

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  345124	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  03/14/2024
NAME OF PROVIDER OR SUPPLIER  Pruitthealth-Elkin		STREET ADDRESS, CITY, STATE, ZIP CODE  560 Johnson Ridge Road Elkin, NC 28621	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0575</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Many</p>	<p>Post a list of names, addresses, and telephone numbers of all pertinent State agencies and advocacy groups and a statement that the resident may file a complaint with the State Survey Agency.</p> <p>37983</p> <p>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.</p> <p>Findings included:</p> <p>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.</p> <p>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.</p> <p>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 facility had just updated the board and stated all staff were responsible to maintain the board where pertinent information was posted for residents.</p>

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 45276</p> <p>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.</p> <p>Findings included:</p> <p>Resident #2 was admitted to the facility on [DATE] 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.</p> <p>A review of the observation for smoking assessment dated [DATE] revealed the facility had marked no on the smoking assessment form, indicating Resident #2 did not smoke.</p> <p>A review of the most recent quarterly minimum data set (MDS) dated [DATE] 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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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 himself.</p> <p>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.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>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.</p> <p>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 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.</p> <p>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 Administrator stated that Resident #2 had been accepted to a facility that allowed smoking.</p>		