STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	425140	A. Building B. Wing	04/28/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pruitthealth- Moncks Corner	505 South Live Oak Drive Moncks Corner, SC 29461

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33938 Based on interview and record review, the facility failed to develop and implement a Baseline Care Plan for each resident that includes the instructions needed to provide effective and person centered care of the resident that meet professional standards of quality care for one (1) of one (1) residents reviewed for care plans out of 29 sampled residents (Resident #96). Findings include: Review of the facility's Care Plan policy, most recently revised 10/5/17, revealed Scope: Baseline Care Plan: Must include the minimum healthcare information necessary to properly care for each patient/resident immediately upon their admission, which would address patient/resident specific health and safety concerns to prevent decline or injury, and would identify needs for supervision, behavioral interventions, and assistance with activities of daily living as necessary. Procedure: New Admission Baseline Plan of Care: Upon a new admission, a baseline care plan will be developed by the admitting nurse/nurses in conjunction with other Interdisciplinary Department Team (IDT), the patient/resident and/or patient/resident representative. The baseline care plan should be initiated in 24 hours and will be completed and implemented within 48 hours of admission. Resident #96 was admitted to the facility on [DATE] from an acute care hospital for skilled nursing services to include Speech Therapy (ST), Physical Therapy (PT) and Occupational Therapy (OT), with the intention of returning to an Assisted Living Facility (ALF), with primary diagnoses of Acute Kidney failure, Sepsis, Urinary Tract Infection (UTI), Dysphagia, Dementia and Malnutrition. Review of the Admitting Physician's Orders dated 2/3/21 indicated orders for amoxicillin capsule 500 milligrams (mg) one (1) by mouth (po) every eight (8) hours for sepsis/UTI. An order for Occupational Therapy (OT) five (5) times a week x four (4) weeks for generalized weakness. An order for Physical Therapy (PT), five (5) times a week x four (4) weeks for sepsis and UTI and generalized weakness. An order for Speech Therapy (ST) five (5) times a week x six (6) weeks for communication deficits and dysphagia. Also orders for behavior monitoring every shift, and regular diet with puree food. Review of the Admission Minimum Data Set (MDS) assessment dated [DATE], revealed that Section V0200 Care Area and Care Planning indicated the following care areas triggered: Cognition, communication, urinary incontinence, psychosocial wellbeing, mood state, behavioral symptoms, activities, falls, nutrition, dehydration/fluid maintenance, dental and pressure ulcer. (continued on next page)

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

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Further review of Resident #96's Care Plan revealed that on 2/11/21 there was one (1) care planned intervention for behaviors (seven (7) days after admission). The clinical record lacked evidence that any other problems were added to his/her care plan. A review of Resident #96's clinical record revealed a note titled Care Conference with a family note, dated 2/8/21, indicated Resident #96 cannot ambulate independently and needs assistance with all Activities of Daily Living and is presently receiving Speech Therapy (ST), Physical Therapy(PT), and Occupational Therapy(OT) to increase mobility, balance, and cognition. On 4/28/21 at 10:30 a.m., an interview with the Director of Nursing (DON) indicated that the admitting nurse should do the baseline care plan on admission to include the admitting diagnosis and should be reviewed the next day at morning meeting, stating, but we obviously didn't review Resident #96. On 4/28/21 at 10:55 a.m., an interview with the MDS Coordinator indicated the baseline care plan should be done within 48 hours of admission to include the resident's admitting diagnosis. The MDS Coordinator also stated the care plan was reviewed during the Professional Advisory Committee (PAC) meeting by the Unit Manager and it was turned into a comprehensive care plan on day 21. On 4/28/21 at 11:15 a.m., an interview with the Nurse Navigator in the presence of four (4) surveyors indicated the baseline care plan was supposed to be completed within 48 hours of admission. The Nurse Navigator confirmed that the admitting diagnosis/concerns on admission should be included in the baseline care plan. During an interview on 4/28/21 at 11:30 a.m. with the Administrator, he/she indicated baseline care plans were to be completed upon admission and discussed in the morning meeting every morning and reviewed at that time, but Resident #96 obviously got by us all.

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33938 Based on observation, record reviews, interviews, and review of facility policy, the facility failed to ensure that the resident's environment remained free of accident hazards as possible and that the resident received adequate supervision as well as assistance to prevent accidents for one (1) of 27 sampled residents (Resident #77). The facility was aware Resident #77 exhibited confusion, ambulated via rolling walker, and had an un-steady gait, however failed to ensure the residents safety by leaving a wheelchair in a shared bathroom, resulting in a fall with fracture to the left scapula. Findings include: Review of the policy titled Occurrence Reduction Program Fall Risk Observation Form, dated 1997 and revised 11/21/2017, revealed the Policy Statement This healthcare center recognizes that due to the frailty of the patients/residents served, there is an increased risk of occurrences that may result in injury to the patient/resident and/or others. In an effort to prevent occurrences, each patient/resident will be assessed for risk and appropriate and realistic interventions will be implemented upon identification of risk and after a fall. These interventions will be included in the care plan. SCOPE: This policy applies to the staff at the healthcare center. PROCEDURE: Admission/Readmission: 1. All patients/residents will have a score Fall Risk Observation Form completed. 2. All patients/residents will be assessed utilizing the Fall Risk Observation Form upon admission/readmission by admitting licensed nurse. Fall Risk Observation Form is available in AHT/LTC electronically or paper copy. E.H.R. facilities should be using the Fall Risk Observation Form electronically and in the event that the electronic documentation is not available, the Fall Risk Observation Form is located in the Policy Tech Software. 3. The licensed nurse will develop an individualized fall care plan with appropriate interventions upon admission/readmission regardless of score on Fall Risk Observation. 4. All new admissions/readmissions will be reviewed at the next Weekly Occurrence Reduction Committee Meeting. Guidelines to be Used: 1. When the patient/resident is admitted to the healthcare center the fall risk assessment will be completed and it will generate appropriate interventions, which could include: (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	-Frequent reorienting and repetitively reinforcing use of the call bell, which is placed within reach -Reassessing for a clutter-free, well lighted environment -Adjusting of bed to its lowest position -Reinforcing use of assistive devices -Assessing for safe footwear -Monitoring use of eyeglasses and hearing aid, if applicable -Using a rehabilitation screen, if appropriate -Instituting bowel/bladder routine program, as appropriate -Conducting a medication review -Consultation with attending physician regarding medication or environmental factors as appropriate -Evaluating the need for an adjustment in patient/resident's daily activity schedule -Educating patient/resident's family/significant other regarding patients/resident's risk of falls and the interventions implemented and encouraging family assistance and support. 2. Quarterly & Significant Change: -A score Fall Risk Observational Form will be completed on all patients/residents quarterly and with significant change (decline or improvement). -If a patient/resident scores greater than 10 on the score Fall Risk Observation Form, an individualized fall care plan will be implemented. -Patients/residents will be placed on the Occurrence Reduction Program as indicated. Determining Placement of Patients/Residents on Occurrence Reduction Program: If a patient/resident has had a fall in the past 30 days regardless of injury or fall risk assessment score he/she will be placed on the Occurrence Reduction Program with appropriate interventions as indicated. -One fall with or without injury -A skin tear requiring the physician intervention and treatment such as stitches, staples, etc. -Three skin tears in a 30- day period, regardless of type of treatment required. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Review of the clinical record revealed Resident #77 was admitted to the facility on [DATE]. The resident was assessed on the Quarterly Minimum Data Set (MDS) assessment, dated 10/2/2020, to have diagnoses of Type 2 Diabetes Mellitus, Unspecified Complications (primary), Unspecified Fracture of Left Femur, (admission) Unspecified Dementia without Behavioral Disturbance, Muscle Weakness, (generalized), Other Encephalopathy, Other Abnormalities of Gait and Mobility, Unsteadiness on Feet, Cognitive Communication Deficit, History of Falling, Pain in Left Hip, Primary Osteoarthritis, Stress Fracture Pelvis, Fracture of Unspecified Part of Capula Left Shoulder, Hyperlipidemia, Essential Primary Hypertension, Hypothyroidism, Chronic Kidney Disease Stage 3, and Multiple Fractures of Ribs Right Side. Resident #77 had a Brief Interview for Mental Status (BIMS) score of 11 of 15 indicating mildly impaired cognition. The MDS revealed Resident #77 did not participate in skilled therapies or restorative nursing programs during the assessment review period. Under Section G functional status, the resident was coded as requiring supervision from staff for all activities of daily living including toileting and the use of mobility devices such as cane/crutch and walker. Review of the Care Plan dated 7/3/2020 with revision date of 12/28/2020, revealed Resident #77 had fallen and was at risk for further falls due to generalized weakness and painful knees, and poor safety awareness. Resident #77 required set up to total assistance with ADL care and used a rolling walker when ambulating. Resident #77 had a fall with left scapula fracture and was sent to (ER) emergency room for evaluation and treatment. Under the goals section, target date 7/9/21, the resident would not sustain any life-threatening injury from falls though the next review. Resident's ADL needs would be met, and independence potential maximized through next review. Under the approaches section, staff were to ensure non-skid socks were on at all times when shoes were not being worn. The ADL flow sheet would be completed every shift. Staff would provide assistive devices as needed, and Physical Therapy (PT) and Occupational Therapy (OT) would evaluate and treat. Set up resident for ADL's if needed and notify the physician of changes. Review of the facility's John Hopkins Fall Assessment Tool, dated 7/3/2020, revealed Resident #77 had a total fall risk score of (15) fifteen, indicating the resident was at high risk of falls. Review of the facility's John Hopkins Fall Assessment Tool, dated 12/28/2020, revealed Resident #77 had a total fall risk score of (0) zero, indicating the resident was at a low risk for falls for not having a fall in the previous (6) six months. Review of the facility's John Hopkins Fall Assessment Tool, dated 3/10/21, revealed Resident #77 had a total fall risk score of (50) fifty indicating the resident was assessed to be a very high risk for falls. Review of the Nursing Progress Note dated 12/28/2020 at 6:22 a.m. for Resident #77 revealed He/she was found on the floor by the bathroom door. Stated he/she grabbed for the door and fell found on bottom sitting. Head to toe assessment yielded no visible injuries and resident family called. Also called physician and is aware of fall with no injuries at present. Resident on neurological checks will continue to monitor stable at present time. Review of the Nursing Progress Note for Resident #77 dated 12/28/2020 at 12:14 p.m. revealed Resident complained of pain in left shoulder, noted small bruise, that is alleviated by PRN (as needed) Tylenol. placed order for left shoulder x-ray. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Review of the Nurse Practitioner Order, dated 12/28/2020 at 3:45 p.m., revealed new order send to emergency room (ER) for evaluation and treat related to left scapula fracture. Spoke with NP. Also notified family of fracture. Review of the Nursing Progress Note for Resident #77 dated 12/28/2020 at 4:35 p.m. revealed send to ER for evaluation via personal care. Left facility at 4:35 p.m. Review of the Nursing Progress Note for Resident #77 dated 12/28/2020 at 8:10 p.m. revealed returned from the hospital with no new orders. Resident has a left arm sling with diagnosis of Scapular Fracture. Resident is resting in bed with call light in reach. Review of the Nurse Practitioner Order for Resident #77 dated 12/29/2020 at 10:30 a.m. revealed a new order noted for Tramadol 50 milligrams (mg) one (1) tablet po (by mouth) q 6 (every six) hours as need for moderate pain related to left scapular fracture. Ortho appointment scheduled for 12/30/2020 at 10:00 a.m. Left message with family to return call. Review of the facility's Accident or Incident Occurred Report, dated 12/28/2020, revealed Resident #77 had an incident occur in the resident's bathroom. Resident had initially stated that he/she slipped and fell , but after investigation, it was found that he/she tripped over another resident's wheelchair that was left in their shared bathroom. Resident #77 later reported pain and an X-ray was done in the facility. He/she was sent to the emergency room (ER) for evaluation and returned with a diagnosis of left scapula fracture. He/she returned with orders for orthopedics follow up, a sling and pain medication. He/she went to orthopedics on 12/30/2020. Review of the [NAME] St. [NAME] Hospital Report, dated 12/28/2020, revealed Resident #77 was diagnosed with a Left Scapula fracture, a break in the large bone behind the shoulder blade. The facility did not provide any documented evidence of in-services related to ensuring trip hazards or equipment were not left in resident's rooms to prevent falls. Observation of Resident #77 on 4/26/21 at 9:40 a.m., revealed the resident was standing up in his/her room moving about using a rolling walker and had on grey tennis shoes. When queried about his/her fall, Resident #77 stated someone pushed me off the subway. Resident #77 appeared confused and not sure of what happened. Observation of Resident #77 on 4/27/21 at 9:36 a.m. revealed he/she was sitting in the dayroom with a rolling walker in front of him/her and had on new grey tennis shoes. Observation of Resident #77 on 4/28/21 at 9:00 a.m. revealed he/she was sitting in his/her chair in the room with clothes laid out on the bed, the rolling walker was close by him/her and he/she had on a pair of blue tennis shoes. Another observation on 4/28/21 at 10:45 a.m. revealed the resident was ambulating down the hallway using the rolling walker with blue tennis shoes on. An interview was conducted on 4/26/21 at 2:23 p.m. with Certified Nursing Assistant (CNA) #2 which revealed I would consider Resident #77 a fall risk at times and other times no. I was told to make sure he/she has on non-skid socks and shoes; and have been in-serviced to ensure there are no trip hazards in the resident's rooms. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	An interview was conducted on 4/26/21 at 2:33 p.m. with Certified Nursing Assistant (CNA) #1 that revealed Resident #77 is considered a fall risk and uses a walker for ambulation. The CNA's are responsible for making sure that all trip hazards are out of bathrooms. Sometimes night shift will leave wheelchairs in the bathrooms after toileting another resident, they forget it's there. An interview was conducted on 4/26/21 at 2:55 p.m. with Licensed Practical Nurse (LPN) #2, which revealed I remember Resident #77 had already exited the bathroom and was sitting on the bed. The resident stated his/her shoulder was hurting and that he/she fell in the bathroom. I looked in the bathroom and seen the resident from the adjoining rooms wheelchair wedged in between the door and that is what he/she tripped over. The LPN stated, There was another resident on the toilet and Resident #77 was trying to go into the bathroom as well. When shown the incident report by the surveyor and queried about the what really happened; the LPN stated, I would agree that what I told you is different from what is stated in the report. The LPN further revealed during the time of the fall he/she was the only unit manager responsible for (2) two units, having one (1) unit manager may have interfered with the interventions to prevent Resident #77's fall. An interview was conducted on 4/26/21 at 3:14 p.m. with the Director of Nursing (DON) that revealed Resident #77 had a history of falls prior to being admitted to the facility. On 12/28/2020, I remember the resident stating that he/she slipped on something, the CNA from the night shift left another resident's wheelchair in the shared bathroom and Resident #77 tripped over it and fell . The DON stated, I did verbal education to the CNA that left the wheelchair in the bathroom, but I did not conduct an in-service. It's my expectation that staff ensure there are no trip hazards in the bathrooms; and I follow up with them to make sure. An interview on 4/27/21 at 9:28 a.m. with the Nurse Practitioner (NP) revealed Resident #77 was considered a high fall risk and because of that he/she was on the NP's list to be seen three (3) times per week. An interview on 4/27/21 at 12:20 p.m. with the Administrator revealed it is his/her expectation that staff absolutely keep the resident's rooms and bathrooms clear of trip hazards to prevent falls. The Administrator stated, I am not sure if the wheelchair in Residents #77's bathroom was folded or open, but it's inappropriate to have it in there.

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F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician. 33938 Based on interview, and review of a position description, the facility failed to hire an individual to direct the dietary department that meets the qualifications of a Certified Dietary Manager (CDM). The facility did not have a qualified Food Service Director managing the kitchen. Findings include: An initial tour of the kitchen was conducted on 4/25/21 at 11:59 a.m. A request was made of the kitchen staff to speak to the Food Service Director. The dietary staff indicated there was currently no one serving as a Food Service Director. In an interview on 4/26/21 at 2:40 p.m. with the Administrator, he/she stated the Food Service Director walked off the job about a week and a half ago. He/she acknowledged there was no one qualified in the kitchen to take over. He/she stated he/she had an add online for the position but had not found a qualified candidate. The Administrator also stated he was trying to get Dietary Aide #2 to take the job and he/she would then enroll them in the Certified Dietary Manager course. In an interview on 04/27/21 at 12:18 p.m., with the Consultant Dietitian s/he stated the company didn't have another Food Service Director to help fill the position right now. S/he stated the other facilities had suffered due to COVID-19 and staffing had been difficult. In an interview on 04/27/21 at 3:00 p.m., with Dietary Aide #2, s/he stated s/he was approached about the Food Service Director position and was considering it. S/he stated s/he could do the food order and the schedule. Review of the facility's Position Description, dated 9/08, documented the minimum licensure/certification required by law for Dietary Manager: Must be certified in an accredited course in dietetic training approved by the Association of Nutrition and Foodservice Professionals and/or the Academy of Nutrition and Dietetics.