

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  345384	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  08/08/2024
NAME OF PROVIDER OR SUPPLIER  Pruitthealth-Farmville		STREET ADDRESS, CITY, STATE, ZIP CODE  4351 South Main Street Farmville, NC 27828	

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 0626</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Permit a resident to return to the nursing home after hospitalization or therapeutic leave that exceeds bed-hold policy.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41009</b></p> <p>Based on observations, record review and resident, family, staff, Long Term Care Ombudsman, and hospital Emergency Department (ED) Case Manager interviews, the facility failed to allow a resident (Resident #23) to return to the facility to the first available bed after he was transferred to the hospital and cleared by a psychiatric evaluation to return to the facility on [DATE]. The facility refused readmission, and the resident remained in the in the hospital Emergency Department until 7/27/23 when the State Agency and Long Term Care Ombudsman intervened. This was for 1 of 2 residents whose discharge was reviewed.</p> <p>Findings included:</p> <p>Resident #23 was admitted to the facility on [DATE] with a diagnosis of dementia.</p> <p>A review of Resident #23's care plan revealed in part a focus area initiated on 4/17/23 related to Resident #23 experiencing agitation when he was brought out of his room. The goal was to avoid bringing Resident #23 out of his room. The intervention was that if Resident #23 needed to be brought out of his room for deep cleaning, to sit Resident #23 in his wheelchair outside his room door.</p> <p>A review of Resident #23's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed he was severely cognitively impaired. He exhibited physical behavioral symptoms directed towards others such as hitting and scratching, and verbal behavioral symptoms directed towards others such as screaming and cursing on 4-6 days of the look back period of the assessment. He exhibited physical behavioral symptoms not directed towards others on 4-6 days of the look back period. He rejected care on 1-3 days of the look back period of the assessment. Resident #23 required the maximal assistance of a helper to go from lying to sitting on the edge of the bed. He did not walk during the assessment period.</p> <p>A review of a nursing progress note for Resident #23 dated 7/25/23 at 3:12 PM written by Nurse #1 revealed the nurse was informed that Resident #23 was in a neighboring residents' room (Resident #33), which was connected to Resident #23's room by an adjoining bathroom. He was sitting on the end of her (Resident #33's) bed. When an attempt was made to redirect Resident #23 back to his room, Resident #23 became agitated, swung his arms at staff, grabbed the window blinds and began to bang the blinds against the window. Resident #23's family member was called in an effort to calm Resident #23 down, but this was unsuccessful. Emergency Medical Services (EMS) was called, and Resident #23 was taken to the hospital for an evaluation.</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 0626</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 8/6/24 at 8:41 AM Resident #23 was observed asleep in his room. He did not respond to attempts to speak with him.</p> <p>On 8/6/24 at 11:49 AM an interview with Nurse #1 indicated she recalled the incident with Resident #23 that occurred on 7/25/23. She stated Resident #26 did not usually walk, but on this occasion had gone into the bathroom that his room shared with an adjoining room, became confused, and exited into another resident's room (Resident #33) instead of his own. Nurse #1 stated Resident #23 had been found sitting on the end this resident's bed. She went on to say she ensured the other resident (Resident #33) was safe by having someone assist her into the activity room. She reported when an attempt was made to redirect Resident #23 back into his room, he became very agitated, got up, and started banging the window blinds against the window. She went on to say she attempted to contact Resident #23's family member to help calm him down. Nurse #1 stated when this was not successful, EMS was called and Resident #23 was taken to the ED for an evaluation. She reported the other resident (Resident #33) was alert and oriented and been very understanding and not upset by the incident at the time.</p> <p>On 8/5/24 at 11:05 AM an interview with Resident #33 indicated she recalled the incident on 7/25/23 when Resident #23 sat on the end of her bed. She stated she had not been upset or afraid and had not been hurt during the incident. She reported this was the only incident she ever had involving Resident #23.</p> <p>A review of a nursing progress note for Resident #23 dated 7/25/23 at 5:58 PM written by the facility's Director of Nursing (DON) revealed she received a call from the hospital regarding Resident #23. It further indicated she told the hospital Resident #23 would need to have a psychiatric evaluation to determine if he could return to the facility or if he might be a better fit at another facility.</p> <p>On 8/6/24 at 12:26 PM an interview with the DON indicated Resident #23 had multiple interventions in place regarding his behaviors. She stated usually if his family member was involved when he became agitated, he could be calmed and reassured. She reported on 7/25/23, this had not been the case. The DON further indicated she had felt that for Resident #23's safety and the safety of other residents he needed to be evaluated in the hospital to determine if he should remain at the facility. She reported with regards to Resident #23 returning to the facility, there would not have been just one person involved in making this decision. She stated this would have involved the interdisciplinary team.</p> <p>A review of a hospital psychiatric evaluation for Resident #23 dated 7/25/23 at 7:50 PM revealed after Resident #23 had an episode of slamming the blinds in another patient's room, the nursing facility had him taken to the Emergency Department (ED) and refused to take him back until a psychiatric evaluation was done. Resident #23 did not appear to be a danger to himself or others and did not meet the criteria for psychiatric hospitalization . Resident #23's disposition (placement) would be turned back over to the ED.</p> <p>A review of a Notice of Termination/Discharge with appeal rights dated 7/27/23 revealed in part Resident #23 was being discharged from the nursing facility because it was necessary for his welfare and his needs could not be met at the facility. It further revealed the safety of individuals in the facility was endangered because of Resident #23's clinical or behavioral status. The notice was signed by the nursing facility's Administrator #2 and indicated a copy of the notice had been sent to the LTC Ombudsman.</p> <p>(continued on next page)</p>		

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<p>F 0626</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A review of a hospital physician progress note for Resident #23 dated 7/27/23 at 3:21 PM revealed Resident #23 became agitated while in the ED the previous evening (7/26/23) when the nurse attempted to check his vital signs, and he required a dose of haloperidol (an antipsychotic medication). He became drowsy and slept the rest of the night. Resident #23's family member was with him, and reported she had been informed that the nursing facility was discharging Resident #23. Resident #23's family member had filed a report with the State Agency and had been working with the Ombudsman. The ED Case Manager was searching for another nursing facility for Resident #23.</p> <p>A review of the ED Case Manager's progress note dated 7/27/23 at 3:42 PM, which indicated it was a late entry, revealed she spoke with the Regional Marketing Director of Resident #23's nursing facility and was told that per the nursing facility's Regional [NAME] President (VP) Resident #23 would not be allowed to return to the facility. The ED Case Manager had consulted with the Long Term Care (LTC) Ombudsman regarding Resident #23's situation, and the LTC Ombudsman would follow-up with Resident #23's family and the nursing facility.</p> <p>On 8/7/24 at 9:18 AM a telephone interview with the ED Case Manager indicated Resident #23 had been sent to the hospital ED by his nursing facility (7/25/23) after an incident at the facility. She went on to say Resident #23 had a family member with him the entire time he was in the hospital, and there were no instances of distress for the resident. She stated the facility's Director of Nursing had wanted a medication review and a psychiatric evaluation before allowing Resident #23 to return to the facility. She reported Resident #23 had these completed, and when the hospital was ready to send Resident #23 back to the facility, the facility Regional Marketing Director told her the facility would not be taking Resident #23 back. The ED Case Manager went on to say she contacted the LTC Ombudsman for assistance. She stated she received Resident #23's discharge notice from the facility on 7/27/23 at 11:49 AM and provided this to Resident #23's family member. She reported at 3:23 PM that same day she received the report that the nursing facility would take Resident #23 back.</p> <p>On 8/8/24 at 10:24 AM a telephone interview with Resident #23's family member indicated Resident #23 had remained in the hospital ED after the hospital cleared him to return to the facility on [DATE]. She stated the nursing facility was not going to allow Resident #23 to return. She went on to say it took her reaching out to the State Agency before the facility would allow Resident #23 to return. She reported she worked closely with the LTC Ombudsman. Resident #23's family member stated after the State Agency intervened, Resident #23 had been allowed to return to the facility on [DATE] and remained at the nursing facility with no further issues. She stated while she felt the stress Resident #23 experienced being in the ER those days was unnecessary, she did not indicate Resident #23 experienced any harm.</p> <p>On 8/8/24 at 11:58 AM a telephone interview with the facility's Regional Marketing Director indicated the decision for Resident #23 not to be able to return to the facility would have been made by Administrator #2 and the Regional [NAME] President. She stated she would not be involved in this type of decision making.</p> <p>On 8/8/24 at 12:23 PM an attempt at a telephone interview with the Regional [NAME] President was unsuccessful.</p> <p>(continued on next page)</p>		

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<p>F 0626</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 8/6/24 at 1:08 PM a telephone interview with the LTC Ombudsman indicated she was familiar with Resident #23. She stated he didn't come out of his room very often. She reported on 7/25/23, he became confused and exited the bathroom into an adjoining room and refused to come out. She further indicated he was sent to the hospital and when the hospital was ready to send Resident #23 back to the facility, Administrator #2 refused to take Resident #23 back. The LTC Ombudsman stated on 7/27/23 the nursing facility provided a discharge notice with appeal rights, and she filed for an expedited appeal hearing. She reported Resident #23's family member called the State Agency, and when the State Agency became involved the nursing facility took Resident #23 back. She went on to say it was her understanding that Resident #23 had a family member with him the entire time he was in the hospital.</p> <p>On 8/8/24 at 8:15 AM a telephone interview with Administrator #2 indicated she recalled the incident with Resident #23 on 7/25/23 where he was unexpectedly able to get up and go into the bathroom. She stated this bathroom adjoined his room and the room of another resident. She went on to say Resident #23 had become confused, and gone into the other resident's room, became very agitated and combative, and refused to leave. She reported while Resident #23 had episodes of verbal and physical aggression towards staff, he had never done anything like that before and she felt the facility needed help managing this behavior. Administrator #2 stated Resident #23 needed to be transferred to the hospital for an evaluation. She indicated she had spoken to Resident #23's family, the State Agency, and the LTC Ombudsman. She went on to say the facility had rooms available, but not any rooms that did not have adjoining bathrooms at the time Resident #23 was ready to come back from the hospital, and she had needed time to coordinate room rearrangements with other residents and their families.</p> <p>On 8/8/24 at 1:34 PM in a telephone interview the facility's Corporate Nurse Consultant stated she had been involved in conversations with the facility regarding Resident #23's return from the hospital. She reported it was her understanding that the facility had not ever refused to take Resident #23 back. She did not explain why the facility issued the notice of discharge date d 7/27/23 and it had taken from 7/25/23, when Resident #23 had been cleared by the psychiatric evaluation to return to the facility, until 7/27/23 when the State Agency and the LTC Ombudsman became involved for him to be allowed to return. The Corporate Nurse Consultant stated she did know that it took some time for the facility to rearrange rooms so that it would be safe for the Resident #23 to return to the facility.</p>		