	-	D HUMAN SERVICES			FOF	RM APPROVED
CENTER	S FOR MEDICARE & I	MEDICAID SERVICES				IO. 0938-0391
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ì í	PLE CONSTRUCTION G	· · · ·	TE SURVEY MPLETED
		345551	B. WING		0	C 9/20/2019
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
		_		5935 MOUNT SINAI ROAD		
PRUITIHE	EALTH-CAROLINA POIN			DURHAM, NC 27705		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
E 000	Initial Comments		E 00	00		
	found to be in complia	rtification survey was to 9/20/19. The facility was ance with the requirement ncy Prepardness. Event ID				
F 000	INITIAL COMMENTS		F 00	00		
F 565	conducted from 9/16/ complaint allegations	int investigation survey was 19 to 9/20/19 . 19 of the 19 were not substantiated. p and Response	F 56	65		10/18/19
SS=E	CFR(s): 483.10(f)(5)(i)-(iv)(6)(7)				
	and participate in resi (i) The facility must pr group, if one exists, w reasonable steps, wit to make residents and upcoming meetings ir (ii) Staff, visitors, or or resident group or fam the respective group's (iii) The facility must p person who is approv group and the facility providing assistance a requests that result fr (iv) The facility must of	ther guests may attend ily group meetings only at s invitation. provide a designated staff ed by the resident or family and who is responsible for and responding to written				
	the grievances and re groups concerning iss in the facility.	be able to demonstrate their				
	response and rational (B) This should not be					
LABORATORY		SUPPLIER REPRESENTATIVE'S SIGNATUR	 E	TITLE		(X6) DATE

Electronically Signed

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.

10/11/2019

	-	D HUMAN SERVICES MEDICAID SERVICES			FORM	APPROVED 0. 0938-0391		
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED C			
		345551	B. WING			_ 20/2019		
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	•			
PRUITTHE	EALTH-CAROLINA POIN	г		5935 MOUNT SINAI ROAD DURHAM, NC 27705				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE		
F 565	request of the resider §483.10(f)(6) The resider §483.10(f)(7) The resident family member(s) or or representative(s) meet families or resident re- residents in the facility This REQUIREMENT by: Based on observation and staff interview, the resident grievances the resident council meet August of 2019 conce availability, posting of meals, and variety of Findings included: Review of Resident P Minutes/ Report dated requested the dining meals, and they want meal menu was prior were no menus on the meal tray slip as to wi No resolution was reco Council/Family Counce Form. The form was on 7/11/2019. Patient/Resident Counce continued to be no me time, they had no alter	t or family group. ident has a right to roups. ident has a right to have other resident et in the facility with the presentative(s) of other y. is not met as evidenced n, record review, resident e facility failed to respond to nat were reported in the ings for June, July and erning dining room i menus, offering alternate	F 56	 PruittHealth Carolina Point acknowlereceipt of the Statement of Deficienciand proposes this plan of correction extent that this summary of finding is factually correct and in order to main compliance with applicable rules and provision of quality of care for the resident. The plan of correction is submitted as written allegation of compliance. PruittHealth Carolina Point s responses the Statement of Deficiencies and the plan of Correction does not denote agreement with the Statement of Deficiencies nor does it constitute an admission that any deficiency is acculated for the statement of the statement of Deficiencies on the statement of Deficiencies through informal dispute resolution, formal appeal procedure, and/or other administrative or legal proceedings. 	ies to the tain see to e d urate. ated			

Facility ID: 20090049

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FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER COMPLETED A. BUILDING С 345551 B. WING 09/20/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 5935 MOUNT SINAI ROAD PRUITTHEALTH-CAROLINA POINT DURHAM, NC 27705 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (X4) ID ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 565 Continued From page 2 F 565 at each meal time. No resolution was recorded Education was provided by Administrator on Patient/Resident Council/Family Council to the Activity Director and Assistant on Department Response Form. The form was not 10/9/19 regarding follow-up and resolution signed off. of grievance revealed in resident council. Review of Patient/Resident Council A resident council meeting was held on Minutes/Report Form dated 8/5/2019 revealed 10/11/19 to ensure facility s residents are the members of Resident Council requested aware of dining room availability, posting Dietary department to have a variety in meal of menus, offering alternate meals, and choices; they were being served the same thing meal variety; a letter will be sent to over and over. No resolution form was attached. residents that could not attend by 10/18/19. Patient/Resident Council Minutes/Report dated 9/13/2019 revealed residents wanted the daily The Administrator in-serviced all staff on menu displayed on the monitors in the dining room availability, posting of menus, hallway/lobby and on channel 4 of their offering alternate meals, and meal variety televisions. They wanted dining room on 10/9/19. cancellations displayed on the monitors in the The Activity s Director and/or Designee hallway/lobby and on channel 4 of their will have a resident council meeting televisions instead of having to go to the dining weekly for 4 weeks to ensure that room and find out the dinning room had been grievances reported in resident council canceled. No resolution or response was are followed up on and resolved. documented. The Activity Director and/or Designee will On 9/18/2019 at 3:00pm a Resident Council report the results of the audits to the Meeting was conducted with 7 cognitively intact **Quality Assurance and Performance** residents. During the meeting, the alert and Improvement Committee for further oriented residents stated they did not receive review and recommendations monthly for response or resolution from the grievances they three months, and as needed thereafter. submitted during their regular resident council Administrator will be responsible for meetings. The residents revealed the following implementation of this plan of correction. concerns had not been resolved: menus were not posted (supposed to be on channel 4 on 10/18/19 resident's television monitors), and alternate meals were not offered regularly. During an interview with Activities Director (AD) on 9/18/2019 at 3:30 PM she stated once grievances were obtained during Resident

FORM CMS-2567(02-99) Previous Versions Obsolete

DEPARTMENT OF HEALTH AND HUMAN SERVICES

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	-	D HUMAN SERVICES					FORM): 10/28/2019 1 APPROVED
STATEMENT C	DF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		CONSTRUCTION		(X3) DATE COMP	LETED
		345551	B. WING			_	(09/	C 20/2019
NAME OF PR	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, ST	ATE, ZIP CODE		
PRUITTHE	ALTH-CAROLINA POINT	r			35 MOUNT SINAI ROAD			
				D	URHAM, NC 27705			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	х	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 565	head and they would morning meeting. Shi up with the resolution department head. An interview conducted with the Dietary Mana concern he was award cancellation. Residem notified of dining room television monitor. He dining would occur wh come in. When asked be closed for stock da staff had to put away interfere with dining til not aware of any cond being posted on the te the supervisor was re meals/menus were por there was no system if ensure the menus we television on a regular responds to grievance During an observation television monitors we the day. The menu of until 7:58 AM. An interview was cond AM with the Administr whomever received th the grievance was sull head and responded	bmitted to each department discuss them during the e stated she did not follow once she gave them to ed on 9/19/19 at 8:15 AM ager and he stated the only e of was the dining room ts requested that they be in cancellation via the e stated cancellation of nen kitchen stock would why the dining room would ays, response was kitchen products which may mes. He added that he was cerns about the menus not elevision screens because sponsible for ensuring the osted daily. He confirmed in place to monitor and re being posted on the r basis. He added that he e on the grievance. In on 9/19/19 at 7:10 AM, the ere checked for the menu of the day did not come up	F	565		PEFICIENCY)		
	should be offered and	lividually. The complainant I receive a copy of the and the action taken. The						

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO		(X3) DATE SURVEY	
	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		COMPLETED	
					с	
		345551	B. WING		09/20/2019	
NAME OF P	ROVIDER OR SUPPLIER	•	STR	EET ADDRESS, CITY, STATE, ZIP COD	E	
PRUITTHE	EALTH-CAROLINA POIN	т	5938 DUI			
(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 ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE COMPLET	
F 565	•		F 565			
F 636 SS=E	Comprehensive Asse CFR(s): 483.20(b)(1)	-	F 636		10/18/19	
	a comprehensive, ac	duct initially and periodically				
	A facility must make a assessment of a resid goals, life history and resident assessment by CMS. The assess the following: (i) Identification and c (ii) Customary routine (iii) Cognitive patterns (iv) Communication. (v) Vision. (vi) Mood and behavi (vii) Psychological we	ent Assessment Instrument. a comprehensive dent's needs, strengths, preferences, using the instrument (RAI) specified sment must include at least demographic information e. 5.				
		ts and procedures. ing.				

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		ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 10/28/2019 FORM APPROVED OMB NO. 0938-039
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345551	B. WING		C 09/20/2019
NAME OF P	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CODE	
PRUITTHI	EALTH-CAROLINA POIN	т		5935 MOUNT SINAI ROAD DURHAM, NC 27705	
(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 CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE COMPLETION
F 636	regarding the addition on the care areas trig the Minimum Data Se (xviii) Documentation assessment. The assi include direct observa- with the resident, as a licensed and nonlicer members on all shifts §483.20(b)(2) When timeframes prescribe chapter, a facility mus assessment of a resid timeframes specified through (iii) of this se prescribed in §413.34 apply to CAHs. (i) Within 14 calendar excluding readmissio significant change in mental condition. (Fo "readmission" means following a temporary or therapeutic leave.) (iii)Not less than once This REQUIREMENT by: Based on record rev facility failed to comp comprehensive Minin assessment within 14 reference date (ARD) resident assessment 17, Resident # 15). Finding included:	hal assessment performed gered by the completion of et (MDS). of participation in sessment process must ation and communication well as communication with used direct care staff a. required. Subject to the d in §413.343(b) of this st conduct a comprehensive dent in accordance with the in paragraphs (b)(2)(i) ction. The timeframes 43(b) of this chapter do not r days after admission, ns in which there is no the resident's physical or r purposes of this section, a return to the facility y absence for hospitalization e every 12 months. T is not met as evidenced iew and staff interview, the lete the annual	F 63	6 The Minimal Data Set nurse comp the annual comprehensive MDS assessment for Resident #12, #17, #15 on 10/11/19. A 100% audit of the last 30 days w completed on 10/14/19 by Minimal Set nurse(s) to ensure annual comprehensive assessments were completed for needed residents; 22 annual assessments noted to be bu	and as Data

Event ID: 7QPK11

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STATEMENT (DF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	OMB NO. 0938-039 (X3) DATE SURVEY COMPLETED
		345551	B. WING		C
NAME OF P	ROVIDER OR SUPPLIER	040001		STREET ADDRESS, CITY, STATE, ZIP CODE	09/20/2019
	EALTH-CAROLINA POIN	г		5935 MOUNT SINAI ROAD DURHAM, NC 27705	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE COMPLETION
F 636	 9/10/15 with diagnose diabetes mellitus and A review of Resident assessment dated 7/* (Health Conditions) at and Programs) had mean and the staff that time. 2. Resident #17 was a 11/30/18 with diagnose disorder, major depreen and assessment dated 8/* (hearing, speech and customary routine and Status), H (Bladder and diagnoses), L (Oral a conditions), N (Medice and programs) had mean and programs) had mean and program and the pr	es that included hemiplegia, depression. #12's annual MDS 18/19 revealed sections J nd O (Special Treatments ot been completed. ducted with the MDS 9 at 10:56 AM. She reported ARD was 7/18/19. The ed annual MDS assessment and locked within 14 days of (7/31/19). She further nt was incomplete and in the n. n 9/20/19 at 12:30 PM, the t was his expectation that all ere completed and locked ator indicated the facility had new medical software was been trained during admitted to the facility on ses that included bipolar ssion and anxiety disorder. #17's annual MDS 14/19 revealed sections B vision), F (Preferences for d activities), G (Functional and bowel), I (Active	F 636		I Data strator

Facility ID: 20090049

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		E CONSTRUCTION	(X3) DATE COMP	
		345551	B. WING				_ 20/2019
NAME OF P	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
PRUITTH	EALTH-CAROLINA POIN	г		-	5935 MOUNT SINAI ROAD DURHAM, NC 27705		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 636	An interview was con coordinator on 9/20/1 indicated the MDS as She stated the annua be completed and loc assessment ARD (8/2 she was in the proces 2019 assessments. During an interview o administrator stated if MDS assessments we timely. The administra recently moved to a n platform and the staff 3. Resident #15 was a 8/31/18 with diagnose fibrillation and falls. A review of Resident assessment dated 8/7 assessment was mar An interview was con coordinator on 9/20/1 indicated the MDS as She stated the annua be completed and loc assessment ARD (8/2 she was in the proces 2019 assessments we timely. The administra recently moved to a n	ducted with the MDS 9 at 10:56 AM. She sessment ARD was 8/14/19. I MDS assessment should ked within 14 days of the 25/19). She further stated as of completing the July n 9/20/19 at 12:30 PM, the t was his expectation that all ere completed and locked ator indicated the facility had new medical software were in training at that time. admitted to the facility on es that included Atrial #15 's annual MDS 13/19 revealed the ked as incomplete ducted with the MDS 9 at 10:56 AM. She sessment ARD was 8/13/19. I MDS assessment should exed within 14 days of the 26/19). She further stated as of completing the July n 9/20/19 at 12:30 PM, the t was his expectation that all ere completed and locked ator indicated the facility had	F	636			

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CENTER	S FOR MEDICARE &	MEDICAID SERVICES				RM APPROVE NO. 0938-03
ATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	· · ·	ATE SURVEY DMPLETED
		345551	B. WING			C 09/20/2019
AME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP		J9/20/2019
				5935 MOUNT SINAI ROAD		
RUITTHE	EALTH-CAROLINA POIN	Г		DURHAM, NC 27705		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETIO DATE
F 638 SS=E	Qrtly Assessment at L CFR(s): 483.20(c)	east Every 3 Months	F 63	38		10/18/19
	and approved by CMS once every 3 months. This REQUIREMENT by: Based on record revi facility failed to condu Set (MDS) assessme previous MDS assess selected to be review (Resident #10, Reside Resident # 382). The findings included 1. Resident # 10's wa 5/3/19 with diagnoses to: morbid obesity, dia depression. A review assessments revealed the admission MDS a 5/10/19. During an interview w 9/20/19 at 10:56 AM, MDS assessments sh completed within 92 c assessment. The MD had missed the Quart resident. During an interview w	a resident using the ument specified by the State S not less frequently than is not met as evidenced ew and staff interviews, the lot a quarterly Minimum Data nt within 92 days of the sment for 4 of 21 residents ed for Resident Assessment ent # 2, Resident #1 and : s admitted to the facility on s that included but not limited abetes mellitus, and major of the resident's MDS d the last assessment was ssessment completed on with MDS Coordinator on the MDS Coordinator stated nould be initiated and		The Minimal Data Set nur completed/conducted a qu Minimum Data Set assess residents #10, #2, #1, and on 10/10/19. A 100% audit of the last 3 completed on 10/16/19 by Set nurse(s) to ensure qu Data Set assessments wer for needed residents; 35 d assessments were noted MDS nurse(s) will comple assessment weekly until d Education was provided to Set nurse(s) on 10/11/19 to ensure completion of qu Minimum Data Set assess days of the previous MDS The Director of nursing wi MDS assessments for cor the 92 day of the previous assessment weekly for tw The Director of Nursing an will report the results of th	uarterly sment for d resident #382 0 days was v Minimal Data arterly Minimum ere completed quarterly to be behind; te one extra completion. D Minimal Data by Administrator uarterly sments within 92 d assessment. Il audit quarterly mpletion within a MDS elve weeks.	
	was his expectation the			Quality Assurance and Pe Improvement Committee	erformance	

Facility ID: 20090049

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		ND HUMAN SERVICES MEDICAID SERVICES				FO	ED: 10/28/2019 RM APPROVED NO. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		CONSTRUCTION	(X3) DA	TE SURVEY MPLETED
		345551	B. WING			0	C 9/20/2019
	ROVIDER OR SUPPLIER	т	STREET ADDRESS, CITY, STATE, ZIP CODE 5935 MOUNT SINAI ROAD DURHAM, NC 27705				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	CTION SHOULD BE COMPLE O THE APPROPRIATE DAT	
F 638	completed within 92 of assessment. 2. Resident #2's was 1/29/16 with diagnose limited to sepsis, dep review of the residen revealed the last asse MDS assessment com During an interview w 9/20/19 at 10:56 AM, MDS assessments set completed within 92 of assessment. The MD had missed the Quar Resident # 2. During an interview w 9/20/19 at 12:30 PM, was his expectation to assessments would be Residents should hav completed within 92 of assessment. 3. Resident #1's was 11/6/17 with diagnose limited to sepsis and the resident's MDS a last assessment was assessment completed During an interview w 9/20/19 at 10:56 AM, MDS assessments set completed within 92 of	ve their MDS assessments days of their previous admitted to the facility on es that included but not ression, and dementia. A t's MDS assessments essment was the quarterly mpleted on 3/26/19. vith MDS Coordinator on the MDS Coordinator stated hould be initiated and days of the previous DS coordinator stated they terly assessment for vith the Administrator on the Administrator stated it hat the all MDS be completed as required. All ve their MDS assessments days of their previous admitted to the facility on es that included but not osteoporosis. A review of ssessments revealed the the quarterly MDS ed on 3/25/19. vith MDS Coordinator on the MDS Coordinator stated hould be initiated and	F	638	review and recommendations month three months, and as needed theread Director of Nursing will be responsib implementation of this plan of correct 10/18/19	fter. le for	

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		D HUMAN SERVICES MEDICAID SERVICES				FORM): 10/28/2019 MAPPROVED). 0938-0391
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	E CONSTRUCTION			LETED
		345551	B. WING		_		C 20/2019
NAME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, ST	ATE, ZIP CODE		
PRUITTHE	ALTH-CAROLINA POIN	г		5935 MOUNT SINAI ROAD DURHAM, NC 27705			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S (EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 638	 9/20/19 at 12:30 PM, was his expectation the assessments would be Residents should have completed within 92 casessment. 4. Resident #382's was 9/6/17 with diagnoses to hemiplegia, hand comellitus type 2. A revial assessments revealed the quarterly MDS assessments as 3/18/19. During an interview was 9/20/19 at 10:56 AM, MDS assessments should have completed within 92 casessment. The MD had missed the Quart Resident #382. During an interview was 9/20/19 at 12:30 PM, was his expectation the assessments would be Residents should have completed within 92 casessment. 	ith the Administrator on the Administrator stated it nat the all MDS e completed as required. All e their MDS assessments lays of their previous as admitted to the facility on a that included but not limited ontractures and diabetes ew of the resident's MDS d the last assessment was sessment completed on the MDS Coordinator on the MDS Coordinator stated nould be initiated and lays of the previous S coordinator stated they terly assessment for the with the Administrator on the Administrator stated it nat the all MDS e completed as required. All e their MDS assessments	F 638	3	DEFICIENCY)		10/18/19
F 640 SS=E	CFR(s): 483.20(f)(1)-		F 640				10/18/19
	§483.20(f) Automated	I data processing					

Facility ID: 20090049

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	MENT OF HEALTH AN S FOR MEDICARE & I	D HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345551	B. WING				-
NAME OF P							
PRUITTHE	EALTH-CAROLINA POIN	r				ULD BE COMPLETION	
PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREF		(EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI		COMPLETION
F 640	requirement- §483.20(f)(1) Encodir a facility completes a facility must encode th each resident in the fa (i) Admission assessment (ii) Annual assessment (iii) Significant change (iv) Quarterly review a (v) A subset of items for reentry, discharge, and (vi) Background (face is no admission assess §483.20(f)(2) Transm after a facility complete a facility must be capa CMS System informat contained in the MDS standard record layou and that passes stand CMS and the State. §483.20(f)(3) Transm 14 days after a facility assessment, a facility encoded, accurate, and the CMS System, incl (i) Annual assessment (ii) Significant correct (v) Significant correct (v) Significant correct (v) Significant correct (vi) Quarterly review. (vii) A subset of items reentry, discharge, an	ing data. Within 7 days after resident's assessment, a he following information for acility: nent. In updates. in status assessments. assessments. upon a resident's transfer, ad death. -sheet) information, if there asment. itting data. Within 7 days tes a resident's assessment, able of transmitting to the tion for each resident in a format that conforms to its and data dictionaries, dardized edits defined by ittal requirements. Within completes a resident's must electronically transmit and complete MDS data to uding the following: nent. it. in status assessment. ion of prior full assessment. ion of prior quarterly upon a resident's transfer,	F	640	0		

Facility ID: 20090049

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TATEMENT (DF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, <i>'</i>		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345551	B. WING				C / 20/2019
NAME OF PI	ROVIDER OR SUPPLIER	•		S	TREET ADDRESS, CITY, STATE, ZIP CODE	•	
PRUITTHE	EALTH-CAROLINA POIN	т			935 MOUNT SINAI ROAD		
-				D	URHAM, NC 27705		1
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG	EFIX (EACH CORRECTIVE ACTION SHOULD BE			(X5) COMPLETION DATE
F 640	Continued From page	o 12		C 4 0			
F 040			F	640			
		MDS data on resident that					
	does not have an adr	mission assessment.					
	\$483.20(f)(4) Data fo	rmat. The facility must					
		ormat specified by CMS or,					
		an alternate RAI approved					
	by CMS, in the forma	at specified by the State and					
	approved by CMS.						
	This REQUIREMENT	Γ is not met as evidenced					
	by:						
		iews and staff interviews, the			The Minimal Data Set nurse complete	ed a	
		lete a Discharge Tracking			discharge tracking minimum data set		
		Set) assessment and failed essments within the required			assessment and transmitted the assessments for residents #62, #8, #1	1	
		1 residents (Resident # 62,			#7, #6, #13, and #3 on 10/15/19.	4,	
		ent # 14, Resident # 7,			π^{-} , π		
		ent # 13 and Resident #3)			A 100% audit of the last 30 days was		
	selected to be review	-			completed on 10/16/19 by Minimal Da	ta	
	Assessments.				Set nurse(s) to ensure discharge track		
					Minimum Data Set and transmission of	-	
	Findings included:				assessments were completed for need	ded	
					residents; 46 discharge		
		s admitted to the facility on			tracking/transmission assessments we		
		es that included but not			noted to be behind, MDS nurse(s) will		
		, diabetes mellitus and			complete one extra assessment week	ly	
	Clostridium Difficile (C. Diff.) colitis.			until completion.		
	A review of Resident	# 15's nursing note dated			Education was provided to Minimal Da	ata	
		resident was discharged			Set nurse(s) on 10/14/19 by Administr		
	home.				to ensure completion of discharge		
					tracking Minimum Data Set and		
	A review of Resident	t # 62's last MDS			transmission of assessments within th	е	
		24/19 was coded as a			required timeframe.		
	discharge return not	anticipated assessment.					
	MDS section Z0500 v	was not signed by			The Director of nursing will audit		
		N) as completed. The			discharge tracking MDS assessments	for	
	-	nt was not completed and			completion and transmission of		
	transmitted to the nat	tional database.			assessments within the required		
					timeframe weekly for twelve weeks.		1

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 10/28/2019 MAPPROVED D: 0938-0391	
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345551	B. WING			C 09/20/2019		
	ROVIDER OR SUPPLIER	т		59	TREET ADDRESS, CITY, STATE, ZIP CODE 935 MOUNT SINAI ROAD URHAM, NC 27705			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 640	During an interview of MDS coordinator stat assessment was not coordinator stated it w forward the assessme assessment was com- indicated she was be resident's assessme During an interview of administrator stated h complete and transm time frame. The Adm facility had recently c software and the staf- learning the new syst 2. Resident #8 was 9/28/15 with diagnose limited to hemiplegia, dementia. A review of resident's assessment revealed Reference Date) of 7. quarterly assessment signed as completed 8/8/19. During an interview of MDS coordinator stat signed on 8/8/19 but She stated the previo finalize button, hence transmitted. MDS coord had recently moved to the period when staff During an interview of	n 9/20/19 at 10:56 AM, the ed Resident # 62's signed by the RN. MDS vas her responsibility to ent to the RN once the apleted. MDS coordinator hind in completion of the nt. n 9/20/19 at 12:30 PM, the he expects the MDS staff to it the within the required inistrator also indicated the hanged to a new medical f were in the process of em. admitted to the facility on es that included but not hand contracture and f most recent MDS an ARD (Assessment /22/19 and was coded as a t. The MDS assessment was by the MDS Coordinator on n 9/20/19 at10:56 AM, the ed the assessment was was not been transmitted. ous MDS nurse did not hit the the MDS was not ordinator stated the facility o a new software and it was	F	540	The Director of Nursing and/or Design will report the results of the audits to t Quality Assurance and Performance Improvement Committee for further review and recommendations monthly three months, and as needed thereaft Director of Nursing will be responsible implementation of this plan of correcti 10/18/19	he v for er. e for		

Facility ID: 20090049

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	-	D HUMAN SERVICES				FORM): 10/28/2019 I APPROVED
STATEMENT C	S FOR MEDICARE & I OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION		(X3) DATE COMP	LETED
		345551	B. WING			(09/:	C 20/2019
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE,	ZIP CODE		
				5935 MOUNT SINAI ROAD			
PRUITIHE	ALTH-CAROLINA POIN			DURHAM, NC 27705			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE CROSS-REFERENCEE	IN OF CORRECTION E ACTION SHOULD BE D TO THE APPROPRIAT CIENCY)		(X5) COMPLETION DATE
F 640	time frame. The Admi facility had recently of software and the staff learning the new syste 3. Resident #14 was 5/2/19 with diagnoses to dementia and psyc A review of Resident a dated 8/14/19 was co assessment. MDS se by Registered Nurse During an interview of MDS coordinator state complete, but was no coordinator stated it w forward the assessme assessment was com indicated she was bel assessment as the pr on 8/15/19. During an interview of administrator stated h complete and transmi time frame. The Admi facility had recently of software and the staff learning the new syste 4. Resident #7 was a 5/21/18 with diagnose	t the within the required nistrator also indicated the nanged to a new medical were in the process of em. admitted to the facility on that included but not limited hosis. # 14's last MDS assessment ded as a quarterly ction Z0500 was not signed (RN) as completed. n 9/20/19 at 10:56 AM, the ed the assessment was t signed by the RN. MDS vas her responsibility to ent to the RN once the pleted. MDS coordinator nind in sending the evious MDS RN left the job	F 640		CIENCY)		
	failure.	ascular disease and heart # 7's last MDS assessment					

		ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE COMF	
		345551	B. WING				20/2019
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
PRUITTH	EALTH-CAROLINA POIN	г			935 MOUNT SINAI ROAD DURHAM, NC 27705		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI. DEFICIENCY)		(X5) COMPLETION DATE
F 640	dated 7/16/19 was co assessment. MDS se by Registered Nurse During an interview of MDS coordinator state complete, but was no coordinator stated it w forward the assessme assessment was com indicated she was bel assessment. During an interview of administrator stated h complete and transmi time frame. The Admi facility had recently of software and the staff learning the new syste 5. Resident #6 was au 7/31/18 with diagnose limited to femur fractu A review of resident's assessment had reve Reference Date) of 7/ annual assessment. T signed as completed 9/17/19. During an interview of MDS coordinator state to a new software and staff were under train	ded as a quarterly ction Z0500 was not signed (RN) as completed. In 9/20/19 at 10:56 AM, the ed the assessment was t signed by the RN. MDS vas her responsibility to ent to the RN once the pleted. MDS coordinator hind in sending the In 9/20/19 at 12:30 PM, the re expects the MDS staff to it the within the required inistrator also indicated the hanged to a new medical f were in the process of em. dmitted to the facility on es that included but not irre and depression. most recent MDS aled an ARD (Assessment (21/19 and was coded as an The MDS assessment was by the MDS Coordinator on In 9/20/19 at10:56 AM, the ed the assessment was t was not transmitted. MDS e facility had recently moved d it was the period when	F	540			

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391	
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED C		
		345551	B. WING				20/2019	
NAME OF PI	ROVIDER OR SUPPLIER		I	S	STREET ADDRESS, CITY, STATE, ZIP CODE			
PRUITTHE	EALTH-CAROLINA POIN	r		-	5935 MOUNT SINAI ROAD DURHAM, 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 I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	3E	(X5) COMPLETION DATE	
F 640	complete and transmit time frame. The Admit facility had recently of software and the staff learning the new syste 6. Resident #13 was a 5/7/19 with diagnoses to dementia and epile A review of Resident dated 8/1/19 was cod assessment. MDS se by Registered Nurse assessment was not f database. During an interview of MDS coordinator state completed, but was n coordinator stated it w forward the assessmen indicated she was bel assessment as the pr job on 8/15/19. During an interview of administrator stated h complete and transmit time frame. The Admit facility had recently of software and the staff learning the new syste 7. Resident #3 was an 12/28/19 with diagnos	he expects the MDS staff to it the within the required inistrator also indicated the hanged to a new medical f were in the process of em. admitted to the facility on a that included but not limited apsy. # 13's last MDS assessment ed as a quarterly ction Z0500 was not signed (RN) as completed. The transmitted to the national n 9/20/19 at 10:56 AM, the ed the assessment was ot signed by the RN. MDS vas her responsibility to ent to the RN once the upleted. MDS coordinator hind in sending the evious MDS RN had left the n 9/20/19 at 12:30 PM, the he expects the MDS staff to it the within the required nistrator also indicated the hanged to a new medical f were in the process of em. dmitted to the facility on ses that included but not	F	640				
	Continued From page administrator stated h complete and transmit time frame. The Admit facility had recently cl software and the staff learning the new syste 6. Resident #13 was a 5/7/19 with diagnoses to dementia and epile A review of Resident a dated 8/1/19 was cod assessment. MDS se by Registered Nurse assessment was not a database. During an interview of MDS coordinator state completed, but was n coordinator stated it w forward the assessment assessment was com indicated she was bel assessment as the pr job on 8/15/19. During an interview of administrator stated h complete and transmit time frame. The Admit facility had recently cl software and the staff learning the new syste 7. Resident #3 was au 12/28/19 with diagnos	e 16 he expects the MDS staff to it the within the required inistrator also indicated the hanged to a new medical were in the process of em. admitted to the facility on that included but not limited apsy. # 13's last MDS assessment ed as a quarterly ction Z0500 was not signed (RN) as completed. The transmitted to the national n 9/20/19 at 10:56 AM, the ed the assessment was ot signed by the RN. MDS vas her responsibility to ent to the RN once the upleted. MDS coordinator hind in sending the evious MDS RN had left the n 9/20/19 at 12:30 PM, the he expects the MDS staff to it the within the required nistrator also indicated the hanged to a new medical were in the process of em. dmitted to the facility on			DEFICIENCY)			

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		D HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMP	
		345551	B. WING				_ 20/2019
NAME OF PF	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
PRUITTHE	ALTH-CAROLINA POIN	r			35 MOUNT SINAI ROAD JRHAM, 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 APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 640	Continued From page	9 17	F6	640			
	Reference Date) of 7/ quarterly assessment completed by the MD and indicates product	most recent MDS an ARD (Assessment 10/19 and was coded as a . The MDS was signed as S Coordinator on 7/15/19 ion accepted. The MDS transmitted to the national					
	MDS coordinator state completed, signed an coordinator stated she assessment was not f coordinator stated the	e was unsure why the transmitted. MDS e facility had recently moved d it was the period when					
F 641 SS=E	administrator stated h complete and transmit time frame. The Admit facility had recently ch software and the staff learning the new syste Accuracy of Assessmit		F6	641			10/18/19
	resident's status. This REQUIREMENT by: Based on record revi facility failed to accura Living (ADL) on the M	of Assessments. t accurately reflect the is not met as evidenced ew and staff interview, the ately code Activities of Daily <i>J</i> inimum Data Set (MDS) i 21 residents reviewed for			The Minimal Data Set nurse(s) ensure accurate ADL coding for residents #84 and #111 on 10/11/19.	d	

Event ID: 7QPK11

Facility ID: 20090049

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED D. 0938-0391
STATEMENT (OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	IPLE	CONSTRUCTION	(X3) DATE	SURVEY
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	NG _		COMF	PLETED
		345551	B. WING _				C / 20/2019
NAME OF P	ROVIDER OR SUPPLIER		- I	ST	TREET ADDRESS, CITY, STATE, ZIP CODE	1 00,	
		T		59	935 MOUNT SINAI ROAD		
PRUITIN	EALTH-CAROLINA POIN	I		D	URHAM, NC 27705		
(X4) ID		ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	x	(EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI		COMPLETION DATE
		,			DEFICIENCY)		
E 044		40	-				
F 641	Continued From page		F6	641			
	ADL's (Resident #84	and Resident # 111),			A 100% audit of all residents was	to	
	Findings included:				completed on 10/17/19 by Minimal Dat Set nurse(s) to ensure accurate ADL	.d	
					coding on Minimum Data Set for the pa	ast	
	1.Resident # 84 was a	admitted to the facility on			30 days; 8 assessment⊡s ADL coding		
		diagnoses, some of which			were noted to be coded incorrect, MDS	3	
	included hemiplegia a	and anxiety.			nurse(s) will complete one extra		
	Poviow of the quarter	ly MDS assessment dated			assessment weekly until completion.		
		resident was cognitively			Education was provided to Minimal Da	ita	
		ne MDS assessment for ADL			Set nurse(s) and all nursing staff on	la	
	assistance was not co	oded as activity never			10/11/19 by Administrator, DHS, and/c	r	
		ility, transfer, walk in the			Nurse Supervisors to ensure accurate		
		comotion in and out of the			ADL coding.		
	hygiene.	toilet use and personal			The Director of nursing will audit 10		
	nygiene.				residents weekly for twelve weeks to		
	During an interview of	n 9/17/19 at 12:54 PM,			ensure accurate ADL coding.		
	Nurse Aide (NA) #5 s	tated resident #84 needs			-		
	-	physical assistance for			The Director of Nursing and/or Design		
	ADL's except for eatin				will report the results of the audits to th	ie	
	self-feed with set up a	assistance.			Quality Assurance and Performance Improvement Committee for further		
	During an interview o	n 9/18/19 at 2:05 PM, Nurse			review and recommendations monthly	for	
		84 was totally dependent			three months, and as needed thereafter		
	from extensive assista	ance with one-person					
		L. Resident was able to eat			Director of Nursing will be responsible		
	independently with se	et up help.			implementation of this plan of correction	∍n.	
	During an interview o	n 9/20/19 at 10:56 AM, MDS			10/18/19		
		MDS assessment was					
	wrongly coded for AD	L.					
	During an interview o	n 9/20/19 at 12:30 PM, the					
	•	ed it was his expectation that					
	the resident assessm	-					
	accurately and timely						
	2. Resident #111 was	admitted to the facility on					

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		D HUMAN SERVICES MEDICAID SERVICES			FOF	0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	(X3) DAT	E SURVEY IPLETED C
		345551	B. WING		0	9/20/2019
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
PRUITTHE	EALTH-CAROLINA POIN	r		5935 MOUNT SINAI ROAD DURHAM, NC 27705		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF ((EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 641 F 642 SS=E	7/23/19 with multiple included Coronary Ari Gastroesophageal Re Review of her admiss assessment, dated 7/ was cognitively intact assessment for ADL a activity never occurre On 9/18/19 at 7:00 Al #4, indicated Resider extensive ADLs assis from the bed to whee During an interview o coordinator stated the for ADL. During an interview o Administrator indicate the resident assessm accurately and timely Coordination/Certificat CFR(s): 483.20(h)-(j) §483.20(i) Coordinatt A registered nurse mu each assessment with participation of health §483.20(i) Certificatio §483.20(i)(2) Each im portion of the assess	diagnoses, some of which tery Disease, effux Disease and Anxiety. ion Minimum Data Set 30/19, revealed resident . Section G of the MDS assistance was not coded as d. M, during an interview, NA it #111 required limited to tance, could transfer herself lchair. n 9/20/19 at 10:56 AM, MDS e MDS was wrongly coded n 9/20/19 at 12:30 PM, the ed it was his expectation that ents were completed ition of Assessment ion. ust conduct or coordinate n the appropriate professionals. n. ered nurse must sign and	F 6 F 6			10/18/19

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT C	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345551	B. WING _				C 20/2019
NAME OF PF	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
PRUITTHE	ALTH-CAROLINA POIN	r			935 MOUNT SINAI ROAD URHAM, NC 27705		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	¢	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 642	Continued From page	20	F 6	642			
	individual who willfully (i) Certifies a material resident assessment penalty of not more th assessment; or (ii) Causes another in and false statement ir subject to a civil mone \$5,000 for each asses §483.20(j)(2) Clinical constitute a material a This REQUIREMENT by: Based on record revi facility failed coordina of the Minimum Data time for 5 of 21 sampl #11, #5, #4, #9, and # assessments. The findings included 1. Resident #11 was 10/29/18 with multiple included Gastrostomy A review of the quarter 7/18/19 indicated that assessed as severely Assessment indicated total dependence with activities of daily living was not signed by the assessment coordinal	edicare and Medicaid, an y and knowingly- and false statement in a is subject to a civil money an \$1,000 for each dividual to certify a material n a resident assessment is ey penalty or not more than asment. disagreement does not and false statement. is not met as evidenced ew and staff interviews, the te and certify the completion Set (MDS) assessment on led residents (Residents 16) reviewed for resident s admitted to the facility on e diagnoses, some of which y and Hemiplegia. ertly MDS assessment dated Resident #11 was cognitively impaired. a resident was extensive to n one-person assist for g (ADL). The assessment e Registered Nurse (RN) tor to certify that it was			The Minimal Data Set nurse coordinate and certified the completion of the Minimum Data Set assessments for residents #11, #5, #4, #9, and resident #16 on 10/11/19. A 100% audit of the last 30 days was completed on 10/17/19 by Minimal Data Set nurse(s) to ensure all MDS assessments are coordinated, certified and completed; 21 assessments were noted not being completed, MDS nurse will complete one extra assessment weekly until completion. Education was provided to Minimal Data Set nurse(s) on 10/14/19 by Administra to ensure all Minimum Data Set assessments are coordinated, certified and completed on time.	a ; :(s) :a itor	
		tor to certify that it was t submitted to the national			The Director of nursing will audit MDS		

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CENTER	S FOR MEDICARE & I	ID HUMAN SERVICES MEDICAID SERVICES			FORI OMB NO	D: 10/28/2019 M APPROVED D. 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	E CONSTRUCTION	COMF	E SURVEY PLETED C
		345551	B. WING			/20/2019
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	•	
PRUITTHE	ALTH-CAROLINA POINT	r		5935 MOUNT SINAI ROAD DURHAM, NC 27705		
			I	PROVIDER'S PLAN OF CORRECT		0(5)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 642	Continued From page	21	F 642			
	database.			assessments for completion weekly twelve weeks.	for	
	coordinator indicated reference date (ARD) the assessment was r 8/5/19 however some complete. This was id was completed on 9/1 assessment should be from the ARD (8/18/19 stated all department complete their section period. She indicated checked for completion for signature and trans further indicated the a and hence was not sign During an interview of Administrator stated if the MDS assessment transmitted within the 2. Resident #5 was 12/27/17 with diagnos and spinal cord disea A review of the quarter 7/9/19 indicated Resid	lentified and the sections 19/19. She further stated the e completed within 14 days 9). The MDS coordinator were provided a calendar to as within of the look back the assessments were on and forwarded to the RN smission. MDS coordinator assessment was incomplete gned and transmitted. In 9/20/19 at 12:30 PM, t was the expectation that s were completed and timeframe. admitted to the facility on ass, that included paraplegia se. erly MDS assessment dated dent #5 was assessed as essment indicated the nsive assistance with		The Director of Nursing and/or Desi will report the results of the audits to Quality Assurance and Performance Improvement Committee for further review and recommendations mont three months, and as needed there Director of Nursing will be responsil implementation of this plan of corre 10/18/19	o the o hly for after. ole for	
	complete and was no database.	signed by the RN tor to certify that it was t submitted to the national n 9/20/19 at 10:56 AM, MDS				

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DEPARTMENT OF HEALTH AND H					FORM	: 10/28/2019 APPROVED
	PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	PLE CONSTRUCTION		(X3) DATE COMP	LETED
	345551	B. WING		_	(09/2	C 20/2019
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, ST	TATE, ZIP CODE		
			5935 MOUNT SINAI ROAD			
PRUITTHEALTH-CAROLINA POINT			DURHAM, NC 27705			
PREFIX (EACH DEFICIENCY MUS	ENT OF DEFICIENCIES ST BE PRECEDED BY FULL DENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
 F 642 Continued From page 22 coordinator indicated the a 7/9/19. She stated as the completed, the assessme the RN. MDS coordinator aware the MDS assessme During an interview on 9/2 Administrator stated it was the MDS assessments we transmitted within the time. 3. Resident #4 was adm 5/16/18 with diagnoses, th depression, anxiety disord pace maker. A review of the quarterly N 7/9/19, revealed the MDS was not signed by RN ass The assessment was not anational data base. During an interview on 9/2 coordinator indicated the I reference Date (ARD) was assessment was marked a 9/17/19. She further states should be completed withi ARD (7/23/19). The MDS department were provided their sections within of the indicated the assessment assessment was marked a 9/17/19. She further states should be completed withi ARD (7/23/19). The MDS department were provided their sections within of the indicated the assessment was marked a coordinator further indicated incomplete and hence was transmitted. 	assessment ARD was MDS was not in twas not forwarded to rindicated she was ents was late. 20/19 at 12:30 PM, is the expectation that ere completed and eframe. hitted to the facility on nat included major der, and having cardiac MDS assessment dated was not completed and sessment coordinator. submitted to the 20/19 at 10:56 AM, MDS MDS assessment is 7/9/19. She stated the as completed on d the assessment in 14 days from the coordinator stated all d a calendar to complete e look back period. She is were checked for d to the Registered and transmission. MDS used the assessment was	F 64				

Facility ID: 20090049

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM): 10/28/2019 APPROVED 0. 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION			LETED
		345551	B. WING		_	(09//	20/2019
NAME OF P	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, ST	ATE, ZIP CODE		
PRUITTHI	EALTH-CAROLINA POIN	r		935 MOUNT SINAI ROAD DURHAM, NC 27705			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 642	Administrator stated in the MDS assessment transmitted within the 4. Resident # 9 was 4/25/14 with diagnose stroke, and Alzheimer A review of the quarte 8/2/19, revealed Resi severely cognitively in indicated resident was one-person assist for indicated as incomplet During an interview of coordinator indicated 8/2/19. She stated as completed, the asses the RN. MDS coordin aware the MDS asses During an interview of Administrator stated in the MDS assessment transmitted within the 5. Resident #16 wa 4/23/13 with multiple included acute embol neuropathy. A review of the quarte 8/14/19, revealed Resi severely cognitively in indicated resident was	t was the expectation that were completed and timeframe. a admitted to the facility on es that included hemiplegia, i's disease. and MDS assessment dated dent #9 was assessed as mpaired. Assessment s extensive assistance with ADL. The assessment ADL. The assessment te. an 9/20/19 at 10:56 AM, MDS the assessment ARD was the MDS was not sment was not forwarded to nator indicated she was assments was late. an 9/20/19 at 12:30 PM, t was the expectation that were completed and timeframe. admitted to the facility on diagnoses, some of which ism of low extremities and and the facility on diagnoses, some of which ism of low extremities and and the facility on diagnoses assessed as mpaired. Assessment s total dependent with ADL. The assessment	F 642				

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		CONSTRUCTION	(X3) DATE SU COMPLE	
		345551	B. WING				20/2019
NAME OF P	ROVIDER OR SUPPLIER			STF	REET ADDRESS, CITY, STATE, ZIP CODE		
PRUITTH	EALTH-CAROLINA POIN	г			5 MOUNT SINAI ROAD RHAM, NC 27705		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	¢	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 642 F 690 SS=D	During an interview o coordinator indicated 8/14/19. She stated a completed, the assess the RN. MDS coordin aware the MDS assess During an interview o Administrator stated i the MDS assessment transmitted within the Bowel/Bladder Incont CFR(s): 483.25(e)(1): §483.25(e) Incontinent §483.25(e)(1) The factor resident who is contin admission receives so maintain continence of condition is or become not possible to maintat §483.25(e)(2)For a re- incontinence, based of comprehensive assess ensure that- (i) A resident who ent indwelling catheter or is assessed for remova as possible unless the demonstrates that cat and (iii) A resident who is	n 9/20/19 at 10:56 AM, MDS the assessment ARD was is the MDS was not sment was not forwarded to nator indicated she was ssments was late. In 9/20/19 at 12:30 PM, t was the expectation that is were completed and timeframe. inence, Catheter, UTI -(3) Ince. cility must ensure that nent of bladder and bowel on ervices and assistance to unless his or her clinical es such that continence is ain. esident with urinary on the resident's ssment, the facility must ers the facility without an not catheterized unless the dition demonstrates that	F6				10/18/19

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	-	D HUMAN SERVICES MEDICAID SERVICES			FORM APPR OMB NO. 0938	OVED
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ° <i>î</i>		(X3) DATE SURVEY COMPLETED	
		345551	B. WING		C 09/20/201	9
NAME OF PR	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	•	
		_		5935 MOUNT SINAI ROAD		
PRUITIHE	ALTH-CAROLINA POIN			DURHAM, NC 27705		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		ETION
F 690	continence to the external continence, based of comprehensive assesses ensure that a resident receives appropriate for restore as much norm possible. This REQUIREMENT by: Based on record revision interview the facility faurinary catheter tubing residents with an indvelling urinary catheter tubing residents with an indvelling urinary catheter tubing resident #37 was addindwelling urinary catheter flow), unschizophrenia. Review Minimum Data Set as revealed his intact con Review of the physicia #37 revealed the order catheter 16 Fr (Frenct balloon 10 ml (millilited care/monitoring every monthly on first shift a Review of Resident 36/5/19, revealed the resident 36/5/19, reveale	nfections and to restore ent possible. esident with fecal on the resident's asment, the facility must t who is incontinent of bowel treatment and services to hal bowel function as is not met as evidenced ew, observations and staff ailed to anchor indwelling g (Resident #37) for 1 of 1 velling urinary catheter. mitted on 5/23/19 with an heter, placed in the hospital esident 37 's diagnoses uropathy (obstruction of ine retention and w of resident 's Quarterly sessment, dated 6/4/19, gnition. an 's orders for Resident ers for indwelling foley h - size of the catheter or shift, changing the catheter and as needed. 7 's Plan of Care, dated esident used indwelling	F 69	0 The Hall Nurse anchored indwelling catheter for resident #37 on 9/19/19. Director of Nursing and/or Designee completed a 100% audit of all resident with catheters to ensure all were anch on 10/10/19. The Director of Nursing in-serviced all nursing staff on ensuring residents wit catheters are anchored at all times on 10/14/19. Director of Nursing and/or designee w audit all resident swith catheters were for twelve weeks to ensure catheters a anchored at all times. The Director of Nursing and/or Design will report the results of the audits to th Quality Assurance and Performance Improvement Committee for further review and recommendations monthly three months, and as needed thereafted	ored n II kkly ire ee ie for er.	
	monthly on first shift a Review of Resident 3 6/5/19, revealed the r urinary catheter for ur	and as needed. 7 ' s Plan of Care, dated esident used indwelling		Improvement Committee for further review and recommendations monthly	er. for	

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CENTER	-	D HUMAN SERVICES MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLI			FORM	0: 10/28/2019 1 APPROVED 0: 0938-0391 SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	. ,			` '	LETED
		345551	B. WING		_		C 20/2019
NAME OF PF	ROVIDER OR SUPPLIER		Ş	STREET ADDRESS, CITY, ST	ATE, ZIP CODE		
PRUITTHE	ALTH-CAROLINA POIN	r		935 MOUNT SINAI ROAD DURHAM, NC 27705			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 690	Continued From page and interventions.	26	F 690				
	and merventions.			10/18/19			
	The foley urinary cath secured to his leg, wit to the drainage bag, r The resident indicated urinary catheter to the confirmed that he was every day. On 9/17/19 at 7:40 AN Resident #37 was in t secured to the resident	A Resident #37 was in bed. eter was in place, not th urinary tubing connected nounted to the bed frame. d "nobody mounted his a leg this week". He s out of bed in wheelchair M, during the observation, bed, with foley catheter not nt 's leg.					
	personal hygiene care #1, Resident #37 was catheter in place, with	M, during the observation of e, provided by Nurse Aide in bed. He had the foley drainage bag covered and ame. The urinary catheter s leg.					
	Nurse Aide #1 indicate urinary catheter was r	M, during an interview, ed that she did not know the not secured. She continued esponsibility to secure the e resident ' s leg.					
	Nurse #3 indicated the indwelling urinary cath retention/obstruction. urinary catheter need leg strap or anchor to nurse was not aware	eter and went to correct the					

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	-	D HUMAN SERVICES MEDICAID SERVICES			FOF	ED: 10/28/2019 RM APPROVED O. 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION	(X3) DAT	E SURVEY IPLETED
		345551	B. WING		0	C 9/20/2019
NAME OF PF	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STATE, ZIP COI		
PRUITTHE	ALTH-CAROLINA POINT	T		935 MOUNT SINAI ROAD URHAM, NC 27705		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	VE ACTION SHOULD BE COMPLETION ED TO THE APPROPRIATE DATE	
F 690	Director of Nursing ex	A, during an interview, the provide the staff to anchor catheter to the resident 's	F 690			
F 761 SS=E	Label/Store Drugs and CFR(s): 483.45(g)(h)(d Biologicals	F 761			10/18/19
	Drugs and biologicals	and cautionary				
	§483.45(h) Storage of	f Drugs and Biologicals				
	biologicals in locked of	lity must store all drugs and compartments under proper and permit only authorized				
	locked, permanently a storage of controlled of the Comprehensive D Control Act of 1976 ar abuse, except when the package drug distribut quantity stored is mini- be readily detected. This REQUIREMENT by: Based on observation facility failed to remove	•		Nurse #1 and #2 disposed of Pneumovax, glutose gel, Per	rformist	
	Preumovax, 3 tubes of Performist Inhalation	of Glutose gel, 50 vials of Solution from 2 of 2		inhalation solution, and max 9/17/19.	neeze gel on	

Event ID: 7QPK11

Facility ID: 20090049

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	OF DEFICIENCIES	MEDICAID SERVICES		LE CONSTRUCTION	OMB NO. 0938 (X3) DATE SURVEN	
	CORRECTION	IDENTIFICATION NUMBER:	· /		COMPLETED	ſ
					с	
		345551	B. WING		09/20/201	9
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
PRUITTHI	EALTH-CAROLINA POIN	т	5935 MOUNT SINAI ROAD DURHAM, NC 27705			
(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 CORRE (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APF DEFICIENCY)	OULD BE COMPL	(5) LETION ATE
F 761	Continued From page	e 28	F 76	1		
	 medication storage rooms (300/400 hall and 500/600 hall), and 1 tube of Max Freeze gel from 1 of 4 medication administration carts (300/400 hall). Findings Included: A.On 9/17/19 at 11:10 AM, observation of the 			Director of Nursing and/or Design completed a 100% audit of all me storage rooms and nursing carts ensure no expired medication are on 10/11/19.	edication to	
	medication storage ro Nurse #1 revealed th	bom on 300/400 hall with e following expired and in the refrigerator: one 9 sealed vials of		Administrator and/or Director of N in-serviced all nursing staff on en med storage areas, to include nu carts, are always free of expired 10/10/19.	suring all rsing	
	discard the medication bag with 3 sealed tub glucose gel, 35.5 g (g on the plastic bag sho			Director of Nursing and/or Design audit all med storage and nursing weekly for twelve weeks to ensur expired medications.	g carts	
	Nurse #1 indicated th on the floor, were res medications from the	AM, during an interview, nat the nurses, who worked sponsible to remove expired medication storage room.		The Director of Nursing and/or D will report the results of the audit Quality Assurance and Performa Improvement Committee for furth review and recommendations mo three months, and as needed the	s to the nce ler onthly for	
	The nurse confirmed that the Pneumovax vials and glucose gel tubes were not opened or used. The nurses had not check the expiration date of the medications in medication storage room refrigerator at the beginning of this shift.			Director of Nursing will be respor implementation of this plan of con 10/18/19		
	medication storage ro Nurse #1 revealed th medications were fou plastic container with 23 mg. The pharmac showed to discard the the cabinet, one oper	Ind: in the refrigerator, one 1 sealed vial of Pneumovax y label on the container e medication after 5/18/19; in				

Facility ID: 20090049

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	-	D HUMAN SERVICES MEDICAID SERVICES			FOR	D: 10/28/2019 M APPROVED O. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING _	CONSTRUCTION	(X3) DATI COM	E SURVEY PLETED
		345551	B. WING			C / 20/2019
NAME OF PI	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STATE, ZIP CO		
PRIJITTHE	EALTH-CAROLINA POIN	r	59	935 MOUNT SINAI ROAD		
			D	URHAM, NC 27705		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE	(X5) COMPLETION DATE
F 761	Continued From page	29	F 761			
		nilliliter). The pharmacy x showed to discard the /19.				
	Nurse #1 indicated the on the floor, were resp medications from the The nurse confirmed and all the Performist were not opened or us check the expiration of medication storage ro shift. B.On 9/17/19 at 12:05 medication administra with Nurse #2 reveale medications were fou Freeze gel, 113.4 g. T	M, during an interview, at the nurses, who worked ponsible to remove expired medication storage room. that the Pneumovax vial Inhalation Solution vials sed. The nurses had not date of the medications in bom at the beginning of this 5 PM, observation of the ation cart on 300/400 hall, ed the following expired nd: 1 opened tube of Max The pharmacy label on the rd the medication after				
	Nurse #2 indicated the on the medication car remove expired medic administration cart. The Max Freeze gel was of it this shift. The nurse expiration date on Ma medication administration her shift. On 9/18/19 at 10:10 A Director of Nursing inter- were responsible to com medication administration					

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					OMB NO. 0938-039
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345551	B WING		C
	ROVIDER OR SUPPLIER	040001		STREET ADDRESS, CITY, STATE, ZIP CODE	09/20/2019
	NOVIDER OR SUFFLIER			5935 MOUNT SINAI ROAD	
PRUITTHE	EALTH-CAROLINA POIN	г		DURHAM, NC 27705	
(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 CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETIO
F 761	Continued From page	2 30	F 76	31	
		Her expectation was that no			
		n the medication carts or			
F 812	-	ore/Prepare/Serve-Sanitary	F 8 ⁴	2	10/18/19
SS=E	CFR(s): 483.60(i)(1)(
	§483.60(i) Food safe The facility must -	ty requirements.			
	state or local authorit (i) This may include for from local producers, and local laws or regu (ii) This provision doe facilities from using p gardens, subject to co safe growing and foo (iii) This provision doe from consuming food §483.60(i)(2) - Store,	ed satisfactory by federal, ies. bod items obtained directly subject to applicable State ulations. is not prohibit or prevent roduce grown in facility ompliance with applicable d-handling practices. es not preclude residents s not procured by the facility. prepare, distribute and unce with professional			
	This REQUIREMENT by: Based on observatio	ns, staff interviews and silicity failed to maintain and		Dietary Manager on 9/17/19 cleane kitchen⊡s stove, oven, steam table	
	•	n equipment; the stove, ate warmer, plate/dome freezer.		warmer, plate dome rack, refrigerat freezer. Dietary Manager completed a 100%	or, and
	AM, the stove had a l	: n tour on 9/16/19 at 10:00 arge volume of heavy e stove burners, walls and		on 10/10/19 to ensure all kitchen equipment and items are cleaned appropriately.	
	grease build up on th	e slove pumers, walls and			

Facility ID: 20090049

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	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	OMB NO. 0938- (X3) DATE SURVEY
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	` ,		COMPLETED
			D. MINO		С
		345551			09/20/2019
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 5935 MOUNT SINAI ROAD	
PRUITTH	EALTH-CAROLINA POIN	т	DURHAM, NC 27705		
(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 CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR(DEFICIENCY)	LD BE COMPLE
F 812	Continued From page	e 31	F 812	2	
	1.0	uid encrusted and splatters	1 012	and dietary staff on 10/11/19 on en	surina
	throughout the stove	•		all kitchen equipment is always cle	U
	During an interview o	on 9/16/19 at 10:05 AM, the		Dietary Manager will audit all kitche	en
		stated the expectation was		equipment cleanliness daily for twe	lve
	for the kitchen staff to checklist.	o follow the kitchen cleaning		weeks.	
				The Dietary Manager and/or Desig	nee will
		tion on 9/16/19 at 10:00 AM,		report the results of the audits to the	e
	-	volume greasy buildup,		Quality Assurance and Performance	
	The grease buildup w	s on the inside and outside.		Improvement Committee for further review and recommendations mon	
		foods were being cooked.		three months, and as needed there	-
	-	lume of dried grease buildup			
	was observed on the the walls.	fronts of the ovens and on		Dietary Manager will be responsible implementation of this plan of corre	
	c. During an observation on 9/16/19 at 10:00 AM, the hot box had large volume of dried brown/yellow liquids matter encrusted on edges inside/outside.			10/18/19	
	DM stated the expect	n 9/16/19 at 10:05 AM, the tation was for the kitchen hen cleaning checklist.			
	AM, the ovens had no the heavy grease bui and stove area. The	ervation on 5/22/19 at 11:15 ot been deep cleaned and ld up remained on the oven DM stated the oven outside n and the stove was wipe			
	down and clean.				
	the 5 compartment st particles in standing	tion on 9/16/19 at 10:00 AM, team tables had floating food water, the lids of the steam nes of dried food and greasy			

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FOR	M APPROVED 0. 0938-0391	
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED	
		345551	B. WING				C / 20/2019	
NAME OF P	ROVIDER OR SUPPLIER		•		STREET ADDRESS, CITY, STATE, ZIP CODE			
PRUITTHE	EALTH-CAROLINA POIN	r			5935 MOUNT SINAI ROAD DURHAM, 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 CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	ЗE	(X5) COMPLETION DATE	
F 812	During an interview o DM stated the expect staff to follow the kitch 3 a. During an observe AM, the two-comparter rows of clean plates is and outside had dried spills, old food crumb removed the plates we returned the clean plat dried food particles and the plate warmer. During an interview o DM stated the expect staff to follow the kitch 4. During an observed there were two plate/of lids/plates had large I crumbs dried liquids we were drying. During an interview o DM stated the expect staff to follow the kitch During an interview o DM stated the expect staff to follow the kitch During a follow-up vis The clean tray rack we dried yellow, brown for During an interview o DM stated the expect follow the kitchen clear presented the expect checklist.	n 9/16/19 at 10:05 AM, the ation was for the kitchen hen cleaning checklist. ration on 9/16/19 at 10:00 ment plate warmer had two stored in them. The inside I food particles and liquids is all around. The staff iped down the top and ates to the warmer. Other hel liquids remained inside n 9/16/19 at 10:05 AM, the ation was for the kitchen hen cleaning checklist. tion on 9/16/19 at 10:00 AM, dome racks with dome eftover food, yellow, brown, were the clean domes/lids n 9/16/19 at 10:05 AM, the ation was for the kitchen hen cleaning checklist.	F	812				

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	-	D HUMAN SERVICES MEDICAID SERVICES			FORM	APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	(X3) DATE COMP	SURVEY LETED
		345551	B. WING			C 20/2019
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
PRUITTHE	EALTH-CAROLINA POIN	r		5935 MOUNT SINAI ROAD DURHAM, NC 27705		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 812 F 867 SS=E	the inside and outside large volumes of dried of dried yellow, brown stored. The outside has food and liquids on has b. During an observati the outside of the free matter, dried yellow s doors, handles and ve During an interview of DM stated the expect staff to follow the kitch During an interview of Administrator stated h manager ensure the k clean and maintained standards. QAPI/QAA Improvem CFR(s): 483.75(g)(2)(2)(2)(2)(2)(2)(2)(2)(2)(2)(2)(2)(2)	e of the refrigerator had d encrusted food and liquids a matter where food was ad large volumes of dried andles, venting area. ion on 9/16/19 at 10:00 AM, ezer had encrusted brown ubstance and food on the ented area of the freezer. In 9/16/19 at 10:05 AM, the ation was for the kitchen nen cleaning checklist. In 9/19/at 8:30 AM, the he expected the dietary sitchen equipment was in accordance to regulatory ent Activities ii) sessment and assurance. ality assessment and	F 8		5	10/18/19

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FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY IDENTIFICATION NUMBER AND PLAN OF CORRECTION COMPLETED A. BUILDING С 345551 B. WING 09/20/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 5935 MOUNT SINAI ROAD PRUITTHEALTH-CAROLINA POINT DURHAM, NC 27705 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (X4) ID ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 867 Continued From page 34 F 867 survey and on the current recertification and The QA meeting has been revised and complaint survey (9/20/19). The repeated changes are being made so that previous deficiencies were in the areas of food citations will be reviewed as needed and procurement store/prepare/serve foods under followed up on with documentation being sanitary conditions (F371 which is now F 812) recorded in the QA minutes. and Quality Assurance and Performance improvement (QAPI)/ QAA improvement activities QAPI team members were in-serviced by (F 867). Two deficiencies were originally cited on the Administrator on 10/14/19. The 8/23/18 during the recertification and during the education included the QA program current recertification and complaint survey. The review of previous survey citations and repeated deficiencies were in the area of the inclusion of on-going monitoring to quarterly assessments at least every 3 months (F maintain compliance. The QA meeting 638), Bowel/bladder incontinence, catheter and has revised, and changes are being made Urinary tract infection, (F690). The continued so that previous citations will be reviewed failure of the facility during three federal surveys as needed and followed up on with of record shows a pattern of the facility's inability documentation being recorded in QA to sustain an effective quality assurance program. minutes. The Administrator will document in the QA The Findings included: minutes the monthly review of on-going QAPI plans with the QA team for three This tag is cross-referred to: months and as needed. QAPI committee 1. During the recertification survey dated 9/20/19, will review the results of the audits F812- food procurement store/prepare/serve monthly for three months and as needed foods under sanitary conditions was cited. Based thereafter. on observations, staff interviews and record review, the facility failed to maintain and clean Administrator will be responsible for following kitchen equipment; the stove, oven, implementation of this plan of correction. steam table, plate warmer, plate/dome rack, 10/18/19 refrigerator and freezer. During the recertification survey in August 2018 the facility was cited for failure to keep the floor of the dry food storage room clean, failed to label leftovers and discard expired food from their walk- in refrigerator and bread rack, the staff failed to wear beard guard. The facility also failed to use the sanitizing solution per manufacturer's recommendations and ensure the kitchen was

FORM CMS-2567(02-99) Previous Versions Obsolete

DEPARTMENT OF HEALTH AND HUMAN SERVICES

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM): 10/28/2019 APPROVED 0. 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · /	E CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345551	B. WING		_		C 20/2019
NAME OF PI	ROVIDER OR SUPPLIER		5	STREET ADDRESS, CITY, ST	ATE, ZIP CODE		
PRUITTHE	EALTH-CAROLINA POIN	r		5935 MOUNT SINAI ROAD DURHAM, NC 27705			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE) CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD B NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 867	Continued From page free of flies.	35	F 867				
	recertification survey nourishment refrigera	tor temperature below 40 I and inappropriately stored two of the three					
	dated 9/20/19, F 638 least every 3 months review and staff interview conduct a quarterly M assessment within 92 assessment for 4 of 2 reviewed for Resident	cation and complaint survey -quarterly assessments at was cited. Based on record views, the facility failed to linimum Data Set (MDS) 2 days of the previous MDS 21 residents selected to be t Assessment (Resident esident #1 and Resident #					
	facility was cited for fa Minimum Data Set (M	tion survey on 8/23/18, the ailure to conduct a quarterly IDS) assessment for 1 of 2 be reviewed for Resident ent #2).					
	dated 9/20/19, F690 - catheter and Urinary f Based on record revie interview the facility fa urinary catheter tubing	cation and complaint survey Bowel/bladder incontinence, tract infection was cited. ew, observations and staff ailed to anchor indwelling g (Resident #37) for 1 of 1 welling urinary catheter.					
	facility was cited for fa indwelling urinary cat	tion survey on 8/23/18, the ailure to secure the heter for 1 of 3 sampled r urinary catheter use.					

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FOR	M APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		E CONSTRUCTION	(X3) DATE COMF	E SURVEY PLETED
		345551	B. WING				C / 20/2019
NAME OF PI	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE	1 00	
	EALTH-CAROLINA POIN	r		5	5935 MOUNT SINAI ROAD		
FROM		•		0	DURHAM, 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 E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 867	Continued From page	9 36	F	867			
	was cited. Based on o and staff interviews, t Assessment and Assi failed to effectively m procedures and effec interventions that the August of 2018. During the recertificat the facility was cited f maintain implemented monitor these interve put into place in Augu During the recertificat the facility was cited f maintain implemented monitor these interve put into place in Sept	QAA improvement activities observations, record review he facility's Quality urance (QAA) Committee aintain implemented tively monitor these committee put into place in tion survey dated 8/23/18, for failing to effectively d procedures and effectively ntions that the committee ust of 2017. Tion survey dated 8/10/17, for failing to effectively d procedures and effectively d procedures and effectively d procedures and effectively ntions that the committee ember of 2016. n 9/20/19 at 4:14 PM, the					
	understanding of the 812 and F 867 during and complaint survey administrator indicate this position in the fac Assurance (QA) com concern, 2) does a ro develops a plan, audi	reciting of F 638, F 690, F the recent recertification in August 2019. The d he had recently accepted cility. He stated the Quality mittee 1) identifies areas of					
	indicated QAA meets as needed basis, and concerns, goals met, The Administrator sta	monthly, quarterly and no discusses the identified and improvement needed. ted it was his expectation rved to the resident in a					

Facility ID: 20090049

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER RUNCEY IDENTIFICATION NUMBER: (X2) UNLITTIEL CONSTRUCTION A BUILDING (X3) DATE SURVEY COMPLETED B. WING NAME OF PROVIDER OR SUPPLIER PRUTTHEALTH-CAROLINA POINT STREET ADDRESS, CITY, STATE, ZIP CODE 5335 MOUNT SNAI ROAD DURHAM, NC 27705 STREET ADDRESS, CITY, STATE, ZIP CODE 5335 MOUNT SNAI ROAD DURHAM, NC 27705 (X4) ID PREFIX TAG ISUMMARY STATEMENT OF DEFICIENCIES IRECARD DEFICIENCY MUST BE PRECEDED BY FULL RECAULTORY OR LSC IDENTIFYING INFORMATION) PREFIX PREFIX RECAULTORY COTORECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE CMS CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY F 867 Continued From page 37 sanitary way and all kitchen equipment to be cleaned. He further stated that the resident 's assessments should be completed accurately and in a timely manner. The administrator indicated that the catheters should be properly secured. The Administrator indicated further QAA was a work in progress. F 867		-	ID HUMAN SERVICES MEDICAID SERVICES				FORM): 10/28/2019 1 APPROVED). 0938-0391
Image: Name of PROVIDER or SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE PRUITTHEALTH-CAROLINA POINT STREET ADDRESS, CITY, STATE, ZIP CODE (X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG PROVIDER'S PLAN OF CORRECTION (EACH ORRECTIVE ACTION SHOULD BE (EACH ORRECTIVE ACTION SHOULD BE DEFICIENCY) (X5) COMPLETION DATE F 867 Continued From page 37 sanitary way and all kitchen equipment to be cleaned. He further stated that the resident 's assessments should be completed accurately and in a timely manner. The administrator indicated that the catheters should be properly secured. The Administrator indicated further QAA F 867							(X3) DATE COMP	SURVEY LETED
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE PRUITTHEALTH-CAROLINA POINT SUMMARY STATEMENT OF DEFICIENCIES 5935 MOUNT SINAI ROAD (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X5) (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX CACH CORRECTIVE ACTION SHOULD BE COMPLETION TAG (EACH DEFICIENCY OR LSC IDENTIFYING INFORMATION) TAG PREFIX CONSS-REFERENCED TO THE APPROPRIATE COMPLETION F 867 Continued From page 37 F 867 F 867 F 867 F 867 F sonitary way and all kitchen equipment to be cleaned. He further stated that the resident 's assessments should be completed accurately and in a timely manner. The administrator indicated that the catheters should be properly secured. The Administrator indicated further QAA F			345551	B. WING				
PRUITTHEALTH-CAROLINA POINT 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 SHOULD BE (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (x5) COMPLETION DATE F 867 Continued From page 37 sanitary way and all kitchen equipment to be cleaned. He further stated that the resident 's assessments should be completed accurately and in a timely manner. The administrator indicated that the catheters should be properly secured. The Administrator indicated further QAA F 867	NAME OF P	ROVIDER OR SUPPLIER	I		STREET ADDRESS, C	ITY, STATE, ZIP CODE	1	
(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 867 Continued From page 37 sanitary way and all kitchen equipment to be cleaned. He further stated that the resident 's assessments should be completed accurately and in a timely manner. The administrator indicated that the catheters should be properly secured. The Administrator indicated further QAA F 867	PRUITTH	EALTH-CAROLINA POIN	г					
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) COMPLÉTION DATE F 867 Continued From page 37 sanitary way and all kitchen equipment to be cleaned. He further stated that the resident 's assessments should be completed accurately and in a timely manner. The administrator indicated that the catheters should be properly secured. The Administrator indicated further QAA F 867								(XE)
sanitary way and all kitchen equipment to be cleaned. He further stated that the resident ' s assessments should be completed accurately and in a timely manner. The administrator indicated that the catheters should be properly secured. The Administrator indicated further QAA	PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFIX	K (EACH C	CORRECTIVE ACTION SHOULD E EFERENCED TO THE APPROPRI		COMPLETION
	F 867	sanitary way and all k cleaned. He further st assessments should l and in a timely manne indicated that the cath secured. The Adminis	attchen equipment to be tated that the resident ' s be completed accurately er. The administrator neters should be properly astrator indicated further QAA	F	367	DEFICIENCY)		

Event ID: 7QPK11

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