STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345061	A. BUILDING _____ B. WING _____	C 11/24/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly 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 an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on staff interviews and record review, the facility failed to accurately assess the Oral/Dental status for 1 of 4 residents (Resident #2) reviewed for Oral/Dental status. Findings included:	F 278	This plan of correction constitutes a written allegation of compliance, preparation, and submission of this plan of correction does not constitute an admission or agreement by the provider of	12/19/15

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

Electronically Signed | 12/19/2015

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F 278	Continued From page 1 Resident #2 was admitted on 6/26/2015 with diagnosis of diabetes. A review of the significant change Minimum Data Set (MDS), dated 11/4/2015 indicated Resident #2 had severe cognitive impairment. A review of the admission MDS dated 7/6/2015 revealed Resident #2 had no natural teeth. A review of a significant change MDS dated 11/4/2015 indicated Resident #2 did have natural teeth. In an interview on 11/24/2015 at 4:05 PM, the MDS coordinator stated Resident #2 had no natural teeth but did have dentures. The MDS coordinator indicated Resident #2 ' s admission MDS (7/6/2015) was completed by a previous MDS nurse. In an interview on 11/24/2015 at 4:23 PM, the MDS nurse who completed the significant change MDS dated 11/4/2015 stated she was unsure how to code for Resident #2. The MDS nurse indicated the resident was edentulous but thought the dentures could be considered natural teeth. In an interview on 11/24/2015 at 4:52 PM, the Director of Nursing (DON) stated her expectation was the MDS assessment should be accurate.	F 278	truth of the facts alleged or the corrections of the conclusions set forth on the statement of deficiencies. The plan of correction is prepared and submitted soley because of requirements under state and federal Law. Corrective Action for those residents that have been affected. On 12/4/15 Resident #2 MDS assesment was opened and the correct coding was completed. Corrective action will be accomplished for those residents to be affected by same deficient practice. On 11/30/15 both Case Mix Director and Case Mix nurse were education on Section L for accuracy and coding. This education was In-serviced by the Clinical Reimbursement Consultant. On 11/30/15 all 116 active charts were reviewed to compare with the last annual assement for oral accuracy. All discrepencys observed were corrected. Measures put into place or systemic changes made to ensure that the deficient practice will not occur. All Comprehensive Section L will be verified prior to closing by two nurses. This is documnented on the Weekly audit	

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F 278	Continued From page 2	F 278	form that is reviewed by the Director of Health Services (DHS) each week. The facility plans to monitor its performance to make sure solutions are sustained. The CMD will present the findings of the Audit Tool for the Section L to the Quality Assurance Performance Improvement Committee monthly for three months or until a patter of compliance is obtained.	
F 333 SS=D	483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS The facility must ensure that residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews, the facility failed to prevent a significant medication error by not administering scheduled doses of eye drops for treatment of glaucoma as ordered for 1 of 1 residents (Resident # 4). Findings include: Resident # 4 was admitted to the facility on 4/22/14 with an accumulative diagnosis which included Alzheimer ' s disease. A review of the most recent comprehensive Minimum Data Set (MDS) dated 8/17/15 revealed Resident # 4 had severe cognitive deficits and required assistance with daily care. A review of an ophthalmic consultation dated 11/6/15 revealed the resident was diagnosed with glaucoma and included recommendations to start	F 333	This plan of correction constitutes a written allegation of compliance, preparation, and submission of this plan of correction does not constitute an admission or agreement by the provider of truth of the facts alleged or the corrections of the conclusions set forth on the statement of deficiencies. The plan of correction is prepared and submitted soley because of requirements under state and federal Law. Corrective Action for those residents that have been affected.	12/19/15

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F 333	Continued From page 3 xalatan eye drops 1 drop in both eyes at bedtime to reduce pressure in the eyes. A review of the medical record revealed the physician ' s orders for the eye drops were written on 11/9/15 by the Physician ' s Assistant. A review of Resident # 4 ' s Medication Administration Record (MAR) for 11/9/15 - 11/22/15 revealed no documentation at all for 11/9/15, 11/10/15 and 11/22/15. The remaining dates during that period revealed the nurses ' initials were circled on 11/12/15 - 11/15/15 and 11/18/15 - 11/21/15 by Nurse # 1, indicating the eye drops were not administered. There was no documentation on the back of the MAR as to why the eye drops were not given. During an interview on 11/24/15 at 3:43 pm, Nurse # 1 stated the order for the xalatan eye drops was written on 11/9/15 and she transcribed the order onto the MAR and faxed it to the pharmacy. She stated it was faxed late in the day and did not come in that night or the following night. She stated she did not report it to the charge nurse or the Director of Nursing Services because she expected it to be delivered each night. She stated she faxed a refill request on 11/12/15, and called the pharmacy again on 11/23/15 and pharmacy staff said again it had been sent and asked if she had checked the refrigerator. Nurse # 1 stated she checked the refrigerator on 11/23/15 and found one bottle of xalatan eye drops dated 11/20/15. During an interview on 11/24/15 at 3:47 pm, the Pharmacy Triage Technician (PTT) stated the pharmacy received a prescription on 11/6/15 from the opthamalogist ' s office for Resident # 4. The PTT stated the order was filled and sent to the facility on that date. The PTT stated they received another order from the facility on 11/9/15 but the order had already been filled. The	F 333	On 11/23/15 Resident #2 had xalatan eye drops administered per order. Corrective action will be accomplished for those residents to be affected by same deficient practice. On 11/25/15 all active MAR were reviewed to ensure all medications had been administered according to order. Any noted medications not administered were addressed per standard of practice. On 11/26/15 all MAR reveiws were completed. On 11/26/15 an In-service was initiated to ensure all direct nurses were educated on steps to prevent medication error (In-service ordering/receiving medications). On 11/26/15 100% of 36 nurses had been in-serviced. This in-service was conducted by DHS (Director of Health Services), Pharmicist, Designated Supervisors and/ or Manager. This education will be part of the new hire orientation for nurses. Measures put into place or systemic changes made to ensure that the deficient practice will not occur. On 11/27/15 all MAR are reviewed daily to ensure proper ordering and receiving is followed. Any discrepancy is addressed per protocol. This will review will be conducted7 days a week for the first month, and then 4 days a week for the second month and three days a week for	

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F 333	Continued From page 4 pharmacy received a faxed request for a refill on 11/12/15 and notified the facility it was too soon to refill the order. They received another request for a refill on 11/20/15 and was able to refill that order. The PTT stated sometimes the medication was placed in the refrigerator until opened, and suggested facility staff check the refrigerator when they called on 11/23/15. During an interview on 11/24/15 at 5:25 pm, the Director of Nursing Services (DNS) stated she had not been made aware of the problem obtaining the eye drops for Resident # 4. The DNS stated her expectation was that the nurses transcribe the physician ' s orders and fax them to the pharmacy. The medications should be received from the pharmacy with the next delivery cycle or be obtained from the emergency medication kit or the back up pharmacy per facility protocol. If not, it should be reported to her and the physician notified so he could order something else or figure out an alternative treatment.	F 333	the third month. This review will be done by DHS or her designee. The facility plans to monitor its performance to make sure solutions are sustained. The Director of Health Services will present the findings of the Audit Tool for ordering and receivding of medications to the Quality Performance Improvement Committee monthly for three months or until a patter of compliance is obtained.	