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 _____	C 02/23/2018

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 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the	F 550		3/22/18

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

Electronically Signed | 03/16/2018

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F 550	Continued From page 1 exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on record review, observations, and staff interviews, the facility failed to provide care in a dignified manner for 1 of 6 residents (Resident #85) by failing to be eye level while feeding assistance was provided, told the resident he was heavy, placed a paper napkin under the residents chin without consent, attempted to feed the resident while he slept, and dressed the resident in a visibly torn hospital gown. Findings included: Resident #85 was readmitted to the facility on 11/3/17. The Quarterly Minimum Data Set-an assessment tool (MDS) dated 1/11/18 revealed Resident #85 was moderately cognitively impaired, had adequate hearing, speech, and vision, was able to understand others and was understood, and had no behaviors or rejection of care. Resident #85 required extensive assistance for all activities of daily living (ADLs) with the exception of dressing and toileting- which Resident #85 was totally dependent on staff for completion. Resident #85 had one upper and one lower limb impairment. Active diagnoses included: pneumonia, diabetes mellitus (DM), and cerebral vascular accident (CVA). A continuous observation was made on 2/21/18 from 9:15 AM - 9:35 AM. Resident #85 was sitting up in bed with his eyes closed and dressed in a hospital gown which was visibly torn above the right chest pocket. His right chest was exposed. A breakfast tray was brought in by Nursing Assistant #2 (NA #2). NA #2 placed the tray on the bedside table, reached around the resident's shoulders, attempted to reposition Resident #85, and stated, "Oh, you're heavy." NA #2 attempted	F 550	This plan of correction constitutes a written allegation of substantial compliance with Federal and Medicaid requirements. Preparation and/or execution of this correction do not constitute admission or agreement by the provider of the truth of items alleged or conclusions set forth for the alleged deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provision of the state and federal law in order to remove the immediate jeopardy. It also demonstrates our good faith and desire to continue to improve the quality of care and services to our residents. Process that lead to the deficiency The Facility Orientation contained an overview of feeding and repositioning a resident without return demonstration by the Certified Nursing Assistant. The Laundry personnel was not educated to remove the worn linen from circulation. The aide was immediately corrected and educated on proper feeding techniques on 2-21-18. Gown was changed for resident #85 and removed from circulation. Process for implementing a plan of correction for specific deficiency The Clinical Competence Coordinator, Administration and the Nurse Managers	

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F 550	Continued From page 2 to rouse the resident and said, "(Resident #85), you have to wake up so I can feed you breakfast." The resident would not awaken. NA #2 placed a paper napkin under the resident's chin without consent, raised the bed, stood over Resident #85 and attempted to spoon oatmeal into the resident's mouth. NA #2 placed his hand on the resident's shoulder and stated, "You have to wake up (Resident #85)." and fed the resident a spoonful of oatmeal. Resident #85 spit the food out and NA #2 stated, "Don't spit your food out. Come on, stay awake so you can eat." He then attempted to place another spoonful of oatmeal into the resident's mouth. NA #2 was asked what he would do if he was not able to wake a resident up. He stated he would keep trying. He then attempted to push a spoonful of oatmeal into the resident's mouth while Resident #85 clenched his jaw shut. NA #2 was asked to stop. The Administrator entered Resident #85's room at 9:36 AM and was not able to rouse Resident #85. Nurse #2 entered the room at 9:40 AM and assessed Resident #85's vital signs and blood glucose (sugar) level. After Resident #85 had his vital signs taken he woke up and indicated he had not wanted breakfast. An interview was conducted on 2/21/18 at 10:10 AM with the Director of Nursing (DON). She stated if a NA entered a resident's room and could not wake the resident up, they notified the nurse immediately. She also stated a resident must be fully awake before being fed or could choke or aspirate. She stated, "After the NA gets the nurse the nurse tried to wake the resident. If she could not, she assessed the resident." She also stated staff sat at eye level when a resident was assisted with eating. She stated staff were not to stand over a resident when feeding assistance was provided.	F 550	began education the Licensed Nurses and Nursing Assistants on 2/26/18 regarding feeding and repositioning residents including , ensuring the resident is awake, feeding a resident at eye level, sitting down when feeding a resident, and when to notify a nurse when unable to arouse the resident. This education has been added to the General Orientation for all Licensed Nurses and Certified Nursing Assistants. The Administrator and Department Managers are visibly observing Certified Nursing Assistants feeding residents sitting and in bed to ensure proper positioning, feeding technique and resident preference is observed for clothing protectors. Monitoring to ensure effectiveness of POC The Administrator and/ or Director of Health Services is correlating the data received from the observation of the residents, sitting and in bed to ensure proper positioning during feeding, feeding technique, and resident preference is observed for clothing protectors, and presenting the trend and analysis to the Quality Assurance and Performance Improvement Committee monthly until three consecutive month of compliance is maintained, then quarterly. Title of person responsible for implementing the POC	

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F 550	Continued From page 3 An interview was conducted on 2/21/18 at 10:15 AM with the Administrator. She stated if an NA could not wake a resident they were to get the nurse immediately. If the nurse could not wake the resident she assessed the resident, including a blood glucose, and if everything was within normal limits but the resident was not awake the doctor was paged. She also stated, "You should never try feeding a resident you can't wake they could choke, aspirate, pocket the food and aspirate later." The Administrator also stated it was her expectation if a resident was in a hospital gown it would not be torn.	F 550	The Administrator/ Director of Health Services is responsible for implementing the plan of correction	
F 558 SS=D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on record review, staff and resident interviews, and observations, the facility failed to place a telephone, television, and water pitcher within reach for 1 of 27 residents (Resident #85), and failed to place a call light within reach for 2 of 27 residents (Resident #22 and Resident #85) reviewed for accommodation of needs. Findings included 1. Resident #85 was readmitted to the facility on 11/3/17. The Quarterly Minimum Data Set, an assessment tool (MDS), dated 1/11/18 revealed Resident #85 was moderately cognitively impaired, had adequate hearing, speech, and vision, was able to understand others and was	F 558	Process that lead to the deficiency The Facility failed to identify the appropriate accommodation of the room to accommodate the left side neglect of the resident. The Facility staff failed to identify that the residents call bell was not within reach. Resident number 85 was moved to a room with the TV and night stand on the right side to accommodate his left sided neglect. The call bell was attached to allow access with residents right hand. Water pitcher was placed on table on right	3/22/18

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F 558	Continued From page 4 understood, and had no behaviors or rejection of care. Resident #85 required extensive assistance for all activities of daily living (ADLs) with the exception of dressing and toileting- which Resident #85 was totally dependent on staff for completion. Resident #85 had one upper and one lower limb impairment. Active diagnoses included: aphasia (loss of ability to understand or express speech), hemiplegia (paralysis on one side of the body), and cerebral vascular accident. A review of the care plans dated 10/16/17 revealed care planning for side effects from antipsychotic medications. Interventions to achieve stated goals included "keep call light within arm's length of resident and teach how to use call light to request assistance." An observation was made on 2/21/18 at 9:15AM.The resident's telephone was on the floor between beds A and B and the handset was off the hook. The call bell was next to Resident #85's left hand. And the television was on and pushed against the wall on the left side of the bed, where the resident was not able to see the screen. The resident was sitting up in bed with his head turned to the right. An observation was made on 2/21/18 at 10:15 AM. The call light hung to the floor from the bed frame behind Resident #85's head. An observation was made on 2/23/18 at 10:10 AM. The resident's phone was under a pillow in the seat of a wheelchair pushed against the wall behind the resident's head. The resident's water filled cup was on his over bed table behind the head of the resident's bed. The call bell was stretched across the resident's bed and placed by his left hand. The resident was sitting up in bed, his left hand was contracted and his head was turned to the right. The television was on and against the wall on the left side of the resident's	F 558	side of bed with phone. Resident number 22 call bell was placed within reach. A new clip was placed on call bell cord to attach to resident. Process for implementing a plan of correction for specific deficiency The Administrator, Director of Health Services, Clinical Competency Coordinator and/or Nurse Managers began educating all staff regarding accommodation of resident needs to include call bells within reach and the resident□s physical environment is accommodating to their weaknesses on 2/23/2018. The Department Managers are observing resident rooms for accommodation of needs related to call bells and physical environment is accommodating the resident weakness. The Director of Nursing and/or Administrator will track and trend the review. Monitoring to ensure effectiveness of POC The Administrator and/or Director of Nursing will present the analysis of the tracking and trending of the accommodation of needs to the Quality Assurance and Performance Improvement Committee monthly until three consecutive months of substantial compliance is maintained then quarterly. Title of person responsible for implementing the POC The Administrator and Director of Nursing	

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F 558	Continued From page 5 bed where the resident was not able to see the screen. Resident #85 was not able to answer questions. An interview was conducted on 2/21/18 at 9:05AM with NA #2 who usually cared for Resident #85. He stated, "Residents press their call bells when they need assistance from the staff. Everyone is expected to answer them. I do checks every 1-2 hours. (Resident #85) has a call bell, but doesn't use it. He can use it, but doesn't always. I don't think he can use his left hand, and he is always looking to the right." An interview was conducted on 2/21/18 at 10:10 AM with the Director of Nursing (DON). She stated, "If a resident is able to use a call bell it should be within reach whether they are in or out of bed. If they can't use the button type they are given a pancake pad. My expectation is for all call bells to be within reach. Staff should check for call bell placement during their 2 hour checks, or anytime they go in the room." An interview was conducted on 2/21/18 at 10:15 AM with the Administrator. She stated her expectation was call bells were kept within reach of all residents while in or out of bed.She also stated telephones and water pitchers should be kept on the over bed table where the resident was able to reach them. She also stated televisions should be where residents were able to see the screen. An additional interview with the Administrator was conducted on 2/23/18 at 10:30 AM. After an observation of Resident #85 she stated his water cup was out of reach, his telephone was under a pillow in the wheelchair, he was not able to see the television, and his call bell was lying across the bed near his left hand. She stated her expectations were for all of these items to be kept within the Resident's reach.	F 558	is responsible for implementation of the plan of correction.	

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F 558	Continued From page 6	F 558		

2. Resident #22 was readmitted to the facility on 11/25/16. The Quarterly MDS dated 11/29/17 revealed Resident #22 was moderately cognitively impaired and had no behaviors or rejection of care, had adequate vision and hearing, and was able to make herself understood. Activities of daily living (ADLs) required extensive assistance, except eating which required limited assistance from others. Resident #22 was always incontinent of urine and stool. Active diagnoses included: heart failure, dementia, anxiety, major depressive disorder, and chronic pain. Resident #22 received Hospice services.

An interview was conducted with Resident #22 on 2/19/18 at 11:00 AM during an observation. The call bell was on the floor underneath the bed. Resident #22 was lying supine (on her back) in the bed and stated she used the call bell when she was able to find it. Additional observations were made on 2/20/18 at 8:50 AM, 2/20/18 at 9:50 AM, 10:50 AM, 12:00 PM, and 4:00 PM, as well as, 2/21/18 at 8:40 AM and all revealed Resident #22 lying supine in the bed and the call bell on the floor underneath the resident's bed.

An interview was conducted with NA #4 on 2/20/18 at 12:05 PM. He stated Resident #22 had been sleeping more and was eating less than usual lately. He also stated Resident #22 was very vocal about her needs and used her call bell 'a lot.' NA #4 stated, "She is always pressing it, pressing it, pressing it. I go in at meal time and wake her up to eat. She'll eat a few bites and then goes back to sleep. She's total care so I check on her every time I walk by her room."

An observation was made on 2/21/18 at 8:55 AM. Resident #22 was lying in bed and yelled out, "Help. Please help me." Nurse #3 went into the room, asked the resident what was needed. The

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F 558	Continued From page 7 resident stated she was in pain. An interview was conducted with Nurse #3 on 2/21/18 at 9:00 AM. She stated, "Residents use call bells to alert us they need something. (Resident #22) yells out mostly, but is able to use her call bell. As of right now, she couldn't use her call bell because it's on the floor, under her bed." Nurse #3 placed the call bell in the resident's right hand. An interview was conducted on 2/21/18 at 10:10 AM with the DON. She stated, "If a resident is able to use a call bell it should be within reach whether they are in or out of bed. If they can't use the button type they are given a pancake pad. My expectation is for all call bells to be within reach. Staff should check for call bell placement during their 2 hour checks, or anytime they go in the room." An interview was conducted on 2/21/18 at 10:15 AM with the Administrator. She stated her expectation was call bells were kept within reach of all residents while in or out of bed.	F 558		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff.	F 657		3/22/18

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F 657	Continued From page 8 (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on record review and family and staff interviews, the facility failed to update care plans quarterly, as required, for 1 of 29 residents (Resident #85). Findings included: Resident #85 was originally admitted to the facility on 10/3/17 and was readmitted 11/3/17. The Quarterly Minimum Data Set-an assessment tool (MDS) dated 1/11/18 revealed Resident #85 was moderately cognitively impaired, was able to understand others and was understood, and had no behaviors or rejection of care. Resident #85 required extensive assistance for all activities of daily living (ADLs) with the exception of dressing and toileting- which Resident #85 was totally dependent on staff for completion. Resident #85 had one upper and one lower limb impairment. Active diagnoses included: pneumonia, diabetes mellitus (DM), hemiplegia (paralysis on one side of the body), manic depression, schizophrenia, and cerebral vascular accident (CVA). Current care plans were dated 10/16/17, except a	F 657	Process that lead to the deficiency The Case Mix Director failed to update the quarterly care plan due to an oversight on the schedule. The care plan was updated for resident number 85 on 2/23/18 and a care plan meeting was scheduled for 2/27/18. Process for implementing a plan of correction for specific deficiency The Case Mix Director began educating the Case Mix Coordinator□s on 2/22/18 regarding maintaining a log that shows the flow of MDS, care plan invitation and care plan updates. The Case Mix Director and Case Mix Coordinator are maintaining a log that correlates the date the MDS was completed, date the care plan letter was sent to the families and the date the care plan meeting was held and updated.	

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F 657	Continued From page 9 care plan which addressed a decline in ADLs (updated 12/7/17), and a care plan which addressed a potential for alteration in nutrition, (updated 2/13/18). An interview was conducted on 2/20/18 at 3:30 PM with a family member (FM) of Resident #85. The FM stated she had attended one care plan meeting, but was not made aware of any other care plan meetings. An interview was conducted on 2/21/18 at 4:00 PM with the Case Mix Director (Nurse #2). She stated, "I manage the MDS office. I ensure all assessments are completed timely, I close the MDS and transmit it. Care plans are generated from resident assessments, the Interdisciplinary team reviews all the records and edits the care plans as needed. If a care plan is updated we will write the date and sign it. We have 48 hours after admission to write a baseline care plan and by day 14 we do a comprehensive assessment and start a comprehensive care plan. Care plans must be reviewed quarterly (every 3 months). If care plans were completed in October one had to be completed in January. I send a letter to the family inviting them to a care plan meeting and include the date and time. We will reschedule a care plan meeting at the family's request. We use a schedule tracker to keep up with when updates are due. We pull the schedule tracker 1-2 times per month and review the residents coming due. For (Resident #85), he has had only 1 care plan meeting in October. We identified yesterday we had missed the quarterly care plan meeting for January so we spoke with the family and sent out a letter. The care plan meeting is scheduled for next Tuesday 2/27/18. It doesn't look like any other care plan meetings were held since October."	F 657	The Case Mix Director is tracking and trending the log that identifies the date the MDS was completed, date the care plan letter was sent to the families and the date the care plan meeting was held and updated. Monitoring to ensure effectiveness of POC The Case Mix Director will present the analysis of the tracking and trending of the log that identifies the date the MDS was completed, date the care plan letter was sent to the families and the date the care plan meeting to the Quality Assurance and Performance Improvement Committee monthly until three consecutive months of substantial compliance is maintained then quarterly. Title of person responsible for implementing the POC The Case Mix Director is responsible for implementing the plan of correction.	

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F 675	Continued From page 10	F 675		
F 675 SS=D	Quality of Life CFR(s): 483.24 § 483.24 Quality of life Quality of life is a fundamental principle that applies to all care and services provided to facility residents. Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observations, record review and interviews with facility staff, the facility failed to keep a resident at 90 degrees during meals as directed by the posted swallowing strategies for 1 (Resident #3) of 7 residents reviewed for activities of daily living (ADLs). The findings included: Resident #3 was admitted to the facility on 8/19/17 with diagnoses which included difficulty walking, Alzheimer ' s Dementia and dementia with behavioral disturbances. The quarterly Minimum Data Set (MDS) dated 2/2/18 revealed Resident #3 was severely cognitively impaired and required extensive assistance with ADLs including assistance of one staff member for eating. The MDS revealed the resident had weight loss and had received speech therapy. The care plan reviewed 2/20/18 revealed Resident #3 had a cognitive deficit and had a potential for alteration in nutrition due to current	F 675	Process that lead to the deficiency The Certified Nursing Assistant failed to properly position the resident to a 90 degree angle during feeding related to the bed mechanics could not position to a 90 degree angle nor did the Certified Nursing Assistant provide pillows to maintain the residents proper positioning. Resident #3 was assessed by nursing. Lung sounds, monitored temperature for 72 hours. Process for implementing a plan of correction for specific deficiency The Director of Nursing, Nurse Manager and/or Administrator began education on 2/23/18 of the Licensed Nurses, Certified Nursing Assistance, on proper positioning of a resident during mealtimes and following the recommendations of the Speech Therapist during feeding. The Administrator and Department	3/22/18

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 _____	C 02/23/2018

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

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F 675	Continued From page 11 disease process. The interventions included to monitor intake, serve diet as ordered and Speech Therapy (ST) to evaluate and treat as needed. A review of a progress note dated 1/22/18 by the Registered Dietitian (RD) read Resident #3 was on a mechanical soft with pureed meats diet and based on the speech therapy evaluation may need the diet to be downgraded. A review of the doctor's orders revealed on 1/25/18 Resident #3's diet was changed to a pureed diet with thin liquids. During an observation on 2/20/18 at 4:04 PM Resident #3 was observed sitting in bed with the head of the bed raised. He was slumped, leaned to his right side and attempted to feed himself. No staff members were present in his room. Also, during this observation a sign posted on the bulletin board near the resident's bed read, "Swallow Strategies: 1. Sit up-right at 90 degrees (bed or chair) with all meals." It was noted the head of the bed was less than 90 degrees during this observation. On 2/23/18 at 9:30 AM Resident #3 was observed sitting in bed with his breakfast tray on the over bed table across his bed. The head of the bed was not elevated to 90 degrees. No staff were present in his room nor assisted him with eating. On 2/23/18 at 9:40 AM Speech Therapist (ST) #1 was interviewed. She stated she was the therapist who worked with this resident. She said the "Swallowing Strategies" posted on the bulletin board were current and should be implemented at all meals. She observed the resident and stated	F 675	Managers are visibly observing Certified Nursing Assistants feeding residents sitting and in bed to ensure proper positioning with Speech Therapy recommendation. Monitoring to ensure effectiveness of POC The Administrator and/ or Director of Health Services is correlating the data received from the observation of the residents, sitting and in bed to ensure proper positioning with Speech Therapy recommendation and presenting the trend and analysis to the Quality Assurance and Performance Improvement Committee monthly until three consecutive month of compliance is maintained, then quarterly. Title of person responsible for implementing the POC The Director of Nursing and/or Administrator is responsible for implementation of the Plan of Correction	

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F 675	Continued From page 12	F 675		

the head of bed was only at 70 degrees and not at the required 90 degrees.

On 2/23/18 at 9:45 AM Nursing Assistant #1 stated Resident #3 did not want to get out of bed this morning so he received his breakfast while in bed. She stated she was not able to get the resident's bed to 90 degrees.

During an observation of the Resident #3 on 2/23/18 at 9:45 AM Nurse #1 stated he was not sitting at 90 degrees and based on the posted swallowing guidelines the resident should be sitting at 90 degrees.

On 2/23/18 at 10:07 AM the Director of Nursing (DON) stated the expectation was for the head of the resident's bed to be at the correct upright position or the resident should be out of bed, or if the bed will not elevated to 90 degrees then the resident ' s bed should be replaced with one which would allow residents to sit in the proper upright position.