STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345061	A. BUILDING _____ B. WING _____	C 10/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEALTH-DURHAM	3100 ERWIN ROAD DURHAM, NC 27705

(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 000	INITIAL COMMENTS A complaint investigation survey was conducted from 10/19/17 through 10/21/17. Immediate Jeopardy was identified at: CFR 483.25 at tag F323 at a scope and severity (J) CFR 483.75 at tag F520 at a scope and severity (J) The tags F323 J constituted Substandard Quality of Care. Immediate Jeopardy began on 09/03/17 and was removed on 10/21/17. An partial extended survey was conducted.	F 000		
F 278 SS=D	ASSESSMENT ACCURACY/COORDINATION/CERTIFIED CFR(s): 483.20(g)-(j) (g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. (h) Coordination A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. (i) Certification (1) A registered nurse must sign and certify that the assessment is completed. (2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.	F 278		11/15/17

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

Electronically Signed | 11/10/2017

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F 278	Continued From page 1 (j) Penalty for Falsification (1) Under Medicare and Medicaid, an individual who willfully and knowingly- (i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment. (2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to accurately code the admission minimum data set (MDS) assessment for one of three residents reviewed for wandering behaviors, Resident #1. Findings included: Resident #1 was admitted to the facility on 07/11/2017 with diagnoses which included, in part, heart failure, depression, and insomnia. The Elopement Risk Observation Form completed upon admission to the facility on 07/11/2017 revealed Resident #1 had a total elopement risk score of 11. The top of the form indicated that a resident with a score of 11 or greater was to have interventions immediately put into place. Interventions listed on the form were Weekly Behavior Management and Wanderguard Program. There was no signature on the form.	F 278	This plan of correction constitutes a written allegation of compliance. Preparation and submission of this plan of correction does not constitute an admission or agreement by the provider of truth of the facts alleged or the corrections of the conclusions set forth on the statement of deficiencies. The plan of correction is prepared and submitted solely because of requirements under state and federal law. Process that lead to the Deficiency: Root Cause Analysis: Resident #1 was admitted to the facility on 7/11/17. Root Cause Analysis: The resident□s elopement risk assessment score upon admission was 11 (high risk) and the facility failed to	

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F 278	Continued From page 2 Review of the quarterly minimum data set (MDS) assessment dated 07/18/2017 revealed Resident #1 had severe cognitive impairment and that he exhibited no wandering behaviors. Supervision of one person was required for a walk in his room and for locomotion on and off the unit. The same MDS assessment indicated Resident #1 was not steady while walking or turning around, but was able to stabilize without staff assistance. In addition, he used no mobility devices. In an interview with Nurse #1 on 10/20/2017 at 2:10 PM, she stated she was the admitting nurse who completed the Elopement Observation Risk Form for Resident #1. In an interview on 10/20/2017 at 2:37 PM, the MDS Nurse acknowledged the Elopement Risk Observation Form was a tool for nurses to observe for elopement and wandering behaviors and that a score of 11 or above was considered to be high risk for elopement. She stated the admitting nurse (Nurse #1) completed the Elopement Risk Observation Form upon admission of Resident #1 on 07/11/2017. The MDS Nurse confirmed this elopement risk was completed during the 7-day look back period for the admission MDS assessment dated 07/18/2017, and added that she missed the score of 11 on the form, so it was not captured on the admission assessment. In an interview with the Director of Health Services (DHS) and the Administrator on 10/21/2017 at 4:11 PM, the DHS stated it was the responsibility of the admitting nurse to complete the elopement risk evaluation. The Administrator stated he would expect for the admission MDS to be coded accurately.	F 278	initiate interventions to prevent elopement at that time. The Admitting Nurse (Nurse #1) was not properly trained on completing the Elopement Risk Observation form. MDS nurses failed to accurately code Resident #1for wandering and being at risk of elopement. On 9/3/2017 Resident #1 was last observed on third floor at approximately 1:00pm. Facility was made aware that the resident was not on the premises when the resident□s mother called the facility at approximately 7:30pm and asked the charge nurse (Nurse #1) to establish if the resident was in the room. The charge nurse quickly checked the room and informed the mother that the resident was not in his room. The mother at this point informed the charge nurse that the resident had called his sister and stated he was trying to get home but had missed the bus. At around 7:54pm, charge nurse notified Administrator and Director of Health Services. At around 8:17pm, the charge nurse called 911 to report the resident missing. The Nurse described the last location the resident was seen, third floor at approximately 1:00pm, description of clothing (tan pants, dark shirt and black lace up shoes) that he was wearing as well as the physical description of resident including height and weight. Around 8:30pm, the police officer arrived to gather more information about the resident. At approximately 9:00pm, the police officer informed the charge nurse that the resident had been	

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F 278	Continued From page 3	F 278	located in Duke Hospital ER. The Resident was re-admitted 9/6/17 at 4:00pm. Upon re-admission, the resident was assessed for elopement by a Licensed Nurse and scored 25 on the Elopement Risk Observation form. The resident□s BIMS score was 4. The following interventions were put in place: a wander guard was put in place, the resident□s description and picture was placed in the wander guard book by the Medical Records Director. Resident #1 expired in the facility on 9/22/2017 of CHF. Process for implementing the acceptable plan of correction for specific deficiency. On 9/3/2017, all other residents were accounted for in the facility by conducting a head count. 100% elopement assessments were initiated on 9/3/2017 and completed on 9/4/2017 by the Director of Health Services and Nurse Management team. Residents with a score of 11 or above, indicating a high-risk for elopement and that have a BIMS score of less than 13, and/or not alert and oriented, had a wander guard placed immediately. The residents were assessed by the Interdisciplinary Team for further intervention recommendations. Behavior documentation on MARs was initiated on 9/4/2017 for residents who are able to move self throughout the facility with a score of 5-10, identified medium risk on elopement observation form, and were kept on behavior management for 4 weeks. Care plan interventions were reviewed and/or revised and,	

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F 278	Continued From page 4	F 278	implemented as needed based on the assessment. The Administrator, the Director of Health Services and, the Facility Clinical Consultants educated the MDS nurses on coding wandering assessments accurately based on RAI guidelines. The education was initiated on 10/21/2017 and completed on10/24/2017. MDS assessments are reviewed upon admission, readmission and, significant change for accuracy according to RAI manual, for elopement and supervision, by the IDT during daily risk meeting. Monitoring procedure to ensure that the plan of correction is effective. The Administrator and the Director of Health Services will conduct a weekly review of MDS assessments for residents that wander to ensure accuracy based on the RAI guidelines. The admission, quarterly and significant change care plans are reviewed for accuracy by the Case Mix Director, Social Service Director and Director of Nursing in the area of wandering during the morning clinical meeting to ensure the care plan matches the coding on the MDS and resident assessments. This will be done for 6 months until compliance is sustained. The Administrator and the Director of Health Services will review and report any findings of non-compliance to the Quality Assurance and Performance Improvement committee for recommendations as needed.	

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F 278	Continued From page 5	F 278	Title of Person Responsible for implementing the acceptable plan of correction. The Administrator is responsible for implementing the acceptable plan of correction. Date of Compliance: 11/15/2017	
F 323 SS=J	FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES CFR(s): 483.25(d)(1)(2)(n)(1)-(3) (d) Accidents. The facility must ensure that - (1) The resident environment remains as free from accident hazards as is possible; and (2) Each resident receives adequate supervision and assistance devices to prevent accidents. (n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. (1) Assess the resident for risk of entrapment from bed rails prior to installation. (2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. (3) Ensure that the bed's dimensions are	F 323		11/15/17

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F 323	Continued From page 6 appropriate for the resident's size and weight. This REQUIREMENT is not met as evidenced by: Based on record review and physician, staff, and responsible party interviews, the facility failed to prevent elopement from the facility for one of three residents who had cognitive impairment, Resident #1. The facility was unable to account for Resident #1's location for a period of approximately 7 hours until he was found by police at the downtown bus terminal. The immediate jeopardy began on 09/03/2017 when Resident #1 left the facility unobserved. Resident #1 was transported by emergency medical services (EMS) at 8:27 PM to a hospital emergency department after being found by at a bus terminal by police. Resident #1 was admitted to the hospital after the emergency department evaluation revealed acute on chronic congestive heart failure, acute kidney injury, elevated liver function tests, and major neurocognitive disorder. The Immediate Jeopardy was removed on 10/21/2017 when the facility provided an acceptable credible allegation of compliance. The facility will remain out of compliance at a scope and severity of no actual harm with the potential of no more than minimal harm that is not immediate jeopardy (D). The facility was in the process of full corrective action at that time. Findings included: Resident #1 was admitted to the facility on 07/11/2017 with diagnoses which included, in part, heart failure, depression, and insomnia. The Elopement Risk Observation Form competed	F 323	This plan of correction constitutes a written allegation of compliance. Preparation and submission of this plan of correction does not constitute an admission or agreement by the provider of truth of the facts alleged or the corrections of the conclusions set forth on the statement of deficiencies. The plan of correction is prepared and submitted solely because of requirements under state and federal law. Process that lead to the Deficiency: Resident #1 was admitted to the facility on 7/11/17. Root Cause Analysis: The facility failed to provide supervision to prevent elopement. The resident□s elopement risk assessment score upon admission was 11 (high risk) and the facility failed to initiate interventions to prevent elopement at that time. The Admitting Nurse (Nurse #1) was not properly trained on completing the Elopement Risk Observation form. Resignations and Nurse Management changes specific to Director Health Services and Clinical Competency Coordinator caused a gap in orientation and education/training for licensed staff. On 9/3/2017 Resident #1 was last observed on third floor at approximately 1:00pm. Facility was made aware that the resident was not on the premises when the resident□s mother called the facility at	

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F 323	Continued From page 7 upon admission to the facility on 07/11/2017 revealed Resident #1 had a total score of 11. The top of the form indicated that a resident with a score of 11 or greater was to have interventions immediately put into place. Some of the interventions on the form were Weekly Behavior Management and Wanderguard Program. (A Wanderguard is a monitoring system to prevent a resident from exiting the facility unsupervised.) This form was not signed by the staff member who completed it. Review of the admission minimum data set (MDS) assessment dated 07/18/2017 revealed Resident #1 had severe cognitive impairment and that he exhibited no signs of wandering or rejection of care behaviors. Supervision of one person was required for a walk in his room and for locomotion on and off the unit. The same MDS assessment indicated Resident #1 was not steady while walking or turning around, but was able to stabilize without staff assistance. In addition, he had functional limitation of his upper extremity on one side and that he used no mobility devices. The nursing care plan for Resident #1 which was last updated on 07/24/2017 revealed there were goals and interventions in place for the potential for injury from falls related to general weakness, cognitive deficits, and the use of psychotropic medications. An additional goal with interventions was in place for the potential for side effects and/or adverse reactions related to the use of antidepressants for depression. The care plan did not address Resident #1's risk for elopement. Review of the facility's incident report for the elopement of Resident #1 dated 9/03/2017 at	F 323	approximately 7:30pm and asked the charge nurse (Nurse #1) to establish if the resident was in the room. The charge nurse quickly checked the room and informed the mother that the resident was not in his room. The mother at this point informed the charge nurse that the resident had called his sister and stated he was trying to get home but had missed the bus. At around 7:54pm, charge nurse notified Administrator and Director of Health Services. At around 8:17pm, the charge nurse called 911 to report the resident missing. The Nurse described the last location the resident was seen, third floor at approximately 1:00pm, description of clothing (tan pants, dark shirt and black lace up shoes) that he was wearing as well as the physical description of resident including height and weight. Around 8:30pm, the police officer arrived to gather more information about the resident. At approximately 9:00pm, the police officer informed the charge nurse that the resident had been located in Duke Hospital ER. The Resident was re-admitted 9/6/17 at 4:00pm. Upon re-admission, the resident was assessed for elopement by a Licensed Nurse and scored 25 on the Elopement Risk Observation form. The resident□s BIMS score was 4. The following interventions were put in place: a wander guard was put in place, the resident□s description and picture was placed in the wander guard book by the Medical Records Director. Resident #1 expired in the facility on 9/22/2017 of CHF.	

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F 323	Continued From page 8 7:30 PM was reviewed. The report indicated Resident #1 left the facility on his own and could not be located. The immediate action listed on the report read, "Res. (Resident) in ER" (emergency room.) The incident report form noted Resident #1 was "taken to hospital: [Hospital #1]" and that the Interim Director of Health Services prepared the report. In an interview with a responsible party (RP) #1 on 10/19/17 at 5:45 PM, she stated that she and 2 other RPs called the facility on 09/03/2017 during the evening hours (not certain of the time) to notify the staff that she had talked with Resident #1 on the phone and he stated he was at the "bus stop." RP #2 explained she didn't know whether to believe him, and she wanted the staff to check his room to see if he was in the facility. She stated she waited while the staff observed his room, and the staff returned to the phone and reported he was not there. RP #2 added that she and the 2 other RPs came to the facility at that point to help find him. She stated she called the police and that the facility also called the police, and that the police called the facility back later that evening to say that Resident #1 had been found at the hospital's emergency department. In an interview with Nursing Assistant (NA) #1 on 10/20/2017 at 10:50 AM, he stated he was working 7:00 AM to 3:00 PM on 09/03/2017, but Resident #1 was not on his assignment. He stated he received a call from a facility staff member after he left work that day (not sure of the time) to ask him if he had seen Resident #1. He stated he told the staff member he had last seen Resident #1 around 1:00 PM on 09/03/2017 as he passed by his room.	F 323	Process for implementing the acceptable plan of correction for specific deficiency. On 9/3/2017, all other residents were accounted for in the facility by conducting a head-count. 100% elopement assessments were initiated on 9/3/2017 and completed on 9/4/2017 by the Interim Director of Health Services and Nurse Management team. Residents with a score of 11 or above, indicating a high-risk for elopement and, have a BIMS score of less than 13, and/or not alert and oriented, had interventions put in place as to include a wander guard placed immediately upon notification of the Resident Representative and the Physician. The residents at risk are reviewed weekly by the Interdisciplinary Team for any further interventions as needed. Behavior documentation on the MARs was initiated on 9/4/2017 for residents who are able to move self throughout the facility with a score of 5-10, identified as medium risk on elopement observation form, and were kept on behavior management for 4 weeks. Care plan interventions were reviewed and/or revised as needed by the Interdisciplinary Team based on the assessments. Education was initiated on 10/21/2017 by the Administrator, Director Health Services, Clinical Competency Coordinator, Nursing Management team and Department managers for all staff (to include the Rehab, dietary and, housekeeping departments) on elopement/code pink including signs of exit seeking behavior, location of the elopement risk book and, who to report	

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F 323	Continued From page 9 On 10/20/2017 at 10:59 AM, an interview was conducted with NA #2, who was assigned to care for Resident #1 on the 3:00 PM to11:00 PM shift on 09/03/2017. NA #2 stated she arrived about 3:30 PM for her shift and that she did not see Resident #1 in his room at that time. She explained she saw his lunch tray sitting on the over bed table and it still had the cover over the plate as though it had not been eaten. NA #2 explained she thought he was probably out with family members, as he did this from time to time. She added that she did not check the sign out book at the nurse's station and took no other action to locate Resident #1. The interview with NA #2 continued, and NA #2 stated she then assisted other residents with their supper meals around 5:00 PM in the dining room. NA #2 did not pass out dinner trays on the hall. She explained that sometime after dinner, Nurse #1 informed her that Resident #1 could not be found, so she started to search for him in his room, the bathroom, the rest of the hall, and the other floors in the facility. NA #2 further clarified that Resident #1 was ambulatory, did not have a Wanderguard and was free to walk to other areas of the facility and go outside. She added there was no code needed for the residents to access the elevator to go to other areas of the facility, and since Resident #1 had no Wanderguard, there was no alarm that would sound if he boarded the elevator or exited the facility. In an interview with the MDS Nurse on 10/20/2017 at 2:37 PM, she stated the Elopement Risk Observation Form was typically completed by the nurse who admitted the resident and she acknowledged the form dated 07/11/2017 with the	F 323	signs of exit seeking behavior to. 100% education will be completed by 11/10/2017. Staff members who have not completed the education will not be allowed to work until they are educated. All newly hired staff will be educated on elopement during new hire orientation by the Clinical Competency Coordinator and/or the Director of Health Services. Education for all licensed nurses including Nurse #1 and all nursing aides on identifying and reporting behavior changes was initiated on10/21/2017 and completed on11/10/2017 Licensed nurses and nursing aides who have not completed the education will not be allowed to work until they are educated. All newly hired licensed nurses and nurse aides will be educated on identifying and reporting behavior changes during new hire orientation by the Clinical Competency Coordinator and/or the Director of Health Services. Education was also initiated on10/21/2017 and completed on 11/10/2017 for all licensed nurses including Nurse #1 on assessing residents for elopement risk upon admission and/or change of condition using the Elopement Risk Observation form and initiating interventions as needed. Licensed nurses who have not completed the education will not be allowed to work until they are educated. All newly hired licensed nurses will be educated on assessing residents for elopement risk upon admission and/or change of condition using the Elopement	

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F 323	Continued From page 10 total score of 11 was not signed. The MDS Nurse stated that the nursing department, would initiate a Wanderguard for residents who were at a high risk for elopement based on Resident #1's score of 11. In a telephone interview with the Interim Director of Health Services (IDHS) on 10/20/2017 at 11:32 AM, she stated she received a call from Nurse #1 on Sunday night, 09/03/2017, (was not certain of the time) to inform her that Resident #1 was missing from the facility. She explained she did not come in to the facility at that time because she did not live in the area. In an interview with NA #3 on 10/20/2017 at 12:50 PM, she stated she was on duty on the 3:00 PM to 11:00 PM shift when Resident #1 wandered away from the facility. She indicated she first became aware that Resident #1 was not in his room on 09/03/2017 when she was picking up dinner trays around 7:00 PM. NA #3 explained that she and another nursing assistant were asked to search for him, so they drove through nearby apartment complexes, gas stations, and the bus terminal and they were unable to find him. She stated they continued looking for him until it got too dark and then they returned to the facility. NA #3 added that typically, the resident was quiet and did not socialize much, but he did come out of his room and was ambulatory. On 10/20/2017 at 2:10 PM, and interview was conducted with Nurse #1 who was on duty on 09/03/2017 on the 3:00 PM to 11:00 PM shift. Nurse #1 stated the Resident #1 had free access to the building, so when he was not in his room, it was possible he was elsewhere on the campus. She explained he did not have a Wanderguard	F 323	Risk Observation form during new hire orientation by the Clinical Competency Coordinator and/or the Director of Health Services. The Administrator, the Director of Health Services and, the Facility Clinical Consultants educated the MDS nurses on coding wandering assessments accurately based on RAI guidelines. The education was initiated on 10/21/2017 and completed on 10/24/2017. The admission, quarterly and significant change care plans are reviewed for accuracy by the Case Mix Director, Social Service Director and Director of Nursing in the area of wandering during the morning clinical meeting to ensure the care plan matches the coding on the MDS and resident assessments. This will be done for 6 months until compliance is sustained. Elopement Risk Observation forms will be completed on admission/readmission, quarterly and change of condition for all residents at risk of elopement. Care plans will be updated with assessment/observation as needed to ensure compliance. Licensed nurses will place immediate intervention to include but not limited to placing the resident on 1:1, complete an elopement observation form, a picture will be placed in the wander guard notebook/elopement risk book with description of the resident; a wander guard will be placed on the resident as needed. The Maintenance Supervisor and/or Housekeeping Supervisor will check	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345061	A. BUILDING _____ B. WING _____	C 10/21/2017

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F 323	Continued From page 11 and at times, he would sit outside the facility. Nurse #1 stated on 09/03/2017, Resident #1's family member had called the facility (could not recall what time it was) and asked her if Resident #1 was in the facility, so she went to check his room and noted he was not there. Nurse #1 returned to the phone and informed the family member he was not in his room, and she would check other areas of the facility and call her back. At that time, she asked two nursing assistants to search other floors of the facility, including the basement level. Nurse #1 stated she called the family member back and reported he was not in the facility, and the family member responded she had called his cell phone, and that Resident #1 stated he was at the bus the bus terminal. Nurse #1 stated she then asked the two nursing assistants to go to the bus station to search for him. She added that she called the police and notified the IDON and the Administrator. In addition, Nurse #1 confirmed she was the nurse who filled out the Elopement Observation Risk Form upon his admission on 07/11/2017. She stated she was told she should have notified the IDHS and initiated behavior monitoring and the Wanderguard Program. She did not specifically remember who told her this, but said she had received in-service education after Resident #1 eloped from the facility. In a follow up interview with Nurse #1 on 10/21/17 at 11:25 AM, she stated the police notified her around 9:00 PM on 09/03/2017 that Resident #1 was found at the bus terminal by a bystander who called EMS. In an interview with the Administrator and the current Director of Health Services (DHS) on 10/20/2017 at 4:11 PM, the DHS explained she	F 323	doors for wander guard compliance using the wander guard tester every day. The Maintenance Director will educate all department heads and weekend supervisors on checking doors for wander guard compliance. On the weekend, the supervisor and/or the Manager on Duty will check the doors for wander guard compliance. Monitoring procedure to ensure that the plan of correction is effective. As of 10/21/2017, an elopement observation audit tool is being utilized by licensed nurses and reviewed by the Director of Health Services and/or Nurse Managers daily for 1 week, then 2x weekly for 3 weeks, then weekly for 4 weeks and, monthly for 4 months. The results of the data collected and interventions implemented of the elopement risk observation audit with tracking and trending by the Director of Health Services will be presented to the Quality Assurance Performance Improvement Committee by the Director of Health Services until 6 months of continued compliance has been sustained. A questionnaire on elopement will be completed with 10% of all staff by the Administrator, Director of Health Services, Clinical Competency Coordinator and, Department Managers weekly for 4 weeks then monthly for 3 months to ensure compliance is maintained. The results of the elopement questionnaire will be correlated by the Administrator and	

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F 323	Continued From page 12 was not involved with the elopement incident for Resident #1 because she was not the DHS at that time. She stated that her role at that time was as a Nurse Navigator, a type of case manager for residents. The Administrator stated the last time the facility could confirm that Resident #1 was seen on 09/03/2017 was at 1:00 PM. The Administrator stated he was called about 7:30 or 7:45 PM on 09/03/2017 by Nurse #1 who reported Resident #1 was not in the facility. He added that he asked Nurse #1 to notify all staff in the building and to assign nursing assistants to search outside. He further stated that Nurse #1 contacted him between 8:00 PM and 9:00 PM to report he was found by the police and that the police reported Resident #1 was taken to the hospital by an emergency medical service (EMS.) The Administrator said that he was never able to confirm who called the EMS, but that police reported he was found at the bus station. The DHS stated Nurse #1, the admitting nurse who filled out the Elopement Risk Observation Form, should have contacted a supervising nurse to initiate behavior monitoring and a Wanderguard program. During the interview on 10/20/2017 at 4:11 PM with the Administrator and the DHS, they provided a corrective action plan the facility had initiated on 09/03/2017 which included educating the nursing staff about the use of the Wanderguard for all residents who had a risk score of 11 or greater with a Brief Interview for Mental Status (BIMS) score of below 13. (A BIMS score below 13 indicates impaired cognition.) On 09/03/2017 through 09/05/2017, Elopement Risk Observation Forms and BIMS assessments were completed for all residents in the facility and Wanderguards were initiated for those who were assessed as	F 323	reported to the Quality Assurance Performance Improvement Committee until 6 months of continued compliance has been sustained Title of Person Responsible for implementing the acceptable plan of correction. The Administrator is responsible for implementing the acceptable plan of correction. Date of Compliance: 11/15/2017	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345061	A. BUILDING _____ B. WING _____	C 10/21/2017

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F 323	Continued From page 13	F 323		

needing one. Follow up with 10% of the staff each week was being completed to test staff on knowledge of information provided in in-service education. Care plans were being updated for those residents who were found to be at risk for elopement and behavior monitoring was being completed weekly in the medication administration records. There was no root cause analysis included in the corrective action plan.

A review of the EMS report dated 09/03/2017 revealed EMS was dispatched to assist the police department for a sick person call. Upon initial assessment at 8:17 PM, Resident #1 had an altered level of consciousness with confusion and disorientation and a heart rate of 95. The report further indicated the resident had bilateral swelling in his feet and that he was transferred to the hospital at 8:27 PM.

The hospital discharge summary dated 09/06/2017 from Hospital #2 indicated Resident #1 was disoriented upon evaluation in the emergency department and was admitted to the coronary intensive care unit on 09/03/2017 with diagnoses including acute kidney injury, elevated liver function tests, acute on chronic congestive heart failure, tricuspid regurgitation, and major neurocognitive disorder. Upon discharge from the hospital, the diagnosis was cardiogenic shock and no problems were resolved. (Cardiogenic shock is a condition in which your heart suddenly can't pump enough blood to meet your body's needs.)

In an interview with Resident #1's physician on 10/21/2017 at 1:17 PM, he stated he had end stage congestive heart failure and was experiencing a slow decline in health and that he

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 323	Continued From page 14	F 323		

felt there was no long term effect on the resident's health due to the elopement. He added that Resident #1 was capable of walking and that it would have been possible for him to ambulate a distance of 3 miles.

Per the google maps revealed the distance between the facility and the bus terminal was 3.0 to 4.5 miles, depending on which route was used.

The weather conditions per AccuWeather on 09/03/2017 for the facility's city was 81 degrees Fahrenheit.

The Administrator and DHS were notified of Immediate Jeopardy on 10/20/2017 at 6:50 PM.

On 10/21/2017 at 6:35 PM, the facility provided an acceptable credible allegation as follows:

Process that lead to the Deficiency:
Resident was admitted to the facility on 7/11/17,
Root Cause Analysis: Failure to provide supervision to prevent elopement.
His elopement risk assessment score was 11 (high risk).
The facility did not initiate interventions to prevent elopement at that time.
Elopement Observation was not completed appropriately.
Admitting Nurse was not properly trained on completing the elopement risk observation form.
Nurse Management change specific to Director Health Services and Clinical Competency Coordinator, caused a gap in orientation and education for licensed staff.
Resignation of positions.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 323	Continued From page 15 On 9/3/2017 resident was last observed on third floor at approximately 1300. Facility was made aware that he was not on the premises when the resident's mother called the facility at approximately 1930 and asked the charge nurse to establish if the resident was in the room. The charge nurse quickly checked the room and informed the mother that the resident was not in his room. The mother at this point informed the charge nurse that the resident had called his sister and said he "was trying to get home but had missed the bus." At around 7:54pm, charge nurse notified Administrator and Director of Health Services. At around 8:17pm, the charge nurse called 911 to report the resident missing. The Nurse described the last location the resident was seen, third floor at approximately 1300, description of clothing (tan pants, dark shirt and black lace up shoes) that he was wearing as well as the physical description of resident including height and weight of resident. Around 8:30pm, the police officer arrived to gather more information about the resident (physical description again). At approximately 9:00pm, the police officer informed the charge nurse that the resident had been located in Duke Hospital ER. The Resident was readmitted 9/6/17 at 4:00pm and was reassessed for elopement by the Licensed Nurse; a wander guard was then put into place. The Resident's description and picture was placed in the wander guard book by the Medical Records Director. Resident expired in the facility on 9/22/2017 of CHF. Process for implementing the acceptable plan of correction for specific deficiency. On 9/3/2017, all other residents were accounted for in the facility. 100% elopement assessments were initiated on 9/3/2017 and completed on	F 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345061	A. BUILDING _____ B. WING _____	C 10/21/2017

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F 323	Continued From page 16	F 323		

9/4/2017 by the Director of Health Services and Nurse Management team. Residents with a score of 11 or above, indicating a high-risk for elopement and that have a BIMS score of less than 13, and/or not alert and oriented, had a wander guard placed immediately. The residents were assessed by the Interdisciplinary Team for further intervention recommendations. Three-day behavior logs were initiated for residents who are able to move self throughout the facility with a score of 5-10, identified medium risk on elopement observation form, and were kept on behavior management for 4 weeks. Care plan interventions were implemented, reviewed and / or revised as needed based on the assessment.

Education was initiated on 9/3/2017 by the Administrator, Director Health Services, Clinical Competency Coordinator, Nursing Management team and Department managers for all staff on elopement including assessment of risk, signs of exit seeking behavior, location of the elopement risk book and, who to report signs of exit seeking behavior to 100% education was completed by 9/11/2017. Staff members who have not completed the education will not be allowed to work until they are educated. All newly hired staff will be educated on elopement during new hire orientation by the Director of Health Services and/or the Clinical Competency Coordinator.

Elopement Risk Observation forms will be completed on admission/readmission, quarterly and change of condition. Care plans will be updated with assessment/observation as needed to ensure compliance. Licensed nurses will place immediate intervention to include but not limited to placing the resident on 1:1, complete an elopement observation form, a picture will be

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	345061	A. BUILDING _____ B. WING _____	C 10/21/2017

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PRUITTHEALTH-DURHAM	3100 ERWIN ROAD DURHAM, NC 27705

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F 323	Continued From page 17	F 323		

placed in the wander guard notebook/elopement risk book with description of the resident; a wander guard will be placed on the resident as needed.
The Maintenance Supervisor and/or Housekeeping Supervisor will check doors for wander guard compliance using the wander guard tester every day. The Maintenance Director will educate all department heads and weekend supervisors on checking doors for wander guard compliance. On the weekend, the supervisor and/or the Manager on Duty will check the doors for wander guard compliance.

Monitoring procedure to ensure that the plan of correction is effective.
As of 9/4/17, an elopement observation audit tool is being utilized by licensed nurse and reviewed by the Director of Health Services, Assistant Director of Health Services and/or Nurse Managers daily for 1 week, then 2x weekly for 3 weeks, then weekly for 4 weeks and, monthly for 1 month. The results of the data collected and interventions implemented of the elopement risk observation audit with tracking and trending by the Director of Health Services will be taken to the Quality Assurance / Performance Improvement Committee by the Director of Health Services until 6 months of continued compliance has been sustained.

A questionnaire on elopement is being completed with 10% of all staff by the Administrator, Director of Health Services, Clinical Competency Coordinator and, Department Managers weekly for 4 weeks then monthly for 2 months to ensure compliance is maintained. The results of the elopement questionnaire will be correlated by the Administrator and reported in the Quality

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345061	A. BUILDING _____ B. WING _____	C 10/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEALTH-DURHAM	3100 ERWIN ROAD DURHAM, NC 27705

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F 323	Continued From page 18 Assurance / Performance Improvement Committee until 6 months of continued compliance has been sustained Title of Person Responsible for implementing the acceptable plan of correction. The Administrator is responsible for implementing the acceptable plan of correction. On 10/21 at/2017 at 7:45 PM, validation of the credible allegation was evidenced via interviews with nurses, nursing assistants, residents, and unit supervisors who stated they received in-service education regarding the importance of observing for signs of elopement. Nurses stated they understood the need for completing elopement risk assessments accurately upon admission and after a significant change in condition especially for residents who had severe cognitive impairment. Staff also stated that residents who had a risk of elopement had pictures with their names in an elopement book kept at the nurse's stations for ready reference. An observation of the facility's two exit doors were observed for Wanderguard function, and each door's alarms and locks engaged upon activation by the Wanderguard. There were no residents observed in the outside area at the time of validation.	F 323		
F 520 SS=J	QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS CFR(s): 483.75(g)(1)(i)-(iii)(2)(i)(ii)(h)(i) (g) Quality assessment and assurance. (1) A facility must maintain a quality assessment and assurance committee consisting at a	F 520		11/15/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345061	A. BUILDING _____ B. WING _____	C 10/21/2017

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F 520	Continued From page 19 minimum of: (i) The director of nursing services; (ii) The Medical Director or his/her designee; (iii) At least three other members of the facility's staff, at least one of who must be the administrator, owner, a board member or other individual in a leadership role; and (g)(2) The quality assessment and assurance committee must : (i) Meet at least quarterly and as needed to coordinate and evaluate activities such as identifying issues with respect to which quality assessment and assurance activities are necessary; and (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (h) Disclosure of information. A State or the Secretary may not require disclosure of the records of such committee except in so far as such disclosure is related to the compliance of such committee with the requirements of this section. (i) Sanctions. 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 record review and physician, staff, and responsible party interviews, the facility's Quality Assessment and Assurance (QAA) Committee	F 520	This plan of correction constitutes a written allegation of compliance. Preparation and submission of this plan of	

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F 520	Continued From page 20 failed to identify how a cognitively impaired resident exited the facility without supervision in order to prevent future elopement. This was evident in one of three cognitively impaired resident with exit seeking behaviors. (Resident #1). The facility was unable to account for Resident #1's location for a period of approximately 7 hours until he was found by police at the downtown bus terminal. The immediate jeopardy began on 09/03/2017 when the facility failed to do a root cause analysis in an attempt to determine how Resident #1 left the facility unobserved. Resident #1 was transported by emergency medical services (EMS) at 8:27 PM to a hospital emergency department after being found at a bus terminal by police. Resident #1 was admitted to the hospital after the emergency department evaluation revealed acute on chronic congestive heart failure, acute kidney injury, elevated liver function tests, and major neurocognitive disorder. The Immediate Jeopardy was removed on 10/21/2017 when the facility provided an acceptable credible allegation of compliance. The facility will remain out of compliance at a scope and severity of no actual harm with the potential of no more than minimal harm that is not immediate jeopardy (D). The facility was in the process of full corrective action at that time. Findings included: This tag is cross referenced to F323: Based on record review and physician, staff, and responsible party interviews, the facility failed to prevent elopement from the facility for one of three residents who had cognitive impairment, Resident #1. The facility was unable to account	F 520	correction does not constitute an admission or agreement by the provider of truth of the facts alleged or the corrections of the conclusions set forth on the statement of deficiencies. The plan of correction is prepared and submitted solely because of requirements under state and federal law. Process that lead to the Deficiency: Resident #1 was admitted to the facility on 7/11/17. Root Cause Analysis: The facility failed to provide supervision to prevent elopement. The resident□s elopement risk assessment score upon admission was 11 (high risk) and the facility failed to initiate interventions to prevent elopement at that time. The Admitting Nurse (Nurse #1) was not properly trained on completing the Elopement Risk Observation form. Resignations and Nurse Management changes specific to Director Health Services and Clinical Competency Coordinator caused a gap in orientation and education/training for licensed staff. On 9/3/2017 Resident #1 was last observed on third floor at approximately 1:00pm. Facility was made aware that the resident was not on the premises when the resident□s mother called the facility at approximately 7:30pm and asked the charge nurse (Nurse #1) to establish if the resident was in the room. The charge	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345061	A. BUILDING _____ B. WING _____	C 10/21/2017

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F 520	Continued From page 21 for Resident #1's location for a period of approximately 7 hours until he was found by police at the downtown bus terminal. An interview was conducted with the administrator on 10/21/17 at 1:52 PM regarding the Quality Assurance (QA) program. The administrator said the facility has a QA committee consisting of the medical director, director of nursing, administrator, pharmacy consult, staff development coordinator, case manager, and department heads. The committee met monthly and quarterly. All quarterly meetings were attended by the medical director and the pharmacy consultant. The administrator stated the facility identified concern or issues for QA activity by: The clinical meeting was conducted daily Monday through Friday to discuss issues documented in the 24 hour report identified by nursing, new admissions and any other issues that were brought up. The QA identified concerns through grievances from residents and families. The facility department heads did daily compliance rounds Monday through Friday to identify any concerns also. The QA addressed non-compliance identified during surveys and the facility by putting a plan of correction in place containing the four components of a plan of corrections as required by the federal regulations. The administrator said the facility did not differentiate in the plan of correction between a federal tag or a concerns identified by the facility during QA activity. If non-compliance continued then the monitoring will be extended until compliance is achieved. The administrator stated there were two doors in the facility and both were equipped with wander guard system. The	F 520	nurse quickly checked the room and informed the mother that the resident was not in his room. The mother at this point informed the charge nurse that the resident had called his sister and stated he was trying to get home but had missed the bus. At around 7:54pm, charge nurse notified Administrator and Director of Health Services. At around 8:17pm, the charge nurse called 911 to report the resident missing. The Nurse described the last location the resident was seen, third floor at approximately 1:00pm, description of clothing (tan pants, dark shirt and black lace up shoes) that he was wearing as well as the physical description of resident including height and weight. Around 8:30pm, the police officer arrived to gather more information about the resident. At approximately 9:00pm, the police officer informed the charge nurse that the resident had been located in Duke Hospital ER. The Resident was re-admitted 9/6/17 at 4:00pm. Upon re-admission, the resident was assessed for elopement by a Licensed Nurse and scored 25 on the Elopement Risk Observation form. The resident□s BIMS score was 4. The following interventions were put in place: a wander guard was put in place, the resident□s description and picture was placed in the wander guard book by the Medical Records Director. Resident #1 expired in the facility on 9/22/2017 of CHF. Process for implementing the acceptable plan of correction for specific deficiency.	

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	345061	A. BUILDING _____ B. WING _____	C 10/21/2017

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F 520	Continued From page 22 resident could have got out from either one of these doors since he did not have a wanderguard. The Administrator was notified of Immediate Jeopardy on 10/20/2017 at 6:50 PM. On 10/21/2017 at 6:35 PM, the facility provided an acceptable credible allegation as follows: Process that lead to the Deficiency: Root Cause Analysis: The Quality Assurance process was ineffective to address supervision, MDS assessment and care plan. QA process was not properly implemented. Director of Nursing was not properly trained on QA process. DON was new to her position and new to being a DON. Resignation of positions. On 9/3/2017 Resident #1 was last observed on third floor at approximately 1 PM. The facility was made aware that he was not on the premises when the resident's mother called the facility at approximately 8:30 PM and asked the charge nurse to establish if the resident was in the room. The charge nurse quickly checked the room and informed the mother that the resident was not in his room. The mother at this point informed the charge nurse that the resident had called his sister and said he "was trying to get home but had missed the bus." At around 7:54pm, charge nurse notified Administrator and Director of Health Services. At around 8:17pm, the charge nurse called 911 to report the resident missing. The Nurse described the last location the resident	F 520	On 9/3/2017, all other residents were accounted for in the facility. 100% elopement assessments were initiated on 9/3/2017 and completed on 9/4/2017 by the Interim Director of Health Services and Nurse Management team. Residents with a score of 11 or above, indicating a high-risk for elopement and that have a BIMS score of less than 13, and/or not alert and oriented, had a wander guard placed immediately. Residents with a score of 11 or above, indicating a high-risk for elopement and, have a BIMS score of less than 13, and/or not alert and oriented, had interventions put in place to include a wander guard placed immediately upon notification of the Resident Representative and the Physician. The residents at risk reviewed weekly by the Interdisciplinary Team for any further interventions as needed. Three-day behavior logs were initiated for residents who are able to move self throughout the facility with a score of 5-10, identified medium risk on elopement observation form, and were kept on behavior management for 4 weeks. Care plan interventions were implemented, reviewed and / or revised as needed based on the assessment. Education was initiated on 10/21/2017 by the Administrator, Interim Director Health Services, Clinical Competency Coordinator, Nursing Management team and Department managers for all staff on elopement including assessment of risk, signs of exit seeking behavior, location of the elopement risk book and, who to report signs of exit seeking behavior to	

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F 520	Continued From page 23 was seen, third floor at approximately 1 PM, description of clothing (tan pants, dark shirt and black lace up shoes) that he was wearing as well as the physical description of resident including height and weight of resident. Around 8:30pm, the police officer arrived to gather more information about the resident (physical description again). At approximately 9:00pm, the police officer informed the charge nurse that the resident had been located in Duke Hospital ER. The Resident was readmitted 9/6/17 at 5 PM and reassessed for elopement by the Licensed Nurse; a wander guard was then put into place. The Resident's description and picture were placed in the wander guard book by the Medical Records Director. Resident expired at the facility on 9/22/17 of congestive heart failure. Process for implementing the acceptable plan of correction for specific deficiency. QA process will be reviewed to put emphasis and focus on root cause analysis to drill down to underlying cause of issues related to supervision to prevent accidents, MDS assessments and care plans related to resident wandering and elopement risk. MDS assessments are being reviewed upon admission and significant change for accuracy according to RAI manual, for wandering and supervision, by the IDT during daily risk meeting. Based on the elopement observation scores in conjunction with the BIMS scores the Care plans will be updated to reflect interventions put in place. The Administrator and the Director of Health Services will educate all staff with emphasis and focus on the root cause of what led to the deficiency. Monitoring procedure to ensure that the plan of	F 520	100% education was completed by 11/10/2017. Staff members who have not completed the education will not be allowed to work until they are educated. All newly hired staff will be educated on elopement during new hire orientation by the Director of Health Services and/or the Clinical Competency Coordinator. Education for all licensed nurses including Nurse #1 and nursing aides on identifying and reporting behavior changes was initiated on 10/21/2017 and completed on 11/10/2017. Licensed nurses and nursing aides who have not completed the education will not be allowed to work until they are educated. All newly hired licensed nurses and nurse aides will be educated on identifying and reporting behavior changes during new hire orientation by the Clinical Competency Coordinator and/or the Director of Health Services. Education was also initiated on 10/21/2017 and completed on 11/10/2017 for all licensed nurses including Nurse #1 on assessing residents for elopement risk upon admission and/or change of condition using the Elopement Risk Observation form and initiating interventions as needed. Licensed nurses who have not completed the education will not be allowed to work until they are educated. All newly hired licensed nurses will be educated on assessing residents for elopement risk upon admission and/or change of condition using the Elopement Risk Observation form during new hire orientation by the Clinical Competency	

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F 520	Continued From page 24 correction is effective. Administrator will lead QA meetings with emphasis and focus on root cause analysis in order to assure that basis of issue is addressed to prevent further deficient practices related to MDS assessment, Care Plans and supervision to prevent elopement. Members of the regional team to include senior nurse consultant, clinical reimbursement consultant or area vice president will attend QA meetings for the next six months to ensure that root cause analysis is an integral part of QA process. Title of Person Responsible for implementing the acceptable plan of correction. The Administrator is responsible for implementing the acceptable plan of correction. Validation of the credible allegation of removal of the immediate jeopardy was conducted on 10/21/17 at 5:15 PM. The administrator was interviewed and verbalized understanding of the need for a root cause analysis of how the resident left the building. The Administrator could not determine for sure how the resident left the building. Record review revealed that elopement risk observation forms were completed on all residents on 9/4/17. Record review of the inservice education records sign in sheet revealed facility staff were inserviced regarding elopement policy and Code Pink on 9/3/17, 9/4/17 and 9/5/17. Nurses and nursing assistants were interviewed on the 100, 200 and 300 Halls. The nurses and nursing assistant acknowledged that they	F 520	Coordinator and/or the Director of Health Services. On 10/24/2017, the Administrator conducted education for the QAPI committee members on the QAA/QAPI process with the focus on the root cause analysis. Further, the committee members employed by the facility were assigned the QAPI courses on Pruitt University and were completed by 11/3/2017. Completion certificates were obtained upon completion of the education Elopement Risk Observation forms will be completed on admission/readmission, quarterly and change of condition. Care plans will be updated with assessment/observation as needed to ensure compliance. Licensed nurses will place immediate intervention to include but not limited to placing the resident on 1:1, complete an elopement observation form, a picture will be placed in the wander guard notebook/elopement risk book with description of the resident; a wander guard will be placed on the resident as needed. Monitoring procedure to ensure that the plan of correction is effective. QA process will be reviewed to put emphasis and focus on root cause analysis to drill down to underlying cause of issues related to supervision to prevent accidents, MDS assessments and care plans related to resident wandering and elopement risk. MDS assessments are being reviewed	

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F 520	Continued From page 25 received inservices few weeks ago regarding residents at risk for elopement. The nurses and nursing assistants were able to verbalize the process as described in the facility credible allegation of removal. A sample of residents with wander guard were checked for placement and functionality of the wander guard placement.	F 520	upon admission and significant change for accuracy according to RAI manual, for wandering and supervision, by the IDT during daily risk meeting. Based on the elopement observation scores in conjunction with the BIMS scores the Care plans will be updated to reflect interventions put in place. The Administrator and the Director of Health Services will educate all staff with emphasis and focus on the root cause of what led to the deficiency. Monitoring procedure to ensure that the plan of correction is effective. Administrator will lead Quality Assurance and Performance Improvement meetings with emphasis and focus on root cause analysis in order to assure that basis of issue is addressed to prevent further deficient practices related to MDS assessment, Care Plans and supervision to prevent elopement. Members of the regional team to include senior nurse consultant, clinical reimbursement consultant or area vice president will attend QAPI meetings for the next six months to ensure that root cause analysis is an integral part of QAPI process. The administrator will report to the Quality Assurance and Performance Improvement Committee and areas of non-compliance on a monthly basis for 6 months. Title of Person Responsible for implementing the acceptable plan of correction. The Administrator is responsible for implementing the acceptable plan of	

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F 520	Continued From page 26	F 520	correction. Date of Compliance: 11/15/2017	