DEPART	MENT OF HEALTH AN	ID HUMAN SERVICES			FOR	M APPROVED
CENTER	S FOR MEDICARE &	MEDICAID SERVICES			OMB NO	<u> </u>
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,		COMF	E SURVEY PLETED
		345061	B. WING			C / 29/2018
NAME OF P	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, STATE, ZIP CODE		20/2010
	EALTH-DURHAM		3	100 ERWIN ROAD		
PROTTIN			D	URHAM, NC 27705		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS		F 000			
		cited as a result of the n survey on 3/29/18 Event				
F 550 SS=D		-	F 550			4/25/18
	self-determination, an access to persons an	ght to a dignified existence, ad communication with and				
	with respect and dign resident in a manner promotes maintenance	and in an environment that be or enhancement of his or ognizing each resident's lity must protect and				
	access to quality care severity of condition, must establish and m practices regarding tr	cility must provide equal e regardless of diagnosis, or payment source. A facility aintain identical policies and ansfer, discharge, and the under the State plan for all of payment source.				
		right to exercise his or her f the facility and as a citizen				
	resident can exercise	cility must ensure that the his or her rights without n, discrimination, or reprisal				
LABORATORY	 DIRECTOR'S OR PROVIDER/S	SUPPLIER REPRESENTATIVE'S SIGNATURE	<u> </u>	TITLE		(X6) DATE
	cally Signed					04/20/2018

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.

		MEDICAID SERVICES					D. 0938-039
	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
			A. BUILDI	ING _			
		345061	B. WING				C
	OVIDER OR SUPPLIER	040001			TREET ADDRESS, CITY, STATE, ZIP CODE	03	/29/2018
					100 ERWIN ROAD		
PRUITTHE	ALTH-DURHAM				DURHAM, NC 27705		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 550	Continued From page	e 1	Í F	550			
1 000				550			
	from the facility.						
	§483.10(b)(2) The re	sident has the right to be					
	free of interference, coercion, discrimination, and						
	reprisal from the facility in exercising his or her						
	rights and to be supported by the facility in the						
	exercise of his or her	rights as required under this					
	subpart.						
		Γ is not met as evidenced					
	by:						
		on, staff interview and record			This plan of correction constitutes a		
	-	led to provide privacy cover			written allegation of compliance. Preparation and submission of this plar	o of	
		er drainage bag for 1 of 3 h an indwelling catheter			correction does not constitute an	101	
	(Resident #5).				admission or agreement by the provide	er of	
	(Reoldent #0).				truth of the facts alleged or the correction		
	The findings included	1:			of the conclusions set forth on the	0110	
	•	Resident #5 was admitted on 2/26/16. The			statement of deficiencies. The plan of		
	diagnoses included u	irinary retention, diabetes			correction is prepared and submitted		
		The most recent Minimum			solely because of requirements under		
	Data Set (MDS) date	-			state and federal law.		
		nitively impaired and was					
		es of bladder and coded as			Process that lead to the Deficiency:		
	incontinent bladder.				Resident #5 was admitted to the facility		
	During an observatio	n 03/26/18 10:02 AM			2/26/2016 with urinary retention among the diagnoses. On 3/26/ 2018 and)	
		n 03/26/18 10:02 AM, g in bed near door with bed			3/27/2018, resident was observed lying	. in	
		e drainage bag and tubing			bed and the drainage/catheter bag on t		
	•	or under the bed without a			floor without a privacy cover. Resident		
		same level as the urinary			still resides in the facility.	-	
	bladder and could be	-					
					Root Cause Analysis:		
		n on 3/27/18 at 9:37 AM,			Failure to supervise and ensure the		
	-	g in bed at lowest position			catheter/drainage bag has a privacy co	ver	
		and tubing were lying on			at all times.		
		ed without a privacy cover at			Lack of education for licensed nurses a		
		e urinary bladder. Resident			certified nursing aides on resident right	S	
1	#5 did not have a lar	strap in place.			as relates to dignity by not providing a		

Event ID: SGT211

Facility ID: 923197

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY IDENTIFICATION NUMBER AND PLAN OF CORRECTION COMPLETED A. BUILDING С 345061 B. WING 03/29/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 3100 ERWIN ROAD PRUITTHEALTH-DURHAM DURHAM, NC 27705 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ID (X5) COMPLETION (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 550 Continued From page 2 F 550 During an interview on 3/27/18, at 9:40 AM, Nurse #7 confirmed Resident #5 's catheter was Process for implementing the acceptable located under the bed, without a leg strap and plan of correction for specific deficiency. without a privacy cover. Nurse #7 stated staff On 3/27/2018, resident #5 was should ensure the privacy cover was in place. immediately provided a privacy cover for the catheter/drainage bag to ensure his During an interview on 3/28/18 at 10:12 AM, NA# resident right was restored and 8 indicated that the expectation would be to maintained. All other residents with check to make sure the leg strap was in place drainage/catheter bags were reviewed on and provide a privacy cover. 3/27/2018 by the Director of Health Services and the Nurse Managers to During an interview on 3/28/18 at 10:20 AM, the ensure privacy covers were in place. Director of Nursing indicated the expectation was Nurse Managers and charges nurses will for staff to check all residents with catheter to observe and document the presence of a ensure the privacy cover was in place. privacy cover for all catheters/drainage bags daily using the catheter checklist tool During an interview on 3/28/18 at 2:01 PM, the initiated on 4/2/2018. Administrator stated the expectation was for staff All licensed nurses and all certified to ensure the privacy cover were provided. nursing aides are responsible for ensuring that all catheter/drainage bags have a privacy cover at all times. Education/in-service for all licensed nurses and all certified nursing aides on resident rights to ensure catheter/drainage bags have a privacy cover was initiated by the Director of Health Services on 3/27/2018 and will completed by 4/25/2018. Licensed nurses and certified nursing aides who have not completed the education will not be allowed to work until they are educated. All newly hired licensed nurses and certified nursing aides will be educated on resident rights to ensure catheter/drainage bags have a privacy cover during new hire orientation by the Clinical Competency Coordinator and/or the Director of Health Services.

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

Facility ID: 923197

If continuation sheet Page 3 of 24

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORI	D: 05/03/2018 MAPPROVED D. 0938-0391
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION	COMF	E SURVEY PLETED
		345061	B. WING				C / 29/2018
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 00	
	ALTH-DURHAM		3100 ERWIN ROAD		100 ERWIN ROAD		
				D	URHAM, NC 27705		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 550	Continued From page	23	F	550			
					Monitoring procedure to ensure that plan of correction is effective. The Director of Health Services and Administrator educated all licensed nurses and all certified nursing aides Administrator and the Director of Hea Services will ensure all new hired lice nurses and certified nursing aides ar educated during orientation. Nurse Managers and charge nurses will ob and document the presence of a priv bag for all catheters/drainage bags of daily using the catheter checklist tool The Administrator and the Director of Health Services will ensure the facilit extra privacy bags for use whenever needed. All new admissions with catheter/drainage bag will be provide with a privacy bag upon admission b admitting nurse. The catheter checklist tool will be util by Nurse Managers and charge nurse daily and reviewed weekly by the Dir of Health Services for 4 weeks and, monthly for 3 months until compliance maintained. The Administrator will re the catheter checklist tool weekly for weeks and then monthly for 3 month report any findings of non-compliance the QAA committee for recommenda as needed and then quarterly therear until compliance has been maintaine 3 quarters. Title of Person Responsible for implementing the acceptable plan of correction. The Administrator is responsible for	the . The alth ensed e serve acy n a f y has rd y the ized es ector e is view 4 s and e to tions fter	

Event ID: SGT211

Facility ID: 923197

If continuation sheet Page 4 of 24

		MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIP	LE CONSTRUCTION		10. 0938-039 TE SURVEY
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	·	COI	MPLETED
		345061	B. WING		0	C 3/29/2018
NAME OF P	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CC		
PRUITTHI	EALTH-DURHAM		3100 ERWIN ROAD DURHAM, NC 27705			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE	(X5) COMPLETIO DATE
F 550	Continued From page	e 4	F 55	0 implementing the acceptable correction.	e plan of	
F 637 SS=D	Comprehensive Asse CFR(s): 483.20(b)(2)	essment After Signifcant Chg (ii)	F 63	Date of Compliance: 4/25/20	018	4/25/18
	determines, or should there has been a sign resident's physical or purpose of this section means a major declin resident's status that itself without further in implementing standar interventions, that ha one area of the reside requires interdisciplin care plan, or both.) This REQUIREMENT by: Based on record rev facility failed to comp Change in Status Ass admission to hospice (Resident # 153) revi The findings included Resident #153 was a 2/07/18 with diagnost thrive, metabolic end cancer, depression a Review of physician's	r mental condition. (For on, a "significant change" ne or improvement in the will not normally resolve intervention by staff or by rd disease-related clinical s an impact on more than ent's health status, and hary review or revision of the Γ is not met as evidenced iew and staff interview, the lete the required Significant sessment (SCSA) following care for 1 of 1 residents ewed for hospice. dt: idmitted to the facility on es that included failure to ephalopathy, cervical nd Dysphagia.		Process that lead to the De Resident #153 was admitted on 2/7/2018 with diagnoses cervical cancer and failure to among others. Resident was admitted to hospice on 3/03. Resident #153 expired on 4, no longer in the facility. A Si Change in Status Assessme was not completed within 14 admission to hospice care a Root Cause Analysis: Lack of training for MDS nur requirement to complete the and assessment for a Signif in Status for hospice resider	d to the facility that included o thrive s later /2018. /9/2018 and is gnificant ent (SCSA) 4 days of is required. rses on the e investigation ficant Change	

Event ID: SGT211

Facility ID: 923197

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DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY IDENTIFICATION NUMBER AND PLAN OF CORRECTION COMPLETED A. BUILDING С 345061 B. WING 03/29/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 3100 ERWIN ROAD PRUITTHEALTH-DURHAM DURHAM, NC 27705 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (X4) ID ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 637 Continued From page 5 F 637 Review of hospice documentation indicated days of admission to hospice has been Resident #153 was admitted to hospice care on identified as the root cause. 3/03/18. Process for implementing the acceptable plan of correction for specific deficiency. Review of the electronic assessments in progress The Significant Change in Status for Resident #153 revealed a Significant Change Assessment (SCSA) for resident #153 in Status Assessment (SCSA) dated 3/15/18 that was completed on 3/29/2018 by the MDS was not complete. Resident # 153's SCSA had nurse following admission to hospice. All not been completed within 14 days of admission residents with a Significant Change in to hospice care (by 3/16/18). Status and/or admitted to hospice in the last 30 days were reviewed on 3/29/2018 During an interview on 03/28/18 at 4:10 PM, the and ensured the SCSA were completed as required. MDS coordinator indicated she thought she had 14 days from the day of significant change to start The Administrator, the Director of Health the MDS and an additional 14 days after to Services and, the MDS Consultant complete the investigation and assessment. initiated education for MDS nurses on completing Significant Change of Status During an interview on 03/29/18 at 4:45 PM, the Assessments within 14 days of any Administrator indicated the facility was short resident being admitted to hospice care staffed related to MDS coordinators and had based on RAI guidelines. Newly hired recently hired a new MDS coordinator. He MDS personnel will be educated on indicated he was aware that the MDS completing Significant Change of Status assessments for some of the residents were Assessments within 14 days of residents being admitted to hospice based on RAI incomplete. guidelines during new hire orientation by the Administrator and/or the Director of Health Services. Upon a resident s admission to hospice services, the Administrator and the Director of Health Services will ensure that MDS nurses set the ARD and the SCSA completed within 14 days. An updated MDS 3.0 Manual has been ordered for MDS nurses to use and latest updates will be sent automatically when available. Monitoring procedure to ensure that the plan of correction is effective. Residents admitted to hospice will be

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

Facility ID: 923197

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	-	ID HUMAN SERVICES	-		PRINTED: 05/03/20 FORM APPROV OMB NO. 0938-03
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED C
		345061	B. WING		03/29/2018
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, Z	
	ALTH-DURHAM		3100 ERWIN ROAD		
				DURHAM, NC 27705	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE CROSS-REFERENCED	I OF CORRECTION (X5) ACTION SHOULD BE COMPLETIC TO THE APPROPRIATE IENCY)
F 637	Continued From page	e 6	F 63	 37 reviewed weekly by the the Director of Health S the SCSA is completed admission in accordance guidelines. The review Administrator and the D Services will be done w and bi-weekly for 2 mor compliance is maintained quarterly thereafter until been maintained for 3 quarterly thereafter until been maintained for	ervices to ensure within 14 days of e with the RAI by the Director of Health reekly for 4 weeks of the until ed and then I compliance has quarters. eport any findings re QAA/QAPI endations as sible for otable plan of sponsible for
F 638 SS=D	CFR(s): 483.20(c) §483.20(c) Quarterly A facility must assess quarterly review instr and approved by CM once every 3 months	s a resident using the ument specified by the State S not less frequently than	F 63	Date of Compliance: 4/2	25/2018 4/25/18
	Based on record rev facility failed to comp	iew and staff interviews, the lete a quarterly Minimum essment within 92 days of the		Process that lead to the Resident # 10 and resid admitted on 5/25/2016 a	lent #359 were

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						0. 0938-03
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION		E SURVEY PLETED
			A. DOILDING			С
		345061	B. WING		03	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C		
				3100 ERWIN ROAD		
PRUITIH	EALTH-DURHAM			DURHAM, NC 27705		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETIO DATE
F 000		_				
F 638			F 63			
		sment for 2 of 6 residents		respectively. Record review		
	(Resident #10 and Re	esident # 359) reviewed.		interviews revealed the faci		
	The findings included	4.		complete a quarterly Minim (MDS) assessment within 9		
				previous MDS assessment.		
	1 Review of Resider	nt # 359's comprehensive				
		nt dated 9/8/17 revealed		Root Cause Analysis:		
	resident was admitted	d to the facility on 9/1/17 with		The loss of key personnel in	n the MDS	
		led but not limited to:		department was the root ca		
	hypertension, diabete	es mellitus type II, transient		deficiency. The unexpected		
	cerebral ischemic atta	ack and cerebrovascular		MDS nurse without backup		
	accident.			quarterly MDS assessment	-	
	During a new investigation of the			Process for implementing the		
	quarterly MDS asses	e resident's most recent		plan of correction for specif A new MDS Director was hi	-	
		nent was in progress and not		February 2018 and has bee		
		eview of the assessment		working on helping the facil		
		or signature of persons		any late quarterly MDS ass	•	
		sment and Registered		The quarterly MDS assessr		
	Nurse assessment co			resident #10 and resident #	359 were	
	assessment as comp	lete was noted to be blank		completed on 4/17/2018 an	d 4/4/2018	
	and no date entry not	ted.		respectively. On 3/30/2018	, the MDS	
				Director and the MDS Coor		
		vith MDS Coordinator #1 on		together with the Administra		
		he MDS Coordinator stated		Director of Health Services		
	the facility was behind	ed the facility and was aware		late and current quarterly N assessments. The MDS Di		
	-	me quarterly assessments		MDS Coordinator reviewed		
	were incomplete for s			with priority given to late qu		
				assessments. The Interdisc	-	
	During an interview w	vith the Administrator on		(IDT) was provided with the		
	03/29/18 at 04:45 PM	 the Administrator stated it 		calendar to ensure each dis	scipline	
	was his expectation t			completes their part in the c		
		be completed as required.		assessment. On 3/30/2018		
		t the facility was short staffed		Administrator and the Direc		
		linators and had recently		Services initiated education		
		ordinator. He indicated that		(including MDS nurses, the		
		e MDS assessments for		Worker, the Director of Rec		
	some of the residents	s were incomplete.		Services and, the Dietary N	ianager) on the	1

Facility ID: 923197

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	OF DEFICIENCIES	MEDICAID SERVICES		E CONSTRUCTION		NO. 0938-03 ATE SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	· ,		· · ·	MPLETED
						С
		345061	B. WING			03/29/2018
NAME OF PR	ROVIDER OR SUPPLIER	•	•	STREET ADDRESS, CITY, STATE, ZIP	CODE	
PRIJITTHE	ALTH-DURHAM			3100 ERWIN ROAD		
				DURHAM, NC 27705		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETIO DATE
F 638	Continued From page	e 8	F 63	8		
				requirement of completing	quarterly MDS	
	2. A review of Reside			assessments within 92 day		
		IDS) was dated 10/30/17. ealed the resident was		previous assessment as re		
	re-admitted to the fac			Education was completed Any new hires to join the I		
	diagnoses that includ	-		educated on the requireme		
		al infraction, anxiety disorder		completing quarterly MDS		
	and depression.			within 92 days of the previ		
	Review of the resider			assessment by the Admini		
	assessment dated 1/3	rogress and not completed.		the Director of Health Serventies of thealth Serventies of the Director of Health Ser	-	
	assessment was in p	rogress and not completed.		Any late quarterly assess	-	
	Another quarterly MD	S assessment dated		completed by 4/25/2018. I		
	2/26/18 had been ope	ened for Resident #10 and it		of key personnel in the ME	DS department,	
	was also incomplete.			the Administrator will seek Area Vice President to ens	-	
		vith MDS Coordinator #1 on		MDS assessments are con	-	
		he MDS Coordinator stated		92 days of the previous as	sessment as	
		ed the facility and was aware din some of the assessment		required. Monitoring procedure to en	osure that the	
	and some quarterly a			plan of correction is effecti		
	incomplete for some			The Administrator and the		
				Health Services will review	v the due	
	-	vith the Administrator on		quarterly assessments 5 d		
		1, the Administrator stated it		4 weeks then weekly for 2		
	was his expectation t	be completed as required.		then quarterly thereafter u has been maintained for 3		
		the facility was short staffed		The quarterly assessment	•	
		linators and had recently		reviewed during daily stan		
	hired a new MDS coo	ordinator. He indicated that		4 weeks and then weekly		
		e MDS assessments for		and then quarterly thereaf		
	some of the residents	s were incomplete.		compliance has been main	ntained for 3	
				quarters. by the IDT to ensure comp	liance is	
				maintained.		
				The Administrator will repo	ort any findings	
				of non-compliance to the C		
				committee quarterly for re-	commendations	

Event ID: SGT211

Facility ID: 923197

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FOR	D: 05/03/2018 M APPROVEI D. 0938-039
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		345061	B. WING				C / 29/2018
NAME OF PI	ROVIDER OR SUPPLIER	•		ST	REET ADDRESS, CITY, STATE, ZIP CODE		
PRUITTHE	EALTH-DURHAM				00 ERWIN ROAD		
				D	URHAM, NC 27705		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 638	Continued From page	ə 9	F 6	38			
					Title of Person Responsible for Implementing the Acceptable plan of Correction. The Administrator is responsible for implementing the acceptable plan of correction.		
F 656 SS=D	Develop/Implement C CFR(s): 483.21(b)(1)	Comprehensive Care Plan	F 6	56	Date of Compliance: 4/25/2018		4/25/18
	implement a compreh care plan for each res resident rights set for §483.10(c)(3), that in objectives and timefra medical, nursing, and needs that are identif assessment. The con describe the following (i) The services that a or maintain the reside physical, mental, and required under §483. (ii) Any services that under §483.24, §483. provided due to the re under §483.10, include treatment under §483. (iii) Any specialized s rehabilitative services provide as a result of recommendations. If	cility must develop and hensive person-centered sident, consistent with the th at §483.10(c)(2) and cludes measurable ames to meet a resident's a mental and psychosocial ied in the comprehensive nprehensive care plan must g- are to be furnished to attain ent's highest practicable psychosocial well-being as 24, §483.25 or §483.40; and would otherwise be required .25 or §483.40 but are not esident's exercise of rights ding the right to refuse 8.10(c)(6). ervices or specialized a the nursing facility will					

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		D HUMAN SERVICES MEDICAID SERVICES				FOF	RM APPROVED
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTIO		(X3) DATE SURVEY COMPLETED	
		345061	B. WING			0	C 3/29/2018
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRES	S, CITY, STATE, ZIP CODE		
PRUITTHI	EALTH-DURHAM			3100 ERWIN ROA DURHAM, NC			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EAC	ROVIDER'S PLAN OF CORRECTI CH CORRECTIVE ACTION SHOUL S-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 656	rationale in the resider (iv)In consultation with resident's representat (A) The resident's goad desired outcomes. (B) The resident's pre- future discharge. Fact whether the resident's community was asses local contact agencies entities, for this purpo (C) Discharge plans in plan, as appropriate, i requirements set forth section. This REQUIREMENT by: Based on record revifacility failed to compl plan following admiss 1 residents (Resident hospice. The findings included Resident #153 was at 2/07/18 with diagnose thrive, metabolic ence cancer, depression at Review of physician's revealed Resident #1 Review of hospice do Resident #153 was at 3/03/18. Review of Resident #	Int's medical record. In the resident and the sive(s)- als for admission and deference and potential for ilities must document a desire to return to the seed and any referrals to a and/or other appropriate se. In the comprehensive care in accordance with the in paragraph (c) of this if is not met as evidenced ew and staff interview, the ete and update the care ion to hospice care for 1 of # 153) reviewed for if the to the facility on as that included failure to ephalopathy, cervical ind dysphagia.	F 6	Process th Resident # on 2/7/201 cervical ca among oth admitted to Resident # no longer i to complet following re hospice. Root Caus Lack of tra completing reflect a Si hospice re hospice ca as the root Process fo	hat lead to the Deficiency: #153 was admitted to the 18 with diagnoses that incl ancer and failure to thrive hers. Resident was later to hospice on 3/03/2018. #153 expired on 4/9/2018 in the facility. The facility f te and update the care plane esident □s admission to se Analysis: aning for MDS nurses on g and updating care plans ignificant Change in Statu isidents after admission to are services has been ident t cause. or implementing the accept prection for specific deficie	facility luded and is failed an s to us for o ntified otable	

Event ID: SGT211

Facility ID: 923197

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	· /	LE CONSTRUCTION	(X3) DATE SURVEY
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	;	COMPLETED
		345061	B. WING		03/29/2018
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
PRUITTHE	ALTH-DURHAM			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 CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE COMPLETIO
F 656	Continued From pag	e 11	F 65	6	
	reflect hospice care.			The Significant Change in Status Assessment (SCSA) for resident #	153
		on 03/28/18 at 4:10 PM, the icated she thought she had		was completed on 3/29/2018 follow admission to hospice. The resident	
		of significant change to start		care plan was updated and comple	eted on
		itional 14 days after to gation and assessment. She		3/29/2018 to reflect hospice care. / residents with a Significant Change	
		sident's care plan would be		Status and/or admitted to hospice	
	updated only after M	DS has been completed.		last 30 days were reviewed by the	
	During an interview of	on 03/29/18 at 4:45 PM, the		team on 3/29/2018 and all care pla updated as needed. Care plans for	
	Administrator stated	it was his expectation that		hospice residents will be updated u	
		nents and care plans were ed. He further stated that the		admission to hospice care. The Interdisciplinary Team (IDT) includi	ing
	facility was short staf			MDS nurses will be responsible for	
		d recently hired a new MDS		updating the care plans upon admi	
		ated that he was aware that ts for some of the residents		of any resident to hospice care ser Education for the Interdisciplinary	
	were incomplete.			including the Social Worker, Dietar	
				Manager, the Director of Recreation	
				Activities, MDS nurses and Unit Ma on updating care plans was initiate	•
				the Administrator and the Director	
				Health Services on 3/29/2018 and	
				join the IDT will be educated by the	
				Administrator and/or the Director o	
				Services on the requirement updat	e care
				plans as and when needed. Monitoring procedure to ensure that	at the
				plan of correction is effective.	
				The Administrator and the Director	
				Health Services will review all resid with a Significant Change of Status	
				clinical meetings and/or stand-up	-
				meetings and ensure that care plan	
				completed and updated as needed IDT. The review will be conducted	

Event ID: SGT211

Facility ID: 923197

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	-	ID HUMAN SERVICES MEDICAID SERVICES			FORM): 05/03/201 1 APPROVE 0. 0938-039
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· <i>`</i>	PLE CONSTRUCTION	(X3) DATE COMP	LETED
		345061	B. WING		03/2	。 29/2018
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
PRUITTHE	ALTH-DURHAM			3100 ERWIN ROAD DURHAM, NC 27705		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 656	Continued From page	e 12	F 6	 2 weeks, then weekly for 2 weeks, then monthly for 2 months until compliance is maintained and quarterly thereafter until compliable been maintained for 3 quarters. Any areas on non-compliance reported by the Administrator as Director of Health Services to the Committee quarterly for recommas needed. Title of Person Responsible for implementing the acceptable procrection. The Administrator is responsible implementing the acceptable procrection. 	I then iance has s. will be and/or the the QAA mendations	
F 658 SS=D	CFR(s): 483.21(b)(3) §483.21(b)(3) Compr The services provide as outlined by the com must- (i) Meet professional This REQUIREMENT by: Based on record rev physician interviews, administer continuous	ehensive Care Plans d or arranged by the facility, mprehensive care plan, standards of quality. is not met as evidenced iews, resident, staff and the facility failed to s oxygen therapy on the rate ian, for 2 of 4 sampled	F 6	Date of Compliance: 4/25/2018 Process that lead to the Defici Resident #104 and resident #3 admitted to the facility on 9/2/2 3/31/2016 respectively. Based review, resident, staff and physi interviews, the facility failed to continuous oxygen therapy on	iency: 309 were 3015 and on record sician administer	4/25/18

Event ID: SGT211

Facility ID: 923197

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		ND HUMAN SERVICES MEDICAID SERVICES				FOF	ED: 05/03/201 RM APPROVE IO. 0938-039
STATEMENT (DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION		TE SURVEY MPLETED
		345061	B. WING			C 03/29/2018	
NAME OF P	ROVIDER OR SUPPLIER			STI	REET ADDRESS, CITY, STATE, ZIP CODE		
				310	00 ERWIN ROAD		
PRUITIN	EALTH-DURHAM			DL	JRHAM, 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 CORRECTIO (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 658	Continued From page	e 13	F 6	58			
					ordered by the physician.		
	1. Resident #104 a	admitted on 7/26/17. Review					
	of the Annual Minimu dated 2/7/18, revealed			Root Cause Analysis:			
	cognition. Her diagno			Licensed charge nurses and Unit			
		pertension (high blood			Manager/supervisors failed to super		
	pressure) and asthm	a.			monitor and, administer oxygen ther		
	Deserved and income				the rate as ordered by the physician		
		led the physician ' s order, sident #104, to receive			There was also lack of follow-throug communication for licensed nurses t		
		asal cannula on the rate of 2			supervise, monitor and, administer	0	
		or any status of SAT (amount			oxygen therapy on rate as ordered b	ov the	
	of oxygen in blood) 9			physician.	<i>y</i>		
	Review of Resident 1				Process for implementing the accep		
		rd for 3/26/18 - 3/28/18			plan of correction for specific deficie	•	
		marked as completed for			The Unit Manager ensured that both		
		the rate of two L per minute and 98% for all shifts.			oxygen concentrators were adjusted 2LPM of oxygen therapy on 3/28/20		
					ordered by the physician. Both resid		
	On 3/26/18 at 8:30 A	M, during the			continue to receive oxygen therapy		
		v, Resident #104 was in her			ordered by the physician. Resident #		
	room. The resident h	ad nasal cannula attached to			has been observed to adjust her oxy	/gen	
		to the oxygen concentrator,			level by herself on the oxygen		
		minute of oxygen rate. The			concentrator. Resident #309 has be		
		at she "supposed to receive			informed of the risks of adjusting oxy		
	oxygen on the rate of	i ∠ L/minute".			up and her care plan has been upda	iea to	
	0n 3/28/18 at 12:30	PM, during the observation			reflect non-compliance regarding adjusting oxygen level on the oxyge	n	
		ether with Nurse #1, unit			equipment (concentrator and oxyger		
	-	gen concentrator was set up			tank). All residents with oxygen there		
		ched to the resident 's nasal			orders were reviewed by the Directo		
		adjusted the oxygen rate to 2			Health Services and Unit Managers		
	L/minute during the c	observation.			3/28/2018 and oxygen therapy was		
					administered continuously on the rat	e as	
		PM, during an interview,			ordered by the physician. The		
		hat Resident #104 had an			Administrator and the Director of He		
		oxygen therapy. The nurse			Services initiated education on 3/28/ for all licensed nurses on	2018	
		ent adjusted the oxygen rate					

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	S FOR MEDICARE &	MEDICAID SERVICES			OMB	NO. 0938-039
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	(X2) MULTIPLE CONSTRUCTION A. BUILDING		
		345061	B. WING			C 03/29/2018
NAME OF P	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE			03/23/2010
				3100 ERWIN ROAD		
PRUITTHI	EALTH-DURHAM			DURHAM, NC 27705		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETIO DATE
F 658	Continued From page	e 14	F 6	-		
1 000			FO		and the second	
	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	tor at times. The staff All nurses on the floor were		administering/following oxy		
				orders on the rate as order		
	therapy for residents.	or the correct rate of oxygen		physician. The education w completed by 4/25/2018. Li		
				who have not completed th		
	On 3/28/18 at 1.30 P	M, during an interview, the		not be allowed to work until		
		xpected the staff to follow		educated. All newly hired li	•	
		r in oxygen therapy. All the		will be educated on		
		ere responsible to monitor		administering/following oxy	gen therapy	
		ygen therapy for residents		orders on the rate as order		
	during the shift.	ygon morapy for reolaonito		physician during new hire of	-	
				the Clinical Competency Co	•	
	On 3/28/18 at 1.50 P	M, during an interview, the		and/or the Director of Healt		
		ndicated that her expectation		Monitoring procedure to en		
		vsician 's orders: check the		plan of correction is effectiv		
		the rate of oxygen provided,				
		er. In the case of decrease in		The Administrator and the I	Director of	
	SAT, the staff should			Health Services will ensure		
				nurse are educated on		
	2. Resident #309 a	dmitted on 9/12/17. Review		administering/following oxy	gen therapy	
		num Data Set assessment,		continuously on rate as ord		
	dated 12/6/17, reveal			physician. Any licensed nu	•	
		oses included heart failure,		educated will not be allowe		
		h (high blood pressure) and		the education has been cor		
	asthma.			oxygen therapy observation		
				initiated on 4/2/2018 to be		
	Record review reveal	led the physician ' s order,		licensed nurses to match th	•	
		ident #309, to receive		therapy orders with the actu		
		asal cannula on the rate of 2		the oxygen equipment (Oxy	-	
		status of SAT 90% or less.		concentrator or Oxygen tar	-	
				The tool will be used daily f		
	Review of Resident 3	309 's Medication		until compliance is maintair	ned and then	
		d for 3/26/18 - 3/28/18		quarterly thereafter until co		
		narked as completed for		been maintained for 3 quar		
		the rate of two L per minute		The Director of Health Serv		
	and SAT between 94	and 98% for all shifts.		the tool weekly for 3 month		
				the Administrator on any fir		
	On 3/26/18 at 9:30 A			Administrator will review the		
	observation/interview	, Resident #309 was in bed.		report any areas of non-cor	mpliance to the	

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	-	D HUMAN SERVICES MEDICAID SERVICES			FORM): 05/03/2018 APPROVED 0. 0938-0391
STATEMENT C	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •	CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345061	B. WING		03/	C 29/2018
NAME OF PR	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STATE, ZIP CODE		
DDUITTUE			3′	100 ERWIN ROAD		
PRUITINE	ALTH-DURHAM		D	URHAM, NC 27705		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI, DEFICIENCY)		(X5) COMPLETION DATE
F 658	connected to the oxyg bed, which showed 4 The resident indicated receive oxygen on the On 3/26/18 - 3/27/18, observations, the oxyg L/minute of oxygen rate On 3/28/18 at 12:30 F of Resident #309 toge oxygen concentrator of attached to the reside nurse adjusted the oxy during the observation On 3/28/18 at 12:32 F Nurse #1 indicated the order for 2 L/minute of on the floor were resp correct rate of oxygen On 3/28/18 at 1:30 PM Director of Nursing ex- the physician ' s order nurses on the floor were the correct rate of oxy during the shift.	a attached to her nose, gen concentrator near the L/minute of oxygen rate. d that she "supposed to e rate of 2 L/minute". during the multiple gen concentrator showed 4 te at all time. PM, during the observation ether with Nurse #1, the was set up for 4 L/minute, nt ' s nasal cannula. The ygen rate to 2 L/minute n. PM, during an interview, at Resident #309 had an xygen therapy. All nurses ionsible to monitor the therapy for residents. A, during an interview, the spected the staff to follow in oxygen therapy. All the ere responsible to monitor gen therapy for residents A, during an interview, the	F 658	QAA committee quarterly for 3 quarters for recommendations as needed. Title of Person Responsible for implementing the acceptable plan of correction. The Administrator is responsible for implementing the acceptable plan of correction. Date of Compliance: 4/25/2018	5	
F 690 SS=D	Physician Assistant in the staff to follow physics SAT and make sure the	dicated that her expectation sician 's orders: check the he rate of oxygen provided, r. In the case of decrease in notify the physician. inence, Catheter, UTI	F 690			4/25/18

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345061	B. WING				C 29/2018
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	•	
PRUITTHE	ALTH-DURHAM				100 ERWIN ROAD URHAM, NC 27705		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIZ TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
F 690	Continued From page	9 16	F	690			
	admission receives seminatin continence of condition is or become not possible to mainta §483.25(e)(2)For a re- incontinence, based of comprehensive assess ensure that- (i) A resident who ent indwelling catheter is resident's clinical con- catheterization was n (ii) A resident who en- indwelling catheter or is assessed for remov- as possible unless that demonstrates that cat and (iii) A resident who is receives appropriate prevent urinary tract i continence to the exter §483.25(e)(3) For a re- incontinence, based of comprehensive assess ensure that a residen receives appropriate restore as much norm possible. This REQUIREMENT by:	cility must ensure that hent of bladder and bowel on ervices and assistance to unless his or her clinical es such that continence is ain. esident with urinary on the resident's sement, the facility must ers the facility without an not catheterized unless the dition demonstrates that ecessary; ters the facility with an subsequently receives one val of the catheter as soon e resident's clinical condition theterization is necessary; incontinent of bladder treatment and services to nfections and to restore ent possible. esident with fecal on the resident's sement, the facility must t who is incontinent of bowel treatment and services to hal bowel function as					
		n, staff and family interviews e facility failed to secure			Process that lead to the Deficiency: The facility failed to secure catheter an	d	

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DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING С 345061 B. WING 03/29/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 3100 ERWIN ROAD PRUITTHEALTH-DURHAM DURHAM, NC 27705 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (X4) ID ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 690 Continued From page 17 F 690 catheter and keep the drainage bag below the keep the drainage bag below the bladder bladder for 3 of 3 sampled resident with a for resident #5, #133 and, #261. For all catheter (Resident #5, #133 and #261). three residents, the catheter bags were not secured in place and the bags were The findings included: on the floor. Resident #261 discharged from the facility on 4/4/2018 while resident 1. Resident #5 was admitted on 2/26/16. The #5 and resident #133 still reside in the diagnoses included urinary retention, diabetes facility. and seizure disorder. The most recent Minimum Data Set (MDS) dated 10/10/17, revealed he was Root Cause Analysis: incontinent at all times of bladder and coded as incontinent bladder. Lack of supervision to ensure the catheter is secure and drainage bag is kept below Review of physician's order dated 7/22/16 the bladder. revealed the catheter site and securement of the There was also lack of education for catheter should be monitored daily for proper licensed nurses and certified nursing placement. aides on securing the catheter and keeping the drainage bag below the Review of the care plan dated 2/27/18, identified bladder. the problem as resident required a catheter related to urinary retention. The goal included Process for implementing the acceptable resident would remain free of UTI. The plan of correction for specific deficiency. approaches included to check catheter every shift On 3/28/2018, the Director of Health for patency, proper position of tubing and bag, Services together with Unit Managers report catheter leakage to charge nurse and secured the catheter and kept the report complaints of pain/discomfort from drainage bag below the bladder for catheter. resident #5, resident #133 and resident #261. All other residents with catheter and During an observation 03/26/18 10:02 AM, drainage bag were reviewed on 3/28/2018 Resident #5 was lying in bed near door with bed by the Director of Health Services and the in lowest position. The drainage bag and tubing Nurse Managers to ensure the catheter were lying on the floor under the bed. Resident was secure and drainage bag below the bladder. Nurse Managers and charges #5's leg strap was not in place. nurses will utilize the catheter checklist During an observation on 3/27/18 at 9:37 AM, tool to document the catheter is secure Resident #5 was lying in bed at lowest position and drainage bag is below the bladder on and the drainage bag and tubing were lying on a daily basis. the floor under the bed. Resident #5's leg strap All licensed nurses and certified nursing was not in place. Resident #5 did not have a leg aides are responsible for ensuring that all

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				LE CONSTRUCTION		IO. 0938-039	
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			(X3) DATE SURVEY COMPLETED	
			A. BUILDING	·		С	
		345061	B. WING	0	3/29/2018		
NAME OF P	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE			0/20/2010	
				3100 ERWIN ROAD			
PRUITTH	EALTH-DURHAM			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 (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 690	Continued From page	a 18	F 69	10			
1 000	strap in place.		1 03	catheter s secure and drai	nage hag is		
				below the bladder. Educat			
	During an interview o	on 3/27/18, at 9:40 AM,		for all licensed nurses and			
		Resident #5's catheter was		nursing aides on securing			
		d, without a leg strap and not		and keeping the drainage	•		
		ated staff should ensure the e, provide a privacy cover		bladder was initiated by th Health Services on 3/28/2			
		ter properly below bladder		completed by 4/25/2018. L			
	level.			and certified nursing aides			
				completed the education v			
	-	n 3/28/18 at 10:12 AM,		allowed to work until they			
	Nurse Aide (NA) # 8 i	ndicated that the		All newly hired licensed nu certified nursing aides will			
		e, provide a privacy cover		securing the catheter and			
		ter in proper position. She		drainage bag below the bl			
		d not noticed it earlier in the		new hire orientation by the			
	shift.			Competency Coordinator a Director of Health Services			
		n 3/28/18 at 10:20 AM, the dicated the expectation was		Monitoring procedure to en	acura that the		
		esidents with catheter to		plan of correction is effecti			
		perly secured with catheter					
		d below bladder level.		The Director of Health Ser Administrator educated all			
	During an interview o	n 3/28/18 at 2:01 PM, the		nurses and all certified nur	rsing aides. The		
		the expectation was for staff		Administrator and the Dire			
		bag were provided to all		Services will ensure all ne			
		er, the leg straps should be should be should be below bladder		nurses and certified nursir educated during orientatio	-		
	level.			Managers and charge nur			
				Managers and charges nu			
		is readmitted on 12/14/17.		the catheter checklist tool	to document the		
		led flaccid neuropathic		catheter is secure and dra			
		Ilitus Type II and chronic e II). The most recent		below the bladder on a da catheter checklist tool will	-		
	Minimum Data Set (N			Nurse Managers and char			
		s cognitively intact and		and reviewed weekly by th			
	coded for indwelling	catheter.		Health Services for 4 weel	ks and, monthly		
	Review of the physici	an order dated 12/14/17		for 3 months until complia	nce is		

Facility ID: 923197

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DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION COMPLETED A. BUILDING С 345061 B. WING 03/29/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 3100 ERWIN ROAD PRUITTHEALTH-DURHAM DURHAM, NC 27705 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (X4) ID ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 690 Continued From page 19 F 690 revealed catheter care every shift and monitor leg maintained and then quarterly thereafter until compliance has been maintained for strap every shift. 3 guarters. Review of the care plan updated on 3/26/18, The Administrator will review the catheter identified the problem as resident required checklist tool weekly for 4 weeks and then indwelling catheter related to benign prostatic monthly for 3 months and then guarterly hyperplasia (BPH) neurogenic. The goal included thereafter until compliance has been resident would remain free of urinary tract maintained for 3 guarters infection (UTI) and injury with indwelling catheter. and report any findings of non-compliance to the QAA committee for The interventions included to change of catheter as ordered, position urine collection bag below recommendations as needed. the bladder, Observe for need to empty bag and empty as needed, observe signs and symptoms Title of Person Responsible for of UTI such as abdominal pain, fever, implementing the acceptable plan of discoloration and foul smell of urine. correction. During an observation on 03/27/18 at 8:00 AM, The Administrator is responsible for Resident #133 was lying in bed. The drainage implementing the acceptable plan of bag and tubing were lying on the floor beside the correction. bed. Resident # 133's leg strap was not in place. On 3/27/18 at 10:15 AM, during the catheter care Date of Compliance: 4/25/2018 observation for Resident # 133, provided by the Nurse Aide (NA) # 6, the Foley catheter tubing was clean, dry, secured to the right leg, went down to the urinary drainage bag, located on the floor near bed. The NA # 6 provided the catheter care, attached the drainage bag to the right side of bed frame. She did not check the location or condition of the urinary drainage bag and left it on the floor. On 3/27/18 at 10:20 AM during an interview, NA # 6 indicated that resident had Foley catheter. She stated the nurses were responsible for urinary catheter changes and drainage bag changes. She also indicated the resident went outside the facility to change the catheter. She also indicated the nurse aides were responsible to empty the

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-		D HUMAN SERVICES					FORM): 05/03/2018 MAPPROVED
STATEMENT OF DEFICIENCE AND PLAN OF CORRECTION	ES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION		(X3) DATE	0. 0938-0391 SURVEY LETED
		345061	B. WING			_		C 29/2018
NAME OF PROVIDER OR S	SUPPLIER			S	TREET ADDRESS, CITY, ST	ATE, ZIP CODE		
PRUITTHEALTH-DURH	HAM				100 ERWIN ROAD URHAM, NC 27705			
	CH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
urinary dra She confir on the floo frame. On 3/29/1 Nurse #1 i provide ca bathing ar checked e catheter c She indica care after and check further ind when a ne On 03/29/ administra that the ur appropriat bladder, h with a digr aware of t 3. Reside diagnoses suprapubi data set (f cognitively) An observ 12:00PM n floor.	med that the or and need 8 at 10:00 A indicated Na indicated Na intheter care ad incontine every shift by hange was ated that nui- the NA have for leg stra- icated an in ev patient w 18 at 2:49 F itor indicate inary cathete ung and no- nity bag. He his issue by nt #261 was in part of n c catheter. MDS) dated v intact with ation of the revealed the observation	e 20 every shift and as needed. e drainage bag cannot be ed to be attached to the bed M during an interview, A were responsible to and usually done during nt care. Drainage bag was y nurses and the resident's done outside the facility. rses monitor the catheter e completed care every shift ps and dignity bags. She -service was done for NA's ras admitted on the floor. PM during an interview, the d that it was his expectation ter was changed r bag placed below the t on the floor and covered indicated that he was made r staff and PPI has started. s admitted on 3/16/18 with eurogenic bladder with The most recent minimum 3/21/18 revealed she was a suprapubic catheter. catheter bag on 3/26/18 e catheter bag laying on the hon 03/27/18 at 9:47 AM bag was laying on the floor privacy cover.	F	690				

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	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA		LE CONSTRUCTION	(X3) DATE SURVE	8-039
	CORRECTION	IDENTIFICATION NUMBER:	· ,		COMPLETED	
		245064			С	
		345061	B. WING		03/29/20	18
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
PRUITTHE	ALTH-DURHAM			3100 ERWIN ROAD DURHAM, NC 27705		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	IOULD BE COMF	(X5) PLETIO DATE
F 690	Continued From pag	e 21	F 69	0		
	$\Omega_{\rm D} = 0.3/27/18$ at 0.50/	AM Nursing Assistant #4				
		d indicated that the bag				
		floor and needed a cover.				
	An interview on 3/28	/18 at 4:14 pm, Nursing				
		d that the catheter bag				
	should be hung from the bed off of the floor and					
	covered.					
F 867	QAPI/QAA Improvem	nent Activities	F 86	7	4/25/	/18
SS=E	CFR(s): 483.75(g)(2)	(ii)				
	§483.75(g) Quality as	ssessment and assurance.				
	§483.75(g)(2) The qu	ality assessment and				
	assurance committee					
		ement appropriate plans of				
		tified quality deficiencies;				
	by:	Γ is not met as evidenced				
	•	ons, staff interviews, and		Process that lead to the Deficie	ncv:	
		ility's Quality Assessment		Facility s Quality Assessment a		
	and Assurance (QAA) Committee failed to		Assurance (QAA) Committee fai	led to	
		d procedures and monitor		maintain implemented procedure		
		the committee put into place		monitor the interventions put in p		
		tion survey in April 2017 and		following recertification survey in	•	
	· •	in March 2018 on the and complaint survey.		2017. This is cross referenced w citations F 656 and F 658.	lith	
		rand complaint survey.				
	The recited deficienc	ies were in the areas of		Root Cause Analysis:		
	provide services to m	neet professional standards,				
		nsive care plan and Quality		The Quality Assurance Committee		
	-	and Implementation (QAPI)/		maintain implemented procedure		
		activities. These deficiencies urrent recertification survey.		monitor their interventions that w	•	
		of the facility during two		place after recertification survey The QAA Committee failed to ide		
		cord shows a pattern of the		complete and update the care p	-	
		ustain an effective Quality		following resident s admission		

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		ND HUMAN SERVICES MEDICAID SERVICES				FC	ED: 05/03/20 RM APPROVE NO. 0938-039	
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		345061	B. WING				C 03/29/2018	
NAME OF P	ROVIDER OR SUPPLIER			STREET AD	DRESS, CITY, STATE, ZIP CODE			
PRUITTHE	EALTH-DURHAM		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 COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE	
F 867	Continued From page	e 22	F 8	67				
	Assurance (QA) Prog			care s	services as well as failure			
	The findings included	d:		the rat	te as ordered by the phys	sician.		
	These tag were cross	s referenced to:			ess for implementing the a of correction for specific d			
	F 658 - Services Pro Standards	vided Meet Professional		The A	Administrator and the Dire	ctor of		
	Based on record revi physician interviews	ews, resident, staff and the facility failed to			018 on the QAPI process e QAA/QAPI Committee v			
		s oxygen therapy on the rate			asis on identifying areas			
	ordered by physician residents	-		be cor	o deficiency practice. Edu mpleted by 4/24/2018. Ac ad Quality Assurance and	dministrator		
	had failed to transcril	survey on 4/07/17, the facility be physician consult orders		Perfor empha	rmance Improvement me asis and focus on ensurir	etings with ng that any		
	for 1 of 1 residents (F				on non-compliance are a event further deficient prace			
		nprehensive Care Plan			d to failure to complete a			
		ew and staff interview, the lete and update the care			Plans and administering on rate as ordered by t			
		sion to hospice care for 1 of			cian. At least a member o			
	1 residents (Residen	t #153) reviewed for hospice.		-	nal team that includes ser ultant, clinical reimbursem			
		recertification survey of			ultant or area vice preside			
	4/07/17 the facility ha	ad failed to provide a plan for 3 of 4 sampled			d QAPI meetings for 3 qua			
	residents who require	ed splints (#55, # 92, and			oring procedure to ensure of correction is effective.			
		pled residents with a and failed to update care		Admin	nistrator will lead Quality	Assurance		
		le goals and individualized		and P with e	Performance Improvement emphasis and focus on an	t meetings eas that		
		ecertification survey on		deficie	led to repeated citations a encies. This will ensure th			
	-	as cited for QAA Committee		-	y is identified areas on			
		plemented procedures and the committee put into			compliance and are addre ent further deficient practic			
	place on April of 201	-			mpleting and updating Ca			
		s originally cited on April 1,			dministering oxygen thera			

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STATEMENT	OF DEFICIENCIES F CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	(X3) DATE SUF COMPLET		
		345061	B. WING	C 03/29/2018		
NAME OF P	ROVIDER OR SUPPLIER			03/29/	2010	
PRUITTH	EALTH-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 CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE C	(X5) OMPLETIO DATE
F 867	2016, on a recertifica was in the area of foc sanitary conditions. During an interview o Administrator indicate (QA) committee 1) id does a root cause an audits and monitors t the outcome. The Ac was a work in progres was focusing on certa	tion survey. The deficiency od procurement, storage and an 3/29/18 at 4:59 PM, the ed the Quality Assurance entifies areas of concern, 2) alysis, 3) develops a plan, hat plan and 4) discusses dministrator indicated QAA ss. He stated that the facility ain areas, but had not looked ns related to citations found	F 867	 as ordered by the physician. At learnember of the regional team that the senior nurse consultant, clinic reimbursement consultant or area president will attend QAPI meetir the next 3 months and then quart quarters to ensure that any areas to deficiency practice identified di clinical and compliance rounds at upon by the facility according to t process. The administrator will rethe Quality Assurance and Perfor Improvement Committee any are non-compliance monthly for 3 mot then quarterly for 3 quarters for recommendations as needed. Title of Person Responsible for implementing the acceptable plan correction. The Administrator is responsible implementing the acceptable plan correction. Date of Compliance: 4/25/2018 	t includes cal a vice logs for cerly for 3 cerly for 4 cerly for 4	

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