STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345124	A. BUILDING _____ B. WING _____	C 03/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEALTH-ELKIN	560 JOHNSON RIDGE ROAD ELKIN, NC 28621

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced recertification and complaint investigation survey was conducted on 3/11/24 through 3/14/24. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID # YAN511.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey were conducted from 3/11/24 through 3/14/24. Event ID# YAN511. The following intake was investigated NC00213682. One (1) of the 6 complaint allegations resulted in deficiency.	F 000		
F 575 SS=C	Required Postings CFR(s): 483.10(g)(5)(i)(ii) §483.10(g)(5) The facility must post, in a form and manner accessible and understandable to residents, resident representatives: (i) A list of names, addresses (mailing and email), and telephone numbers of all pertinent State agencies and advocacy groups, such as the State Survey Agency, the State licensure office, adult protective services where state law provides for jurisdiction in long-term care facilities, the Office of the State Long-Term Care Ombudsman program, the protection and advocacy network, home and community based service programs, and the Medicaid Fraud Control Unit; and (ii) A statement that the resident may file a complaint with the State Survey Agency concerning any suspected violation of state or federal nursing facility regulation, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, and non-compliance with the advanced directives requirements (42 CFR part 489 subpart I) and requests for information regarding returning	F 575		4/10/24

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

Electronically Signed | 04/07/2024

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F 575	Continued From page 1 to the community. This REQUIREMENT is not met as evidenced by: Based on observations, resident and staff interviews, the facility failed to post the contact information for the State Survey Agency in an area accessible to residents and resident representatives and failed to post a statement that a resident may file a complaint with the State Survey Agency. This observation occurred for 2 of the 4 days of the recertification survey. Findings included: During tours of the facility on 3/12/24 at 4:07 PM and 3/13/24 at 10:20 AM, there was no information posted in the facility about how to contact the State Survey Agency or how to file a complaint with the State Survey Agency. A Resident Council group meeting was conducted on 3/13/24 at 2:30 PM. During the meeting, Resident #29 and Resident #58 stated they had seen some contact numbers on a board located on the wall on the 100 hall, but they were unsure if the contact information included the State Survey Agency. A tour of the facility was conducted with the Administrator on 3/13/24 at 2:45 PM. The Administrator verified the contact information for the State Survey Agency and process for filing a complaint was not posted on the board on the 100 hall and shared that typically information for contacting the State Survey Agency was posted on the board on the 100 hall. The Administrator explained the facility had recently taken some old information off the board and had replaced it with new information. The Administrator said the	F 575	The Administrator immediately posted the telephone number to the state survey agency on March 13th 2024 in the glass display wall cabinet on 100 hall. All other pertinent documents for State Agencies and advocacy groups such as Adult Protective Services for Surry County, Long Term Care Ombudsman, Medicaid Fraud Control Unit, and How to Apply for Medicaid and covered services can also be found in the same location. The cabinet will be kept locked with only the administrator and HR having the keys. Resident Town Hall Meeting conducted April 5th by Activity Director and information of the postings along with their location discussed. All other alert and oriented residents will be visited by activity director by April 10th and made aware of the postings as well. All new admissions will be given in writing where the postings are located during the admission paperwork by Admission Director and/or Social Service Director. Administrator and/or HR Director will monitor weekly for posting compliance times three then monthly thereafter for three consecutive months of sustained compliance then quarterly thereafter for one year. Date of Compliance April 10, 2024	

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F 575	Continued From page 2 facility had just "updated the board" and stated all staff were responsible to maintain the board where pertinent information was posted for residents.	F 575		
F 689 SS=D	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 observation, record review and resident, staff and physician interviews, the facility failed to secure smoking materials, specifically, a lighter and failed to assess a resident's ability to smoke independently for 1 of 1 resident (Resident #2) reviewed for smoking. Findings included: Resident #2 was admitted to the facility on 04/18/23 with diagnoses that included cerebral infarction due to embolism of left middle cerebral artery, hemiplegia and hemiparesis following cerebral infarction affecting right dominant side, idiopathic epilepsy, and epileptic syndromes with seizures of localized onset, intractable, without status epilepticus (also called refractory, uncontrolled, or drug-resistant epilepsy), repeated falls, and vascular dementia, moderate, with other behavioral disturbance.	F 689	Resident #2 no longer resides in facility. The Administrator, Director of Health Services, Skin Integrity Nurse, Assistant Director of Nursing, medical records director, and certified dietary manager checked 100% of the resident rooms for smoking material on March 12, 2024 with no smoking materials being found. Staff education for all employees on Smoke free policy with emphasis being placed on "no smoking materials in resident rooms or in their possession. This will be completed by Director of Health Services, Assistant Director of Health Services, Administrator and Clinical Competency Coordinator by April 10th 2024.	4/10/24

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F 689	Continued From page 3 A review of the observation for smoking assessment dated 04/18/23 revealed the facility had marked "no" on the smoking assessment form, indicating Resident #2 did not smoke. A review of the most recent quarterly minimum data set (MDS) dated 01/05/24 for Resident #2 revealed the resident had severe cognitive impairment. Resident #2 had impairment on both his upper and lower extremity and he was independent with setup/supervision for his activities of daily living. The MDS also revealed the resident was independent with ambulation. A review of Resident #2's care plan dated 01/15/24 revealed the problem area as the Resident used tobacco cigarettes. The goal was for the Resident to not have an injury related to smoking through the next review target date of 04/16/2024. The intervention for this goal was to offer a smoking apron to the Resident when he smoked. During the entrance conference on 03/11/24 at 10:10 AM the Administrator revealed the facility was a "no smoking" campus, but they did have one resident, Resident #2, who was permitted to smoke to deter aggressive behaviors. On 03/12/24 at 4:24 PM an interview with the Director of Nursing (DON) stated Resident #2 was a smoker and he smoked independently. The DON stated the observation for smoking assessment was incorrectly marked "no" on admission on 04/18/23. On 03/12/24 at 4:38 PM an interview was conducted with Nurse #1, and she stated Resident #2 kept his own smoking materials on	F 689	The Admission Director and/or Social Service Director will review the Smoke Free Policy for all newly admitted residents and/or responsible party. The signed copy will then be uploaded in Matrixcare. The Director of Health Services and Nurse Managers completed a new smoking observation for all in-house residents on March 14, 2024 to accurately reflect their smoking status. The Licensed Nurse completes all new admission smoking observations to accurately reflect their smoking status and to remind them of the facilities smoke free environment. All new admissions will be monitored for signed smoking policy in matrix and completion of smoking assessments on admission by Administrator and/or DHS weekly times three then monthly thereafter until 3 consecutive months of sustained compliance is achieved then quarterly, Administrator will present the analysis of the findings of smoking observations and smoking policy to the Quality Assurance Improvement Committee monthly times three consecutive months of compliance the quarterly for 1 year thereafter. Date of Compliance April 10, 2024	

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F 689	Continued From page 4	F 689		

himself.

On 03/12/24 at 4:40 PM an interview was conducted with a Nurse Aide #1 (NA) on Resident #2's assigned hall. When asked where Resident #2 kept his smoking materials she stated, "That is a [Administrator] question." The NA #1 stated she thought it could be possible the nurse kept them and gave them to him when he wanted to smoke.

An in-room interview was conducted with Resident #2 on 03/12/24 at 5:00 PM and he stated he kept his cigarettes and lighters in his room. He turned on the light and indicated his cigarettes were on the floor by bed. On the floor by the bed was a clear plastic container with a lid and no lock. The container contained multiple loose cigarettes and a lighter inside, and 4-6 loose cigarettes were observed on the top of the container.

On 03/12/24 at 5:35 PM an interview was conducted with the Administrator, and she stated a smoking assessment should have been done on admission and then quarterly. She further stated the resident was admitted in April, had behaviors that included attempts to exit the facility. The Administrator said the resident's sister advised the facility if Resident #2 could smoke his behaviors would decrease. The Administrator added they tried nicotine patches and vape pens but Resident #2 refused. She stated they started allowing Resident #2 to smoke in May 2023. The Administrator stated she kept Resident #2's smoking materials and apron in her office. She added she allowed Resident #2 to keep a couple of cigarettes on his person to placate him. The Administrator said when Resident #2 wanted to smoke, he would inform

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F 689	Continued From page 5 staff. Staff would then take Resident #2 to the courtyard and place a smoking apron on him and light his cigarette. When informed that Resident #2 had cigarettes and a lighter in his room, the Administrator and this Surveyor went to the Resident's room. Resident #2 showed this surveyor and the Administrator the cigarettes and lighter. Resident #2 gave the Administrator the lighter and she took him to the courtyard to smoke. A follow-up interview with the Administrator was conducted on 03/14/24 at 4:48 PM. She said the Resident should never have had a lighter in his possession. The Admistrator stated that Resident #2 had been accepted to a facility that allowed smoking.	F 689		