STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345538	A. BUILDING _____ B. WING _____	05/12/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEALTH-RALEIGH	2420 LAKE WHEELER ROAD RALEIGH, NC 27603

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 275 SS=D	483.20(b)(2)(iii) COMPREHENSIVE ASSESS AT LEAST EVERY 12 MONTHS A facility must conduct a comprehensive assessment of a resident not less than once every 12 months. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to conduct an annual Minimum Data Set (MDS) assessment for 1 of 20 residents (Resident #135). Findings included: Resident #135 was admitted to the facility on 07/17/14 with diagnoses including: muscle weakness, Non-Alzheimer ' s dementia, Psychosis, cognitive communication deficit, hypertension (HTN), and anxiety. Resident needed limited assistance with toilet use, and personal hygiene. A review of the MDS assessment for Resident #135 revealed the last comprehensive assessment was the Significant Change assessment dated 04/15/15. During an interview on 05/12/16 at 1:40 PM, the MDS Coordinator stated Resident #135 ' s comprehensive assessment dated 04/10/16 was only partially completed, and should have been completed within 366 days after completion of the most recent comprehensive resident assessment dated 04/15/15 and it was not. During an interview with the Director of Nursing (DON) on 05/12/16 at 3:05 PM, the DON stated it	F 275	Residents Affected: Resident #135 comprehensive assessment was completed on 5/24/26. Resident(s) with potential to be affected: All residents have the potential to be affected. A review of all current residents will be completed to identify all residents who have not had an annual assessment completed in the last 12 months. All residents identified will have an annual assessment completed. The MDS Department will be responsible to complete. Systemic Changes: Education will be provided by the Regional Clinical Reimbursement Coordinator to all MDS Staff to ensure they are aware of the annual assessment requirements. Case Mix Director or other MDS Staff will review the annual assessment schedule with the DHS, Administrator or other	6/9/16

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		05/30/2016

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F 275	Continued From page 1 was her expectation that an annual comprehensive MDS assessment would be completed as required.	F 275	Nursing Management Staff weekly for four weeks. Findings will be reviewed by the QAPI Team and appropriate actions taken as indicated to secure compliance. If significant improvements are noted by the end of the 4 week period as determined by the QAPI Team the weekly review will end and be changed to a monthly review. Findings will be reviewed by the QAPI Team and appropriate actions taken as indicated to secure compliance. QAPI: The Case Mix Director or other MDS Staff will report findings monthly to the QAPI Team. Findings will be reviewed by the QAPI Team and appropriate actions taken as indicated to secure compliance. After substantial compliance has been determined to have been obtained by the QAPI Team the audits will be discontinued. Monitored by the QAPI Team.	
F 276 SS=D	483.20(c) QUARTERLY ASSESSMENT AT LEAST EVERY 3 MONTHS A facility must assess a resident using the quarterly review instrument specified by the State and approved by CMS not less frequently than once every 3 months.	F 276		6/9/16

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F 276	Continued From page 2 This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to conduct a comprehensive quarterly assessment for 1 of 20 residents reviewed for complete and accurate assessment information (Resident # 34). Findings included: Resident #34 was admitted to the facility in December of 2010. Upon review on 5/11/16, the most updated comprehensive Minimum Data Set (MDS) was dated 1/14/16. The quarterly comprehensive MDS was due for transmission by 4/26/16 but stated "Open" as its status and had not had all sections completed. The MDS Nurse Consultant/Reimbursement Coordinator was interviewed on 5/12/16 at 9:22 AM. She indicated that parts of Resident # 34's quarterly MDS were done, but the areas that were to be completed by the MDS department were not complete and should have been done by 4/26/16. She stated that they ran a report daily and weekly of assessments that were coming up due and late assessments and that they did have some that were running late due to staff turnover in the MDS Department. The MDS Nurse Consultant/Reimbursement Coordinator reported that the MDS assessments were important because they provided the necessary information needed for resident care planning and that it was her expectation that all MDS assessments be completed and transmitted on or before the due date. In an interview with the Director of Nursing (DON) on 5/12/16 at 3:50 PM she stated that there had been some staffing turnover in the	F 276	Residents affected: Resident #34 quarterly assessment was completed on 5/24/16. Resident(s) with potential to be affected: All residents have the potential to be affected. A review of all current residents will be completed to identify all residents who have not had a quarterly assessment completed in the last three months. All residents identified will have a quarterly assessment completed. The MDS Department will be responsible to complete. Systemic changes: Education will be provided by the Regional Clinical Reimbursement Coordinator Consultant to MDS staff to ensure they are aware of the quarterly assessment requirements. Case Mix Director or other MDS Staff will review the Quarterly Assessment schedule with the DHS, Administrator or other Nursing Management Staff weekly for four weeks. Findings will be reviewed by the QAPI Team and appropriate actions taken as indicated to secure compliance. If significant improvements are noted by the end of the 4 week period as determined	

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F 276	Continued From page 3 MDS department and they were working to get back on track, but it was her expectation that the assessments be completed on time.	F 276	by the QAPI Team the weekly review will be changed to a monthly review. Findings will be reviewed by the QAPI Team and appropriate actions taken as indicated to secure compliance. QAPI: The Case Mix Director or other MDS Staff will report findings monthly in QAPI. Findings will be reviewed by the QAPI Team and appropriate actions taken as indicated to secure compliance. After substantial compliance has been determined to have been obtained by the QAPI Team the audits will be discontinued. Monitored by the QAPI Team.	
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after	F 280		6/9/16

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F 280	Continued From page 4 each assessment. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to conduct a quarterly care plan meeting and update the care plan for 1 of 20 residents (Resident #66) whose care plans were reviewed. Findings included: Resident #66 was originally admitted to the facility in June of 2008 and her most recent readmission was 6/15/2015 with a diagnosis history that included peripheral vascular disease (PVD), chronic obstructive pulmonary disease (COPD), dysphagia, senile dementia, chronic ischemic heart disease, hypertension, hyperlipidemia, and hypothyroidism. According to the most recent Quarterly Minimum Data Set (MDS), dated 1/27/16, Resident #66 had moderate cognitive impairment and required extensive to total assistance with activities of daily living (ADLs). Review of care plan meeting invitation letters that were usually sent to Resident #66's responsible party (RP) to inform of and invite to the care plan meeting showed that the last letter that was drafted and sent to the RP was for the care plan meeting that was held on 12/08/2015. Review of the most recently updated care plan revealed that the last review and revision of Resident #66's care plan was done on 12/22/2015.	F 280	Resident affected: Resident #66 invitation letter to family member(s) or legal representative was sent 5/26/16. Care Plan for Resident #66 will be updated after the care plan meeting scheduled 5/31/16. Resident(s) with potential to be affected: All residents have the potential to be affected. A 100% audit of care plans will be completed on all current residents to ensure care plans have been reviewed and revised timely. For all care plans identified as not completed timely, a care plan meeting will be scheduled and an invitation will be sent to the resident, family member(s) or legal representative to attend the care plan meeting and participate in the care planning process with the IDT. The care plans identified will be reviewed and revised by the IDT in the care plan meeting.	

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F 280	Continued From page 5 During an interview on 5/12/16 at 9:22 AM, the MDS Nurse Consultant/Reimbursement Coordinator attempted to locate a care plan invitation letter in the electronic medical record (EMR) for Resident# 66 as well as on the paper chart and was unable to locate one in either location. She reviewed the most up to date care plan for Resident #66, dated for 12/22/15, and stated that she should have had a care plan meeting and updated care plan since December 2015 and that it may have gotten missed in staffing turnover time frame. She reported that there had been MDS staffing shortage since December 2015, but the expectation was that there should be an adequate number of people in the department to work and ensure that assessments and care planning did not fall behind. At 3:50 PM on 5/12/16, the Director of Nursing (DON) stated Resident #66 should have had a care plan meeting and updated care plan since December 2015 and it was her expectation that residents have care plan meetings and updated care plans quarterly and as needed.	F 280	Systemic Changes: Education will be provided by the Regional Clinical Reimbursement Coordinator Consultant to the IDT to ensure all members are aware of the timeliness/procedures of care planning requirements to include invitation letters. The Case Mix Director or MDS Staff will generate a listing of all care plans due each month. From daily standup meeting the Nursing 24 hour report and the PointRight DIA reports will be reviewed to identify if a change has occurred that would warrant a care plan revision to be completed. Identified needs will be added to the care plan calendar. From the care plan calendar the Case Mix Director or other MDS Staff will ensure a care plan meeting is scheduled and an invitation will be sent to the resident, resident(s) family member(s) or legal representative to attend the care plan meeting and participate in the care planning process with the IDT. The care plans identified will be reviewed and revised by the IDT in the care plan meeting. The Case Mix Director or other MDS Staff will then notify the IDT of the care plan meeting dates and times. Findings will be reviewed by the QAPI	

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F 280	Continued From page 6	F 280	Team and appropriate actions taken as indicated to secure compliance. Monitored by the Case Mix Director. QAPI: The Case Mix Director or other MDS Staff will report any findings monthly in QAPI meeting. Findings will be reviewed by the QAPI Team and appropriate actions taken as indicated to secure compliance. After substantial compliance has been determined to have been obtained by the QAPT Team the audits will be discontinued. Monitored by the QAPI Team.	
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by:	F 315		6/9/16

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F 315	Continued From page 7 Based on physician assistant interview, staff interview, and record review the facility failed to administer an antibiotic prescribed for a urinary tract infection (UTI) for the duration specified in a physician order for 1 of 5 sampled residents (Resident #193) reviewed for unnecessary medications. Findings included: Resident #193 was admitted to the facility on 03/24/16. Her documented diagnoses included diabetes, hypertension, and chronic kidney disease. A 03/24/16 interim care plan identified treatment of an infection as a problem for Resident #193 (pneumonia). Interventions included, "Administer medications as ordered." The resident's 03/31/16 admission minimum data set (MDS) documented her cognition was intact, she required extensive assistance from a staff member with toileting, and she was frequently incontinent of urine. 04/27/16 lab results documented Resident #193's urine sample contained greater than 100,000 colony forming units (CFU) of Enterococcus faecalis bacteria. A 04/27/16 physician order started Resident #193 on Ampicillin (antibiotic) 250 milligrams (mg) four times daily (QID) x 7 days (indication: UTI). Review of the resident's April 2016 medication administration record (MAR) revealed the resident received one dose of Ampicillin on 04/27/16, and four doses of Ampicillin on 04/28/16, 04/29/16, and 04/30/16.	F 315	Residents affected: Resident #193 was reviewed by Physician Assistant who determined there was no need to reinstitute or change antibiotic med therapy on 5/12/16. Resident(s) with potential to be affected: All residents with a UTI being addressed by antibiotic med therapy have the potential to be affected. Antibiotic med therapy for all residents with a UTI will be reviewed by the DHS, ADHS or other Nursing Management Staff during the month end changeover to ensure all antibiotic med therapies from the prior month that are still being administered are carried over to ensure treatment as prescribed continues. Monitored by DHS, ADHS or other Nursing Management Staff. Systemic changes: Education for all staff participating in the month end changeover will be provided by Clinical Competency Coordinator, DHS, ADHS or other Nursing Management Staff. In addition, general orientation for all licensed nurses will address month end changeover procedures to include antibiotic med therapies for UTI's. The DHS, ADHS, or other Nursing	

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F 315	Continued From page 8 A 04/29/16 physician progress note did not document Resident #193 reporting any signs and symptoms which might be indicative of a UTI. Review of the resident's May 2016 MAR revealed Ampicillin was not carried forward, resulting in the resident not receiving the antibiotic for the 3 3/4 days remaining in the antibiotic treatment regimen ordered by the physician. A 05/03/16 physician progress note did not document Resident #193 reporting any signs and symptoms which might be indicative of a UTI. At 11:35 AM on 05/12/15 Nurse Supervisor #1 stated it was important to make sure Resident #193 received Ampicillin antibiotic for the full duration of seven days, as ordered by the physician, to make sure "the infection was completely cleared and the bacteria was destroyed." She reported beginning on the 25th - 26th of the current months all nurses (mostly hall nurses) were involved in MAR reconciliation, making sure ongoing orders were transcribed from one month to the next. Nurse Supervisor #1 commented she was not aware of any problems with medication transcription in the past. At 11:50 AM on 05/12/15 Nurse #1 stated Resident #193 was not currently exhibiting any signs and symptoms of a UTI. At 1:58 PM on 05/12/15 physician assistant (PA) #1, who cared for Resident #193, stated she expected the facility to administer antibiotics for the duration specified in the order to make sure the treatment was effective. She reported Resident #193 did not currently exhibit any signs and symptoms of a UTI, and had not reported any	F 315	Management Staff will review all residents with a UTI that require antibiotic med therapies to ensure they are carried over to new month MAR's unless that antibiotic med therapy was discontinued prior to month's end. This will be completed monthly at month end changeover for two months at a minimum. The DHS, ADHS or other Nursing Management Staff will report monthly to the QAPI Team. Findings will be reviewed by the QAPI Team and appropriate actions taken as indicated to secure compliance. QAPI: The DHS, ADHS or other Nursing Management Staff will report findings monthly to the QAPI Team. Findings will be reviewed by the QAPI Team and appropriate actions taken as indicated to secure compliance. After substantial compliance has been determined to have been obtained by the QAPI Team the audits will be discontinued. Monitored by the QAPI Team.	

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F 315	Continued From page 9 signs and symptoms of a UTI during her two follow-up visits since the resident was begun on Ampicillin on 04/27/16. At 2:10 PM on 05/12/15 the director of nursing (DON) explained the facility received preprinted MARs for the upcoming month, and two nurses compared the newly printed MARs against the current MARs, phone orders, and the chart to make sure all medications that were ongoing got carried over to the new MARs. The DON stated she thought what happened in the case of Resident #193 was on the MAR the reconciling nurse mistook the 'X" on 04/31/16 as meaning the resident had completed her antibiotic rather than there was no 31st day in April. She commented it was important to make sure the full dose of the antibiotic was administered so that the bacteria was eliminated and to make sure the physician order was being completely honored.	F 315		
F 520 SS=D	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies.	F 520		6/9/16

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F 520	Continued From page 10 A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review the facility's quality assurance (QA) committee failed to prevent the reoccurrence of deficient practice related to updating care plans/conducting care plan meetings and catheter care/maintenance of urinary health which resulted in repeat deficiencies at F280 and F315. The re-citing of F280 and F315 during the last year of federal survey history showed a pattern of the facility's inability to sustain an effective QA program. Findings included: This tag is cross-referenced to: F280: Updating Care Plans/Conducting Care Plan Meetings : Based on record review and staff interviews, the facility failed to conduct a quarterly care plan meeting and update the care plan for 1 of 20 residents (Resident #66) whose care plans were reviewed. F315: Catheter Care/Maintenance of Urinary Health: Based on physician assistant interview, staff interview, and record review the facility failed to administer an antibiotic prescribed for a urinary tract infection (UTI) for the duration specified in a	F 520	Resident(s) affected: All residents have the potential to be affected. Corrections for residents are accomplished by responses to F315 and F280 citations Residents with the potential to be affected: All residents have the potential to be affected. Corrections for residents are accomplished by responses to F315 and F280 citations. Systemic Changes: Education will be provided to the QAPI Team on how to identify and analyze information from the facilities internal processes for items that should be included in QAPI meetings. This will ensure the QAPI Team is identifying and addressing issues that should be brought	

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F 520	Continued From page 11 physician order for 1 of 5 sampled residents (Resident #193) reviewed for unnecessary medications. Review of the facility's survey history revealed F280 (failure to update care plans) and F315 (improper catheter and perineal care) were cited during a 02/12/16 complaint investigation survey, and wer re-cited during the current 05/12/16 annual recertification survey. At 2:45 PM on 05/12/15 the administrator and direrctor of nursing (DON) stated after receiving the F280 citation in February 2016 they did an audit of all resident care plans in the building, and for the first month following that facility-wide audit they audited a large percent of care plans monthly to make sure they were continuing to be updated. They reported the compliance rate was good for this first month so they reduced the number of care plans reviewed the following month. They commented they thought this period of reduced auditing may have been how the updating of Resident #66's care plan was missed. According to the administrator and DON, the F315 citation in February 2016 related to improper catheter and perineal care so they did inservicing and return demonstration until they reached 100% staff compliance. They stated this time the were being cited at F315 for not completing antibiotic treatment which was an entirely different issue even though it still fell under the F315 umbrella.	F 520	forward to QAPI for evaluation and actions taken as indicated to secure substantial compliance. QAPI plan to address F280 now includes a component for timeliness of care plans and invitations to resident, resident(s) family members or legal guardian to attend care plan meeting and participate in the care planning process. This will be monitored by the Case Mix Director, DHS, ADHS and Administrator. Findings will be reported to the QAPI team and actions taken as indicated to secure compliance. QAPI: The QAPI Team will review all audit tools triggered by issued deficiencies monthly. Actions will be taken as indicated to obtain substantial compliance. Duration of audits will continue as listed in F280 and F315 and monitored by the QAPI Team. When substantial compliance is obtained the audits will discontinue. The QAPI Team will identify and analyze data from internal processes for consideration of actions to be taken as indicated to secure substantial compliance. Items identified will result in Performance Improvement Plans or (PIP's) to ensure	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEALTH-RALEIGH	2420 LAKE WHEELER ROAD RALEIGH, NC 27603

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 520	Continued From page 12	F 520	those items are addressed and that substantial compliance is obtained. Monitored by the Regional Nurse Consultant monthly for 4 months. When substantial compliance has been maintained those reviews will be discontinued.	