STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345384	A. Building B. Wing	08/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pruitthealth-Farmville	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)
F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interviews, the facility failed to accurately code the Pre-admission Screening and Resident Review (PASARR) status and failed to accurately code the Minimum Data Set (MDS) assessment in the area of oral/dental status for 2 of 15 resident MDS assessments reviewed (Resident #4, Resident #21). Findings included: 1. Resident #4 was admitted to the facility on [DATE]. Her active diagnoses included schizophrenia, major depressive disorder, and anxiety disorder. Review of Resident #4’s PASARR Level II Determination Notification letter dated 4/29/21 revealed it had no end date. Review of Resident #4’s Minimum Data Set (MDS) assessment dated [DATE] revealed she was coded as not currently considered by the state PASARR Level II process to have a serious mental illness. During an interview on 8/5/25 at 11:29 AM the Social Worker stated Resident #4 had a PASARR Level II determination with no end date. During an interview on 8/5/25 at 11:50 AM the MDS Coordinator stated the 12/6/24 MDS assessment for Resident #4 was incorrect. She concluded it was an oversite that would be corrected. During an interview on 8/5/25 at 11:55 AM the Administrator stated MDS assessments should accurately reflect the resident's PASARR status. 2. Resident #21 was admitted to the facility on [DATE]. A review of Resident #21’s nursing admission Observation form dated 11/1/24 at 4:26 PM completed by Nurse #1 revealed documentation that Resident #21 had obvious or likely cavity or broken natural teeth. Attempts for an interview with Nurse #1 were unsuccessful. A review of Resident #21’s admission Minimum Data Set (MDS) assessment dated [DATE] revealed he was severely cognitively impaired. He had no dental issues. The dental care area was not triggered. The dental care planning decision was not checked. (continued on next page)

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

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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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/5/25 at 8:14 AM Resident #21 was observed to have three front bottom teeth broken at the gumline and blackened in color, and one darkened discolored front bottom tooth. An interview with Resident #21 at that time indicated he had no dental pain, or trouble eating. On 8/6/25 at 10:23 AM a telephone interview with Dietary Manager #2 indicated she coded the oral/dental section of Resident #21’s MDS assessment dated [DATE]. She reported she did not recall observing Resident #21’s teeth for completion of the assessment, but she recalled asking him if he had any dental issues and he denied any. She went on to say while the nursing admission Assessment form would be something she reviewed to assist with completion of the oral/dental section of the MDS assessment, she could not recall whether or not she had done this for Resident #21’s MDS assessment dated [DATE]. On 8/6/25 at 10:44 AM an interview with the Director of Nursing (DON) indicated she was familiar with Resident #21. She reported Resident #21 had broken and discolored teeth since his admission to the facility. She stated this was documented on his nursing admission Observation dated 11/1/24. The DON stated Resident #21’s admission MDS assessment should have been coded to accurately reflect this. On8/6/25 at 1:32 PM an interview with the Administrator indicated Resident #21’s admission MDS assessment dated [DATE] should have been coded to accurately reflect his oral/dental status.

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, and staff interviews, the facility failed to implement the care planned intervention of a fall mat for 1 of 2 residents (Resident #21) reviewed for accidents.Findings included:Resident #21 was admitted to the facility on [DATE] with a diagnosis of dementia.A review of Resident #21's comprehensive care plan revealed a focus area initiated on 11/1/24 and last reviewed on 8/4/25 of at risk for falls related to senile dementia of the brain. The goal was for Resident #21 to not sustain any injury related to falling through the next review. An intervention, dated 6/6/25, was fall mat beside bed right side.A review of Resident #21's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed he was severely cognitively impaired. He had no functional limitation in range of motion of his upper or lower extremities. He used a wheelchair for mobility. He required supervision to roll left and right in bed, to go from sitting on the side of the bed to lying flat and to go from lying flat on the bed to sitting. Resident #21 required partial assistance to go from sitting to standing and to transfer from bed to chair. He had no falls since his prior assessment.On 8/6/25 at 8:04 AM Resident #21 was observed lying on his bed which was in a low position. No fall mat was observed on the right side of his bed or in his room.On 8/7/25 at 5:05 AM Resident #21 was observed lying on his bed which was in a low position. No fall mat was observed on the right side of his bed or in his room. On 8/7/2025 at 5:08 AM an interview with Nurse Aide (NA) #1 indicated she cared for Resident #21 regularly on the 11PM-7AM shift and was caring for him now. She reported she was familiar with Resident #21. NA #1 stated Resident #21 was at risk for falls. She stated at one time Resident #21 did have a fall mat in place, but he did not have one last night. She indicated she could not recall when she last saw a fall mat beside Resident #21's bed. She reported she did have access to residents' care plans. NA #1 stated the way she knew if a resident should have a fall mat while they were in bed was she would visually see it in the room. She stated that she didn't normally review the care plan for those residents she was familiar with but did for new residents. On 8/7/2025 at 5:18 AM an interview with Nurse #2 indicated she cared for Resident #21 on the 11PM-7AM shift and was familiar with him. She reported she knew at one point Resident #21 did have a fall mat at his bedside, but she hadn't seen one lately. Nurse #2 stated when she first noticed Resident #21's fall mat was not in place, she should have looked into the matter to determine whether it had been discontinued but she had not.On 8/7/25 at 7:26 AM an interview with the Director of Nursing (DON) indicated she was familiar with Resident #21. She reported he was at risk for falls. She indicated the intervention of a fall mat beside bed right side which appeared on Resident #21's comprehensive care plan was still a current appropriate intervention, and this fall mat should have been in place. The DON stated ensuring care planned fall interventions were in place was a team effort.On 8/7/25 at 8:35 AM an interview with the Administrator indicated if a fall prevention intervention appeared on a resident's care plan, it should be in place.

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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 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. (continued on next page)

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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 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, and resident, staff, and Responsible Party (RP) interviews the facility failed to provide or obtain routine dental services for a resident with obvious or likely cavity and broken natural teeth. This was for 1 of 1 resident (Resident #21) reviewed for dental care.Findings included:Resident #21 was admitted to the facility on [DATE] with a diagnosis of dementia.A review of a physician's order for Resident #21 dated 11/1/24 revealed in part May have dental care as needed.A review of Resident #21's nursing admission Observation form dated 11/1/24 at 4:26 PM completed by Nurse #1 revealed documentation that Resident #21 had obvious or likely cavity or broken natural teeth.Attempts at telephone interview with Nurse #1 were unsuccessful.A review of Resident #21's comprehensive care plan revealed a focus area dated as initiated on 11/1/24 and last revised on 7/18/25 for alteration in dentition. The goal was to maximize Resident #21's dentition and resolve to maximize independence through the next review. An intervention was dental consult as needed.A review of Resident #21's admission Minimum Data Set (MDS) assessment dated [DATE] revealed he was severely cognitively impaired. He had no dental issues. The dental care area was not triggered. The dental care planning decision was not checked.On 8/5/25 at 8:14 AM Resident #21 was observed to have three front bottom teeth broken at the gumline and blackened in color, and one darkened discolored front bottom tooth. An interview with Resident #21 at that time indicated he had no dental pain, or trouble eating.A review of Resident #21's facility medical record on 8/5/25 did not reveal any evidence of dental care since his admission to the facility.On 8/6/25 at 2:08 PM a telephone interview with the Responsible Party (RP) listed as the #1 contact on Resident #21's facility medical record face sheet indicated Resident #21 had fragmented and discolored teeth prior to his admission to the facility. She reported Resident #21 had never complained of any dental pain that she was aware of. She stated she did not recall anyone at the facility ever speaking with her about Resident #21's dental issues or informing her of any available dental care options.On 8/5/25 at 1:58 PM a telephone interview with the RP listed as #2 on Resident #21's facility medical record face sheet indicated she visited Resident #21 at least every other day at the facility. She reported that Resident #21 had fragmented and discolored teeth prior to his admission to the facility. She indicated Resident #21 had never complained of any dental pain that she was aware of. She stated she participated in Resident #21's care plan meetings when she was able to. RP #2 reported that she did not recall anyone at the facility ever speaking with her about Resident #21's dental issues or informing her of any available dental care options.On 8/6/25 at 2:14 PM an interview with Resident #21 indicated he used to have a dentist that he visited before he came to live at the facility. He reported he had last seen a dentist about two or three years ago. He stated he did not recall anyone at the facility ever offering him any dental care options. Resident #21 indicated he would like to see a dentist if one was available to him.On 8/6/25 at 10:44 AM an interview with the Director of Nursing (DON) indicated she was familiar with Resident #21. She reported Resident #21 had broken and discolored teeth since his admission but had never complained of any dental pain. She stated if the admitting nurse documented dental issues on the nursing admission assessment, typically nursing would ensure this was reflected on the resident's care plan. The DON reported for any acute dental issues like pain, she would ensure that the resident's dental need was addressed. She went on to say the facility had an inhouse dental provider that came to the facility quarterly (every 3 months) for routine dental care, and she thought the Social Work (SW) handled that.On 8/6/25 at 1:00 PM an interview with the facility's SW indicated Resident #21 was a long term resident at the facility. She reported his payor source was Medicaid. She stated normally a resident's dental care was something that would be addressed during the interdisciplinary team (IDT) process. The SW reported the facility had an inhouse dental provider that saw residents who were on the list quarterly. She stated the dental hygienist had last been at the facility in May 2025, but Resident #21 had not been seen then. She indicated she had not been responsible for adding residents to the list to be seen by the dental provider. She reported she thought the Administrator was working on getting a list together for the next dental visit.On 8/6/25 at 2:24 PM an interview with the Administrator indicated there was no documentation in Resident #21's medical record that he had been offered dental care on admission to the facility or had received dental care in the facility since his admission. She reported Resident #21 was not on the list to be seen by the inhouse dental provider on their next scheduled visit in August 2025. She stated because the facility knew that Resident #21 was going to remain in the facility long term on his admission, the dental care options that were available to him in the

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations, record review, and staff interviews the facility failed to discard out of date leftover resident food items stored in the facility's resident nourishment refrigerator. This deficient practice was for 1 of 1 resident nourishment refrigerators reviewed.Findings included:On 8/5/25 at 11:21 AM an observation of the facility's resident nourishment refrigerator with Dietary Manager #1 revealed a sign on the refrigerator door indicating it was the resident's refrigerator. Blank labels were observed in a plastic sleeve on the door with a sign reading, All food requires a name and date. Food left past 2 days will be discarded. Dietary Manager #1 was interviewed during the observations. The interior of the refrigerator revealed one large white foam container labeled and dated 7/27/25 containing cooked chicken, one large white foam container labeled and dated 7/27/25 containing corn, macaroni and cheese, and cooked greens which all appeared hard and dry, and a plastic bag labeled and dated 7/26/25 containing an unrecognizable hard, light pink rectangular object that Dietary Manager #1 reported appeared to be turkey breast. Continued observations revealed a small square white foam container labeled and dated 8/1/25 containing a slice of blueberry pie topped with whipped cream, an unlabeled and undated square white foam container containing a portion of white cake with frosting, and a rectangular clear plastic container with a red lid labeled and dated 7/25/25 with unrecognizable contents that Dietary Manager #1 indicated were possibly beans. In an interview during the observation, Dietary Manager #1 reported all the items should have already been discarded as they were past the time limit of 3 days and the cake was unlabeled and undated. She reported it was her responsibility to check the resident's nourishment refrigerator daily Monday through Friday for unlabeled or past date items. She stated all food should be labeled with the resident's name and the date it was placed in the refrigerator and should be discarded after 3 days. She reported she had not checked the refrigerator yet today and had not checked it yesterday. She stated she had gotten busy in the kitchen yesterday and forgot. Dietary Manager #1 stated the last time she had checked the refrigerator would have been last week and she did recall some of those items had been in there at that time. On 8/7/25 at 8:32 AM an interview with the Administrator indicated it was Dietary Manager #1's responsibility to check the resident's nourishment refrigerator for out of date food items which should be discarded after 2 days in accordance with the facility's policy.