	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
			A. BUILDING	ġ		С
		345061	B. WING		06/29/2018	
NAME OF PR	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO		
	ALTH-DURHAM			3100 ERWIN ROAD		
PROTTINE				DURHAM, NC 27705		
(X4) ID		STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF C		(X5)
PREFIX TAG	· ·	ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	IE APPROPRIATE	COMPLETIO DATE
F 000	INITIAL COMMEN	TS	F 00	00		
	investigation was o	/18 and 6/29/18, a complaint conducted. The survey /18 to obtain vital interviews.				
F 558	Reasonable Accor	nmodations Needs/Preferences	F 55	58		7/25/18
SS=D	CFR(s): 483.10(e)	(3)				
	services in the faci accommodation of preferences excep endanger the healt other residents. This REQUIREME by: Based on observa family member and failed to accommo residents (Residen resident a bed to fi the resident's right board. Findings included: Resident #3 was re 6/19/18 with cumu Type 2 diabetes, P below the knee arr	eadmitted to the facility on lative diagnoses which included Peripheral vascular disease, left uputation and blindness.		This plan of correction cons written allegation of complia Preparation and submission correction does not constitut admission or agreement by truth of the facts alleged or t of the conclusions set forth of statement of deficiencies. Th correction is prepared and s solely because of requirement state and federal law.	nce. of this plan of te an the provider of he corrections on the ne plan of ubmitted ents under	
	assessment dated	rterly Minimum Data Set 4/16/18 coded a BIMS score ited the resident was		Process that lead to the Def Resident #3 was re-admitted	-	
	• •	required extensive assistance		6/19/2018, the staff did not r	•	
		for bed mobility, and limited both lower extremities. The		resident⊡s toes pressed aga footboard to the Administrati		
	•	as recorded as 75 inches.			ve stall.	
	-	he "Wound Observation and		Root Cause Analysis:		
		" revealed on 6/23/18 Resident		Failure to communicate the	resident⊡s	
		house sacral excoriated skin		needs to facility managemer		
	#5 developed an il			noodo to raolinty managomor		

**Electronically Signed** 

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

07/20/2018

	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DA	10. 0938-03 TE SURVEY	
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		CO	MPLETED	
						С	
		345061	B. WING		0	6/29/2018	
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
PRUITTHE	EALTH-DURHAM						
	SUMMARY S			DURHAM, NC 27705		(17)	
(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 CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETIC DATE	
F 558	Continued From pag	e 1	F 558	3			
		ength by 0.2 cm in width with		communicate/notify the Directo	r of Health		
	no depth.			Services (DHS), Administrator			
	Interview on 6/26/18	at 1:35 PM with the		supervisor that the resident s f			
	Restorative Aide (sta	ff member responsible for		pressing against the foot board			
		vealed the resident's current					
		(no specific date stated)		Process for implementing the a			
	was 228 pounds.			plan of correction for specific de	eficiency.		
		at 2:30 PM with Resident #3		On 6/07/2010, resident #2 was			
	-	oot hits the foot board since ed. "I am 6 feet 2 inches tall		On 6/27/2018, resident #3 was immediately provided an extend	tor on the		
		nan." With the previous bed		bed to ensure the right toes did			
	-	ed the foot board. Resident		against the footboard. All other			
	#3 stated the mattree			were reviewed on 6/27/2018 an			
		ad complained to various		6/28/2018 by the Director of He			
		Nurses (DON) and the		Services and the Nurse Manage			
	administrator.			ensure they did not have their t	oes		
		18 at 2:45 PM revealed		pressing against the footboards			
		rge body frame and was		Managers and charges nurses			
		bed with his head elevated at		observe and notify the DHS of a			
	• •	Ithough, there was a right		resident whose toes press agai			
		e resident's right great toe		footboard while lying in bed dai	iy using a		
	-	foot board frame of the bed. at 10:52 AM with a family		resident observation tool. All licensed nurses and certified	Inursing		
		nily members visit almost		aides are responsible for report	•		
		noticed his foot touching the		Administrator and the DHS any	•		
		nily members have verbally		whose toes are pressing against			
		cility staff and administration		footboard. In-service for all licer			
	but nothing happens			nurses and certified nursing aid	es on		
		rview on 6/27/18 at 11:01		reporting residents needs to in			
		liar with resident) revealed		discomfort while lying in bed wa			
		as pressing against the foot		on 6/27/2018 and will be compl	•		
		ed on several occasions she		7/20/2018. Licensed nurses and			
		lent's foot pressing on the d interview with NA #2 who		nursing aides who have not cor in-service will not be allowed to	-		
		would change his position		they are in-serviced. All newly h			
		Il press against the foot		licensed nurses and certified nu			
		htened his leg out." NA #2		aides will be educated on repor			
	-	t informed the nurse about		residents needs to include dis	-		

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If continuation sheet Page 2 of 16

TATEMENT	OF DEFICIENCIES	MEDICAID SERVICES	(X2) MULTIPI	LE CONSTRUCTION	OMB NO. 0938-039 (X3) DATE SURVEY			
AND PLAN OI	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	·	COMPLETED			
		345061	B. WING	C 06/29/2018				
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	00/29/2018			
PRUITTH	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 CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION			
F 558	Interview on 6/27/18 administrator who sta conversations with R members regarding ti indicated his expecta "stopper" (a foam we uncomfortable and at bed. Interview on 6/27/18 family member revea uncomfortable laying bed was shorter than caused his right foot Continued interview r	at 2:21 PM with the ated he had numerous esident #3 and his family he bed. The administrator tion was for staff to use a dge) if the mattress was ttach a foot extender to the at 3:24 PM with another led Resident #3 was in the bed and the current the previous bed which to hit the foot board. revealed family has been the administrator about the	F 55	8 orientation by the Clinical Competer Coordinator and/or the Director of H Services. Monitoring procedure to ensure that plan of correction is effective. The Director of Health Services and Clinical Competency Coordinator in-serviced all licensed nurses and certified nursing aides. The Administ and the Director of Health Services ensure all new hired licensed nurse certified nursing aides are educated during orientation. Nurse Manager: charges nurses will observe and, not the DHS of any resident whose toes against the footboard while lying in using the resident observation tool. The Administrator and the Director Health Services verified presence of extenders and will ensure the facilit extra bed extenders whenever need new admissions will have their heig reviewed by the Admissions Director ensure the facility has an appropria so the resident observation tool, all residents will be reviewed weekly b Managers for 4 weeks, then monthl months and, the quarterly until compliance is maintained. Unit Mar will report any findings of non-compt to the DHS and the DHS will report findings to the Administrator. The Administrator will report any finding non-compliance to the QAPI/QAA	Health t the d the strator will s and d s and otify s press bed of of of of y has ded. All ht or to te bed s y Unit y for 3 hagers bliance these			

Event ID: C4R011

Facility ID: 923197

If continuation sheet Page 3 of 16

		ID HUMAN SERVICES MEDICAID SERVICES				FORM	): 07/31/20 1 APPROVE 0. 0938-039
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345061	B. WING			C 06/29/2018	
NAME OF P	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
PRUITTHE	EALTH-DURHAM				100 ERWIN ROAD URHAM, NC 27705		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETIO DATE
F 558	Continued From page	ə 3	F	558	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: 7/25/2018		
F 677 SS=D	CFR(s): 483.24(a)(2) §483.24(a)(2) A resid out activities of daily	lent who is unable to carry living receives the necessary good nutrition, grooming, and	F	677			7/25/18
	by: Based on observatio record review and sta to cleanse Resident # when a urinary incom occurred in 1 of 3 res of daily living (ADL). Findings included: Resident #3 was read 6/19/18 with cumulati type 2 diabetes, perip below the knee ampu Review of the quarter assessment dated 4/ as 15 (which indicate oriented), extensive a	idents reviewed for activities dmitted to the facility on ve diagnoses which included oheral vascular disease, left			Process that lead to the Deficiency: Resident #3 was re-admitted on 6/19/2018. On 6/26/ 2018, while providi ADL, facility failed to cleanse resident skin during perineal care when a urinary incontinence episode had occurred. Root Cause Analysis: Failure by the Nursing Assistant (NA) # to follow proper procedure while providi perineal care has been identified as the root cause. Process for implementing the acceptabl plan of correction for specific deficiency The Nursing Assistant (NA) #1 was immediately educated by the Clinical Competency Coordinator on proper procedure for perineal care before 6/27/2018 before her next scheduled we	s y 1 ng le	

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		MEDICAID SERVICES				38-039
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SUR COMPLETE	
					с	
		345061	B. WING		06/29/2018	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
PRUITTHI	EALTH-DURHAM					
(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 CO	(X5) MPLETIO DATE
F 677	Continued From page	۵ <i>4</i>	F 677	,		
F 0//	<ul> <li>677 Continued From page 4 <ul> <li>use, always incontinent of bowel and bladder and at risk for the development of pressure ulcers.</li> <li>Review of the revised care plan dated 5/8/18</li> <li>revealed a potential problem with alteration in skin integrity related to incontinence of bowel and bladder and decreased mobility. The goal included being free from skin breakdown.</li> <li>Another problem identified was self-care deficit related to blindness and impaired mobility requiring extensive assistance for the completion of ADL. In part, one intervention for the (2) problems was incontinent care (perineal care) after each incontinence episode.</li> <li>Record review of the "Wound Observation and Assessment Form" revealed on 6/23/18 Resident #3 had developed an in-house sacral excoriated skin area which measured 0.3 centimeters (cm) in length by 0.2 cm in width with no depth.</li> <li>On 6/26/18 at 2:50 PM an observation during perineal care and interview with Nursing Assistant</li> </ul></li></ul>		F 67	shift. The Nursing Assistant (NA) a observed doing a return demonstr ensure she learned to follow the ri procedure while providing perinea residents. All residents that are incontinent of bowel and bladder v observed by the DHS, the Clinical Competency Coordinator and, Un Managers on 6/28/2018 and 6/29/ ensure they receive proper perine from Nursing Assistants. Certified Nursing Assistant are responsible for providing proper p care among other activities of dail and Licensed Nurses are respons monitoring Nursing Assistants to e proper care is provided. In-service Clinical Competency Coordinator of DHS for all certified nursing aides following proper procedures while providing perineal care was initiate 6/27/2018 and will be completed b 7/20/2018. Certified Nursing Assist	ation to ght I care to vere it 2018 to al care erineal y living ible for ensure by the and the on ed on by	
	(NA) #1 was conduct bedside table were 2 incontinent spray pro- While the resident wa NA #1 removed the s had experienced a un Resident #3 was ther and a white colored c skin near his coccyx a white colored cream protect the skin. Res the buttocks had been Interview on 6/27/18	ed. On Resident #3's opened bottles of Peri-wash duct for cleansing the skin. is positioned on his back, oiled brief and the resident inary incontinence episode. In positioned on his left side ream was applied to the area. NA # 1 stated the was a barrier cream to ident #3's perineal area nor in cleansed of urine residue. at 9:58 AM with NA #1 who d the pre-moistened wipes		<ul> <li>who have not completed the in-se not be allowed to work until they a in-serviced. All newly hired Certific Nursing Assistants will be educate following proper procedures while providing perineal care during new orientation by the Clinical Compet Coordinator and/or the Director of Services.</li> <li>Monitoring procedure to ensure th plan of correction is effective.</li> <li>The Administrator and the Directo Health Services ensured that in-se</li> </ul>	rvice will re ed ed on v hire ency Health at the	

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## FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER COMPLETED A. BUILDING С 345061 B. WING 06/29/2018 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 677 Continued From page 5 F 677 wanted me to use soap and water and he denied. providing perineal care was conducted for "An inquiry was made about using one of the 2 all Certified Nursing Assistants. The bottles of incontinence spray located at the Nursing Assistants that are not in-serviced resident's bedside and the response was "I could by 7/20/2018 will not be allowed to work have used the spray." until they have received the in-service. A return demonstration was observed by the Interview on 6/27/18 at 10:15 AM with the Clinical Competency Coordinator. Director of Nurses (DON) who stated she Based on the weekly schedule for Nursing expected the NA to use the Peri wash solution or Assistants, 20% of all Certified Nursing obtain another package of pre-moistened wipes Assistants including Nursing Assistant to cleanse the resident's skin. (NA) #1 will be observed performing perineal care weekly by the Clinical Interview on 6/27/18 at 10:31 AM with Co-unit Competency Coordinator and Unit coordinator #4 who stated she expected the Managers for 6 weeks and then monthly resident's skin be cleansed after a urinary for 3 months, and then quarterly for 2 incontinence episode. Co-unit coordinator #4 guarters to ensure proper procedure for stated if the pre-moistened wipes were not in the perineal care is followed. The Director of room, NA #1 could have used the Peri- wash Health Services and the Clinical solution or have left the room to obtain another Competency Coordinator will ensure all package of pre-moistened wipes to cleanse the shift are covered. The Clinical resident's skin. Further interview revealed NA #1 Competency Coordinator and Unit did not notify her about not having pre-moistened Managers will report to the DHS any wipes or that the skin was not cleansed. findings of non-compliance and Nursing Assistants will be assigned a course on Interview with the resident at 11:15 AM on ADL care on Pruitt University. The 6/27/18 who stated he never told NA #1 not to Director of Health Services will report to wash him with soap and water. "There was never the Administrator any findings of a discussion about that. I did not realize she had non-compliance. The Administrator will not washed my skin." review and report any findings of non-compliance to the QAPI committee guarterly for recommendations as needed until compliance is maintained. Title of Person Responsible for implementing the acceptable plan of correction. The Administrator is responsible for implementing the acceptable plan of correction.

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Event ID: C4R011

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA		CONSTRUCTION	(X3) DATE S	. 0938-03
	CORRECTION	IDENTIFICATION NUMBER:			COMPL	
					с	
		345061	B. WING		06/29/2018	
NAME OF P	ROVIDER OR SUPPLIER		S	STREET ADDRESS, CITY, STATE, ZIP CODE		
PRUITTHE	EALTH-DURHAM			100 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 CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	DBE	(X5) COMPLETIC DATE
F 677	Continued From page	e 6	F 677			
				Date of Compliance: 7/25/2018		
F 726 SS=D	Competent Nursing S CFR(s): 483.35(a)(3)		F 726			7/25/18
	the appropriate comp provide nursing and r resident safety and at practicable physical, it well-being of each res resident assessments and considering the r diagnoses of the facil accordance with the f at §483.70(e). §483.35(a)(3) The fac licensed nurses have and skill sets necessa needs, as identified th assessments, and de §483.35(a)(4) Providi limited to assessing, a implementing resident to resident's needs. §483.35(c) Proficience The facility must ensu- to demonstrate comp techniques necessary needs, as identified th assessments, and de This REQUIREMENT	e sufficient nursing staff with betencies and skills sets to related services to assure ttain or maintain the highest mental, and psychosocial sident, as determined by s and individual plans of care number, acuity and ity's resident population in facility must ensure that the specific competencies ary to care for residents' hrough resident escribed in the plan of care. Ing care includes but is not evaluating, planning and th care plans and responding ey of nurse aides. ure that nurse aides are able etency in skills and y to care for residents'				
	techniques necessary needs, as identified th assessments, and de This REQUIREMENT by:	y to care for residents' hrough resident escribed in the plan of care.		Process that lead to the Deficiency:		

Event ID: C4R011

Facility ID: 923197

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## FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION COMPLETED A. BUILDING С 345061 B. WING 06/29/2018 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 726 Continued From page 7 F 726 resident interviews the facility failed to During observation, the facility failed to demonstrate Nursing Assistant (NA) competency demonstrate Nursing Assistant when performing perineal care despite training for competency when performing perineal 1 of 3 residents reviewed for activities of daily care while assisting with ADLs for resident living. (Resident #3) #3. Nursing Assistant #1 failed to Findings included: demonstrate competency while Resident #3 was readmitted to the facility on performing perineal care. 6/19/18 with cumulative diagnoses which included type 2 diabetes and blindness. Root Cause Analysis: Review of the quarterly Minimum Data Set Lack of education for Nursing Assistants assessment dated 4/16/18 coded the BIMS score (NA) #1 on competency for perineal care as 15 (which indicated the resident was alert and is the root cause of the deficiency. oriented), required extensive assistance of 1 staff Process for implementing the acceptable for bathing, extensive assistance of 1 staff for plan of correction for specific deficiency. toilet use, always incontinent of bowel and The Nursing Assistant (NA) #1 was bladder and at risk for the development of immediately educated by the Clinical pressure ulcers. Competency Coordinator on proper Review of the revised care plan dated 5/8/18 procedure for perineal care before revealed a potential problem with alteration in 6/27/2018 before her next scheduled work skin integrity related to incontinence of bowel and shift. The Nursing Assistant (NA) #1 was bladder and decreased mobility. The goal observed doing a return demonstration to included being free from skin breakdown. ensure she learned to follow the right Another problem was self-care deficit related to procedure while providing perineal care to blindness and impaired mobility requiring residents. Resident #3 still resides in the extensive assistance for the completion of ADL. facility and continues to receive proper In part, one intervention for these (2) problems perineal care. All residents that are was incontinent care (perineal care) after each incontinent of bowel and bladder were incontinence episode. observed by the DHS, the Clinical Observation on 6/26/18 at 2:50 PM during Competency Coordinator and, Unit perineal care performed by NA #1 revealed Managers on 6/28/2018 and 6/29/2018 to Resident #3's had experienced urine ensure they receive proper perineal care incontinency. During the observation the perineal from Nursing Assistants. area nor the buttocks had been cleansed of urine Certified Nursing Assistant are residue. NA #1 applied a white colored barrier responsible for providing proper perineal cream on the skin that was not cleansed of urine care among other activities of daily living residual then a clean brief was placed on the and Licensed Nurses are responsible for resident. monitoring Nursing Assistants to ensure Interview and record review on 6/27/18 at 4PM proper care is provided. In-service for all with the Director of Nurses (DON) was certified nursing aides on following proper

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

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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 06/29/2018 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 726 | Continued From page 8 F 726 conducted. The DON indicated Performance procedures while providing perineal care reviews were done quarterly then annually. was initiated on 6/27/2018 and will be Review of the guarterly performance review last completed by 7/20/2018 Certified Nursing done on 2/26/18 indicated NA #1 fully achieved Assistants who have not completed the the performance criteria. in-service will not be allowed to work until Review of NA #1 's training transcript for the they are in-serviced. All newly hired 11/2018 ending cycle revealed an accrual of 4.5 Certified Nursing Assistants will be hours. NA #1 participated in the skills educated on following proper procedures competency training conducted on 1/4/18 and the while providing perineal care during new skills competency checklist indicated NA #1 had hire orientation by the Clinical Competency Coordinator and/or the perineal care training. Interview on 6/27/18 at 10:15 AM with the Director of Health Services. Director of Nurses (DON) who stated she expected NA #3 skin to be cleansed after a urine Monitoring procedure to ensure that the incontinence. plan of correction is effective. Interview on 6/27/18 at 10:31 AM with Co-unit coordinator #4 who stated she expected the The Administrator and the Director of resident's skin be cleansed after a urinary Health Services ensured that in-service incontinence episode. on following proper procedures while Interview with Resident #3 at 11:15 AM on providing perineal care was conducted for 6/27/18 who stated he never told NA #3 not to all Certified Nursing Assistants including wash him with soap and water. "There was never Nursing Assistant (NA) #1. The Nursing a discussion about that. I did not realize she had Assistants that are not in-serviced will not not washed my skin." be allowed to work until they are At the time of the survey, the staff development in-serviced. A return demonstration was coordinator was not available. observed by the Clinical Competency Coordinator. Based on the weekly schedule for Nursing Assistants, 20% of all Certified Nursing Assistants including Nursing Assistant (NA) #1 will be observed performing perineal care weekly by the Unit Managers for 6 weeks and then monthly for 3 months and, then guarterly for 2 guarters to ensure proper procedure for perineal care is followed. The Director of Health Services and the Clinical Competency Coordinator will ensure all shift are covered. The Clinical

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	-	ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 07/31/20 FORM APPROVE OMB NO. 0938-039		
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · /		(X3) DATE SURVEY COMPLETED C		
		345061	B. WING		06/29/2018		
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	1 00.20.20.0		
PRUITTH	EALTH-DURHAM		3100 ERWIN ROAD				
	1			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 CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETIO		
F 726	Continued From page	e 9	F 72	<ul> <li>Competency Coordinator and Unit Managers will report to the DHS any findings of non-compliance and Nur Assistants will be assigned a course ADL care on Pruitt University. The Director of Health Services will report the Administrator any findings of non-compliance. The Administrator review and report any findings of non-compliance to the QAPI commi for recommendations as needed un compliance is observed.</li> <li>Title of Person Responsible for implementing the acceptable plan o correction.</li> <li>The Administrator is responsible for implementing the acceptable plan o correction.</li> </ul>	sing e on wrt to will ttee til		
F 732 SS=C	<ul> <li>§483.35(g) Nurse Sta</li> <li>§483.35(g)(1) Data remust post the following basis:</li> <li>(i) Facility name.</li> <li>(ii) The current date.</li> <li>(iii) The total number by the following category unlicensed nursing staresident care per shift</li> <li>(A) Registered nurse</li> <li>(B) Licensed practication</li> </ul>	-(4) affing Information. equirements. The facility ng information on a daily and the actual hours worked gories of licensed and taff directly responsible for ft: s.	F 73	Date of Compliance: 7/25/2018	7/25/18		

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	MENT OF HEALTH AN S FOR MEDICARE & I						FORM	): 07/31/2018 MAPPROVED ). 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 P	ROVIDER OR SUPPLIER			STF	REET ADDRESS, CITY, STA	ATE, ZIP CODE		
PRUITTHE	EALTH-DURHAM				0 ERWIN ROAD IRHAM, NC 27705			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	×	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION TIVE ACTION SHOULD BI CED TO THE APPROPRIA EFICIENCY)		(X5) COMPLETION DATE
F 732	<ul> <li>(C) Certified nurse aid</li> <li>(iv) Resident census.</li> <li>§483.35(g)(2) Posting</li> <li>(i) The facility must post of present the specified in paragraph daily basis at the begi</li> <li>(ii) Data must be post (A) Clear and readable</li> <li>(B) In a prominent plaresidents and visitors.</li> <li>§483.35(g)(3) Public as staffing data. The face written request, make available to the public exceed the communit</li> <li>§483.35(g)(4) Facility requirements. The far posted daily nurse states and the communit for the specified on record revises are the face on record revises and the face of the retained of 3 months of posted (April 2018. May 2018)</li> <li>Findings included:</li> <li>Review of the retained Healthcare Centers F the facility and via emant administrator revealed on record revealed for the retained Healthcare revealed for the retained Healthcare revealed for the retained for the retained Healthcare revealed for the retained Healthcare revealed for the retained for the retained Healthcare revealed for the revealed for the retained healthcare revealed for the revealed for the retained healthealthealthealthealthealthealthe</li></ul>	les. requirements. bot the nurse staffing data in (g)(1) of this section on a nning of each shift. ed as follows: e format. ce readily accessible to access to posted nurse ility must, upon oral or nurse staffing data for review at a cost not to y standard. data retention cility must maintain the affing data for a minimum of ired by State law, whichever is not met as evidenced ew and staff interview the a minimum of 18 months of iata. This was evident in 2 staffing data reviewed.	F7	732	Process that lead to Based on record rev interview the facility minimum of 18 mon staffing data. The fa account for 6 days i posted staffing data Root Cause Analysi Lack of training for I Nursing Manageme staffing hours led to	view and staff failed to retain a ths of daily posted acility could not n a 3-months period that was reviewed s: Unit Managers and nt team to post dail	the y	

Event ID: C4R011

Facility ID: 923197

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		ND HUMAN SERVICES MEDICAID SERVICES			FOF	ED: 07/31/2018 RM APPROVED IO. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	IPLE CONSTRUCTION	(X3) DAT	E SURVEY IPLETED
		345061	B. WING _		0	C 6/29/2018
NAME OF P	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP COI		
PRUITTH	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 CC (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 732	Director of nurses (D DON stated the facilit forms missing especi because the weeken	18 at 3:20 PM with the ON) was conducted. The ty had multiple DNHHC ally on the weekends d nurse and myself were letimes staff posting was not	F7	<ul> <li>to properly file and retain all data for a minimum of 18 mo Process for implementing the plan of correction for specific The Administrator, the sched Director of Health Services reposted staffing data/records there is a minimum of 18 mo retained and properly filed. T Administrator and the Director Services educated Unit Mana scheduler on posting daily st and properly filing the data for of 18 months. Newly hired U and scheduler will be educat and retaining a minimum of 1 daily posted staffing data dur orientation by the Director of Services. The Director of Health Service responsible for ensuring that hours are posted daily. The Administrator and the Di Health Services will review th daily staffing hours daily for 4 then weekly for 3 months to 6 compliance is maintained. Th Supervisor and/or the design nurse will be responsible for staffing hours on the weeken Administrator will report any non-compliance to the QAPI for further recommendations until total compliance is maintained. The Director of Health Service to ensuring that hours on the weeken Administrator will report any non-compliance to the QAPI for further recommendations until total compliance is maintained. The Director of Health Service to ensuring that hours on the weeken Administrator will report any non-compliance to the QAPI for further recommendations until total compliance is maintained.</li> </ul>	onths. e acceptable c deficiency. duler and, the eviewed daily to ensure onths of data The or of Health agers and the taffing hours or a minimum nit Managers ted on posting 18 months of ring new hire T Health ces will be t staffing irector of he posted 4 weeks and ensure he Weekend hated charge posting daily nd. The findings of committee as needed hatined. ure that the s. ces will be	

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Facility ID: 923197

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	-	ND HUMAN SERVICES MEDICAID SERVICES	-		FORM APPRON OMB NO. 0938-03	
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		(X3) DATE SURVEY COMPLETED	
		345061	B. WING		C 06/29/2018	
AME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	•	
RUITTHE	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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETI	
F 732	Continued From pag	e 12	F 732	hours are posted daily and will report/inform to the Administrator of a designated Unit Managers responsible posting daily staffing hours when the Director of Health Services is out of the facility. The Administrator will receive and rev the posted daily staffing hours daily for weeks and then weekly for 3 months the ensure compliance is maintained. The Administrator will report any findings of non-compliance to the QAPI committee for further recommendations as needed until total compliance is maintained. Title of Person Responsible for implementing the acceptable plan of correction. The Administrator is responsible for implementing the acceptable plan of correction.	e for ie iew r 4 so of ee	
F 925 SS=F	CFR(s): 483.90(i)(4) §483.90(i)(4) Mainta program so that the t rodents.		F 925	Date of Compliance: 7/25/2018	7/25/18	
	Based on observation facility failed to prom	on and staff interviews the ote an insect free out the facility's main kitchen		Process that lead to the Deficiency: Based on observation and staff intervi conducted on 6/27/2018 the facility fa to promote an insect free environmen throughout the facility's main kitchen a Root Cause Analysis:	iled t	

Event ID: C4R011

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		MEDICAID SERVICES				NO. 0938-03	
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION	· · ·	TE SURVEY MPLETED	
		345061	B. WING		0	C 06/29/2018	
NAME OF P	ROVIDER OR SUPPLIER		•	STREET ADDRESS, CITY, STATE, ZIP CODE	•		
PRUITTHE	EALTH-DURHAM						
(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) COMPLETIC DATE	
F 925	Continued From page	e 13	F 92	5			
1 923	A kitchen worker was 10:00am who stated a yesterday (6-26-18) b kitchen. She also stat work 4 days a week." when she saw the roa reported it to her supe The dietary manager at 10:05am who state yesterday that there w bread rack and she ir also stated they have before but felt the roa outside vendors and o the last time she had employee saw any ro An observation of the 6-27-18 at 10:05am. cockroach noted in the dead cockroach noted The maintenance sup 6-27-18 at 10:15am v of the roaches in the immediately called th out and sprayed. He a came regularly every	interviewed on 6-27-18 at she saw live roaches behind the bread rack in the ted, "I see them but I only "The kitchen worker stated aches yesterday she ervisor. was interviewed on 6-27-18 ed she was made aware were roaches behind the offormed maintenance. She had roaches in the kitchen iches were brought in by could not remember when a complaint that an aches. • kitchen was conducted on There was one dead he dry storage room and one d behind the ice machine. • pervisor was interviewed on who stated he was informed kitchen yesterday and he e exterminator who came also stated the exterminator month but did not know	F 92	The contracted vendor did not kitchen area monthly as stipula contract/service agreement. The control vendor and the facility of review the contract on a regulat ensure Process for implementing the applan of correction for specific of The main kitchen and all kitchen were deep cleaned by houseke 6/28/2018. The contracted ven Control was contacted by the Administrator on 6/28/2018 and for a pest control technician to treat the kitchen area again and kitchenettes. The technician ca facility on 7/2/2018 and treated area again and treated all threat kitchenettes. After every treatment treated areas will be checked 22 after by the Maintenance Direct on 7/2/2018, the Administrator the Maintenance Director and Housekeeping Manager on en- the pest control technician service agreement/contract and as new	ated in the ne pest did not ar basis to acceptable leficiency. enettes eeping on dor for Pest d requested return and d treat all ame to the d the kitchen enent, the 24 hours ctor to kroaches. in-serviced the suring that vices all eded.		
	company that provide	control contract specified the ed the facility's pest control		In-service was initiated on 7/2/ dietary staff to ensure the kitch cleaned daily as required to he insects/cockroaches away. In-	ien is Ip keep service for		
	would treat the kitche	n area every month.		all other staff from all departme observing and reporting any pe			
		control log revealed the he facility on 5-30-18 but did s were treated.		including cockroaches was init 7/23/2018 by the Administrator Health Services, Dietary Mana	iated on , Director of		

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		MEDICAID SERVICES	a				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION	· · ·	E SURVEY IPLETED	
			A. BUILDING				
		345061	B. WING		C		
		345061			06	5/29/2018	
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
PRUITTHE	EALTH-DURHAM		3100 ERWIN ROAD				
	1			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 CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETIO DATE	
F 925	Continued From page	a 14	F 92	5			
1 525			F 923		a will mak		
		exterminator occurred on he exterminator stated he		completed by 7/25/2018. Staff who be in-serviced by 7/25/2018 will be			
	-	sterday for their monthly		in-serviced before they allowed re			
		spray the kitchen because		work. The Dietary Manager will ma			
		e were roaches in the		daily cleaning schedule for the kite			
		ed he only sprayed the					
		nd entry points every month		Monitoring procedure to ensure th	at the		
	and he only sprayed			plan of correction is effective.			
i	kitchenettes if he was	s informed there were					
	issues. He stated he	did remember there were		The Administrator and the Mainter	nance		
		n the kitchen but could not		Director reviewed the contract/agr			
		occurred or the last time he		and discussed with the pest control	bl		
	treated the main kitch	nen area.		vendor of the expectation and			
	<b>-</b> , , , , , , ,			commitment to keep the kitchen a			
		s interviewed on 6-27-18 at		kitchenettes free of insects. After e	-		
		e expected the exterminator		treatment, the treated areas will be	9		
		as any bugs were seen. He		checked 24 hours after by the			
		r's pest control contract or was supposed to treat the		Maintenance Director to ensure no residual insects/cockroaches. Any			
	main kitchen area ev			insects/cockroaches will be remov			
		Gry monur.		discarded immediately. If live			
	A telephone conferen	ice was conducted on		insects/cockroaches are observed	. 24		
	6-29-18 at 10:05am v			hours after treatment, the pest cor			
	company's Area Vice			vendor will be called back by the			
		the pest control company's		Administrator, Maintenance Direct	or or		
		e Administrator of the facility.		the Housekeeping Manager to adr			
	The area manager di	scussed the company being		further treatment for effective pest			
		ne exterminator could and		The housekeeping manager will m			
	did not treat the kitch	-		a monthly schedule to ensure the			
		was in operation. He also		and kitchenettes are stripped and	cleaned		
		had a "night service" that		regularly and as needed. The			
		ay service to make sure the		Maintenance Director, the Housek			
	kitchen was treated e	-		Manager and/or the Dietary Manager	ger will		
	Administrator for the			check the kitchen area and the	~~		
	-	invoices showing when the		kitchenettes for insects/cockroach			
	-	ovided to the kitchen area		weekly for 4 weeks and then mont			
	-	er for the company stated he ate of the last treatment		months until compliance is mainta The Administrator will review and i			
		מוכ טו נווכ ומשו נוכמנווופוונ	1		CUUIL	1	

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES							PRINTED: 07/31/2018 FORM APPROVED OMB NO. 0938-0391	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		345061	B. WING			C 06/29/2018		
NAME OF PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP				
PRUITTHE			3100 ERWIN ROAD					
			DURHAM, NC 27705		URHAM, NC 27705			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	ON SHOULD BE COMPLETION DE APPROPRIATE DATE		
F 925	Continued From page 15 exterminator.		F	925	<ul> <li>QAPI committee for recommendations as needed until compliance is maintained.</li> <li>Title of Person Responsible for implementing the acceptable plan of correction.</li> <li>The Administrator is responsible for implementing the acceptable plan of correction.</li> <li>Date of Compliance: 7/25/2018</li> </ul>			
	7(02-99) Previous Versions Ob	solete Event ID: C4			sility ID: 923197 If contin	uation sheet		

Event ID: C4R011

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