PRINTED: 03/11/2019 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		345061	B. WING				C
NAME OF PE	ROVIDER OR SUPPLIER	040001			TREET ADDRESS, CITY, STATE, ZIP CODE	02	/19/2019
PRUITTHE	EALTH-DURHAM				I00 ERWIN ROAD URHAM, NC 27705		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 000	INITIAL COMMENTS		F	000			
F 600 SS=J	1/18/19 and a Statem posted on 1/23/19. Ac obtained on 2/12/19. Immediate Jeopardy of CFR 483.12(a)(1) at severity of J The tag F600 constitution. The immediate Jeopardy of An partial extended so 2/19/19. The 2567 was The exit date of the so 2/19/19. Free from Abuse and CFR(s): 483.12(a)(1) §483.12 Freedom from Exploitation The resident has the ineglect, misapproprial and exploitation as desincludes but is not limic corporal punishment,	rag F600 at a scope and attes Substandard Quality of a rdy began on 1/7/19. The vas removed on 2/13/19. The vas removed on 2/13/19. The vas removed on 2/19/19. The vas amended on 2/19/19. The vas amended on 2/19/19. The vas amended on 2/19/19. The vas changed to a right to be free from abuse, tion of resident property, of fined in this subpart. This ited to freedom from involuntary seclusion and ical restraint not required to redical symptoms.	F	600			3/3/19
	§483.12(a)(1) Not use physical abuse, corpo involuntary seclusion;	e verbal, mental, sexual, or oral punishment, or					
ADODATODY		IS HOLITIEL AS EVIDENCED	DE.		TITI F		(X6) DATE

01/24/2019

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

Electronically Signed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	LE CONSTRUCTION	, ,	(X3) DATE SURVEY COMPLETED	
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		345061	B. WING)2/19/2019	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	₫		
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PROTTINE	ALI H-DUNHAW			DURHAM, NC 27705			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF COR	RRECTION	(X5)	
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	COMPLETION DATE	
F 600	Continued From page	n 1	F 60				
1 000	Continued From page	= 1	F 60	0			
	by:						
		iew, radiology interview,		This plan of correction constit			
		services interview, nurse		written Allegation of Complian			
		, family interview, and staff		federal and state requirements			
		failed to prevent femur		Preparation and submission o			
	fractures for 1 (Resid			Allegation of Compliance does			
		or injuries of unknown origin.		constitute an admission or agr			
		d femur fractures in both her		the provider of truth of the fact	•		
	legs without a plausib	Die reason for this		the corrections of the conclusi forth on the statement of defic			
	occurrence.						
	Immediate Joanardy	hagan an 1/7/10 when		plan of correction is prepared			
		began on 1/7/19 when		submitted solely because of reunder state and federal law.	equirements		
		acute fracture of the proximal		under state and lederal law.			
		ite fracture of the distal right e Jeopardy was removed on		Corrective action the resident	found to		
		ility provided an acceptable		have been affected by the def			
		compliance. The facility will		practice:	ICIETIL		
	_	ance at a scope and severity		practice.			
		no actual harm with potential		Resident #1 no longer resides	in the		
		Il harm that is not immediate		facility.	iii tiiC		
		nonitoring and all staff have		laomty.			
	been in-serviced.	normoring and an stan have		Corrective action for other res	idents		
	been in servicea.			having the potential to be affe			
	Findings included:			same deficient practice:	sted by the		
		nitted to the facility with		On 2/13/2109, skin and pain a			
	diagnoses of multiple			for all residents in the facility v			
		, seizure disorder, and		and completed the same day	•		
	placement of a gastro	ostomy feeding tube.		Director of Health Services (D			
				Coordinators and, charge nurs			
		most recent quarterly		the residents assessed exhibit	•		
	,	DS) assessment dated		signs or symptoms of possible			
		ent #1 as cognitively intact		The Senior Clinical Nurse Co			
		ve assistance of one person		present to ensure skin and pa			
		omotion, dressing and		assessments were initiated ar			
		ocumentation on the MDS		completed appropriately. For r			
		ealed the resident did not		who were out of the facility on			
		rred out of bed once or twice		skin and pain assessments we			
	with the assistance of	f two people during the		conducted upon return/readm	ission to the		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING COMPL		ATE SURVEY DMPLETED	
		345061	B. WING			C 02/19/2019
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 3100 ERWIN ROAD DURHAM, NC 27705		32/10/2010
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
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	assessment period. the MDS assessment belowed and bladder a motion impairment of lower extremities. The documentation on 10/16/18, for Re area for the potentiato a history of multipaccidents with impatransfer, and some Interventions on the reminder to call for ambulation, bed in I reach, and maintain mechanical lift with The documentation addressed the need assistance of one to activities of daily lividue to impaired modeconditioning, and There was no documursing progress not 1/7/19 and signed be 3:00 PM Nurse (Nu had edema on her I	Resident #1 was coded on ant as always incontinent of as well as having range of on both sides of upper and in the care plan, last updated sident #1 revealed a focus al for injury from falls relative ble cerebral vascular sired mobility, mechanical lift cognitive impairment. It care plan included a assist with transfers and/or ow position, call light within sing safety with transfers via the assistance of two people. In the care plan also a for Resident #1 to have be two staff members with the sing and incontinent care needs bility, tube feeding, general weakness.		facility. For new admissions, ski pain assessments will be conduct the charge nurse and/or the Unit Coordinator upon admission. An residents who exhibit any signs possible fractures, a charge nurse the Unit Coordinator will immedinotify the for further treatment recommendations to include but limited to X-rays as needed for practures. Therapy referrals will be made a based on the assessments for recommendations on resident traccordance with their diagnoses minimize any injuries during resit transfers. On 2/13/2019, MDS Coordinators printed out a diagnosed sequence for all residents with dincluding but not limited to Osteo Osteoporosis, Osteoarthritis, Osteomyelitis, and Cerebro-Vas Accident (CVA) to be used by the team to conduct weekly assess possible fractures for residents a risk. Interviews on abuse and neglect and oriented residents were conthe Director of Social Services a completed by 2/13/2019. For alle oriented residents admitted to the hospital, interviews for abuse and will be conducted by the Directo Services upon readmission to the	cted by t ny of pain for se and/or ately t not cossible as needed ansfers in s to ident noses diagnoses openia, cular ne nursing ments for at high t for alert aducted by and ert and ne nd neglect of Social	
	documented on this			There is no concern of abuse ide during the interviews. Systemic changes made to ensuthe deficient practice will not rec	entified ure that	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
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PRUITTHE	EALTH-DURHAM			DURHAM, NC 27705			
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	fracture of the distal r to closer to the cente	nal left femur and an acute right femur. Proximal refers r of the body while distal ne center of the body.		Education was initiated on 2/13/2 the Administrator, Director Healt Services, Clinical Competency Coordinator, Nursing Manageme and Department managers for a	h ent team		
	transfer form dated 3 Resident #1 was tran a fracture and pain in	on at the nursing home to		Prevention of Patient Abuse (me verbal, sexual, physical -includin of unknown origin), Neglect, Exp Mistreatment, and Misappropriat Resident Property. 100% educat completed on 2/19/2019. Staff m who have not completed the edunot be allowed to work until they	ental, g injuries ploitation, ion of tion was nembers ucation will		
	"Patient (Resident #1 oriented to EMS arriv Facility staff state pat fractures, which discordiology consult. EM upon receipt of the rethat patient states the overnight. Patient stabed by a facility CNA in the evening. Facility of circumstances of for notified of fall or reas pain, but fully alert ar	d dated 1/7/19 revealed,) found in her bed, alert and ral in significant distress. cient has bilateral femur overed following a bedside dS was activated by facility results. Facility staff reports at she fell out of bed retes she was pulled out of (certified nursing assistant) rety staff at bedside is unaware all as they had not been rety oriented. Patient endorses reg. Patient has L (left) sided revious CVA		educated. All newly hired staff w educated on Prevention of Patie (mental, verbal, sexual, physical injuries of unknown origin), Negl Exploitation, Mistreatment, and Misappropriation of Resident Produring new hire orientation by the of Health Services and/or the Cli Competency Coordinator. Skin and pain assessments will completed on admission/readmisten weekly using the skin audit the pain assessment tool. Care poeupodated with observations from assessments as needed to ensure compliance. On 2/13/2019, Unit Managers/Coordinators and chanurses were notified by the DHS responsibility to do skin and pain assessments and they will immediate in the pain assessments and they will immediate the service of the pain assessments and they will immediate the service of the pain assessments and they will immediate the pain assessments and the pain assessmen	ill be nt Abuse -including ect, pperty e Director nical pe ssion and tool and plans will pm ire rge of their		
	PM with the paramed documentation in the He stated he heard F	ducted on 2/18/19 at 1:22 lic who wrote the EMS record dated 1/7/19. Resident #1 correct a staff that Resident #1 fell out of		notify the DHS and the physiciar concerns for appropriate recommendations. The Unit Coordinators/Managers and MD Coordinators are responsible for	n of any		

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
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PRUITTHE	ALTH-DURHAM				URHAM, NC 27705		
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			+		DEL IGIERO I)		
F 600	say she was pulled of the night shift. The part by the nurse who gave was someone who consumed the paramedic also stated extreme pain that she werbalizing much at the transport to the hospital transport to the reduction note data assessment of the reduction of the reduction of the reduction of the reduction of the plan was traction due to bilater surgical repair when the surgical repair when the reduction of the resident was identificated by the resident was identificated that the resident was stated that th	stated he heard Resident #1 ut of bed by a nurse aide on aramedic stated he was told we him report, Resident #1 buld be believed. The d Resident #1 was in such e really was not talking or he time of the emergency ital. ke Orthopedic surgery ed 1/7/19 revealed an sident. The resident was enting with "altered mental onfusion and inability to e exam portion of the led the swelling in her distal n defect" as well as swelling skin defect." Documentation is to put the resident in al femur fractures and the patient was medically o care for Resident #1 from on 1/7/19, was interviewed it. Nurse #1 explained how itified as having a fracture. on Monday morning two	F	600	care plans and were notified of the sam on 2/13/2019 by the Administrator and DHS. The Senior Clinical Nurse Consultant we conduct unannounced audits/checks for skin and pain assessments monthly for months. Any areas of non-compliance be reported to the QA committee for further recommendations. The Senior Clinical Nurse Consultant will attend Quality Assurance and Performance Improvement meetings to ensure compliance is maintained. Starting on 2/18/2019, a questionnaire Abuse will be completed with 10% of a staff by the Administrator, Director of Health Services, Clinical Competency Coordinator and, Department Manager weekly for 4 weeks then monthly for 2 months and then quarterly for 3 quarter to ensure compliance is maintained. The results of the Abuse questionnaire will collected by the Administrator and reported to the Quality Assurance / Performance Improvement Committee until 6 months of continued compliance has been sustained. Starting on 2/18/2019, a questionnaire Abuse will be conducted and complete with 50% of alert and oriented residents.	the vill or s will on ll s rs ne on d s	
	Resident #1 was in p Nurse #1 stated she Resident #1. Nurse # indicated she was red she fell out of bed. No #1 told her the nurse	and NA #5) informed her ain and stated she had a fall. went into the room to assess to stated that Resident #1 ceiving incontinent care and urse #1 stated that Resident aide, who was providing ut her back in bed by herself.			by the Director of Social Services and/of the Activities Director weekly for 4 wee then monthly for 2 months and then quarterly for 3 quarters to ensure compliance is maintained. The results of the Abuse questionnaire will be collected by the Administrator and reported to the Quality Assurance / Performance	ks, of ed	

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NAME OF PI	ROVIDER OR SUPPLIER	1.000		STREET ADDRESS, CITY, STATE, ZIP CODE	02/19/2019	
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F 600	Continued From page	e 5	F 600			
	a mechanical lift was bed after the fall and mechanical lift was u skin assessment and had swelling but no be that she also noted the but that this was not Nurse #1 stated that left lower leg was bein hose. Nurse #1 state bruising on any part of Nurse #1 said she gather gastrostomy tubes.	ne questioned Resident #1 if used to put her back in the Resident #1 denied a sed. Nurse #1 said she did a noticed the right upper thigh truising. Nurse #1 revealed he left lower leg had swelling unusual for this resident. It the edema to the Resident's ng treated with compression d that she did not note any of the body of Resident #1. It we Resident #1 Tylenol via and then called the Director d the Administrator. Nurse		Improvement Committee until 6 more continued compliance has been sustained. Plans to monitor its performance to sure that solutions are sustained; A skin audit tool and a pain assessmant tool will be utilized by Unit Coordinators/Managers starting on 2/13/2019 and reviewed by the Dire Health Services and/or the Clinical I Consultant daily for 1 week, then 2x weekly for 3 weeks, then weekly for weeks and, monthly for 1 month and	make nent ctor of Nurse	
	#1 stated she then co ordered x-rays to be Nurse #1 noted that t normal. Nurse #1 sta	ontacted the doctor who done as soon as possible. the resident's vital signs were ted she received no report ft of any fall that occurred for		quarterly thereafter. The results of a and assessments will be collected a presented to the Quality Assurance Performance Improvement Committ the Director of Health Services until months of continued compliance habeen sustained.	audits and / dee by 6	
	Resident #1 for the 7 1/7/19 was interviewed NA #1 stated that at 1 to 3:00 PM shift, Resistated Resident #1 with began to raise the her #1 in preparation for #1 stated NA #5 cam Resident #1 cried out the bed was raised. It room of Resident #1 wrong. NA #1 stated both her legs were her strying to change her stream of the stated has been strying to change her stream of the stated has been strying to change her strying to change her stream of the stated has been strying to change her strying to the strying to change her strying to change her strying to change her strying to the stry	#1) assigned to care for :00 AM to 3:00 PM shift on ed on 1/18/19 at 11:20 AM. the beginning of the 7:00 AM ident #1 was asleep. NA #1 ras awakened by NA #5 who rad of the bed for Resident being served a meal tray. NA e to get her because t in pain when the head of NA #1 stated she went to the and asked her what was that Resident #1 told her curting and that a girl was and she fell on the floor. The int to get the nurse who came		Starting on 2/18/2019, a questionnal Abuse was initiated with 10% of all by the Administrator, Director of Heist Services, Clinical Competency Coordinator and, Department Manaweekly for 4 weeks then monthly for months and then quarterly for 3 quato ensure compliance is maintained results of the Abuse questionnaire vacilected by the Administrator and reported to the Quality Assurance / Performance Improvement Committuntil 6 months of continued complianas been sustained. Starting on 2/18/2019, a questionna Abuse was initiated and will be com	staff alth gers 2 irters . The vill be gee ince	

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NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 3100 ERWIN ROAD			345061	B. WING			_
			1		3100 ERWIN ROAD	•	02/13/2013
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COM	PREFIX	(EACH DEFICIENC	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
immediately. NA #1 said she considered Resident #1 to be reliable and that she recognized her by name. NA #1 stated that Resident #1 was able to communicate her needs and it was very unlike her to not want to sit up. The nurse practitioner (NP #1) who assessed Resident #1 before she was sent to the hospital on 17/719 was interviewed on 1/18/19 at 12:04 PM. NP #1 stated that 17/719 was the first time she had ever seen Resident #1. NP #1 stated was told Resident #1 that she fell off the bed. NP #1 stated she saw no deformity or bruising on the resident skin. NP #1 stated that if the resident had fell off the bed like she had stated then she would have hit the radiator and would have had scratches and bruising. NP #1 did not understand how the resident could have sustained the fractures and had no explanation. A family member of Resident #1 was interviewed on 1/18/19 at 12:54 PM. The family member stated that in the hospital Resident #1 stated to him that a nurse aide pulled her out of the bed in the facility and she fell. The family member revealed that at the time of the investigation the resident had both her legs. The family member revealed that at the time of the investigation the resident had both her legs in traction and was on a ventilator. The family member revealed that at the time of the care of Resident #1. The nurse aide (NA #2) who was assigned to	F 600	immediately. NA #1 s #1 to be reliable and name. NA #1 stated communicate her ne her to not want to sit The nurse practitione Resident #1 before s on 1/7/19 was intervi PM. NP #1 stated the she had ever seen R that she did an asses to sending her to the told Resident #1 that stated she saw no de resident's skin. NP # had fell off the bed lil would have hit the ra scratches and bruisit how the resident cou- fractures and had no A family member of R on 1/18/19 at 12:54 R stated that in the hos him that a nurse aide the facility and she fe he did not know how broken both her legs revealed that at the t resident had both he a ventilator. The fam were in the process of decisions with regard	said she considered Resident that she recognized her by that Resident #1 was able to eds and it was very unlike up. er (NP #1) who assessed she was sent to the hospital lewed on 1/18/19 at 12:04 at 1/7/19 was the first time resident #1. NP #1 stated ssment of the resident prior hospital. NP #1 stated was the fell off the bed. NP #1 reformity or bruising on the resident would have had ang. NP #1 did not understand all have sustained the rexplanation. Resident #1 was interviewed PM. The family member spital Resident #1 stated to repulled her out of the bed in rell. The family member stated resident #1 could have sustained the relies in traction and was on illy member stated that they of making some hard did to the care of Resident #1.	F 6	with 50% of alert and oriented by the Director of Social Serve the Activities Director weekly then monthly for 2 months are quarterly for 3 quarters to enscompliance is maintained. The Abuse questionnaire will by the Administrator and report Quality Assurance Performar Improvement committee until continued compliance has be sustained. On 2/13/2019, the QAPI committee was notified deficiency and the plan of continued to the plan of continued compliance has be sustained.	vices and/or for 4 weeks, and then source ne results of the collected to the force need 6 months of the collected to the force force for ad-hoc for the force for the forc	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345061	B. WING _			02/) 19/2019
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(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFII TAG	PROVIDER'S PLAN (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	ACTION SHOULD BE O THE APPROPRIA		(X5) COMPLETION DATE
F 600	on 1/6-7/19 was intel PM. NA #2 stated tha #1 on the beginning was asleep and dry. on Resident #1 on a and the resident was she did not hear any Resident #1 overnigh stated that nothing u overnight shift excep on that same night o The Nurse (Nurse #2 for Resident #1 from 1/5/19 and 1/6/19, w 3:50 PM. Nurse #2 s any report from the r falls involving Resider monitored and check her shift on 1/6/19. N checked on Resident #2 stated that at app she checked on Res watching television. I requested pain medi she administered thr Nurse #2 stated she Resident #1 at the el resident was asleep. resident did complain frequently but did no on the 11:00 PM to 7 1/6/19.	from 11:00 PM to 7:00 AM reviewed on 1/18/19 at 3:46 at she checked on Resident of her shift and the resident NA #2 stated she checked second time later in the shift still asleep. NA #2 stated complaints of pain from not or into the morning. NA #2 musual occurred on the triangle for another resident falling in another hall. 2), who was assigned to care 11:00 PM to 7:00 AM on as interviewed on 1/18/19 at tated that she did not receive the saides regarding any ent #1. She stated that she are the don Resident #1 through flurse #2 stated that she that the beginning of her the voiced no concerns. Nurse roximately 3:30 to 4:00 AM fident #1 who was awake and Nurse #2 stated Resident #1 cation for a headache which ough the gastrostomy tube. Went back to check on and of the shift and the Nurse #2 revealed the	F	600			

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	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 3100 ERWIN ROAD DURHAM, NC 27705		2/19/2019	
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F 600	interviewed on 1/18/orthopedic surgeon show Resident #1 coufractures on her legs surgeon stated, "I car for which [Resident # legs at the same time surgeon did not know medical condition that that could have giver surgeon stated that sfractures sustained braccident victims and or fall that would have fractures seen in Resident victims and or fall that would have fractures seen in Resident victims and or fall that would have fractures seen in Resident victims and or fall that would have fractures seen in Resident victims and or fall that would have fractures seen in Resident victims and or fall that would have fractures seen in Resident victims and or fall that would have fractures seen in Resident victims and or fall that would have fractures seen in Resident victims and vict	es on Resident #1's legs was 19 at 4:15 PM. The stated she did not understand ald have sustained the from a fall. The orthopedic mot think of a mechanism et 1] could have broken both e from a fall." The orthopedic of any diagnoses or at Resident #1 currently had a her two fractured legs. The she had only seen the kind of y Resident #1 in car could not think of a process e sustained the kind of	F 60	00			
	itchy and thirsty. NA is unusual happened or was complaining of p NA #3 confided she was care to Resident #1 of shift without the know broken legs.	#3 stated that nothing In the shift but Resident #1 Isain in her legs after dinner. Isas upset she was providing In the 3:00 PM to 11:00 PM Isain in the Resident #1 Isan PM to 11:00 PM and on					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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		345061	B. WING			02/	19/2019	
	ROVIDER OR SUPPLIER			310	EET ADDRESS, CITY, STATE, ZIP CODE 0 ERWIN ROAD RHAM, NC 27705			
(X4) ID PREFIX TAG	(EACH DEFICIENCE	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 600	interviewed on 1/18/ stated she was at the between the time of #3 said she was aler that Resident #1 was #3 stated her first the Resident #1 might he because Resident # care resident. Nurse Resident #1 and ask Nurse #3 stated Res from Nurse #3 and s #3 stated that Reside pain to her at all on stated that there was have fallen out of be taken two people to stated that she was residents and makin that Resident #1 free drink and complaine times. Nurse #3 com and oriented and wa aides providing care The facility document the injuries to Reside Statements were ob staff members who of the same floor as Re January 4, 2019 to N None of the stateme factor for the injuries Documentation of a	Ito 11:00 PM. Nurse #3 was 19 at 6:27 PM. Nurse #3 e nurses station on 1/6/19 7:00 PM and 9:00 PM. Nurse rted by the nurse aide (NA #3) is saying that she fell. Nurse ought was the possibility ave a urinary tract infection 1 did not walk and was a total e #3 said she went to see ited her if she was alright. Sident #1 requested water she was given water. Nurse ent #1 did not complain of 1/5/19 or 1/6/19. Nurse #3 is no way Resident #1 could ind because it would have put her back in bed. Nurse #3 constantly checking on the grounds. Nurse #3 stated quently requested water to do f generalized pain at firmed the resident was alert in its familiar with the nurse for her. Intation of investigation into ent #1 was reviewed. Italied by the facility of all cared for or were working on esident #1 from Friday, Monday, January 7, 2019. Interested the provided by the statement provided by the statement provided by the	F	600				
	facility from the nurs	e aide (NA #6) who cared for						

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		345061	B. WING			C 2/19/2019	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COI 3100 ERWIN ROAD DURHAM, NC 27705		2/19/2019	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 600	shift revealed, "On Si 2019 I [NA #6] was the first shift, 7:00 AM -3 - 10:45 AM I went to bath and she seemed was doing a lot of made her more comf (Nurse #3) that she wasking [Resident #1] and she said yes." Documentation of a see facility from the nurse Resident #1 on 1/5/1 AM shift revealed, "Verification [Resident #1] at about feed (ing) tube I laid he change her then I let her feed tube back of cared for her if anyth she never said anyth the whole time. I put up the little mess aro room. The lady never linterviews were concontracted investigation preceding investigation. The fact with a causative factor.	9 on the 7:00 AM to 3:00 PM unday which was January 6, ne CNA for [Resident #1] on :00 PM. At around 10:00 AM give [Resident #1] a bed do to not be doing well. She baning and groaning, so I ar a quicker bed bath and cortable. I then told the nurse was in pain. I remember was her leg or arm in pain was her leg or arm in pain was her leg or arm in pain when I went to do care with set aide (NA #7) who cared for 9 on the 11:00 PM to 7:00 when I went to do care with set at 1:00 PM to	F 6				

		IDENTIFICATION NUMBED:) MULTIPLE CONSTRUCTION BUILDING			(X3) DATE SURVEY COMPLETED	
		345061	B. WING				C 19/2019	
	ROVIDER OR SUPPLIER		•	STREET ADDRESS, CITY, STATE, ZIP CODE 3100 ERWIN ROAD DURHAM, NC 27705				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 600	AM with a hospital rad 1/7/19 x-ray results for radiologist stated that Resident #1 appeared injuries as evidenced bone. He stated that healing that would had fractures occurred at On 2/12/19 at 1:49 Plinformed of the immer provided a credible at 2/14/19 at 9:03 AM. Trindicated: This plan of correction Allegation of Complia requirements. Prepar Allegation of Complia admission or agreem of the facts alleged or conclusions set forth deficiencies. The plar and submitted solely under state and feder Address how correctifiaccomplished for thospeen affected by the Resident no longer recon 1/7/2019 at aroun nurse aide that her less the fell out of bed. With when she fell, the ress 3:00 am in the night. The notified the charge numediately went in a happened, and the ressident results and the results are results and the results and the results are results an	diologist who reviewed the or Resident #1. The the femur fractures for d to him as acute recent by the jagged edges of the he saw no manifestations of eve typically be seen had the an earlier time period. M, the administrator was diate jeopardy. The facility llegation of compliance on The allegation of compliance on the allegation of compliance on the statement of the corrections of the on the statement of the of correction is prepared because of requirements ral law. Ve action will be se residents found to have deficient practice:	F	600				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345061	B. WING		C 02/19/2019		
	NAME OF PROVIDER OR SUPPLIER PRUITTHEALTH-DURHAM			TREET ADDRESS, CITY, STATE, ZIP CODE 100 ERWIN ROAD URHAM, NC 27705	1 02/10/2010		
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETION		
F 600	skin assessment wiscratches to the skil the leg. The charge Coordinator, the Dir (DHS) and, the physical an order for X-ray frequency fewer as ordered for results. The X-ray refemur fractures were 2:00pm. Upon notification orders to send their room for further evan Administrator was not started interviewing with the resident the the alleged event. A knowledge of this record the day before. Comployees, the Administrator was not the day before. Comployees, the Administrator as the facility or the the the treatment of the	Inmediately did a head to toe th no notable bruising or in except for slight swelling on nurse notified the Unit ector of Health Services sician. The charge nurse got om the physician. Tylenol was r pain while waiting for X-ray esults indicating bilateral e sent to the facility around cation, the physician gave esident to the emergency fluation and treatment. The notified and immediately employees that had worked e day before and the night of all employees denied esident ever falling that night on 1/8/2019, after interviewing ministrator decided to conduct ation for injury of unknown al femur fractures. On nistrator sent report to on for a self-reported injury of and the DHS re-interviewed all the the resident on the days sing (1/7/2019) of the alleged nied the resident ever falling or responses were consistent liews conducted independently	F 600				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
						С	
		345061	B. WING			02/	19/2019
NAME OF PROVIDER OR SUPPLIER PRUITTHEALTH-DURHAM			3	STREET ADDRESS, CITY, STATE, ZIP CODE 1100 ERWIN ROAD DURHAM, NC 27705			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 600	be completed the san Health Services (DHS charge nurses for all the same time, all respossible fractures by and, charge nurses. Consultant was presepain assessments we properly. Residents a be assessed for fractic conducted upon re-acresidents who exhibit possible fractures, a coordinator will immed and an order will be devaluation as needed. Therapy referrals will assessments for recotransfers in accordant minimize any injuries. On 2/13/2019, MDS codiagnoses sequence with diagnoses includ. Osteopenia, Osteopo Osteomyelitis, and Coc (CVA) to be used by tweekly assessments residents at high risk. Interviews on abuse a oriented residents we of Social Services and For alert and oriented hospital, interviews for	actice: udits were initiated and will ne day by the Director of 6), Unit Coordinators and, residents in the facility. At idents were assessed for the DHS, Unit Coordinators The Senior Clinical Nurse ent to ensure skin audits and are initiated and done dmitted in the hospital will ures and skin audits dmission to the facility. Any any signs of pain for charge nurse and/or the Unit ediately notify the physician obtained for X-ray and further . be made based on the mmendation on resident ce with the diagnoses to during resident transfers. Coordinators printed out a for all to ensure all residents ing but not limited to rosis, Osteoarthritis, erebrovascular Accident the nursing team to conduct for possible fractures for and neglect for alert and are conducted by the Director d completed by 2/13/2019. It residents admitted to the or abuse and neglect will be elector of Social Services	F	600			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345061	B. WING				C 19/2019	
NAME OF PROVIDER OR SUPPLIER PRUITTHEALTH-DURHAM				STREET ADDRESS, CITY, STATE, ZIP CODE 3100 ERWIN ROAD DURHAM, NC 27705		V2	10,2010	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE		(X5) COMPLETION DATE	
F 600	systemic changes madeficient practice will Education was initiated Administrator, Director Competency Coordinate am and Department Prevention of Patient sexual, physical -inclusioning, Neglect, Explomisappropriation of Reducation will be commembers who have rewill not be allowed to educated. All newly have prevention of Patient sexual, and physical unknown origin), Negmistreatment, and Mi Property during new Director of Health Se Competency Coordinate Skin audits and pain completed on admission weekly using the skin assessment tool. Car assessment/observation compliance. On 2/13/ Managers/Coordinator notified by the DHS of skin audits and pain a immediately notify the any concerns for app The Unit Coordinator Coordinators are resplans and have been	res will be put into place or ade to ensure that the not recur: ed on 2/13/2019 by the or Health Services, Clinical ator, Nursing Management t managers for all staff on Abuse (mental, verbal, uding injuries of unknown bitation, Mistreatment, and tesident Property. 100% apleted by 2/19/2019. Staff not completed the education work until they are sired staff will be educated on Abuse (mental, verbal, including injuries of allect, Exploitation, sappropriation of Resident hire orientation by the rvices and/or the Clinical ator. assessments will be sion/readmission and then audit tool and the pain e plans will be updated with tion as needed to ensure	F 60					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED			
		345061	B. WING			02/4		
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 3100 ERWIN ROAD DURHAM, NC 27705			02/19/2019		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF X (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIENT	TION SHOULD BI THE APPROPRIA	I	(X5) COMPLETION DATE	
F 600	unannounced audits, pain assessments m Senior Clinical Nurse Quality Assurance ar Improvement meetin maintained. Starting on 2/18/2019 will be completed wit Administrator, Direct Clinical Competency Department Manage monthly for 2 months quarters to ensure coresults of the Abuse collected by the Adm Quality Assurance / I Committee until 6 mc compliance has been Starting on 2/18/2019 will be conducted an alert and oriented res Social Services and/weekly for 4 weeks, and then quarterly for	Jurse Consultant will conduct (checks for skin audits and onthly for 3 months. The consultant will attended Performance gs to ensure compliance is 9, a questionnaire on Abuse th 10% of all staff by the cor of Health Services, Coordinator and, rs weekly for 4 weeks then and then quarterly for 3 compliance is maintained. The questionnaire will be inistrator and reported to the Performance Improvement onths of continued	Fé	DEFICIENT SOLUTION OF THE PROPERTY OF THE PROP	<u> </u>			
	Administrator and re Assurance / Perform Committee until 6 mo compliance has been Indicate how the faci performance to make sustained;	ance Improvement onths of continued n sustained. lity plans to monitor its e sure that solutions are						
	A skin audit tool and	a pain assessment tool with						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		345061	B. WING			C	
	ROVIDER OR SUPPLIER	1 040001		STREET ADDRESS, CITY, STATE, ZIF 3100 ERWIN ROAD DURHAM, NC 27705	CODE	02/19/2019	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN ((EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE O THE APPROPRIA	DATE	
F 600	on 2/13/2019 and re Health Services and Consultant daily for weeks, then weekly 1 month and then quof audits and assess presented to the Quaperformance Improving Director of Health Secontinued compliance Starting on 2/13/201 was initiated with 10 Administrator, Direct Clinical Competency Department Manage monthly for 2 months quarters to ensure or results of the Abuse collected by the Adm Quality Assurance / Committee until 6 mc compliance has been Starting on 2/13/201 was initiated and will alert and oriented re Social Services and/weekly for 4 weeks, and then quarterly for compliance is maintary Administrator and re Assurance / Perform Committee until 6 mc compliance has been	dinators/Managers starting viewed by the Director of for the Clinical Nurse 1 week, then 2x weekly for 3 for 4 weeks and, monthly for larterly thereafter. The results aments will be collected and ality Assurance / tement Committee by the ervices until 6 months of the has been sustained. 9, a questionnaire on Abuse of all staff by the cor of Health Services, or Coordinator and, the weekly for 4 weeks then a sand then quarterly for 3 compliance is maintained. The questionnaire will be an author and reported to the Performance Improvement conths of continued in sustained. 9, a questionnaire on Abuse 1 be completed with 50% of sidents by the Director of for the Activities Director then monthly for 2 months or 3 quarters to ensure a sined. The results of the will be collected by the ported to the Quality cance Improvement conths of continued in sustained. On 2/13/2019, mmittee was notified of the	F	500			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE COMP	(X3) DATE SURVEY COMPLETED		
		D. WILLO			С		
ROVIDER OR SUPPLIER	345061	B. WING	STREET ADDRESS. CITY. STATE. ZIP CODE	02/	19/2019		
PRUITTHEALTH-DURHAM			3100 ERWIN ROAD DURHAM, NC 27705				
SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHO		HOULD BE	(X5) COMPLETION DATE		
Continued From page	e 17	F 60	00				
Date of Compliance:	2/13/2019						
evidenced by record reducation, abuse inte audit forms, pain obse assurance. Interviews	review of the staff abuse rviews with residents, body ervation forms and quality with the staff were						
	ROVIDER OR SUPPLIER SUMMARY STA (EACH DEFICIENCY REGULATORY OR LE Continued From page The Administrator is r the acceptable plan of Date of Compliance: 2 The credible allegation evidenced by record reducation, abuse inter audit forms, pain observations. Interviews	TORRECTION IDENTIFICATION NUMBER: 345061 ROVIDER OR SUPPLIER EALTH-DURHAM SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL	ROVIDER OR SUPPLIER EALTH-DURHAM SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 17 The Administrator is responsible for implementing the acceptable plan of correction. Date of Compliance: 2/13/2019 The credible allegation was verified on 2/19/19 as evidenced by record review of the staff abuse education, abuse interviews with residents, body audit forms, pain observation forms and quality assurance. Interviews with the staff were	A BUILDING 345061 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 3100 ERWIN ROAD DURHAM, NC 27705 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 17 The Administrator is responsible for implementing the acceptable plan of correction. Date of Compliance: 2/13/2019 The credible allegation was verified on 2/19/19 as evidenced by record review of the staff abuse education, abuse interviews with residents, body audit forms, pain observation forms and quality assurance. Interviews with the staff were	A BUILDING COMP 345061 345061 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 3100 ERWIN ROAD DURHAM, NC 27705 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 17 The Administrator is responsible for implementing the acceptable plan of correction. Date of Compliance: 2/13/2019 The credible allegation was verified on 2/19/19 as evidenced by record review of the staff abuse education, abuse interviews with residents, body audit forms, pain observation forms and quality assurance. Interviews with the staff were		