance to make sure that the solutions are sustained. The facility wound manager report will be brought to the monthly Quality Assurance Performance Improvement (QAPI) Committee meeting by the Director of Health Services (DHS) for review of physician notification monthly x 3 months or until substantial compliance is achieved. Date of compliance: 1/23/23	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345384	A. BUILDING _____ B. WING _____	C 01/04/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEATH-FARMVILLE	4351 SOUTH MAIN STREET FARMVILLE, NC 27828

(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 686	Continued From page 11	F 686		

getting treatment orders if Resident #1 was going to the hospital. The DON stated when Resident #1 returned from the hospital on 12/10/22 she did contact a provider to obtain treatment orders for the wound. She went on to say she was not aware of any facility standing wound treatment orders that could have been put in place. She further indicated she would have expected a medical provider to be contacted to obtain wound treatment orders immediately when Resident #1's new sacral pressure ulcer was first identified. The DON stated a lack of timely initiation of proper treatment orders for her sacral pressure ulcer could have put Resident #1 at risk for wound deterioration.

On 1/4/23 at 8:58 AM a telephone interview with Resident #1's RP indicated he had been very upset when he found out Resident #1 developed a pressure ulcer and had not been seen by a physician. He stated he felt that her waiting until Monday 12/12/22 to be seen was not good care. He went on to say when he saw Resident #1's pressure ulcer on 12/9/22 there was no dressing on it, and it didn't look like it had been treated. He further indicated he had her sent to the hospital so a doctor could look at it.

A review of Resident #1's hospital Emergency Room (ER) report dated 12/9/22 revealed she was in the ER for 15 hours from 12/9/22 until 12/10/22. She was seen for a stage 2 pressure ulcer to her sacrum. The area did not appear to be infected. No measurements were provided. Resident #1 was sent back to the facility.
A nursing progress note dated 12/10/22 at 9:30 AM written by the DON revealed Resident #1 returned from the ER. She assessed Resident #1's sacral pressure ulcer. She obtained

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345384	A. BUILDING _____ B. WING _____	C 01/04/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEATH-FARMVILLE	4351 SOUTH MAIN STREET FARMVILLE, NC 27828

(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 686	Continued From page 12	F 686		

treatment orders to apply a hydrocolloidal (a gel forming moisture retentive wound dressing) dressing to Resident #1's sacral wound and change this every 72 hours and as needed for soiling.

A physician's order for Resident #1 dated 12/10/22 revealed Wound Dressing for Sacral Area: Cleanse area with normal saline. Apply skin prep to surrounding intact tissue. Apply a hydrocolloid dressing to open area, cut to fit. Change every 72 hours or PRN for soiling. Change Saturday, Monday, Thursday. Once A Day; 07:00 AM - 03:00 PM.

On 1/4/23 at 2:14 PM a telephone interview with Physician (MD) #1 indicated she was Resident #1's facility physician. She stated she would have expected a medical provider to be notified when Resident #1's new pressure ulcer was first identified on 12/7/22. She stated a provider was available 24 hours a day. She went on to say this would have enabled treatment orders to be put in place in a timely manner to address Resident #1's wound care needs. She went on to say based on her knowledge of Resident #1's medical history she felt her sacral wound was not avoidable. MD #1 further indicated she didn't feel the delay in getting treatment orders caused any harm to Resident #1 or caused her sacral wound to worsen.

On 1/4/23 at 5:18 PM an interview with the Administrator indicated when Nurse #2 became aware of Resident #1's new sacral pressure wound, she should have made sure there were proper treatment orders put in place to care for the wound. She stated Nurse #2 should have done this either by using the facility formulary or

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345384	A. BUILDING _____ B. WING _____	C 01/04/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEATH-FARMVILLE	4351 SOUTH MAIN STREET FARMVILLE, NC 27828

(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 686	Continued From page 13 contacting a provider for treatment orders.	F 686		