DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/23/2017 FORM APPROVED OMB NO. 0938-0391

	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
	345061	B. WING _			C 04/22/2017
		,	STREET ADDRESS, CITY, STATE, ZIP CO 3100 ERWIN ROAD DURHAM, NC 27705	ODE	
(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
(b)(2) Foot care. To proper treatment an and good foot health (i) Provide foot care with professional state to prevent complicate medical condition(s) (ii) If necessary, assappointments with a arranging for transpappointments (f) Colostomy, urete The facility must ensequire colostomy, uservices, receive suprofessional standar comprehensive persectives the approparate of the resident's goals (g)(5) A resident who receives the approparate of the resident's goals (g)(5) A resident who receives the approparate of the resident's goals (g)(5) A resident who receives the appropagation of the propagation of the propagatio	ensure that residents receive d care to maintain mobility in, the facility must: and treatment, in accordance andards of practice, including tions from the resident's and itst the resident in making qualified person, and ortation to and from such erostomy, or ileostomy care. Sure that residents who ireterostomy, or ileostomy ch care consistent with rds of practice, the son-centered care plan, and and preferences. To is fed by enteral means riate treatment and services cations of enteral feeding ited to aspiration pneumonia, dehydration, metabolic hasal-pharyngeal ulcers. The preferences is and in accordance with expensive the plan, and the resident's est.	F 3	28		5/5/17
DIRECTOR'S OR PROVIDER	R/SUPPLIER REPRESENTATIVE'S SIGNATUR	RE	TITLE		(X6) DATE
	(EACH DEFICIEN REGULATORY OF REGULATORY OF AREGULATORY OF AREGULAT	ASJUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 483.25(b)(2)(f)(g)(5)(h)(i)(j) TREATMENT/CARE FOR SPECIAL NEEDS (b)(2) Foot care. To ensure that residents receive proper treatment and care to maintain mobility and good foot health, the facility must: (i) Provide foot care and treatment, in accordance with professional standards of practice, including to prevent complications from the resident's medical condition(s) and (ii) If necessary, assist the resident in making appointments with a qualified person, and arranging for transportation to and from such appointments (f) Colostomy, ureterostomy, or ileostomy care. The facility must ensure that residents who require colostomy, ureterostomy, or ileostomy services, receive such care consistent with professional standards of practice, the comprehensive person-centered care plan, and the resident's goals and preferences. (g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. (h) Parenteral Fluids. Parenteral fluids must be administered consistent with professional standards of practice and in accordance with physician orders, the comprehensive person-centered care plan, and the resident's goals and preferences.	ROVIDER OR SUPPLIER SALTH-DURHAM SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 483.25(b)(2)(f)(g)(5)(h)(i)(j) TREATMENT/CARE FOR SPECIAL NEEDS (b)(2) Foot care. To ensure that residents receive proper treatment and care to maintain mobility and good foot health, the facility must: (i) Provide foot care and treatment, in accordance with professional standards of practice, including to prevent complications from the resident's medical condition(s) and (ii) If necessary, assist the resident in making appointments with a qualified person, and arranging for transportation to and from such appointments (f) Colostomy, ureterostomy, or ileostomy care. The facility must ensure that residents who require colostomy, ureterostomy, or ileostomy services, receive such care consistent with professional standards of practice, the comprehensive person-centered care plan, and the resident's goals and preferences. (g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. (h) Parenteral Fluids. Parenteral fluids must be administered consistent with professional standards of practice and in accordance with physician orders, the comprehensive person-centered care plan, and the resident's goals and preferences.	ROVIDER OR SUPPLIER SALTH-DURHAM SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACT (E	A BUILDING 345061 345061 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 3100 ERWIN ROAD DURHAM, NC 27705 BUNMARY STATEMENT OF DEPICIENCIES (EACH DEPICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 483.25(b)(2)(f)(g)(5)(h)(i)(j) TREATMENT/CARE FOR SPECIAL NEEDS (b)(2) Foot care. To ensure that residents receive proper treatment and care to maintain mobility and good foot health, the facility must: (i) Provide foot care and treatment, in accordance with professional standards of practice, including to prevent complications from the resident's medical condition(s) and (ii) If necessary, assist the resident in making appointments with a qualified person, and arranging for transportation to and from such appointments with a qualified person, and arranging for transportation to and from such appointments with professional standards of practice, the comprehensive person-centered care plan, and the resident's goals and preferences. (g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. (h) Parenteral Fluids. Perenteral fluids must be administered consistent with professional standards of practice and in accordance with physician orders, the comprehensive person-centered care plan, and the resident's goals and preferences. (i) Respiratory care, including tracheostomy care

05/05/2017

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

Electronically Signed

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AND DI AN OF CORRECTION INDESTRUCTION NUMBER		l ` ′	IPLE CONSTRUCTION	, ,	(X3) DATE SURVEY COMPLETED	
		345061	B. WING _		04	C I/22/2017
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C 3100 ERWIN ROAD DURHAM, NC 27705		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 328	that a resident who reincluding tracheostor suctioning, is provided professional standard comprehensive personal standard subpart. (j) Prostheses. The resident who has a pand assistance, constandards of practice person-centered care and preferences, to prosthetic device. This REQUIREMENT by: Based on observation and staff interview that toenails and seek poor (Resident #4) of 5 satincluded: Resident #4 was addressident #4 was addressident #4 was addressident #4. An admission minimulated 2/28/17 coded limited assistance of hygiene. An interim care pland readmission to the fawith activities of daily Resident #4.	ing. The facility must ensure needs respiratory care, my care and tracheal ed such care, consistent with ds of practice, the on-centered care plan, the preferences, and 483.65 of facility must ensure that a prosthesis is provided care sistent with professional enter the comprehensive enter and be able to use the transfer of the comprehenced on, record review, resident to the facility failed to trim the	F3	1.Immediate corrective actitis alleged deficient practice. a. Resident #4 has a podial scheduled on 5/3/2017 2. Resident with potential to a. All resident stoenails heassessed and a podiatry coordered as needed. 3. Measures put into place the alleged deficient practice recur include: a. On 4/22/2017 the Direct Clinical Competency Coord Nurse Managers began ed Certified Nursing Assistance Nursing regarding observa	try appointment o be affected. ave been onsult has been to assure that ce does not or of Nursing, dinator and/or lucation with the ce and Licensed	

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION (X3) DATE SURVEY COMPLETED		
			A. BUILDII	NG	С	
		345061	B. WING		04/22/2017	
NAME OF P	ROVIDER OR SUPPLIER	0.000.	1	STREET ADDRESS, CITY, STATE		\dashv
NAME OF T	NOVIDEN ON 301 1 LIEN			3100 ERWIN ROAD	, ZII CODE	
PRUITTHE	ALTH-DURHAM					
				DURHAM, NC 27705		_
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIV CROSS-REFERENCE	AN OF CORRECTION (X5) E ACTION SHOULD BE COMPLETIO D TO THE APPROPRIATE CIENCY)	N
F 328	Continued From pa	ge 2	F3	328		
	coded Resident #4	as cognitively intact. Resident		Licensed Nurses and	Certified Nursina	
		on 4/22/17 at 9:10 AM. She		Assistants not educate		
	stated she was not	able to trim her toenails.		be removed from the s	-	
				education is complete		
	An observation of the	he toe nails of Resident #4				
		unit supervisor on 4/22/17 at		b. Toe Nail care and s		
		ails on both feet were very long		added to the new part	ner orientation for	
		supervisor stated that the		nursing staff.		
		did need cutting and that one		a The Contified Numein	an Assistanta and	
	in particular on the left foot, which was curling under, would require a podiatrist to cut it. She			c. The Certified Nursin visualizing the residen		
		rimming of toenails was the		reporting to the Licens	-	
		•		thick or jagged nails. T		
	responsibility of the nurse aides after the resident had showered. The unit supervisor stated the			notified the Social Wor		
		uire assistance to trim her		resident on the podiati		
	toenails.			needed.		
	The nurse aide #1,	assigned to Resident #4, was		d.The Nurse Manager	s are randomly	
	interviewed on 4/22	2/17 at 9:55 AM. Nurse aide #1		reviewing 10 residents	toenails daily for 7	
		dressed herself and took care		days, then weekly for		
		Il hygiene except for set up of		monthly thereafter for	need of podiatry	
		s. Nurse aide #1 did not know		care.		
	what the toe nails o	of Resident #4 looked like.		4.84 %	, , , , , ,	
	An interview was a	and coted with the facility assist		4.Monitoring put in pla		
		onducted with the facility social at 9:45 AM. She said the		alleged deficient pract includes:	ice does not recui	
		trist that came to the facility at		includes.		
		said the podiatrist was last in		a.The Director of Heal	th Services will	
		17 but Resident #4 was not on		present the toenail rev		
	the list to be seen of			improvement and perf	. ,	
		-		improvement committe		
	An additional interv	iew with the unit supervisor		revision monthly until		
		4/22/17 at 10:05 AM. She		continued compliance	sustained.	
	_	pleted skin assessments and				
		Wednesday on Resident #4.				
		sessments and body audits				
		completed on 4/3/17, 4/5/17,				
		uld not be located. A body				
	auuil completed on	4/19/17 documented the		1		- 1

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION G	(X3) DATE SU COMPLE	(X3) DATE SURVEY COMPLETED			
		345061	B. WING		C	2/2047		
NAME OF PROVIDER OR SUPPLIER PRUITTHEALTH-DURHAM				STREET ADDRESS, CITY, STATE, ZIP CODE 3100 ERWIN ROAD DURHAM, NC 27705	04/22	04/22/2017		
(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 CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE		
F 328	toenails of Resident # The Director of Nursir	as dry and thick. In g was interviewed on the cknowledged and	F 3	28				