STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	425296	A. BUILDING _____ B. WING _____	**08/19/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
PRUITTHEALTH- NORTH AUGUSTA	**1200 TALISMAN DRIVE NORTH AUGUSTA, SC 29841**

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 0580 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, review of inservice records and staff interview, the facility failed to notify the resident's responsible party when the resident experienced a significant weight loss and failed to notify the physician that the resident was not receiving the tube feeding supplement as ordered per the Gastrostomy tube ([DEVICE]) This deficient practice affected one (Resident #13) of three residents reviewed on tube feedings. Findings include: 1. Review of Resident #13's face sheet revealed he/she was admitted to the facility on [DATE] from the hospital for short term rehabilitation. His/her [DIAGNOSES REDACTED]. Review of Resident #13's Admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 04/17/20 revealed the resident had a Brief Interview for Mental Status (BIMS) score of 7 which indicated that the resident had a severe cognitive deficit. According to the MDS, the resident was holding food in mouth/cheeks or residual food in mouth after meals; complained of difficulty or pain with swallowing; weighed 92 pounds; had not had any significant weight loss or gain; and was on a tube feeding for 51% or more of his/her total calories. According to Resident #13's weight records, the resident weighed 92 pounds on admission to the facility on [DATE]; 85 pounds on 04/20/20, 89.9 pounds on 04/30/20, and 90 pounds on 05/01/20. Review of Resident #13's admitting physician's orders [REDACTED]. On 04/16/20, the physician discontinued the [MEDICATION NAME] supplement by mouth and ordered [MEDICATION NAME] full strength via [DEVICE] at 75 milliliters (ml)/hour (hr) for 10 hours from 8:00 PM to 6:00 AM. Review of a nursing progress note dated 04/16/20 at 12:10 PM written by Licensed Practical Nurse (LPN) #2 revealed LPN #2 spoke with Resident #13's family member (responsible party) to review his/her physician's orders [REDACTED].#13 told the nurse the [MEDICATION NAME] supplement was to be administered via [DEVICE]. The note indicated that family member #13 called the Veterans Administration (VA) Medical Center and an order was faxed to the facility stating the supplement was to be administered via [DEVICE]. Review of physician's orders [REDACTED]. Review of a nursing progress note dated 04/17/20 at 7:24 PM, the nurse documented the resident did not have the extension for his/her [DEVICE]. He/she documented that due to the missing part, the resident drinks his/her four cans of supplement daily. Review of a nursing progress note dated 04/25/20 at 11:27 AM, documented that the resident was accepting the pureed diet and supplements frequently by mouth and refused the enteral feedings, stating he/she drinks them at home. According to the note, family member #13 stated he/she would bring the extension for the [DEVICE] to the facility. Review of the Medication Administration Record [REDACTED]. Review of the electronic medical record revealed that there was no documentation that the physician was notified of the resident not receiving his/her tube feeding as ordered. During an interview on 08/17/20 at 3:00 PM, LPN #2 (the unit manager) stated that the resident drinks the supplement with no problem. LPN #2 stated that the physician ordered the Two Cal supplement per [DEVICE] on 04/16/20. When he/she reviewed the orders with family member #13, the family member insisted that the resident received the supplement via the [DEVICE]. LPN #2 stated that he/she spoke on the phone with family member #13 and told him/her that the nurses needed the extension for the feeding tube. LPN #2 stated that the extension was not in the facility. Family member #13 stated that she/he would bring it to the facility. LPN #2 stated that family member #13 did not bring it to the facility until a week later. LPN #2 stated that once the extension was received was when the resident first received the supplement per the [DEVICE]. LPN #2 stated the resident consumed the supplement by mouth and received the supplement by mouth until family member #13 brought the [DEVICE] extension. LPN #2 verified that he/she did not notify Resident #13's physician that the resident was not receiving his/her supplemental feeding per the [DEVICE] and that the reason was because of the missing part and/or of the resident's refusals. On 8/18/20 at 7:40 AM LPN #3 stated that the Resident #13 had no problems consuming the [MEDICATION NAME] supplement by mouth. He/she stated it took family member #13 a week to bring the extension for the [DEVICE] to the facility, so the resident continued receiving the supplement by mouth. LPN #3 stated the resident often refused the supplement. LPN #3 confirmed that he/she did not notify the physician because the nurse manager (LPN #2) usually notifies the physician. 2. Review of Resident #13's weights located under the vital signs tab in the electronic medical record revealed his/her weight was recorded as 92 pounds on 04/14/20 (on admission). The resident's next weight was recorded as 85 pounds on 04/20/20, which would constitute a significant weight loss of 7.61 percent in six days. The medical record was reviewed in its entirety and there was no evidence that the responsible party was notified of the weight loss. On 08/17/20 at 12:32 PM the Director of Nursing (DON) verified that there was no documentation in the resident's clinical record that the family/responsible party were notified of the weight loss. On 08/19/20 at 3:00 PM the Administrator stated he/she was unable to find a policy that addressed notification of responsible parties related to weight loss. Review of an Inservice Education Program Summary Record Form dated 04/28/20 documented that nursing staff was educated to notify the physician and family/responsible party of weight loss. This deficiency was cited based on complaint #SC 988

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