STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345551	A. BUILDING _____ B. WING _____	C 09/20/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEALTH-CAROLINA POINT	5935 MOUNT SINAI ROAD DURHAM, NC 27705

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannouced recertification survey was conducted on 9/16/19 to 9/20/19. The facility was found to be in compliance with the requirement CFR 483.73, Emergency Prepardness. Event ID # 7QPK11	E 000		
F 000	INITIAL COMMENTS A recert with complaint investigation survey was conducted from 9/16/19 to 9/20/19 . 19 of the 19 complaint allegations were not substantiated.	F 000		
F 565 SS=E	Resident/Family Group and Response CFR(s): 483.10(f)(5)(i)-(iv)(6)(7) §483.10(f)(5) The resident has a right to organize and participate in resident groups in the facility. (i) The facility must provide a resident or family group, if one exists, with private space; and take reasonable steps, with the approval of the group, to make residents and family members aware of upcoming meetings in a timely manner. (ii) Staff, visitors, or other guests may attend resident group or family group meetings only at the respective group's invitation. (iii) The facility must provide a designated staff person who is approved by the resident or family group and the facility and who is responsible for providing assistance and responding to written requests that result from group meetings. (iv) The facility must consider the views of a resident or family group and act promptly upon the grievances and recommendations of such groups concerning issues of resident care and life in the facility. (A) The facility must be able to demonstrate their response and rationale for such response. (B) This should not be construed to mean that the facility must implement as recommended every	F 565		10/18/19

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

Electronically Signed | 10/11/2019

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F 565	Continued From page 1 request of the resident or family group. §483.10(f)(6) The resident has a right to participate in family groups. §483.10(f)(7) The resident has a right to have family member(s) or other resident representative(s) meet in the facility with the families or resident representative(s) of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on observation, record review, resident and staff interview, the facility failed to respond to resident grievances that were reported in the resident council meetings for June, July and August of 2019 concerning dining room availability, posting of menus, offering alternate meals, and variety of meals. Findings included: Review of Resident Patient/Resident Council Minutes/ Report dated 6/10/2019 stated residents requested the dining room will be available for all meals, and they wanted to be aware of what the meal menu was prior to meal times. Also, there were no menus on their trays, no items listed on meal tray slip as to what they were being served. No resolution was recorded on Patient/Resident Council/Family Council Department Response Form. The form was signed off by Administrator on 7/11/2019. Patient/Resident Council Minutes/Report dated 7/8/2019 revealed members complained there continued to be no menu provided prior to meal time, they had no alternate meal offered regularly, and they wanted to have alternate meals offered	F 565	PruittHealth Carolina Point acknowledges receipt of the Statement of Deficiencies and proposes this plan of correction to the extent that this summary of finding is factually correct and in order to maintain 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 response to the Statement of Deficiencies and the plan of Correction does not denote agreement with the Statement of Deficiencies nor does it constitute and admission that any deficiency is accurate. Further, Pruitt Health Carolina Point reserves the right to submit documentation to refute any of the stated deficiencies on the statement of Deficiencies through informal dispute resolution, formal appeal procedure, and/or other administrative or legal proceedings.	

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F 565	Continued From page 2 at each meal time. No resolution was recorded on Patient/Resident Council/Family Council Department Response Form. The form was not signed off. Review of Patient/Resident Council Minutes/Report Form dated 8/5/2019 revealed the members of Resident Council requested Dietary department to have a variety in meal choices; they were being served the same thing over and over. No resolution form was attached. Patient/Resident Council Minutes/Report dated 9/13/2019 revealed residents wanted the daily menu displayed on the monitors in the hallway/lobby and on channel 4 of their televisions. They wanted dining room cancellations displayed on the monitors in the hallway/lobby and on channel 4 of their televisions instead of having to go to the dining room and find out the dinning room had been canceled. No resolution or response was documented. On 9/18/2019 at 3:00pm a Resident Council Meeting was conducted with 7 cognitively intact residents. During the meeting, the alert and oriented residents stated they did not receive response or resolution from the grievances they submitted during their regular resident council meetings. The residents revealed the following concerns had not been resolved: menus were not posted (supposed to be on channel 4 on 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	F 565	Education was provided by Administrator to the Activity Director and Assistant on 10/9/19 regarding follow-up and resolution of grievance revealed in resident council. A resident council meeting was held on 10/11/19 to ensure facility□s residents are aware of dining room availability, posting of menus, offering alternate meals, and meal variety; a letter will be sent to residents that could not attend by 10/18/19. The Administrator in-serviced all staff on dining room availability, posting of menus, offering alternate meals, and meal variety on 10/9/19. The Activity□s Director and/or Designee will have a resident council meeting weekly for 4 weeks to ensure that grievances reported in resident council are followed up on and resolved. The Activity Director and/or Designee will report the results of the audits to the Quality Assurance and Performance Improvement Committee for further review and recommendations monthly for three months, and as needed thereafter. Administrator will be responsible for implementation of this plan of correction. 10/18/19	

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F 565	Continued From page 3	F 565		

Council, they were submitted to each department head and they would discuss them during the morning meeting. She stated she did not follow up with the resolution once she gave them to department head.

An interview conducted on 9/19/19 at 8:15 AM with the Dietary Manager and he stated the only concern he was aware of was the dining room cancellation. Residents requested that they be notified of dining room cancellation via the television monitor. He stated cancellation of dining would occur when kitchen stock would come in. When asked why the dining room would be closed for stock days, response was kitchen staff had to put away products which may interfere with dining times. He added that he was not aware of any concerns about the menus not being posted on the television screens because the supervisor was responsible for ensuring the meals/menus were posted daily. He confirmed there was no system in place to monitor and ensure the menus were being posted on the television on a regular basis. He added that he responds to grievance on the grievance.

During an observation on 9/19/19 at 7:10 AM, the television monitors were checked for the menu of the day. The menu of the day did not come up until 7:58 AM.

An interview was conducted on 9/19/19 at 8:30 AM with the Administrator and he stated whomever received the grievance should ensure the grievance was submitted to the department head and responded within 5 days to either resident council or individually. The complainant should be offered and receive a copy of the grievance resolution and the action taken. The

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F 565	Continued From page 4 department head should follow-up with the grievance within 5 days after the initial grievance. He stated the grievance process needed to be revised.	F 565		
F 636 SS=E	Comprehensive Assessments & Timing CFR(s): 483.20(b)(1)(2)(i)(iii) §483.20 Resident Assessment The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. §483.20(b) Comprehensive Assessments §483.20(b)(1) Resident Assessment Instrument. A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following: (i) Identification and demographic information (ii) Customary routine. (iii) Cognitive patterns. (iv) Communication. (v) Vision. (vi) Mood and behavior patterns. (vii) Psychological well-being. (viii) Physical functioning and structural problems. (ix) Continence. (x) Disease diagnosis and health conditions. (xi) Dental and nutritional status. (xii) Skin Conditions. (xiii) Activity pursuit. (xiv) Medications. (xv) Special treatments and procedures. (xvi) Discharge planning. (xvii) Documentation of summary information	F 636		10/18/19

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F 636	Continued From page 5 regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS). (xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and nonlicensed direct care staff members on all shifts. §483.20(b)(2) When required. Subject to the timeframes prescribed in §413.343(b) of this chapter, a facility must conduct a comprehensive assessment of a resident in accordance with the timeframes specified in paragraphs (b)(2)(i) through (iii) of this section. The timeframes prescribed in §413.343(b) of this chapter do not apply to CAHs. (i) Within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or therapeutic leave.) (iii)Not less than once every 12 months. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to complete the annual comprehensive Minimum Data Set (MDS) assessment within 14 days of the assessment reference date (ARD) for 3 of 21 reviewed for resident assessment (Resident # 12, Resident # 17, Resident # 15). Finding included: 1.Resident #12 was admitted to the facility on	F 636	The Minimal Data Set nurse completed the annual comprehensive MDS assessment for Resident #12, #17, and #15 on 10/11/19. A 100% audit of the last 30 days was completed on 10/14/19 by Minimal Data Set nurse(s) to ensure annual comprehensive assessments were completed for needed residents; 22 annual assessments noted to be behind,	

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F 636	Continued From page 6 9/10/15 with diagnoses that included hemiplegia, diabetes mellitus and depression. A review of Resident #12's annual MDS assessment dated 7/18/19 revealed sections J (Health Conditions) and O (Special Treatments and Programs) had not been completed. An interview was conducted with the MDS coordinator on 9/20/19 at 10:56 AM. She reported the MDS assessment ARD was 7/18/19. The MDS coordinator stated annual MDS assessment should be completed and locked within 14 days of the assessment ARD (7/31/19). She further stated the assessment was incomplete and in the process of completion. During an interview on 9/20/19 at 12:30 PM, the administrator stated it was his expectation that all MDS assessments were completed and locked timely. The administrator indicated the facility had recently moved to a new medical software platform and the staff was been trained during that time. 2. Resident #17 was admitted to the facility on 11/30/18 with diagnoses that included bipolar disorder, major depression and anxiety disorder. A review of Resident #17's annual MDS assessment dated 8/14/19 revealed sections B (hearing, speech and vision), F (Preferences for customary routine and activities), G (Functional Status), H (Bladder and bowel), I (Active diagnoses) , L (Oral and dental) , M (Skin conditions) , N (Medications), P (restraints and alarms) and Z (Assessment administration) were not signed and marked as completed.	F 636	MDS Nurse(s) will complete 1 extra annual assessment weekly until completion. Education was provided to Minimal Data Set nurse(s) on 10/9/19 by Administrator to ensure completion of annual comprehensive Minimum Data Set assessments within 14 days of the assessment reference date. The Director of nursing will audit annual comprehensive MDS assessment for completion within the 14-day ARD weekly for twelve weeks. The Director of Nursing and/or Designee will report the results of the audits to the Quality Assurance and Performance Improvement Committee for further review and recommendations monthly for three months, and as needed thereafter. Director of Nursing will be responsible for implementation of this plan of correction. 10/18/19	

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F 636	Continued From page 7	F 636		

An interview was conducted with the MDS coordinator on 9/20/19 at 10:56 AM. She indicated the MDS assessment ARD was 8/14/19. She stated the annual MDS assessment should be completed and locked within 14 days of the assessment ARD (8/25/19). She further stated she was in the process of completing the July 2019 assessments.

During an interview on 9/20/19 at 12:30 PM, the administrator stated it was his expectation that all MDS assessments were completed and locked timely. The administrator indicated the facility had recently moved to a new medical software platform and the staff were in training at that time.

3. Resident #15 was admitted to the facility on 8/31/18 with diagnoses that included Atrial fibrillation and falls.

A review of Resident #15 's annual MDS assessment dated 8/13/19 revealed the assessment was marked as incomplete

An interview was conducted with the MDS coordinator on 9/20/19 at 10:56 AM. She indicated the MDS assessment ARD was 8/13/19. She stated the annual MDS assessment should be completed and locked within 14 days of the assessment ARD (8/26/19). She further stated she was in the process of completing the July 2019 assessments.

During an interview on 9/20/19 at 12:30 PM, the administrator stated it was his expectation that all MDS assessments were completed and locked timely. The administrator indicated the facility had recently moved to a new medical software platform and the staff were in training at that time.

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F 638 SS=E	Qrtly Assessment at Least Every 3 Months CFR(s): 483.20(c) §483.20(c) Quarterly Review Assessment A facility must assess a resident using the quarterly review instrument specified by the State and approved by CMS not less frequently than once every 3 months. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to conduct a quarterly Minimum Data Set (MDS) assessment within 92 days of the previous MDS assessment for 4 of 21 residents selected to be reviewed for Resident Assessment (Resident #10, Resident # 2, Resident #1 and Resident # 382). The findings included: 1. Resident # 10's was admitted to the facility on 5/3/19 with diagnoses that included but not limited to: morbid obesity, diabetes mellitus, and major depression. A review of the resident's MDS assessments revealed the last assessment was the admission MDS assessment completed on 5/10/19. During an interview with MDS Coordinator on 9/20/19 at 10:56 AM, the MDS Coordinator stated MDS assessments should be initiated and completed within 92 days of the previous assessment. The MDS coordinator stated they had missed the Quarterly assessment for the resident. During an interview with the Administrator on 9/20/19 at 12:30 PM, the Administrator stated it was his expectation that the all MDS assessments would be completed as required. All	F 638	The Minimal Data Set nurse completed/conducted a quarterly Minimum Data Set assessment for residents #10, #2, #1, and resident #382 on 10/10/19. A 100% audit of the last 30 days was completed on 10/16/19 by Minimal Data Set nurse(s) to ensure quarterly Minimum Data Set assessments were completed for needed residents; 35 quarterly assessments were noted to be behind; MDS nurse(s) will complete one extra assessment weekly until completion. Education was provided to Minimal Data Set nurse(s) on 10/11/19 by Administrator to ensure completion of quarterly Minimum Data Set assessments within 92 days of the previous MDS assessment. The Director of nursing will audit quarterly MDS assessments for completion within the 92 day of the previous MDS assessment weekly for twelve weeks. The Director of Nursing and/or Designee will report the results of the audits to the Quality Assurance and Performance Improvement Committee for further	10/18/19

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F 638	Continued From page 9 Residents should have their MDS assessments completed within 92 days of their previous assessment. 2. Resident #2's was admitted to the facility on 1/29/16 with diagnoses that included but not limited to sepsis, depression, and dementia. A review of the resident's MDS assessments revealed the last assessment was the quarterly MDS assessment completed on 3/26/19. During an interview with MDS Coordinator on 9/20/19 at 10:56 AM, the MDS Coordinator stated MDS assessments should be initiated and completed within 92 days of the previous assessment. The MDS coordinator stated they had missed the Quarterly assessment for Resident # 2. During an interview with the Administrator on 9/20/19 at 12:30 PM, the Administrator stated it was his expectation that the all MDS assessments would be completed as required. All Residents should have their MDS assessments completed within 92 days of their previous assessment. 3. Resident #1's was admitted to the facility on 11/6/17 with diagnoses that included but not limited to sepsis and osteoporosis. A review of the resident's MDS assessments revealed the last assessment was the quarterly MDS assessment completed on 3/25/19. During an interview with MDS Coordinator on 9/20/19 at 10:56 AM, the MDS Coordinator stated MDS assessments should be initiated and completed within 92 days of the previous assessment. The MDS coordinator stated they	F 638	review and recommendations monthly for three months, and as needed thereafter. Director of Nursing will be responsible for implementation of this plan of correction. 10/18/19	

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F 638	Continued From page 10 had missed the Quarterly assessment for Resident # 1. During an interview with the Administrator on 9/20/19 at 12:30 PM, the Administrator stated it was his expectation that the all MDS assessments would be completed as required. All Residents should have their MDS assessments completed within 92 days of their previous assessment. 4. Resident #382's was admitted to the facility on 9/6/17 with diagnoses that included but not limited to hemiplegia, hand contractures and diabetes mellitus type 2. A review of the resident's MDS assessments revealed the last assessment was the quarterly MDS assessment completed on 3/18/19. During an interview with MDS Coordinator on 9/20/19 at 10:56 AM, the MDS Coordinator stated MDS assessments should be initiated and completed within 92 days of the previous assessment. The MDS coordinator stated they had missed the Quarterly assessment for the Resident #382. During an interview with the Administrator on 9/20/19 at 12:30 PM, the Administrator stated it was his expectation that the all MDS assessments would be completed as required. All Residents should have their MDS assessments completed within 92 days of their previous assessment.	F 638		
F 640 SS=E	Encoding/Transmitting Resident Assessments CFR(s): 483.20(f)(1)-(4) §483.20(f) Automated data processing	F 640		10/18/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 640	Continued From page 11	F 640		

requirement-
§483.20(f)(1) Encoding data. Within 7 days after a facility completes a resident's assessment, a facility must encode the following information for each resident in the facility:
(i) Admission assessment.
(ii) Annual assessment updates.
(iii) Significant change in status assessments.
(iv) Quarterly review assessments.
(v) A subset of items upon a resident's transfer, reentry, discharge, and death.
(vi) Background (face-sheet) information, if there is no admission assessment.

§483.20(f)(2) Transmitting data. Within 7 days after a facility completes a resident's assessment, a facility must be capable of transmitting to the CMS System information for each resident contained in the MDS in a format that conforms to standard record layouts and data dictionaries, and that passes standardized edits defined by CMS and the State.

§483.20(f)(3) Transmittal requirements. Within 14 days after a facility completes a resident's assessment, a facility must electronically transmit encoded, accurate, and complete MDS data to the CMS System, including the following:
(i)Admission assessment.
(ii) Annual assessment.
(iii) Significant change in status assessment.
(iv) Significant correction of prior full assessment.
(v) Significant correction of prior quarterly assessment.
(vi) Quarterly review.
(vii) A subset of items upon a resident's transfer, reentry, discharge, and death.
(viii) Background (face-sheet) information, for an

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PRUITTHEALTH-CAROLINA POINT	5935 MOUNT SINAI ROAD DURHAM, NC 27705

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F 640	Continued From page 12 initial transmission of MDS data on resident that does not have an admission assessment. §483.20(f)(4) Data format. The facility must transmit data in the format specified by CMS or, for a State which has an alternate RAI approved by CMS, in the format specified by the State and approved by CMS. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews, the facility failed to complete a Discharge Tracking MDS (Minimum Data Set) assessment and failed to transmit MDS assessments within the required time frame for 7 of 21 residents (Resident # 62, Resident # 8, Resident # 14, Resident # 7, Resident # 6, Resident # 13 and Resident #3) selected to be reviewed for Resident Assessments. Findings included: 1. Resident # 62 was admitted to the facility on 6/21/19 with diagnoses that included but not limited to depression, diabetes mellitus and Clostridium Difficile (C. Diff.) colitis. A review of Resident # 15's nursing note dated 7/24/19 revealed the resident was discharged home. A review of Resident # 62's last MDS assessment dated 7/24/19 was coded as a discharge return not anticipated assessment. MDS section Z0500 was not signed by Registered Nurse (RN) as completed. The discharge assessment was not completed and transmitted to the national database.	F 640	The Minimal Data Set nurse completed a discharge tracking minimum data set assessment and transmitted the assessments for residents #62, #8, #14, #7, #6, #13, and #3 on 10/15/19. A 100% audit of the last 30 days was completed on 10/16/19 by Minimal Data Set nurse(s) to ensure discharge tracking Minimum Data Set and transmission of assessments were completed for needed residents; 46 discharge tracking/transmission assessments were noted to be behind, MDS nurse(s) will complete one extra assessment weekly until completion. Education was provided to Minimal Data Set nurse(s) on 10/14/19 by Administrator to ensure completion of discharge tracking Minimum Data Set and transmission of assessments within the required timeframe. The Director of nursing will audit discharge tracking MDS assessments for completion and transmission of assessments within the required timeframe weekly for twelve weeks.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345551	A. BUILDING _____ B. WING _____	C 09/20/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEALTH-CAROLINA POINT	5935 MOUNT SINAI ROAD DURHAM, NC 27705

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F 640	Continued From page 13 During an interview on 9/20/19 at 10:56 AM, the MDS coordinator stated Resident # 62's assessment was not signed by the RN. MDS coordinator stated it was her responsibility to forward the assessment to the RN once the assessment was completed. MDS coordinator indicated she was behind in completion of the resident's assessment. During an interview on 9/20/19 at 12:30 PM, the administrator stated he expects the MDS staff to complete and transmit the within the required time frame. The Administrator also indicated the facility had recently changed to a new medical software and the staff were in the process of learning the new system. 2. Resident #8 was admitted to the facility on 9/28/15 with diagnoses that included but not limited to hemiplegia, hand contracture and dementia. A review of resident's most recent MDS assessment revealed an ARD (Assessment Reference Date) of 7/22/19 and was coded as a quarterly assessment. The MDS assessment was signed as completed by the MDS Coordinator on 8/8/19. During an interview on 9/20/19 at10:56 AM, the MDS coordinator stated the assessment was signed on 8/8/19 but was not been transmitted. She stated the previous MDS nurse did not hit the finalize button, hence the MDS was not transmitted. MDS coordinator stated the facility had recently moved to a new software and it was the period when staff were under training. During an interview on 9/20/19 at 12:30 PM, the administrator stated he expects the MDS staff to	F 640	The Director of Nursing and/or Designee will report the results of the audits to the Quality Assurance and Performance Improvement Committee for further review and recommendations monthly for three months, and as needed thereafter. Director of Nursing will be responsible for implementation of this plan of correction. 10/18/19	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345551	A. BUILDING _____ B. WING _____	C 09/20/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEALTH-CAROLINA POINT	5935 MOUNT SINAI ROAD DURHAM, NC 27705

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F 640	Continued From page 14	F 640		

complete and transmit the within the required time frame. The Administrator also indicated the facility had recently changed to a new medical software and the staff were in the process of learning the new system.

3. Resident #14 was admitted to the facility on 5/2/19 with diagnoses that included but not limited to dementia and psychosis.

A review of Resident # 14's last MDS assessment dated 8/14/19 was coded as a quarterly assessment. MDS section Z0500 was not signed by Registered Nurse (RN) as completed.

During an interview on 9/20/19 at 10:56 AM, the MDS coordinator stated the assessment was complete, but was not signed by the RN. MDS coordinator stated it was her responsibility to forward the assessment to the RN once the assessment was completed. MDS coordinator indicated she was behind in sending the assessment as the previous MDS RN left the job on 8/15/19.

During an interview on 9/20/19 at 12:30 PM, the administrator stated he expects the MDS staff to complete and transmit the within the required time frame. The Administrator also indicated the facility had recently changed to a new medical software and the staff were in the process of learning the new system.

4. Resident #7 was admitted to the facility on 5/21/18 with diagnoses that included but not limited to peripheral vascular disease and heart failure.

A review of Resident # 7's last MDS assessment

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345551	A. BUILDING _____ B. WING _____	C 09/20/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEALTH-CAROLINA POINT	5935 MOUNT SINAI ROAD DURHAM, NC 27705

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F 640	Continued From page 15	F 640		

dated 7/16/19 was coded as a quarterly assessment. MDS section Z0500 was not signed by Registered Nurse (RN) as completed.

During an interview on 9/20/19 at 10:56 AM, the MDS coordinator stated the assessment was complete, but was not signed by the RN. MDS coordinator stated it was her responsibility to forward the assessment to the RN once the assessment was completed. MDS coordinator indicated she was behind in sending the assessment.

During an interview on 9/20/19 at 12:30 PM, the administrator stated he expects the MDS staff to complete and transmit the within the required time frame. The Administrator also indicated the facility had recently changed to a new medical software and the staff were in the process of learning the new system.

5. Resident #6 was admitted to the facility on 7/31/18 with diagnoses that included but not limited to femur fracture and depression.

A review of resident's most recent MDS assessment had revealed an ARD (Assessment Reference Date) of 7/21/19 and was coded as an annual assessment. The MDS assessment was signed as completed by the MDS Coordinator on 9/17/19.

During an interview on 9/20/19 at10:56 AM, the MDS coordinator stated the assessment was signed on 9/17/19 but was not transmitted. MDS coordinator stated the facility had recently moved to a new software and it was the period when staff were under training.
During an interview on 9/20/19 at 12:30 PM, the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345551	A. BUILDING _____ B. WING _____	C 09/20/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEALTH-CAROLINA POINT	5935 MOUNT SINAI ROAD DURHAM, NC 27705

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 640	Continued From page 16	F 640		

administrator stated he expects the MDS staff to complete and transmit the within the required time frame. The Administrator also indicated the facility had recently changed to a new medical software and the staff were in the process of learning the new system.

6. Resident #13 was admitted to the facility on 5/7/19 with diagnoses that included but not limited to dementia and epilepsy.

A review of Resident # 13's last MDS assessment dated 8/1/19 was coded as a quarterly assessment. MDS section Z0500 was not signed by Registered Nurse (RN) as completed. The assessment was not transmitted to the national database.

During an interview on 9/20/19 at 10:56 AM, the MDS coordinator stated the assessment was completed, but was not signed by the RN. MDS coordinator stated it was her responsibility to forward the assessment to the RN once the assessment was completed. MDS coordinator indicated she was behind in sending the assessment as the previous MDS RN had left the job on 8/15/19.

During an interview on 9/20/19 at 12:30 PM, the administrator stated he expects the MDS staff to complete and transmit the within the required time frame. The Administrator also indicated the facility had recently changed to a new medical software and the staff were in the process of learning the new system.

7. Resident #3 was admitted to the facility on 12/28/19 with diagnoses that included but not limited to stroke, hemiplegia, and depression.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345551	A. BUILDING _____ B. WING _____	C 09/20/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEALTH-CAROLINA POINT	5935 MOUNT SINAI ROAD DURHAM, NC 27705

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 640	Continued From page 17 A review of resident's most recent MDS assessment revealed an ARD (Assessment Reference Date) of 7/10/19 and was coded as a quarterly assessment. The MDS was signed as completed by the MDS Coordinator on 7/15/19 and indicates production accepted. The MDS assessment was not transmitted to the national database. During an interview on 9/20/19 at 10:56 AM, the MDS coordinator stated the assessment was completed, signed and transmitted. MDS coordinator stated she was unsure why the assessment was not transmitted. MDS coordinator stated the facility had recently moved to a new software and it was the period when staff were under training. During an interview on 9/20/19 at 12:30 PM, the administrator stated he expects the MDS staff to complete and transmit the within the required time frame. The Administrator also indicated the facility had recently changed to a new medical software and the staff were in the process of learning the new system.	F 640		
F 641 SS=E	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to accurately code Activities of Daily Living (ADL) on the Minimum Data Set (MDS) assessments for 2 of 21 residents reviewed for	F 641	The Minimal Data Set nurse(s) ensured accurate ADL coding for residents #84 and #111 on 10/11/19.	10/18/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345551	A. BUILDING _____ B. WING _____	C 09/20/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEALTH-CAROLINA POINT	5935 MOUNT SINAI ROAD DURHAM, NC 27705

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F 641	Continued From page 18 ADL's (Resident #84 and Resident # 111), Findings included: 1.Resident # 84 was admitted to the facility on 5/31/18 with multiple diagnoses, some of which included hemiplegia and anxiety. Review of the quarterly MDS assessment dated 7/11/19 revealed the resident was cognitively intact. Section G of the MDS assessment for ADL assistance was not coded as activity never occurred for bed mobility, transfer, walk in the room and corridor, locomotion in and out of the unit, dressing, eating, toilet use and personal hygiene. During an interview on 9/17/19 at 12:54 PM, Nurse Aide (NA) #5 stated resident #84 needs extensive one-person physical assistance for ADL's except for eating as resident able to self-feed with set up assistance. During an interview on 9/18/19 at 2:05 PM, Nurse #4 stated Resident # 84 was totally dependent from extensive assistance with one-person physical assist for ADL. Resident was able to eat independently with set up help. During an interview on 9/20/19 at 10:56 AM, MDS coordinator stated the MDS assessment was wrongly coded for ADL. During an interview on 9/20/19 at 12:30 PM, the Administrator indicated it was his expectation that the resident assessments were completed accurately and timely. 2. Resident #111 was admitted to the facility on	F 641	A 100% audit of all residents was completed on 10/17/19 by Minimal Data Set nurse(s) to ensure accurate ADL coding on Minimum Data Set for the past 30 days; 8 assessment□s ADL coding were noted to be coded incorrect, MDS nurse(s) will complete one extra assessment weekly until completion. Education was provided to Minimal Data Set nurse(s) and all nursing staff on 10/11/19 by Administrator, DHS, and/or Nurse Supervisors to ensure accurate ADL coding. The Director of nursing will audit 10 residents weekly for twelve weeks to ensure accurate ADL coding. The Director of Nursing and/or Designee will report the results of the audits to the Quality Assurance and Performance Improvement Committee for further review and recommendations monthly for three months, and as needed thereafter. Director of Nursing will be responsible for implementation of this plan of correction. 10/18/19	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345551	A. BUILDING _____ B. WING _____	C 09/20/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEALTH-CAROLINA POINT	5935 MOUNT SINAI ROAD DURHAM, NC 27705

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F 641	Continued From page 19 7/23/19 with multiple diagnoses, some of which included Coronary Artery Disease, Gastroesophageal Reflux Disease and Anxiety. Review of her admission Minimum Data Set assessment, dated 7/30/19, revealed resident was cognitively intact. Section G of the MDS assessment for ADL assistance was not coded as activity never occurred. On 9/18/19 at 7:00 AM, during an interview, NA #4, indicated Resident #111 required limited to extensive ADLs assistance, could transfer herself from the bed to wheelchair. During an interview on 9/20/19 at 10:56 AM, MDS coordinator stated the MDS was wrongly coded for ADL. During an interview on 9/20/19 at 12:30 PM, the Administrator indicated it was his expectation that the resident assessments were completed accurately and timely.	F 641		
F 642 SS=E	Coordination/Certification of Assessment CFR(s): 483.20(h)-(j) §483.20(h) Coordination. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. §483.20(i) Certification. §483.20(i)(1) A registered nurse must sign and certify that the assessment is completed. §483.20(i)(2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.	F 642		10/18/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345551	A. BUILDING _____ B. WING _____	C 09/20/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEALTH-CAROLINA POINT	5935 MOUNT SINAI ROAD DURHAM, NC 27705

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F 642	Continued From page 20 §483.20(j) Penalty for Falsification. §483.20(j)(1)Under Medicare and Medicaid, an individual who willfully and knowingly- (i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment. §483.20(j)(2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed coordinate and certify the completion of the Minimum Data Set (MDS) assessment on time for 5 of 21 sampled residents (Residents #11, #5, #4, #9, and #16) reviewed for resident assessments. The findings included: 1. Resident #11 was admitted to the facility on 10/29/18 with multiple diagnoses, some of which included Gastrostomy and Hemiplegia. A review of the quarterly MDS assessment dated 7/18/19 indicated that Resident #11 was assessed as severely cognitively impaired. Assessment indicated resident was extensive to total dependence with one-person assist for activities of daily living (ADL). The assessment was not signed by the Registered Nurse (RN) assessment coordinator to certify that it was complete and was not submitted to the national	F 642	The Minimal Data Set nurse coordinated 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(s) will complete one extra assessment weekly until completion. Education was provided to Minimal Data Set nurse(s) on 10/14/19 by Administrator to ensure all Minimum Data Set assessments are coordinated, certified, and completed on time. The Director of nursing will audit MDS	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345551	A. BUILDING _____ B. WING _____	C 09/20/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEALTH-CAROLINA POINT	5935 MOUNT SINAI ROAD DURHAM, NC 27705

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 642	Continued From page 21 database. During an interview on 9/20/19 at 10:56 AM, MDS coordinator indicated the MDS assessment reference date (ARD) was 7/18/19. She stated the assessment was marked as completed on 8/5/19 however some sections were not complete. This was identified and the sections was completed on 9/19/19. She further stated the assessment should be completed within 14 days from the ARD (8/18/19). The MDS coordinator stated all department were provided a calendar to complete their sections within of the look back period. She indicated the assessments were checked for completion and forwarded to the RN for signature and transmission. MDS coordinator further indicated the assessment was incomplete and hence was not signed and transmitted. During an interview on 9/20/19 at 12:30 PM, Administrator stated it was the expectation that the MDS assessments were completed and transmitted within the timeframe. 2. Resident #5 was admitted to the facility on 12/27/17 with diagnoses, that included paraplegia and spinal cord disease. A review of the quarterly MDS assessment dated 7/9/19 indicated Resident #5 was assessed as cognitively intact. Assessment indicated the resident needed extensive assistance with one-person physical assist for ADL's. The assessment was not signed by the RN assessment coordinator to certify that it was complete and was not submitted to the national database. During an interview on 9/20/19 at 10:56 AM, MDS	F 642	assessments for completion weekly for twelve weeks. The Director of Nursing and/or Designee will report the results of the audits to the Quality Assurance and Performance Improvement Committee for further review and recommendations monthly for three months, and as needed thereafter. Director of Nursing will be responsible for implementation of this plan of correction. 10/18/19	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345551	A. BUILDING _____ B. WING _____	C 09/20/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEALTH-CAROLINA POINT	5935 MOUNT SINAI ROAD DURHAM, NC 27705

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 642	Continued From page 22	F 642		

coordinator indicated the assessment ARD was 7/9/19. She stated as the MDS was not completed, the assessment was not forwarded to the RN. MDS coordinator indicated she was aware the MDS assessments was late.

During an interview on 9/20/19 at 12:30 PM, Administrator stated it was the expectation that the MDS assessments were completed and transmitted within the timeframe.

3. Resident #4 was admitted to the facility on 5/16/18 with diagnoses, that included major depression, anxiety disorder, and having cardiac pace maker.

A review of the quarterly MDS assessment dated 7/9/19, revealed the MDS was not completed and was not signed by RN assessment coordinator. The assessment was not submitted to the national data base.

During an interview on 9/20/19 at 10:56 AM, MDS coordinator indicated the MDS assessment reference Date (ARD) was 7/9/19. She stated the assessment was marked as completed on 9/17/19. She further stated the assessment should be completed within 14 days from the ARD (7/23/19). The MDS coordinator stated all department were provided a calendar to complete their sections within of the look back period. She indicated the assessments were checked for completion and forwarded to the Registered Nurse (RN) for signature and transmission. MDS coordinator further indicated the assessment was incomplete and hence was not signed and transmitted.

During an interview on 9/20/19 at 12:30 PM,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345551	A. BUILDING _____ B. WING _____	C 09/20/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEALTH-CAROLINA POINT	5935 MOUNT SINAI ROAD DURHAM, NC 27705

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F 642	Continued From page 23	F 642		

Administrator stated it was the expectation that the MDS assessment were completed and transmitted within the timeframe.

4. Resident # 9 was admitted to the facility on 4/25/14 with diagnoses that included hemiplegia, stroke, and Alzheimer's disease.

A review of the quarterly MDS assessment dated 8/2/19, revealed Resident #9 was assessed as severely cognitively impaired. Assessment indicated resident was extensive assistance with one-person assist for ADL. The assessment indicated as incomplete.

During an interview on 9/20/19 at 10:56 AM, MDS coordinator indicated the assessment ARD was 8/2/19. She stated as the MDS was not completed, the assessment was not forwarded to the RN. MDS coordinator indicated she was aware the MDS assessments was late.

During an interview on 9/20/19 at 12:30 PM, Administrator stated it was the expectation that the MDS assessment were completed and transmitted within the timeframe.

5. Resident #16 was admitted to the facility on 4/23/13 with multiple diagnoses, some of which included acute embolism of low extremities and neuropathy.

A review of the quarterly MDS assessment dated 8/14/19, revealed Resident #16 was assessed as severely cognitively impaired. Assessment indicated resident was total dependent with one-person assist for ADL. The assessment indicated as incomplete.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345551	A. BUILDING _____ B. WING _____	C 09/20/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEALTH-CAROLINA POINT	5935 MOUNT SINAI ROAD DURHAM, NC 27705

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 642	Continued From page 24 During an interview on 9/20/19 at 10:56 AM, MDS coordinator indicated the assessment ARD was 8/14/19. She stated as the MDS was not completed, the assessment was not forwarded to the RN. MDS coordinator indicated she was aware the MDS assessments was late. During an interview on 9/20/19 at 12:30 PM, Administrator stated it was the expectation that the MDS assessment were completed and transmitted within the timeframe.	F 642		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to	F 690		10/18/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345551	A. BUILDING _____ B. WING _____	C 09/20/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEALTH-CAROLINA POINT	5935 MOUNT SINAI ROAD DURHAM, NC 27705

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 690	Continued From page 25 prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on record review, observations and staff interview the facility failed to anchor indwelling urinary catheter tubing (Resident #37) for 1 of 1 residents with an indwelling urinary catheter. The findings include: Resident #37 was admitted on 5/23/19 with an indwelling urinary catheter, placed in the hospital prior to admission. Resident 37 ' s diagnoses including obstructive uropathy (obstruction of normal urine flow), urine retention and schizophrenia. Review of resident ' s Quarterly Minimum Data Set assessment, dated 6/4/19, revealed his intact cognition. Review of the physician ' s orders for Resident #37 revealed the orders for indwelling foley catheter 16 Fr (French - size of the catheter) with balloon 10 ml (milliliters), to provide catheter care/monitoring every shift, changing the catheter monthly on first shift and as needed. Review of Resident 37 ' s Plan of Care, dated 6/5/19, revealed the resident used indwelling urinary catheter for urinary retention due to urinary flow obstruction, with appropriate goals	F 690	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 residents with catheters to ensure all were anchored on 10/10/19. The Director of Nursing in-serviced all nursing staff on ensuring residents with catheters are anchored at all times on 10/14/19. Director of Nursing and/or designee will audit all resident□s with catheters weekly for twelve weeks to ensure catheters are anchored at all times. The Director of Nursing and/or Designee will report the results of the audits to the Quality Assurance and Performance Improvement Committee for further review and recommendations monthly for three months, and as needed thereafter. Director of Nursing will be responsible for implementation of this plan of correction.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345551	A. BUILDING _____ B. WING _____	C 09/20/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEALTH-CAROLINA POINT	5935 MOUNT SINAI ROAD DURHAM, NC 27705

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 690	Continued From page 26 and interventions. On 9/16/19 at 2:10 PM, during the observation/interview, Resident #37 was in bed. The foley urinary catheter was in place, not secured to his leg, with urinary tubing connected to the drainage bag, mounted to the bed frame. The resident indicated "nobody mounted his urinary catheter to the leg this week". He confirmed that he was out of bed in wheelchair every day. On 9/17/19 at 7:40 AM, during the observation, Resident #37 was in bed, with foley catheter not secured to the resident ' s leg. On 9/18/19 at 2:00 PM, during the observation of personal hygiene care, provided by Nurse Aide #1, Resident #37 was in bed. He had the foley catheter in place, with drainage bag covered and attached to the bed frame. The urinary catheter was not secured to his leg. On 9/18/19 at 2:05 PM, during an interview, Nurse Aide #1 indicated that she did not know the urinary catheter was not secured. She continued that it was nurses ' responsibility to secure the urinary catheter to the resident ' s leg. On 9/18/19 at 2:10 PM, during an interview, Nurse #3 indicated that Resident #37 received indwelling urinary catheter based on his urinary retention/obstruction. She mentioned that the urinary catheter needed to be secured with the leg strap or anchor to the resident ' s leg. The nurse was not aware of Resident 37 ' s unsecured foley catheter and went to correct the situation after the interview.	F 690	10/18/19	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345551	A. BUILDING _____ B. WING _____	C 09/20/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEALTH-CAROLINA POINT	5935 MOUNT SINAI ROAD DURHAM, NC 27705

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 690	Continued From page 27 On 9/18/19 at 2:30 PM, during an interview, the Director of Nursing expected the staff to anchor the indwelling urinary catheter to the resident ' s leg at all time to prevent complications.	F 690		
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to remove expired 10 vials of Pneumovax, 3 tubes of Glutose gel, 50 vials of Performist Inhalation Solution from 2 of 2	F 761	Nurse #1 and #2 disposed of the Pneumovax, glutose gel, Performist inhalation solution, and max freeze gel on 9/17/19.	10/18/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345551	A. BUILDING _____ B. WING _____	C 09/20/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEALTH-CAROLINA POINT	5935 MOUNT SINAI ROAD DURHAM, NC 27705

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F 761	Continued From page 28 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 medication storage room on 300/400 hall with Nurse #1 revealed the following expired medications were found in the refrigerator: one plastic container with 9 sealed vials of Pneumovax 23 mg (milligram) each. The pharmacy label on the container showed to discard the medication after 4/15/19; one plastic bag with 3 sealed tubes of Glutose 15 oral glucose gel, 35.5 g (gram). The pharmacy label on the plastic bag showed to discard the medication after 8/31/19. On 9/17/19 at 11:15 AM, during an interview, Nurse #1 indicated that the nurses, who worked on the floor, were responsible to remove expired medications from the medication storage room. 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. On 9/17/19 at 11:50 AM, observation of the medication storage room on 500/600 hall with Nurse #1 revealed the following expired medications were found: in the refrigerator, one plastic container with 1 sealed vial of Pneumovax 23 mg. The pharmacy label on the container showed to discard the medication after 5/18/19; in the cabinet, one opened paper box of 50 Performist Inhalation Solution vials, 20 mcg	F 761	Director of Nursing and/or Designee completed a 100% audit of all medication storage rooms and nursing carts to ensure no expired medication are present on 10/11/19. Administrator and/or Director of Nursing in-serviced all nursing staff on ensuring all med storage areas, to include nursing carts, are always free of expired meds on 10/10/19. Director of Nursing and/or Designee will audit all med storage and nursing carts weekly for twelve weeks to ensure free of expired medications. The Director of Nursing and/or Designee will report the results of the audits to the Quality Assurance and Performance Improvement Committee for further review and recommendations monthly for three months, and as needed thereafter. Director of Nursing will be responsible for implementation of this plan of correction. 10/18/19	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345551	A. BUILDING _____ B. WING _____	C 09/20/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEALTH-CAROLINA POINT	5935 MOUNT SINAI ROAD DURHAM, NC 27705

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 761	Continued From page 29	F 761		

(microgram) in 2 ml (milliliter). The pharmacy label on the paper box showed to discard the medication after 6/13/19.

On 9/17/19 at 11:55 AM, during an interview, Nurse #1 indicated that the nurses, who worked on the floor, were responsible to remove expired medications from the medication storage room. The nurse confirmed that the Pneumovax vial and all the Performist Inhalation Solution vials were not opened or used. The nurses had not check the expiration date of the medications in medication storage room at the beginning of this shift.

B.On 9/17/19 at 12:05 PM, observation of the medication administration cart on 300/400 hall, with Nurse #2 revealed the following expired medications were found: 1 opened tube of Max Freeze gel, 113.4 g. The pharmacy label on the tube showed to discard the medication after 9/15/19.

On 9/17/19 at 12:10 PM, during an interview, Nurse #2 indicated that the nurses, who worked on the medication carts, were responsible to remove expired medications from the medication administration cart. The nurse confirmed that the Max Freeze gel was opened, but she did not use it this shift. The nurse had not check the expiration date on Max Freeze gel in the medication administration cart at the beginning of her shift.

On 9/18/19 at 10:10 AM, during an interview, the Director of Nursing indicated that all the nurses were responsible to check all the medications in medication administration carts and medication storage rooms for expiration date and remove

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345551	A. BUILDING _____ B. WING _____	C 09/20/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEALTH-CAROLINA POINT	5935 MOUNT SINAI ROAD DURHAM, NC 27705

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 761	Continued From page 30 expired medications. Her expectation was that no expired items be left in the medication carts or medication storage rooms.	F 761		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record review, the facility failed to maintain and clean following kitchen equipment; the stove, oven, steam table, plate warmer, plate/dome rack, refrigerator and freezer. The findings included: 1a. During the kitchen tour on 9/16/19 at 10:00 AM, the stove had a large volume of heavy grease build up on the stove burners, walls and fronts of the stove. There were large amounts of	F 812	Dietary Manager on 9/17/19 cleaned the kitchen□s stove, oven, steam table, plate warmer, plate dome rack, refrigerator, and freezer. Dietary Manager completed a 100% audit on 10/10/19 to ensure all kitchen equipment and items are cleaned appropriately. Administrator in-serviced Dietary Manager	10/18/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345551	A. BUILDING _____ B. WING _____	C 09/20/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEALTH-CAROLINA POINT	5935 MOUNT SINAI ROAD DURHAM, NC 27705

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 812	Continued From page 31 burnt foods, dried liquid encrusted and splatters throughout the stove area. During an interview on 9/16/19 at 10:05 AM, the Dietary Manger (DM) stated the expectation was for the kitchen staff to follow the kitchen cleaning checklist. b. During an observation on 9/16/19 at 10:00 AM, the oven had a large volume greasy buildup, dried food and liquids on the inside and outside. The grease buildup was encrusted on doors/shelves where foods were being cooked. There was a large volume of dried grease buildup was observed on the fronts of the ovens and on the walls. 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. During an interview on 9/16/19 at 10:05 AM, the DM stated the expectation was for the kitchen staff to follow the kitchen cleaning checklist. During follow-up observation on 5/22/19 at 11:15 AM, the ovens had not been deep cleaned and the heavy grease build up remained on the oven and stove area. The DM stated the oven outside had been wiped down and the stove was wipe down and clean. 2. During an observation on 9/16/19 at 10:00 AM, the 5 compartment steam tables had floating food particles in standing water, the lids of the steam table had large volumes of dried food and greasy build up around edges.	F 812	and dietary staff on 10/11/19 on ensuring all kitchen equipment is always clean. Dietary Manager will audit all kitchen equipment cleanliness daily for twelve weeks. The Dietary Manager and/or Designee will report the results of the audits to the Quality Assurance and Performance Improvement Committee for further review and recommendations monthly for three months, and as needed thereafter. Dietary Manager will be responsible for implementation of this plan of correction. 10/18/19	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345551	A. BUILDING _____ B. WING _____	C 09/20/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEALTH-CAROLINA POINT	5935 MOUNT SINAI ROAD DURHAM, NC 27705

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 812	Continued From page 32	F 812		

During an interview on 9/16/19 at 10:05 AM, the DM stated the expectation was for the kitchen staff to follow the kitchen cleaning checklist.

3 a. During an observation on 9/16/19 at 10:00 AM, the two-compartment plate warmer had two rows of clean plates stored in them. The inside and outside had dried food particles and liquids spills, old food crumbs all around. The staff removed the plates wiped down the top and returned the clean plates to the warmer. Other dried food particles and liquids remained inside the plate warmer.

During an interview on 9/16/19 at 10:05 AM, the DM stated the expectation was for the kitchen staff to follow the kitchen cleaning checklist.

4. During an observation on 9/16/19 at 10:00 AM, there were two plate/dome racks with dome lids/plates had large leftover food, yellow, brown, crumbs dried liquids were the clean domes/lids were drying.

During an interview on 9/16/19 at 10:05 AM, the DM stated the expectation was for the kitchen staff to follow the kitchen cleaning checklist.

During a follow-up visit on 9/18/19 at 11:20 AM, The clean tray rack with dome plates/lids (32) had dried yellow, brown food particles, dried liquids.

During an interview on 9/18/19 at 11:25 AM, the DM stated the expectations for the kitchen staff to follow the kitchen cleaning checklist. He presented the expected daily, weekly and monthly checklist.

5. During an observation on 9/16/19 at 10:00 AM,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345551	A. BUILDING _____ B. WING _____	C 09/20/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEALTH-CAROLINA POINT	5935 MOUNT SINAI ROAD DURHAM, NC 27705

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 812	Continued From page 33 the inside and outside of the refrigerator had large volumes of dried encrusted food and liquids of dried yellow, brown matter where food was stored. The outside had large volumes of dried food and liquids on handles, venting area. b. During an observation on 9/16/19 at 10:00 AM, the outside of the freezer had encrusted brown matter, dried yellow substance and food on the doors, handles and vented area of the freezer. During an interview on 9/16/19 at 10:05 AM, the DM stated the expectation was for the kitchen staff to follow the kitchen cleaning checklist. During an interview on 9/19/at 8:30 AM, the Administrator stated he expected the dietary manager ensure the kitchen equipment was clean and maintained in accordance to regulatory standards.	F 812		
F 867 SS=E	QAPI/QAA Improvement Activities CFR(s): 483.75(g)(2)(ii) §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews, the facility's Quality Assessment and Assurance (QAA) Committee failed to effectively maintain implemented procedures and effectively monitor these interventions that the committee put into place in August of 2018. There were for two deficiency, which were originally cited on 8/10/17 and 8/23/18 during the recertification	F 867	The facility held a Ad Hoc QAPI meeting on 10/17/19 to review previous citations regarding the recurring citation of food procurement store/prepare/serve foods under sanitary conditions, QAPI, quarterly assessments, and bowel/bladder incontinence (catheter and UTI).	10/18/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345551	A. BUILDING _____ B. WING _____	C 09/20/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEALTH-CAROLINA POINT	5935 MOUNT SINAI ROAD DURHAM, NC 27705

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 867	Continued From page 34 survey and on the current recertification and complaint survey (9/20/19). The repeated deficiencies were in the areas of food procurement store/prepare/serve foods under sanitary conditions (F371 which is now F 812) and Quality Assurance and Performance improvement (QAPI)/ QAA improvement activities (F 867). Two deficiencies were originally cited on 8/23/18 during the recertification and during the current recertification and complaint survey. The repeated deficiencies were in the area of quarterly assessments at least every 3 months (F 638), Bowel/bladder incontinence, catheter and Urinary tract infection, (F690). The continued failure of the facility during three federal surveys of record shows a pattern of the facility's inability to sustain an effective quality assurance program. The Findings included: This tag is cross-referred to: 1.During the recertification survey dated 9/20/19, F812- food procurement store/prepare/serve foods under sanitary conditions was cited. Based on observations, staff interviews and record review, the facility failed to maintain and clean following kitchen equipment; the stove, oven, steam table, plate warmer, plate/dome rack, 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	F 867	The QA meeting has been revised and changes are being made so that previous citations will be reviewed as needed and followed up on with documentation being recorded in the QA minutes. QAPI team members were in-serviced by the Administrator on 10/14/19. The education included the QA program review of previous survey citations and the inclusion of on-going monitoring to maintain compliance. The QA meeting has revised, and changes are being made so that previous citations will be reviewed as needed and followed up on with documentation being recorded in QA minutes. The Administrator will document in the QA minutes the monthly review of on-going QAPI plans with the QA team for three months and as needed. QAPI committee will review the results of the audits monthly for three months and as needed thereafter. Administrator will be responsible for implementation of this plan of correction. 10/18/19	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345551	A. BUILDING _____ B. WING _____	C 09/20/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEALTH-CAROLINA POINT	5935 MOUNT SINAI ROAD DURHAM, NC 27705

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 867	Continued From page 35	F 867		

free of flies.

The facility was also cited during the 8/10/17 recertification survey for to maintain the nourishment refrigerator temperature below 40 degrees, discard food and inappropriately stored staff personal food in two of the three nourishment refrigerators.

1. During the recertification and complaint survey dated 9/20/19, F 638 -quarterly assessments at least every 3 months was cited. Based on record review and staff interviews, the facility failed to conduct a quarterly Minimum Data Set (MDS) assessment within 92 days of the previous MDS assessment for 4 of 21 residents selected to be reviewed for Resident Assessment (Resident #10, Resident # 2, Resident #1 and Resident # 382).

During the recertification survey on 8/23/18, the facility was cited for failure to conduct a quarterly Minimum Data Set (MDS) assessment for 1 of 2 residents selected to be reviewed for Resident Assessments. (Resident #2).

2. During the recertification and complaint survey dated 9/20/19, F690 -Bowel/bladder incontinence, catheter and Urinary tract infection was cited. Based on record review, observations and staff interview the facility failed to anchor indwelling urinary catheter tubing (Resident #37) for 1 of 1 residents with an indwelling urinary catheter.

During the recertification survey on 8/23/18, the facility was cited for failure to secure the indwelling urinary catheter for 1 of 3 sampled residents reviewed for urinary catheter use. (Resident # 1.)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345551	A. BUILDING _____ B. WING _____	C 09/20/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEALTH-CAROLINA POINT	5935 MOUNT SINAI ROAD DURHAM, NC 27705

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 867	Continued From page 36	F 867		

3. During the recertification survey dated 9/20/19, F867 QAPI/QAA improvement activities was cited. Based on observations, record review and staff interviews, the facility's Quality Assessment and Assurance (QAA) Committee failed to effectively maintain implemented procedures and effectively monitor these interventions that the committee put into place in August of 2018.

During the recertification survey dated 8/23/18, the facility was cited for failing to effectively maintain implemented procedures and effectively monitor these interventions that the committee put into place in August of 2017.

During the recertification survey dated 8/10/17, the facility was cited for failing to effectively maintain implemented procedures and effectively monitor these interventions that the committee put into place in September of 2016.

During an interview on 9/20/19 at 4:14 PM, the Administrator acknowledged understanding of the reciting of F 638, F 690, F 812 and F 867 during the recent recertification and complaint survey in August 2019. The administrator indicated he had recently accepted this position in the facility. He stated the Quality Assurance (QA) committee 1) identifies areas of concern, 2) does a root cause analysis, 3) develops a plan, audits and monitors that plan and 4) discusses the outcome. Administrator indicated QAA meets monthly, quarterly and no as needed basis, and discusses the identified concerns, goals met, and improvement needed. The Administrator stated it was his expectation that the foods was served to the resident in a

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345551	A. BUILDING _____ B. WING _____	C 09/20/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEALTH-CAROLINA POINT	5935 MOUNT SINAI ROAD DURHAM, NC 27705

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 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		