

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345182	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/15/2024
NAME OF PROVIDER OR SUPPLIER Pruitthealth-Sealevel		STREET ADDRESS, CITY, STATE, ZIP CODE 468 Highway 70 East Sealevel, NC 28577	

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 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48230</p> <p>Based on observations, staff and resident interviews, the facility failed to keep 3 of 8 resident rooms (Rooms #204, #206 and #706) and 4 of 4 day rooms at a temperature of 71 degrees to 81 degrees Fahrenheit (F).</p> <p>Findings included:</p> <p>An observation of the thermostat in the 700 hall day room on 8/14/24 at 8:40 AM revealed the temperature to be 61 degrees F. The thermostat was set for the room to be 72 degrees F. The room felt cold. A resident in a wheelchair was in the room and she stated her hands were cold.</p> <p>An observation of the thermostat in the 400 hall day room on 8/14/24 at 12:54 PM revealed the temperature to be 65 degrees F and the room felt cold. The thermostat was set for the room to be 72 degrees F.</p> <p>An observation of the thermostat in the 200 hall day room on 8/14/24 at 1:05 PM revealed the temperature to be 64 degrees F and the room felt cold. The thermostat was set for the room to be 71 degrees F.</p> <p>An observation of the thermostat in the 100 hall day room on 8/14/24 at 1:15 PM revealed the temperature to be 66 degrees F and the room felt cold. The thermostat was set to 71 degrees F.</p> <p>An interview with 1 of the 3 residents who resided in room [ROOM NUMBER] on 8/15/24 at 11:30 AM, revealed his room was cold so he was wearing a sweater. He stated the hallway was cold as well. Resident #1 revealed he did not know how to operate the thermostat in his room. He further revealed he had not asked staff to adjust the thermostat. An observation of the thermostat in the room revealed the temperature to be 69 degrees F.</p> <p>During an interview with 1 of the 3 residents who resided in room [ROOM NUMBER] on 8/15/24 at 11:35 AM, he stated his room was too cold. He further stated he was wearing a quilted jacket to keep warm. The resident revealed the hallway was colder than his room and he did not know how to operate the thermostat in his room. Resident #2 had not asked staff to adjust the thermostat. An observation of the thermostat in the room revealed the temperature to be 68 degrees.</p> <p>(continued on next page)</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 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview with 1 of the 3 residents who resided in room [ROOM NUMBER] on 8/15/24 at 11:45 AM, he stated his room was too cold, but he did not know how to work the thermostat in his room. He further stated he wore extra layers to keep warm. He had not asked staff to adjust the thermostat. An observation of the thermostat in the room revealed the temperature to be 68 degrees.</p> <p>An interview with Nurse #1 on 8/14/24 at 8:30 AM revealed the 700 hallway and day room were very cold today and she had called the Maintenance Director to tell him the rooms were cold. She stated the building had problems with being too cold since it opened in March. Nurse #1 further stated she did not know how to operate thermostats in resident rooms and the day room thermostat was locked so it could only be accessed by Maintenance.</p> <p>Follow up observations conducted on 8/15/24 from 2:00 PM until 2:12 PM revealed the temperature to be 72 degrees F in room [ROOM NUMBER], 72 degrees F in room [ROOM NUMBER], and 72 degrees F in room [ROOM NUMBER].</p> <p>Follow-up observations were conducted with the Maintenance Director on 8/15/24 from 2:34 PM to 2:44 PM of the temperatures in the day rooms on the 100 hall, 200 hall, 400 hall, and 700 hall. The observation of the 700 hall dayroom revealed the air temperature to be 68 degrees F, tested by temperature gun in the center of the room pointed straight ahead. The observation of the 400 hall dayroom revealed the air temperature to be 67 degrees F, tested by temperature gun in the center of the room pointed straight ahead. The observation of the 200 hall dayroom revealed the air temperature to be 66 degrees F, tested by temperature gun in the center of the room pointed straight ahead. The observation of the 100 hall dayroom revealed the air temperature to be 65 degrees F, tested by temperature gun in the center of the room pointed straight ahead.</p> <p>In an interview with the Maintenance Director on 8/14/24 at 8:45 AM in the 700 hall day room, he revealed the facility had been having issues with the heating, ventilation and air conditioning (HVAC) since the building opened in March of 2024. He stated he called the company that installed the system about 3 times a month with temperature control issues that resulted in parts of the system having to be replaced or repaired. He had just contacted them regarding the 700 hall day room at 8:40 AM, on the date of the interview.</p> <p>During a follow-up interview with the Maintenance Director on 8/15/24 at 11:55 AM he was made aware Resident's #1, #2 and #3 had concerns they were cold and their room temperatures were below 71 degrees F. He stated he would go to see them. The Maintenance Director stated on 8/15/24 at 1:54 PM he had adjusted the thermostats for Resident's #1, #2 and #3.</p> <p>In an interview with the Administrator on 8/15/24 at 3:00 PM she stated she was aware the building was having trouble with the HVAC system and that the Maintenance Director had the company that installed it come in at least twice a month.</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48230</p> <p>Based on observations and staff interviews the facility failed to secure resident medications stored in an unattended medication cart and left medications on top of the cart in a unit with residents with dementia (800 hall medication cart), for 1 of 4 medication carts.</p> <p>The findings included:</p> <p>A continuous observation was conducted of the 800 hall medication cart, on a unit with residents with dementia, on 8/15/24 from 11:40 to 11:45 AM, followed immediately by an interview with Nurse #1. The cart was parked midway down the hall near room [ROOM NUMBER], facing out. The cart was not visible from the nurse's station. The medication cart was observed to have the red dot on the push lock visible, which meant the push lock was not engaged. There was no staff member with the medication cart. Nurse #1 came out of resident room [ROOM NUMBER] which was approximately 2 doors down the hall on the opposite side. She returned to the medication cart at 11:45 AM. Nurse #1 opened the top drawer without having to unlock the cart. During an interview with Nurse #1 when she returned to the cart, she stated she left the medication cart unlocked. She further stated the cart should be locked any time she was not using it. During the interview, and upon closer observation, it was observed there was an unattended medication cup of pills on top of the unattended medication cart. Nurse #1 stated she should have locked the pills in cart before she walked away.</p> <p>An interview with the Administrator was conducted on 8/15/24 at 3:00 PM and she revealed medication carts should not be unlocked unless the nurse was using it. The Administrator stated the nurse assigned to that medication cart was responsible for it for their entire shift. She further stated medication should not be left unattended and the nurse should lock them in the cart if not administering them immediately.</p>		