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PRUTITEALTH-DURHAM DURHAM, NC 27705 (M) ID TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDE BY FULL REGULATORY OR LSC DENTIFYING INFORMATION) ID PROVIDERS FLAN OF CORRECTIVA ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY CO E 000 Initial Comments E 000 An unannounced Recertification survey was conducted from 4/29/19 through 5/2/19. This facility was found to be in compliance with the requirements CFR 483.73 Emergency Preparedness. EVEN ID BOXN11. F 558 E 000 F 558 Reasonable Accommodations Needs/Preferences SS=0 CFR(s): 483.10(e)(3) F 558 5/28 S483.10(e)(3) The right to resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. F 558 This plan of correction constitutes a written allegation of compliance. 5/28 Based on observation, resident interview, staff interview, and record review, the facility failed to place a resident's call light writhin reach and provide an appropriate type of call bell to allow for the resident to use at all impts to reguest staff assistance if need6 for one of two resident reviewed for accommodation of needs (Resident #304). The findings included: Resident #304 was admitted to the facility on 5/26/16 and most recently readmitted on 4/23/19 with multiple diagnoses that included contractures of muscles multiple tises, postural spasiticity, cerebrai infraction, major depression and generalized anxiety. Corrective action the resident		VIDER OR SUPPLIER		s	TREET ADDRESS, CITY, STATE, ZIP CODE		
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PREFIX TAG IEACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED To THE APPROPRIATE DEFICIENCY. CONSTRUCTION CONTRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY. CONTRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY. E 000 Initial Comments E 000 An unannounced Recertification survey was conducted from 4/28/19 through 5/2/19. This facility was found to be in compliance with the requirements CFR 483.73 Emergency Preparedness. Event ID BOXN11. F 558 5/28 F 558 Reasonable Accommodations Needs/Preferences SS=0 CFR(s): 483.10(e)(3) F to the resident or other resident. 5/28 S483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other resident. This plan of correction constitutes a written allegation of compliance. Based on observation, resident interview, staff interview, and record review, the facility facility to a place a resident's call light within reach and provide an appropriate type of call bell to allow for the resident to set at all times to request staff assistance if needed for one of two resident #304). The findings included: Resident #304 was admitted to the facility on 5/26/16 and most recently readmitted on 4/23/19 with multiple diagnoses that included contractures of muscles multiple sites, postural spassicity, cerebral infraction, major depression and generalized anxiety. Corrective action the resident found to have been affected by the deficient provide r				C	OURHAM, NC 27705		
An unannounced Recertification survey was conducted from 4/29/19 through 5/2/19. This facility was found to be in compliance with the requirements CFR 483.73 Emergency Preparedness . Event ID BOXN11.F 558558F 558S=DCFR(s): 483.10(e)(3)F 558S=DCFR(s): 483.10(e)(3)F 5585/26S483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodations Needs/Preferences accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, and record review, the facility failed to place a resident 's call light within reach and provide an appropriate type of call bell to allow for the resident to use at all times to request staff assistance if needed for one of two resident reviewed for accommodation of needs (Resident #304).The findings included: Resident #304 was admitted to the facility on 5/26/16 and most recently readmitted on 4/23/19 with multiple diagnoses that included contractures of muscles multiple sites, postural spasticity, cerebral infraction, major depression and generalized anxiety.Corrective acion the resident found to have been affected by the deficient practice: On 5/2/2019, the Housekeeping Manager provided resident #304 with a flat-pad call	PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	(X5) COMPLETIC DATE	
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§483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, and record review, the facility failed to place a resident 's call light within reach and provide an appropriate type of call bell to allow for the resident to use at all times to request staff assistance if needed for one of two resident reviewed for accommodation of needs (Resident #304). This plan of correction constitutes a written allegation of compliance. Preparation and submission of this plan of correction does not constitute an admission or agreement by the provider of truth of the facts alleged or the corrections of the conclusions set forth on the statement of deficiencies. The plan of correction is prepared and submitted solely because of requirements under state and federal law. Resident #304 was admitted to the facility on 5/26/16 and most recently readmitted on 4/23/19 with multiple diagnoses that included contractures of muscles multiple sites, postural spasticity, cerebral infraction, major depression and generalized anxiety. Corrective action the resident found to have been affected by the deficient practice: On 5/2/2019, the Housekeeping Manager provided resident #304 with a flat-pad call	F 558	onducted from 4/29/ acility was found to b equirements CFR 48 Preparedness . Event Reasonable Accommo	19 through 5/2/19. This e in compliance with the 3.73 Emergency ID BOXN11.	F 558		5/28/19	
assessment dated 4/30/19 indicated Resident # hand on it. A cord clip was also provided 304 was cognitively intact, unclear speech and to help keep the call light cord in place.	si a pi e o T b E in p p t t a re f T R 5, w o c c g T a	ervices in the facility ccommodation of res references except w ndanger the health of ther residents. This REQUIREMENT y: Based on observation neterview, and record lace a resident 's ca rovide an appropriate he resident to use at ssistance if needed to eviewed for accomm 304). The findings included (26/16 and most record) f muscles multiple si erebral infraction, ma eneralized anxiety. The admission Minimi	with reasonable sident needs and hen to do so would or safety of the resident or " is not met as evidenced n, resident interview, staff review, the facility failed to all light within reach and e type of call bell to allow for all times to request staff for one of two resident odation of needs (Resident continued to the facility on ently readmitted on 4/23/19 es that included contractures tes, postural spasticity, ajor depression and um Data Set (MDS) 80/19 indicated Resident #		 written allegation of compliance. Preparation and submission of this plan correction does not constitute an admission or agreement by the provider truth of the facts alleged or the correction of the conclusions set forth on the statement of deficiencies. The plan of correction is prepared and submitted solely because of requirements under state and federal law. Corrective action the resident found to have been affected by the deficient practice: On 5/2/2019, the Housekeeping Manage provided resident #304 with a flat-pad callight that she can operate by placing her hand on it. A cord clip was also provided 	of ns er all	

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.

					OMB NO. 0938-03	
F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	IPLE CONSTRUCTION		TE SURVEY MPLETED	
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			Corrective action for other res	dents		
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An observation and i	nterview was conducted with					
Resident #304 on 4/2	29/19 at 9:20 PM, Resident		needed.	2		
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alert. The resident's	call light and the cord were					
			the deficient practice will not re	ecur:		
activities of ually living	y (ADL) HEEUS.					
An observation was	conducted of Resident #304		_ ·· ·			
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call light cord and cal	I bell were on the floor, out		they are in-serviced. All newly	hired		
of her reach.				-		
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	Continued From page usually could make s 304 required assistar was totally dependent locomotion on/off uni hygiene. Resident w for upper and lower b motion and was on p therapy. Review of Resident# reviewed 5/1/19, indi- planned for activities to total immobility and extremities and care communication relate An observation and i Resident #304 on 4/2 #304 was lying on he alert. The resident's observed on the floor resident indicated sho call staff for assistant call bell was at this ti was totally dependent activities of daily livin An observation was on 4/30/19 12:38 PM observed in her room call light cord and cal of her reach. An observation and in 05/01/19 10:00 AM re- her hands. The call b right shoulder. An inter	345061 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 1 usually could make self-understood. Resident # 304 required assistance of 2 or more staff and was totally dependent with bed mobility, transfers, locomotion on/off unit, toileting, and personal hygiene. Resident was impaired on both sides for upper and lower body regarding range of motion and was on physical and occupation therapy. Review of Resident# 304 's plan of care, last reviewed 5/1/19, indicated the resident was care planned for activities of daily living deficit related to total immobility and severe contractures of all extremities and care planned for difficulty communication related to unclear speech. An observation and interview was conducted with Resident #304 on 4/29/19 at 9:20 PM, Resident #304 was lying on her back in bed and appeared alert. The resident's call light and the cord were observed on the floor, out of resident's reach. The resident indicated she could use the call bell to call staff for assistance but was unsure where her call bell was at this time. Resident indicated she was totally dependent on staff for most of her activities of daily living (ADL) needs. An observation was conducted of Resident #304 on 4/30/19 12:38 PM. The resident was observed in her room in bed. Resident #304 's call light cord and call bell were on the floor, out	ALBULDIN COVIDER OR SUPPLIER ALTH-DURHAM SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 1 usually could make self-understood. Resident # 304 required assistance of 2 or more staff and was totally dependent with bed mobility, transfers, locomotion on/off unit, toileting, and personal hygiene. Resident was impaired on both sides for upper and lower body regarding range of motion and was on physical and occupation therapy. Review of Resident# 304 's plan of care, last reviewed 5/1/19, indicated the resident was care planned for activities of daily living deficit related to total immobility and severe contractures of all extremities and care planned for difficulty communication related to unclear speech. An observation and interview was conducted with Resident #304 on 4/29/19 at 9:20 PM, Resident #304 was lying on her back in bed and appeared alert. The resident's call light and the cord were observed on the floor, out of resident's reach. The resident indicated she could use the call bell to call staff for assistance but was unsure where her call bell was at this time. Resident indicated she was totally dependent on staff for most of her activities of daily living (ADL) needs. An observation was conducted of Resident #304 on 05/01/19 12:38 PM. The resident #304 on 05/01/19 10:00 AM revealed the resident #304 on 05/01/19 10:00 AM revealed the resident was in her room, lying in her bed and had splints on both her nands. The call bell was to the side near her right shoulder. An interview with the resident	A BUILING OWDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE ALTH-DURHAM STREET ADDRESS, CITY, STATE, ZIP CODE SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MEST REPRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX AG PROVIDER'S PLAN OF COD (EACK CORRECTVE ACTION CROSS-REFERENCED TO THE, DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX AG PROVIDER'S PLAN OF COD (EACK CORRECTVE ACTION CROSS-REFERENCED TO THE, DEFICIENCY) Continued From page 1 usually could make self-understood. Resident # 304 required assistance of 2 or more staff and was totally dependent with bed mobility, transfers, locornotion or/0f unit, tolieting, and personal hygiene. Resident was impaired on both sides for upper and lower body regarding range of notion and was on physical and occupation therapy. F 558 Review of Resident# 304 's plan of care, last reviewed 51/119, indicated the resident was care planned or activities of dail lyining deficit related to total immobility and severe contractures of all extremities and care planned for difficulty communication related to unclear speech. On 5/2/2019, all other resident meeded. More cord clips and call lights (pressure and flat pr available in the facility should needed. An observation and interview was conducted of Resident #304 on 4/30/19 12:38 PM. The resident mas call light cord and call bell were on the floor, out of her reach. Staff who have not completed by the 2/30/19 10:0AM revealed the resident #304 on 6/30/19 10:0AM revealed the resident #304 on 6/30/19 10:0AM revealed the resident #304 on 6/30/19 10:0AM revealed the resident #304	345061 B: WING	

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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 345061 B. WING 05/02/2019 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 558 Continued From page 2 F 558 use the call bell with splints on her both of her reach of residents. A call light tool was hands. Resident stated she was unable to reach introduced by the Administrator and will be or press the call bell as she could not move her utilized on weekdays to check call lights hand or fingers. by department heads and/or designated staff during compliance rounds twice a During an interview on 05/01/19 10:00 AM. day for 1 week, then 1x a day for 1 month Nursing Aide (NA) #3 indicated she was familiar until 3 consecutive months of compliance. with Resident # 304 and the resident had recently On weekends, floor nursing staff including returned from the hospital. NA# 3 indicated supervisors, charge nurses and nursing resident's voice was very low, unclear speech aides are responsible for ensuring the call due to recent hospitalization, but was able to lights are appropriate and within in reach communicate her needs. NA# 3 stated Resident of residents. # 304 was able to use his call light to request staff assistance. The NA indicated she normally placed Plans to monitor its performance to make Resident #304 's call light near her chest so she sure that solutions are sustained: was able to reach it. She was unsure how resident could use the call bell with her splints on The Administrator and the Director of both of her hands. Health Services will review the clinical rounds tool weekly for a month until During an interview and observation on 5/1/19 compliance is maintained. The 10:35 AM, Nurse # 10 stated Resident # 304 had Administrator and the Director of Health returned from hospital a week ago, had splints Services will conduct random checks to prior to hospitalization for her contractures and ensure call lights are appropriate and did not have splints after the resident's returned. within reach of the resident. The Nurse added the resident had a very low voice, Administrator will report any findings of had communication difficulty and could non-compliance to Quality Assurance and communicates her needs to staff. Nurse #10 Performance Improvement committee indicated resident was able to call for assistance monthly for further recommendations as by using the call bell. During the resident's needed until compliance is maintained. observation Nurse#10 indicated she was unaware therapy was trying out new splints for Date of Compliance: 5/28/2019 the resident. The nurse was unable to state how the resident would use the call bell with her splints on both of her hands. Nurse #10 stated Resident # 304 may need a touch pad call bell if the resident needs to wear splints on both of her hands. The Nurse further stated the NA assigned to the resident should be checking to make sure the call bell was functional and within reach of the

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

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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 ___ 345061 B. WING 05/02/2019 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) Continued From page 3 F 558 F 558 resident. During an interview on 5/1/19 at 1:28 PM, Occupation Therapist (OT) stated the resident was evaluated for splints upon return from the hospital and new splint testing was in progress. OT stated the certified occupation therapy assistant (COTA) was responsible of applying the splints for the Resident# 304 during the testing period. OT added the COTA should inform the assigned nurse when splints where applied for the resident. During an interview on 5/2/19 at 3:55 PM, the COTA stated she had applied splints for Resident # 304 and had not communicated it to the nurse. COTA was unable state how the resident could use the call bell and indicated the resident would need to be provided with a touch pad for call bell to allow her to utilize a call bell even when she was wearing splints on both of her hands. An interview was conducted with the interim Director of Nursing (DON) on 05/02/19 at 04:01 PM regarding Resident # 304 's call light not being placed within her reach and resident unable to use the call bell when splints were placed on her both of her hands. The DON indicated her expectations were for staff to place resident's call bell within reach at all times. She further stated that appropriate kind of call bell should be used so that the resident could call for assistance when on splints. DON added there should be appropriate communication between therapy and nursing staff. F 638 **Qrtly Assessment at Least Every 3 Months** F 638 5/28/19 CFR(s): 483.20(c) SS=D

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

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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 345061 B. WING 05/02/2019 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 638 Continued From page 4 F 638 §483.20(c) Quarterly Review Assessment A facility must assess a resident using the guarterly review instrument specified by the State and approved by CMS not less frequently than once every 3 months. This REQUIREMENT is not met as evidenced bv: Based on record review and staff interviews, the Corrective action the resident found to facility failed to complete a guarterly assessment have been affected by the deficient for 1 of 24 residents who had Minimum Data Set practice: (MDS) assessments reviewed (Resident #355). Resident #355 still resides in the facility. The quarterly assessment was completed Findings included: on 5/2/2019 by the MDS Director. Resident #355 had been originally admitted on Corrective action for other residents 9/19/18. His diagnoses included abnormal having the potential to be affected by the posture and muscle weakness. same deficient practice: Resident #355's admission MDS assessment had On 5/3/2019, the MDS Director and the been completed on 9/26/18 and indicated he was MDS Coordinator together with the cognitively intact. He did not ambulate and Administrator and the Director of Health required extensive to total assistance with Services reviewed guarterly MDS assessments to ensure there were no activities of daily living. other late assessments. The MDS Record review revealed the next completed MDS Director and the MDS Coordinator assessment for Resident #355 was a guarterly reviewed the assessments calendar with dated 2/7/19. focus on late assessments. The Interdisciplinary Team (IDT) was provided On 5/02/19 at 9:39 AM an interview with the MDS with the calendar to ensure each nurse was conducted. The nurse stated when discipline completes their part in the Resident #355 had returned from the hospital, 5 quarterly MDS assessment. day and a 14 day MDS assessments had been On 5/3/2019, the Administrator and the completed for insurance payment only. The nurse Director of Health Services initiated stated a guarterly MDS assessment should have education for the IDT (including MDS been completed with the 14 day assessment. The nurses, the Social Worker, the Director of nurse stated a guarterly MDS assessment should Recreational Services and, the Dietary have been completed in December 2018 for Manager) on the requirement of Resident #355. completing guarterly MDS assessments not less frequently than once every 3

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

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TATEMENT	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIP	LE CONSTRUCTION	OMB NO. 0938-03 (X3) DATE SURVEY	
ND PLAN OI	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	<u> </u>	COMPLETED	
		345061	B. WING		05/02/2019	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
PRUITTH	EALTH-DURHAM			3100 ERWIN ROAD DURHAM, NC 27705		
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F 638	On 5/02/19 at 9:57 A	M an interview with the DON) was conducted. The Ild expect the MDS	F 63	 months. Education was completed of 5/21/2019. Any new hires to join the will be educated on the requirement completing quarterly MDS assessments iter than once every is months by the Administrator and/or Director of Health Services during measurements identified will be comproved by 5/25/2019 by MDS nurses. Systemic changes made to ensure the deficient practice will not recur: On 5/3/2019, the Administrator and Director of Health Services initiated education for the IDT (including MDS nurses, the Social Worker, the Director of Health Services initiated education for the IDT (including MDS nurses, the Social Worker, the Director of Least Services and, the Dieter Manager) on the requirement of completing quarterly MDS assessments. Education was completed of 5/21/2019. Any new hires to join the will be educated on the requirement completing quarterly MDS assessments is frequently than once every fronthes by the Administrator and/or Director of Health Services during new hire orientation. The Administrator, the Director of Health Services and MDS Nurses will review due assessments days a week for 4 weeks on a contir basis to ensure assessments are completed and transmitted timely. M nurses have been informed by the Administrator of their responsibility to the services during to the services and to the requirement and the services have been informed by the Administrator of their responsibility to the services during to the services have been informed by the Administrator of their responsibility to the services have been informed by the Administrator of their responsibility to the services have been informed by the Administrator of their responsibility to the services. 	e IDT of ents 3 the ew leted hat the S stor of ary ents 3 on e IDT of ents 3 the ew he S s 5 nuing IDS	

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		ID HUMAN SERVICES MEDICAID SERVICES			FORM	D: 06/10/201 MAPPROVE D. 0938-039
STATEMENT (DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		345061	B. WING		05/	02/2019
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F 638	Continued From page	e 6	F 638	Plans to monitor its performance to	o make	
F 640 SS=D	CFR(s): 483.20(f)(1)- §483.20(f) Automated requirement- §483.20(f)(1) Encodir a facility completes a facility must encode t each resident in the fi (i) Admission assessme (ii) Annual assessme (iii) Significant change (iv) Quarterly review a (v) A subset of items reentry, discharge, ar (vi) Background (face is no admission asses §483.20(f)(2) Transm	d data processing ng data. Within 7 days after resident's assessment, a he following information for acility: ment. nt updates. e in status assessments. assessments. upon a resident's transfer, nd death. e-sheet) information, if there	F 640	sure that solutions are sustained: The Administrator, the Director of H Services and MDS Nurses will revi assessments due during daily stan meeting for 4 weeks and then wee months and then monthly thereafter consecutive months of compliance maintained. The Administrator will any findings of non-compliance to Quality Assurance and Performance Improvement committee quarterly as needed for recommendations to ensure compliance is maintained. Date of Compliance: 5/28/2019	Health iew idup kly for 2 er until 6 is report the ce and/or	5/28/19

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DEPARTMENT OF HEALTH AND HUMAN SERVICES **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 ___ 345061 B. WING 05/02/2019 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 640 Continued From page 7 F 640 a facility must be capable of transmitting to the CMS System information for each resident contained in the MDS in a format that conforms to standard record layouts and data dictionaries, and that passes standardized edits defined by CMS and the State. §483.20(f)(3) Transmittal requirements. Within 14 days after a facility completes a resident's assessment, a facility must electronically transmit encoded, accurate, and complete MDS data to the CMS System, including the following: (i)Admission assessment. (ii) Annual assessment. (iii) Significant change in status assessment. (iv) Significant correction of prior full assessment. (v) Significant correction of prior quarterly assessment. (vi) Quarterly review. (vii) A subset of items upon a resident's transfer, reentry, discharge, and death. (viii) Background (face-sheet) information, for an initial transmission of MDS data on resident that does not have an admission assessment. §483.20(f)(4) Data format. The facility must transmit data in the format specified by CMS or, for a State which has an alternate RAI approved by CMS, in the format specified by the State and approved by CMS. This REQUIREMENT is not met as evidenced bv: Based on record review and staff interviews, the Corrective action the resident found to facility failed to complete and transmit an entry have been affected by the deficient tracking Minimum Data Set (MDS) assessment practice: within the required time frame for 1 of 24 Resident #355 still resides in the facility. residents reviewed for submission of MDS The resident s entry tracking assessment assessments (Resident #355). was completed and transmitted on 5/2/2019 by the MDS Director.

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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 345061 B. WING 05/02/2019 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 640 Continued From page 8 F 640 Findings included: Corrective action for other residents Resident #355 had been originally admitted on having the potential to be affected by the 9/19/18. His diagnoses included abnormal same deficient practice: posture and muscle weakness. On 5/3/2019, the MDS Director, MDS Resident #355's admission MDS assessment Coordinator and, the DHS initiated review was completed on 9/26/18 and indicated he was of all admissions and readmissions since cognitively intact. He did not ambulate and 12/1/2018 for entry tracking assessments. required extensive to total assistance with The review will be completed by activities of daily living. 5/24/2019 and any entry assessments not completed, will be completed and Review of Resident #355's medical record transmitted by 5/28/2019 by the MDS revealed he was discharged, with return nurses. anticipated on 12/11/18. Resident #355 was readmitted to the facility on 12/18/18. No MDS Systemic changes made to ensure that entry tracking assessment for 12/18/18 was the deficient practice will not recur: found in the resident's medical record. The next completed MDS assessment in Resident #355's On 5/3/2019, the Administrator and the medical record was dated 2/7/19. Director of Health Services initiated education for MDS nurses on the On 5/02/19 at 9:39 AM an interview with the MDS requirement of completing and nurse was conducted. The nurse stated Resident transmitting entry tracking assessments #355 was readmitted to the facility on 12/18/18 timely as specified by the state and and a MDS entry tracking assssment should have approved by CMS. Education was been completed at that time, but it was completed on 5/21/2019. Any newly hired overlooked and not completed. MDS staff will be educated on the requirement of completing and On 5/02/19 at 9:57 AM an interview with the transmitting entry tracking assessments Director of Nursing (DON) was conducted. The timely as specified by the state and DON stated she expected the MDS assessments approved by CMS by the Administrator to be completed on time. and/or the Director of Health Services during new hire orientation. The Administrator, the Director of Health Services and MDS Nurses will review all new admissions and readmissions 5 days a week for 4 weeks on a continuing basis to ensure entry tracking assessments are completed and transmitted timely. MDS

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		ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 06/10/2 FORM APPRO OMB NO. 0938-0
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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PRUITTHE	ALTH-DURHAM			DURHAM, NC 27705	
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F 640	Continued From page		F 64	 nurses have been informed by f Administrator of their responsib ensuring entry tracking assessin completed and transmitted in the specified the state and approve Plans to monitor performance to sure that solutions are sustaine The Administrator, the Director Services and MDS Nurses will r entry and reentry tracking assess for all new admissions and react during daily standup meeting fo and then weekly for 2 months a monthly thereafter until 6 consee months of compliance is mainta Administrator will report any find non-compliance to the Quality A and Performance Improvement committee quarterly and/or as r recommendations to ensure con is maintained. 	ility of ments are be format and by CMS. or make d: of Health review ssments dmissions ar 4 weeks and then ecutive ained. The dings of Assurance meeded for mpliance
F 658 SS=D	CFR(s): 483.21(b)(3)		F 65	58	5/28/19
	as outlined by the cor must- (i) Meet professional	d or arranged by the facility, nprehensive care plan,			
	Based on observatio	n, record review and staff vs, the facility failed to assist opointments with a		Corrective action the resident f have been affected by the defic practice:	

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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 ___ 345061 B. WING 05/02/2019 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 658 Continued From page 10 F 658 rheumatologist and for podiatry services for 1 of 1 Resident #103 still resides in the facility. resident reviewed for need for specialized On 4/15/2019, a rheumatologist services (Resident #103). appointment was scheduled by the charge Findings Included: nurse for 7/1/2019 -the earlier available appointment. The podiatry appointment 1. Resident #103 was admitted to the facility from was scheduled for 5/21/2019 by the Unit the hospital on 10/11/18 with diagnosis in part, of Manager. rheumatoid arthritis (RA). Resident #103's hospital discharge order dated Corrective action for other residents 10/10/18 specified, "He should follow up with having the potential to be affected by the rheumatologist as outpatient for improved same deficient practice: management of his RA which is fairly debilitating." On 5/6/2019 the DHS, Unit Managers The most recent quarterly Minimum Data Set and, charge nurses conducted a review of dated 4/15/19, revealed he was cognitively intact all current resident charts for physician with no long or short term memory problems. He orders and/or recommendations for was dependent on staff for daily dressing, specialized services and follow up appointments. The review of orders was toileting and hygiene, had limited range of motion on upper and lower extremities of one side of his completed on 5/9/2019. No residents body. He used a wheelchair for mobility. were found to have missed any follow up appointments and/or recommendations as During interview on 04/30/19 at 10:49 AM ordered by the physician. Resident #103 stated he wanted to see his rheumatologist and the facility had not made any Systemic changes made to ensure that appointments. He stated he usually went the deficient practice will not recur: regularly, but had not seen the rheumatologist since being admitted to the facility The Director of Health Services together with the clinical team (including but not Observation revealed on 4/30/19 at 10:49 AM limited to Unit Managers/Supervisors and both hands had severely contracted fingers from the Interdisciplinary team) will review all arthritis. Also, his shoes had been cut to orders for new admissions and accommodate the deformity of his feet. readmissions daily during the clinical rounds. The Director of Health Services During an interview on 05/01/19 at 10:42 AM, and the Clinical Competency Coordinator Nurse #4 stated on 4/15/19 Resident #103 had initiated education on 5/3/2019 for all asked to see his Rheumatologist. She called the licensed nurses on following physician Rheumatology clinic on 4/15/19 to set up an orders and/or recommendations to ensure appointment. She was informed that he had a appointments and referrals are made as routine appointment that had been scheduled for ordered. The education will be completed

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	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	TIPLE CONSTRUCTION		ATE SURVEY MPLETED	
	CONTRECTION		A. BUILDI	NG			
		345061	B. WING			05/02/2019	
NAME OF P	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 PREFI) TAG		CTION SHOULD BE) THE APPROPRIATE	(X5) COMPLETIO DATE	
F 688	Continued From page	- 14	F	688			
	at bedtime and remove Record review of the summary dated 3/22/ with left ankle orthosis place." The most recent Mini revealed he was sever rejection of care behas staff for daily dressing limited range of motion side of his body. He up mobility. He had not re physical therapy or sp assessment period. Observation on 04/30 Resident #72 had a left severe. He had left si which was resting on Record review of curre assistant) care guide revealed carrot to left	ve in morning" a physical therapy discharge 19 revealed in part, "Patient s and wearing schedule in mum Data Set dated 4/9/19 erely impaired, had no avior. He was dependent on g, toileting and hygiene, had on on upper and lower of one used a wheelchair for received any occupation or oblint application during this 0/19 at 10:07 AM revealed eft hand contracture that was ded paralysis of his left leg wheelchair foot rest. rent C.N.A (certified nursing record not dated reviewed hand, left ankle PRAFO foot orthosis) boot at night	F	Systemic changes made the deficient practice will The Director of Health Se Clinical Competency Coo education for charge nurs Managers/supervisors on as recommended by thera are not educated, will not work until they are educat care plans and nurse aide be updated as needed du clinical rounds. Any reside signs of contracting will be therapy by the charge nur evaluate and make recom needed for nurses to follo Plans to monitor its perfor sure that solutions are su The Director of Health Se Nurse Managers will revie splints daily for 5 days the	not recur: ervices and the ordinator initiated ses and Unit applying splints apy. Nurses who be allowed to ted. Resident e care guides will uring the morning ent showing any e referred to rse. Therapy will mmendations as ww. rmance to make stained; ervices and ew residents with		
	administration record documented, "Apply I as tolerated through r area it indicated in per administration record application document TAR. The MAR docur behaviors on all shifts Record review on 5/2 administration record revealed "Apply LUE	(MAR). There was no splint red on the April 2019 MAR or mentation revealed no		thereafter for 4 weeks the consecutive months of su compliance is obtained. T Health Services will prese of non-compliance to the Assurance and Performan Improvement committee of as needed for further reco ensure compliance is main Date of Compliance: 5/28	Instained The Director of ent any findings Quality nce quarterly and/or commendations to intained.		

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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 345061 B. WING 05/02/2019 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 689 Continued From page 17 F 689 Free of Accident Hazards/Supervision/Devices F 689 5/28/19 F 689 CFR(s): 483.25(d)(1)(2) SS=E §483.25(d) Accidents. The facility must ensure that -§483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced bv: Based on observations, record review, staff and Corrective action the resident found to resident interviews, the facility did not enforce the have been affected by the deficient was smoke-free facility rules, allowed practice: independent resident smokers to smoke on facility property, failed to provide a place to Resident # 79 and #356 no longer reside in the facility. Resident #24 still resides in extinguish smoking material, and a did not provide a safe smoking area for residents during the facility. smoking activities for 3 of 4 residents reviewed Residents were notified individually on for accidents (Resident #24, #79, and #356). 5/16/2019 by the Administrator and the Findings included: Director of Health Services of the requirement to abide by the facility policy 1. Resident #24 had been admitted on 5/24/18. with emphasis on not smoking on facility The facility's Smoke Free Policy indicated as of property/premises. Resident #24 was also 1/01/15 smoking was not allowed on the notified that non-compliance with the premises. Smoking would only be allowed for facility policy will lead to a 30-day residents who had been "grandfathered" in prior discharge notice being issued by the to 1/01/15. facility. A meeting to include the Ombudsman is scheduled for 5/30/2019 The Admission Agreement dated 5/24/18 for all smoking residents. indicated Resident #24's Representative had A meeting for all residents who smoke received a copy of the Guest Services Guide and was scheduled for 5/23/2019 at 2:00pm had accepted all terms and conditions stated in with the Administrator, the Director of this agreement and in the Guest Services Guide. Health Services and, the Director of Social Services to emphasize following A copy of the Guest Services Guide was the smoking policy requirements. reviewed. The guide indicated the facility Residents can smoke on the sidewalk

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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 345061 B. WING 05/02/2019 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) Continued From page 18 F 689 F 689 prohibited the use of all forms of tobacco. (public area) or away from the property. The Ombudsman has been invited to a Resident #24's care plans initiated on 5/24/18 meeting on 5/30/2019 with smoking and updated on 4/29/19 indicated he did not residents, the Administrator, the Director require supervision with smoking as he was of Health Services and, the Director of independent with mobility, alert and oriented. Social Services to again emphasize the Interventions included to educate Resident #79 need to comply with the facility smoking that there was no smoking on the facility property. policy. Residents who do not comply with will be issued a 30-day discharge notice Resident #24's admission Minimum Data Set and while still in the facility, smoking dated 5/31/18 indicated he was cognitively intact. privileges will be revoked. He was independent or required supervision/set up assistance with his activities of daily living. The Corrective action for other residents assessment did not indicate Resident #24 used having the potential to be affected by the tobacco. same deficient practice: A Leave of Absence/Release From Responsibility A meeting for all residents who smoke Form for Resident #24 was reviewed. The form was scheduled for 5/23/2019 at 2:00pm indicated " ... the resident is leaving, accepts with the Administrator, the Director of Health Services and, the Director of complete responsibility for [themselves] while away from the center, and absolves the center, its Social Services to emphasize following management, its personnel and the attending the smoking policy requirements. physician of responsibility for any deterioration in Residents were notified that they can only condition or accident that may occur while the smoke on the sidewalk (public area) or resident is away." The form included areas for the away from the property and not in the resident to date, time and sign in and out of the parking lot. The Ombudsman has been facility. Multiple entries were observed for invited to a meeting on 5/30/2019 with Resident #24. smoking residents, the Administrator, the Director of Health Services and, the A Smoking Observation Form dated 4/29/19, Director of Social Services to again filled out by with admitting nurse, indicated emphasize the need to comply with the Resident #24 had been assessed as safe to facility smoking policy. Residents who do smoke unsupervised. not comply with will be issued a 30-day discharge notice and, while still in the An observation was made of the facility parking facility, smoking privileges will be revoked. lot on 4/30/19 at 9:10 AM. A no parking zone, Education for staff was initiated on indicated by yellow stripes painted on the 5/13/2019 by the Administrator, The pavement, was noticed to have many cigarette Director of Health Services, The Clinical butts discarded both on the pavement and in the Competency Coordinator and, department

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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 345061 B. WING 05/02/2019 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 689 Continued From page 19 F 689 grassy area located between the parking lot and heads on helping to enforce the policy by the public sidewalk. Discarded cigarette butts informing residents not to smoke on the were also observed in the pine straw mulch property and to report to the Administrator around the plants near the front door. No any residents who violate the policy. The cigarette disposal containers were observed in education will be completed by 5/28/2019. these areas. Systemic changes made to ensure that During an interview with the Administrator (AD) on the deficient practice will not recur: 5/01/19 at 3:00 PM, he stated this was no-smoking facility. The AD indicated there was a The Administrator, the Director of Health smoking policy in the admission packet that the Services and, the Director of Social new residents would read and sign prior to Services have informed smoking admission. The AD stated that all new residents residents that they can only smoke on the were assessed for smoking. Residents who were sidewalk (public area) or any other place alert, oriented, capable of signing themselves in away from the property (including the and out of the facility, and assessed as safe parking lot). The Ombudsman has been smokers, were allowed to go outside and smoke. invited to a meeting on 5/30/2019 with All smoking materials were kept locked in the smoking residents, the Administrator, the medication carts, and the nurse would provide Director of Health Services and, the them to the resident when requested. The AD Director of Social Services to again also stated, based on the location of the building, emphasize the need to comply with the residents would go to the bus stop to smoke. He facility smoking policy. Residents who do not comply with will be issued a 30-day stated people who were waiting for the bus would discharge notice and, while still in the smoke and he had no control over that. The AD stated when it was hot, cold or rainy weather, facility, smoking privileges will be revoked. people waiting for the bus would utilize the Education for staff was conducted to help covered porch and sometimes smoke. He further enforce the smoking policy. The stated he had no control over residents who were Administrator and the Director of Social alert and oriented and would like to go out or who Services will request to attend the next were assessed as safe smokers. The AD stated scheduled resident council meeting to residents were not monitored in the evening or address the smoking policy. night when going outside to smoke. He stated as the facility was a no-smoking facility, the staff did Plans to monitor its performance to make not monitor the smoking residents. The AD stated sure that solutions are sustained: he would check people at various times and remind them that this was a smoke-free facility. Facility management will hold weekly The AD also stated there were no ash trays or meetings with all smoking residents to sand buckets for the cigarette butts in front of the emphasize the need to comply with the building as this would encourage residents to smoking policy for 4 weeks, bi-weekly for

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			0/00 100		OMB NO. 0938-03	
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345061	B. WING		05/02/2019	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
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 CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE COMPLETIC	
F 689	smoke. On 5/02/19 at 10:29 / Resident #24 was co standing in the facility parking zone, smokin told to stand here to s by the facility's street was unsure who had area. He stated he has 5 months. On 5/02/19 at 4:47 Pl observed sitting on hi he goes outside when On 5/02/19 at 4:51 Pl was conducted. She alert, oriented, able to mobile without any as Resident #24 smoked times a day. On 5/02/19 at 5:24 Pl observed standing in no parking zone, smo cigarette, he extinguis the pavement and lef On 5/02/19 at 10:35 / the AD was conducted zone area was on the further stated there w the facility who had b the no smoking policy The AD stated upon a	AM an interview with inducted. He was observed y parking lot, in the no g. He stated he had been smoke or he could go over sign to smoke. He stated told him to stand in this ad been in the facility for 4 or M Resident #24 had been is bed in his room. He stated in he can. M an interview with Nurse #2 stated Resident #24 was o make his needs known and ssistive devices. She stated d and went outside several M Resident #24 was the facility parking lot, in the oking. When he finished his shed the cigarette butt on t the butt. AM a follow up interview with d. He stated the no parking e facility property. The AD rere currently no residents in een "grandfathered" in when y had been put into effect. admission the smoking id they are told that they	F 689	1 month and then monthly for 3 mu until compliance is sustained. The Administrator will report any finding non-compliance to Quality Assurat Improvement Committee for further recommendations as needed. Date of Compliance: 5/28/2019	gs of nce and	

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 06/10/2019 MAPPROVED D. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345061	B. WING			05/	02/2019
NAME OF P	ROVIDER OR SUPPLIER			s	STREET ADDRESS, CITY, STATE, ZIP CODE		
PRUITTHE	EALTH-DURHAM				3100 ERWIN ROAD DURHAM, 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 CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 689	smoking rule. He furth the residents to follow enforce the rules and 2. Resident #79 had b The facility's Smoke F 1/01/15 smoking was premises. Smoking w residents who had be to 1/01/15. The Admission Agree indicated Resident #7 the Guest Services G terms and conditions and in the Guest Service A copy of the Guest Service reviewed. The guide i prohibited the use of a A Smoking Observation filled out by the admit Resident #79 had bee smoke unsupervised. Resident #79's admiss dated 4/2/19 indicated She was independent up assistance with he The assessment indic Resident #79's care p indicated she did not smoking as she was i alert and oriented. Int	were non-compliant with the ner stated he would expect v the rules and for staff to policies. Deen admitted on 3/26/19. Free Policy indicated as of not allowed on the ould only be allowed for en "grandfathered" in prior ment dated 3/26/19 '9 had received a copy of uide and had accepted all stated in this agreement vices Guide. Services Guide was ndicated the facility all forms of tobacco. on Form dated 3/26/19, ting nurse, indicated en assessed as safe to sion Minimum Data Set d she was cognitively intact. t or required supervision/set er activities of daily living. cated she used tobacco.	F	689			

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	-	D HUMAN SERVICES				FORM	: 06/10/2019 APPROVED
STATEMENT C	S FOR MEDICARE & I of Deficiencies CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	CONSTRUCTION		OMB NO. 0938-039 (X3) DATE SURVEY COMPLETED	
		345061	B. WING		_	05/	02/2019
NAME OF PF	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, ST	TATE, 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 PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 689	Form for Resident #79 indicated " the resid complete responsibilit away from the center, management, its pers physician of responsit condition or accident " resident is away." The resident to date, time facility. Multiple entrie Resident #79. An observation was n lot on 4/30/19 at 9:10 indicated by yellow st pavement, was notice butts discarded both of grassy area located b the public sidewalk. D were also observed in around the plants nea- cigarette disposal con- these areas. On 4/30/19 at 9:10 AN #79 was conducted. S in the facility parking I smoking. When she fi extinguished the cigar left the butt in the gras	Release from Responsibility 9 was reviewed. The form dent is leaving, accepts by for [themselves] while and absolves the center, its connel and the attending bility for any deterioration in that may occur while the e form included areas for the and sign in and out of the s were observed for hade of the facility parking AM. A no parking zone, ripes painted on the etween the parking lot and biscarded cigarette butts on the pine straw mulch in the front door. No tainers were observed in M an interview with Resident She was observed standing ot, in the no parking zone, nished her cigarette, she rette butt on the curb and ssy area between the facility blic sidewalk. She stated	F 689		DEFICIENCY)		
		Resident #79 had been the facility parking lot, in 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 345061 B. WING 05/02/2019 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 689 Continued From page 23 F 689 no parking zone, smoking. During an interview with the Administrator (AD) on 5/01/19 at 3:00 PM, he stated this was no-smoking facility. The AD indicated there was a smoking policy in the admission packet that the new residents would read it and sign prior to admission. The AD stated that all new residents were assessed for smoking. Residents who were alert, oriented, capable of signing themselves in and out of the facility, and assessed as safe smokers, were allowed to go outside and smoke. All smoking materials were kept locked in the medication carts, and the nurse would provide them to the resident when requested. The AD also stated, based on the location of the building, residents would go to the bus stop to smoke. He stated people who were waiting for the bus would smoke and he had no control over that. The AD stated when it was hot, cold or rainy weather, people waiting for the bus would utilize the covered porch and sometimes smoke. He further stated he had no control over residents who were alert and oriented and would like to go out or who were assessed as safe smokers. The AD stated residents were not monitored in the evening or night when going outside to smoke. He stated as the facility was a no-smoking facility, the staff did not monitor the smoking residents. The AD stated he would check people at various times and remind them that this was a smoke-free facility. The AD also stated there were no ash trays or sand buckets for the cigarette butts in front of the building as this would encourage residents to smoke. On 5/02/19 at 10:26 AM a second interview with Resident #79 was conducted. She was observed standing in the facility parking lot, in the no

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

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	-	D HUMAN SERVICES				FORM): 06/10/2019 1 APPROVED
STATEMENT (S FOR MEDICARE & DF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		(X3) DATE	0. 0938-0391 SURVEY LETED
		345061	B. WING		_	05/	02/2019
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, S	TATE, ZIP CODE		
PRUITTHE	EALTH-DURHAM			3100 ERWIN ROAD DURHAM, NC 27705			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD B NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 689	had been told to smol lot but had been unsu She further stated she wanted to stand in the other side of the facilit trees. On 5/02/19 at 12:50 F #1 was conducted. Th #79 was alert, oriente known and was ambu device. Resident #79 to smoke and would s On 5/02/19 at 10:35 A the AD was conducted zone area was on the further stated there w residents in the facility "grandfathered" in wh had been put into effe admission the smokin they are told that they property to smoke. He to end up in that part were non-compliant w further stated he woul follow the rules and fo and policies. 3. Resident #356 had A Minimum Data Set a been completed for R The Admission Agree indicated Resident #3	g. Resident #79 stated she ke in this area of the parking ire who had told her that. a had been told if she e shade, to stand on the ty's street sign, closer to the PM an interview with Nurse he nurse stated Resident d, could make her needs ilatory without an assistive had been assessed as safe sign herself out to smoke. AM a follow up interview with d. He stated the no parking facility property. The AD ere currently no smoking y who had been en the no smoking policy ect. The AD stated upon g policy is explained and r must stay off of the facility e stated the smokers seem of the parking area and <i>v</i> ith the smoking rule. He ld expect the residents to or staff to enforce the rules been admitted on 4/29/19. assessment had not yet esident #356.	F 689				

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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 ___ 345061 B. WING 05/02/2019 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 689 Continued From page 25 F 689 terms and conditions stated in this agreement and in the Guest Services Guide. A copy of the Guest Services Guide was reviewed. The guide indicated the facility prohibited the use of all forms of tobacco. Nursing admission documentation dated 4/29/19, indicated Resident #356 was alert, oriented, followed commands, and had no exit seeking behaviors. A Smoking Observation Form dated 4/29/18, filled out by the admitting nurse, indicated Resident #356 had been assessed as safe to smoke unsupervised. His baseline care plan dated 4/30/19 indicated Resident #356 was a smoker. Goals included Resident #356 would demonstrate safe practices when smoking outside as evidenced by no unsafe behavior or injury related to smoking. Interventions included to encourage Resident #356 to communicate when going out to smoke, review smoking safety guarterly and as needed and observe for safe practice when smoking. A Leave of Absence/Release from Responsibility Form for Resident #356 was reviewed. The form indicated " ... the resident is leaving, accepts complete responsibility for [themselves] while away from the center, and absolves the center, its management, its personnel and the attending physician of responsibility for any deterioration in condition or accident that may occur while the resident is away." The form included areas for the resident to date, time and sign in and out of the facility. Multiple entries were observed for Resident #356.

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	-	ID HUMAN SERVICES			FC	TED: 06/10/2019 DRM APPROVED
STATEMENT (DF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	E CONSTRUCTION	(X3) D	NO. 0938-0391 ATE SURVEY OMPLETED
		345061	B. WING			05/02/2019
NAME OF P	ROVIDER OR SUPPLIER		5	STREET ADDRESS, CITY, STATE, ZIP C	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 .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 689	Continued From page	26	F 689			
	lot on 4/30/19 at 9:10 indicated by yellow st pavement, was notice butts discarded both of grassy area located b the public sidewalk. E were also observed in around the plants nea- cigarette disposal con- these areas. On 4/30/19 at 10:21 A Resident #356 was co- just been admitted an concerns regarding h He stated he was able independently. On 4/30/19 at 10:27 A observed standing in no parking zone, smo- cigarette, he extinguis the pavement and left On 5/1/19 at 1:22 PM observed standing in no parking zone, smo- cigarette, he extinguis the pavement and left On 5/1/19 at 1:22 PM observed standing in no parking zone, smo- cigarette, he at 1:20 PM observed standing in no parking zone, smo- During an interview w 5/01/19 at 3:00 PM, h no-smoking facility. T smoking policy in the new residents would admission. The AD st were assessed for sm alert, oriented, capab	ad to have many cigarette on the pavement and in the between the parking lot and Discarded cigarette butts in the pine straw mulch ar the front door. No intainers were observed in AM an interview with onducted. He stated he had id had no problems or is short time in the facility. e to do most things AM Resident #356 had been the facility parking lot, in the oking. When he finished his shed the cigarette butt on it the butt. Resident #356 had been the facility parking lot, in the oking.				

Facility ID: 923197

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	-	D HUMAN SERVICES				FORM	: 06/10/2019 APPROVED
STATEMENT (S FOR MEDICARE & I OF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	E CONSTRUCTION		OMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED	
		345061	B. WING		_	05/0	02/2019
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, S	TATE, ZIP CODE	-	
PRUITTHE	ALTH-DURHAM			3100 ERWIN ROAD DURHAM, NC 27705			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 689	All smoking materials medication carts, and them to the resident w also stated, based on residents would go to stated people who we smoke and he had no stated when it was ho people waiting for the covered porch and so stated he had no cont alert and oriented and were assessed as saf residents were not mo night when going outs the facility was a no-s not monitor the smoki he would check peopl remind them that this The AD also stated th sand buckets for the o building as this would smoke. On 5/02/19 at 12:50 F #1 was conducted. Th #356 was alert, orient known and was ambu device. Resident #356 safe to smoke and wo smoke. On 5/02/19 at 10:35 A the AD was conducted zone area was on the further stated there w residents in the facility	d to go outside and smoke. were kept locked in the the nurse would provide when requested. The AD the location of the building, the bus stop to smoke. He re waiting for the bus would control over that. The AD t, cold or rainy weather, bus would utilize the metimes smoke. He further rol over residents who were would like to go out or who e smokers. The AD stated onitored in the evening or side to smoke. He stated as moking facility, the staff did ng residents. The AD stated e at various times and was a smoke-free facility. ere were no ash trays or sigarette butts in front of the encourage residents to PM an interview with Nurse he nurse stated Resident ed, could make his needs latory without an assistive b had been assessed as build sign himself out to M a follow up interview with d. He stated the no parking facility property. The AD ere currently no smoking	F 68				

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		D HUMAN SERVICES MEDICAID SERVICES				FOF	ED: 06/10/2019 RM APPROVED IO. 0938-0391
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DAT	E SURVEY IPLETED
		345061	B. WING			0	5/02/2019
NAME OF PROVIDER (OR SUPPLIER		1	ST	TREET ADDRESS, CITY, STATE, ZIP CODE	•	
PRUITTHEALTH-D	URHAM				100 ERWIN ROAD DURHAM, NC 27705		
	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIZ TAG	<	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
 had be admiss they ar propert to end were ner further follow to and po F 761 Label/S SS=E SS=E SS=E SK483.4 Drugs a labeled profess approp instruct applica \$483.4 S483.4 <li< td=""><td>sion the smokin re told that they ty to smoke. He up in that part of on-compliant w stated he would the rules and for licies. Store Drugs and biologicals to and biologicals of a cordance sional principles riate accessory tions, and the e able. 5(h) Storage of 5(h)(1) In acco a laws, the facilic cals in locked of a ture controls, nel to have acco 5(h)(2) The face of controlled of mprehensive D I Act of 1976 ar except when the g drug distribu y stored is mini- dily detected.</td><td>ct. The AD stated upon g policy is explained and must stay off of the facility e stated the smokers seem of the parking area and rith the smoking rule. He d expect the residents to or staff to enforce the rules d Biologicals</td><td></td><td>761</td><td></td><td></td><td>5/28/19</td></li<>	sion the smokin re told that they ty to smoke. He up in that part of on-compliant w stated he would the rules and for licies. Store Drugs and biologicals to and biologicals of a cordance sional principles riate accessory tions, and the e able. 5(h) Storage of 5(h)(1) In acco a laws, the facilic cals in locked of a ture controls, nel to have acco 5(h)(2) The face of controlled of mprehensive D I Act of 1976 ar except when the g drug distribu y stored is mini- dily detected.	ct. The AD stated upon g policy is explained and must stay off of the facility e stated the smokers seem of the parking area and rith the smoking rule. He d expect the residents to or staff to enforce the rules d Biologicals		761			5/28/19

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	OF DEFICIENCIES	MEDICAID SERVICES				O. 0938-03
ND PLAN OF CORRECTION IDENTIFICATION NUMBER: 345061		. ,	(X2) MULTIPLE CONSTRUCTION A. BUILDING			
		B. WING		0	05/02/2019	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZI	P CODE	
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 (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETIO DATE
F 761	Continued From page	e 29	F 76	1		
	by:					
		ns and staff interviews the		Corrective action the res		
	-	ve one expired container of		have been affected by th	e deficient	
		ed insulin pen injector,		practice:		
	-	late of opening for one , stored in 3 of 6 medication		All residents are affected	I On 5/3/2019 all	
		100 hall and 300 hall).		6 medication carts were		
				by the Director of Health		
	Findings included:			Managers and the Clinic		
				Coordinator. Any expired		
		AM, observation of the		and undated medications		
	medication administration cart on 300 short hall, with Nurse #3, revealed opened medication			and returned to the phar	• • • •	
		i dose vial, 100 units/ml		Corrective action for othe having the potential to be		
	(milliliter), 10 ml, with			same deficient practice:		
		M, during an interview,		All residents have the po		
		at the nurses, who worked		affected by the deficient		
		rts, were responsible to hing on the multi dose vial of		5/3/2019, all 6 medicatio checked/audited by the I		
		xpired medications from the		Services, Unit Managers		
	medication administra	-		Competency Coordinato		
		sulin was opened but she did		and undated and undate	• •	
		on during her shift. The		were removed and return	ned to the	
		ed the insulin multi dose vial		pharmacy per policy.		
	in her medication adm			Quotomia abarrar 1	to oppute that	
	beginning of her shift			Systemic changes made the deficient practice will		
	2.On 4/30/19 at 9:30	AM, observation of the				
		ation cart on 300 long hall,		On 5/6/2019, the Clinical	I Competency	
		ed one container of Vitamin		Coordinator and the Dire		
		, 100 tablets, expired in		Services educating the L		
	June 2018.			on Labeling/Storage of E		
	On 4/20/10 -+ 0.25 AL	A during on interview		Biologicals. All licensed i		
		M, during an interview, at the nurses, who worked		educated by 5/25/2019. nurses will review their a		
		rts, were responsible to		medication rooms and m	-	
		cations from the medication		for unlabeled medication		
		he nurse confirmed that she		as well as expired medic	-	

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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 345061 B. WING 05/02/2019 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 761 Continued From page 30 F 761 did not use this medication during her shift. The Biologics daily for 7 days then weekly nurse had not checked the expiration dates in her thereafter. The licensed nurse review will medication administration cart at the beginning of be given to the Director of Health Services her shift. to validate the removal of all expired and/or unlabeled medications and 3.On 4/30/19 at 9:50 AM. observation of the biologics. The Consultant Pharmacist will medication administration cart on 100 long hall. review the medication rooms and with Nurse #1, revealed one expired Novolog medication carts for expired and/or (insulin) Flex Pen, 100 units/ml, 3 ml. Per the unlabeled medications and biologics label on the insulin pen, it was opened on monthly. 3/28/19. Review of the manufacturer 's literature/information (or package insert) Plans to monitor its performance to make recommended to discard the Novolog Flex Pen sure that solutions are sustained: 28 days after opening, which would have been on 4/25/19. The Director of Nursing and/or Nurse Mangers will validate the License Nurse On 4/30/19 at 9:55 AM, during an interview, review of the Medication rooms and Nurse #1 indicated that the nurses, who worked medication carts daily for 7 days then on the medication carts, were responsible to weekly thereafter for 4 weeks then remove expired medications from the medication monthly thereafter. The Consultant Pharmacist will review the medication administration cart. The nurse confirmed that the insulin pen was expired. The nurse had not check rooms and medication carts for expired the expiration date on Novolog Flex Pen in his and/or unlabeled medications and medication administration cart at the beginning of biologics monthly. The Director of Health the shift. Services will present an analysis of their review to On 5/2/19 at 2:55 PM, during an interview, the the Quality Assurance Performance Director of Nursing indicated that all the nurses Improvement committee monthly until 3 were responsible to put date of opening on insulin consecutive months of compliance is pens and multi dose vials, check all the sustained then quarterly. medications in medication administration carts for expiration date and remove expired medications. Date of Compliance: 5/28/2019 Her expectation was that no expired items be left in the medication carts. F 867 **QAPI/QAA** Improvement Activities F 867 5/28/19 CFR(s): 483.75(g)(2)(ii) SS=D §483.75(g) Quality assessment and assurance.

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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 345061 B. WING 05/02/2019 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 867 Continued From page 31 F 867 §483.75(g)(2) The quality assessment and assurance committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; This REQUIREMENT is not met as evidenced bv: Based on staff interviews, and record review the Corrective action the resident found to facility's Quality Assessment and Assurance have been affected by the deficient (QAA) Committee failed to maintain implemented practice: procedures and monitor the interventions that the Resident #355 still resides in the facility. committee put into place following a recertification The quarterly assessment was completed survey in March 2018 and subsequently recited in on 5/2/2019 by the MDS Director. May 2019 on the current recertification survey. Corrective action for other residents The recited deficiency was in the area of develop having the potential to be affected by the a quarterly Minimum Data Set assessment at same deficient practice: least every 3 months. The deficiency was recited in the current recertification survey. The The Administrator and the Director of continued failure of the facility during two federal Health Services educated on the Quality surveys of record shows a pattern of the facility's Assurance and Performance inability to sustain an effective Quality Assurance Improvement policy/process for members (QA) Program. of the QA Committee with emphasis on identifying areas that may lead to The findings included: deficiency practice. Education will be completed by 5/25/2019. Administrator will lead Quality Assurance and Performance The tag was cross referenced to: Improvement meetings with emphasis F 638 - Quarterly assessments at least every 3 and focus on ensuring that any areas on months. non-compliance are addressed to prevent Based on record review and staff interviews, the further deficient practices related facility failed to complete a quarterly assessment completing quarterly MDS assessment. At least a member of the regional team that for 1 of 24 residents who had Minimum Data Set (MDS) assessments reviewed (Resident #355). includes senior nurse consultant, clinical reimbursement consultant or area vice During the previous recertification survey on president will attend QAPI meetings for 3 3/29/18 the facility failed to complete a guarterly quarters. MDS assessment within 92 days of the previous MDS assessment for 2 of 6 residents (Resident Systemic changes made to ensure that

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CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPL	(X2) MULTIPLE CONSTRUCTION				
ND PLAN OI	- CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		COMPLETED		
345061		B. WING	05/02/2019				
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE				
PRUITTHEALTH-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 COMPLETIC		
F 867	Continued From page	e 32	F 867	7			
	#10 and Resident # 3	359) reviewed.		the deficient practice will not recur:			
	Administrator indicate (QA) committee 1) id does a root cause an audits and monitors to the outcome. The Adv was a work in progre any deficient practice the QAPI and the tim based on the severity monitoring tools were outcomes, and impro-	During an interview on 5/2/19 at 6:50 PM, the Administrator indicated the Quality Assurance (QA) committee 1) identifies areas of concern, 2) does a root cause analysis, 3) develops a plan, audits and monitors that plan and 4) discusses the outcome. The Administrator indicated QAA was a work in progress. The Administrator stated any deficient practice identified was addressed in the QAPI and the time line for monitoring was based on the severity of the deficiency. The monitoring tools were used for tracking the butcomes, and improvements and training to staff were done accordingly.		The Quality Assurance and Perform Improvement committee will continu- monitor implemented procedures a monitor the plan of correction (POC in place for Tag F638 monthly until consecutive months of compliance maintained then quarterly thereafte Quality Assurance and Performance Improvement committee will meet r to review the tracking and trending analysis of areas that led to a repea- tag/deficiency. The facility will deve retrospective plan to examine faciliti standards and ensure no repeat cit Plans to monitor its performance to sure that solutions are sustained: Administrator will lead Quality Assu	ually nd (2) put 3 is r.The e nonthly at dop a ty ations. make		
				and Performance Improvement me monthly with emphasis and focus o areas that have led to repeated def (Tag F638). This will ensure the fac identifying areas on non-complianc addressing them as needed to prev further deficient practice related to Quarterly MDS assessments. A me of the regional team that includes th senior nurse consultant, clinical reimbursement consultant or Area V President will attend QAPI meeting the next 3 months and then quarter quarters to ensure the QAPI process effective. The administrator will rep the Quality Assurance and Perform Improvement Committee any areas non-compliance monthly for 3 monther the context of the second second second second the second second second second second second the second second second second second second the second second second second second second second the second second second second second second second the second second second second second second second second second second the second seco	etings n iciency ility is e and vent ember ne Vice s for ly for 3 es is ort to ance s of		

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		MEDICAID SERVICES				IO. 0938-039 E SURVEY
IND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		. ,	(X2) MULTIPLE CONSTRUCTION A. BUILDING			
		345061	B. WING		0	5/02/2019
NAME OF P	ROVIDER OR SUPPLIER	•	S	TREET 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 CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETIO DATE
F 867	Continued From page	e 33	F 867	then quarterly and/or as needed for quarters for further recommendation compliance is sustained. Date of Compliance: 5/28/2019		
F 880 SS=D	Infection Prevention a CFR(s): 483.80(a)(1)		F 880			5/28/19
	 CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; 					
	procedures for the pr but are not limited to:	llance designed to identify ble diseases or / can spread to other				

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	: 06/10/2019 APPROVED
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION A. BUILDING			OMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED	
		345061	B. WING		_	05/0	02/2019
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, ST	ATE, ZIP CODE		
				3100 ERWIN ROAD			
PRUITIN	EALTH-DURHAM		1	DURHAM, NC 27705			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 880	communicable diseas reported; (iii) Standard and tran to be followed to prev (iv)When and how iso resident; including but (A) The type and dura depending upon the in involved, and (B) A requirement tha least restrictive possific circumstances. (v) The circumstances must prohibit employed disease or infected sk contact with residents contact will transmit th (vi)The hand hygiene by staff involved in dir §483.80(a)(4) A syster identified under the far corrective actions take §483.80(e) Linens. Personnel must hand transport linens so as infection. §483.80(f) Annual rev The facility will condu- IPCP and update thei This REQUIREMENT by: Based on observation interviews, the facility contamination of sciss	n possible incidents of the or infections should be smission-based precautions ent spread of infections; lation should be used for a t not limited to: ation of the isolation, infectious agent or organism t the isolation should be the ble for the resident under the s under which the facility ees with a communicable tin lesions from direct to or their food, if direct he disease; and procedures to be followed rect resident contact. Im for recording incidents cility's IPCP and the en by the facility. le, store, process, and to prevent the spread of	F 880		he resident found to t by the deficient		

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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 345061 B. WING 05/02/2019 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 880 Continued From page 35 F 880 on a wound dressing during the wound treatment Resident # 96 still resides in the facility. procedure for 1 of 2 residents, Resident #96. On 5/3/2019, Nurse #5 was educated on cross contamination. On 5/6/2019, nurse Findings included: #5 was observed doing wound dressing on resident #96 by the Director of Health Resident #96 was admitted to the facility on Services to ensure no cross 6/29/18. Review of his recent Quarterly Minimum contamination. Data Set assessment, dated 4/16/19, revealed Corrective action for other residents the resident had severe impaired cognition. Resident 96 's diagnoses included pressure having the potential to be affected by the same deficient practice: ulcers, chronic right foot osteomyelitis (bone infection), and moderate protein-calorie malnutrition. The resident required total On 5/6/2019, the Director of Health assistance with activities of daily living, received Services (DHS), Unit Managers, the indwelling urinary catheter and was always Clinical Competency Coordinator and the incontinent for bowel. Treatment Nurse reviewed all residents with wounds using the weekly wound Resident 96's plan of care, dated 4/23/19, report to ensure treatments were being reflected his potential and actual skin integrity done as ordered by the physician. On issues, compromised healing process of resident 5/3/2019, Nurse #5 was educated on 's wounds, due to multiple diseases and cross contamination during wound conditions with appropriate goals and dressing change. On 5/6/2019, education interventions. was initiated by the DHS and the Clinical Competency Coordinator for all licensed On 5/1/19 at 10:10 AM, an observation was nurses on cross contamination during conducted of pressure ulcer treatment for wound dressing changes to ensure no Resident #96, provided by Nurse #5, wound cross contamination for all other residents treatment nurse and Nurse #6. There were three with wounds. pressure ulcers noted: stage IV pressure ulcer on the right heel, unstageable pressure ulcer on the Systemic changes made to ensure that left lateral foot, and stage II pressure ulcer on the the deficient practice will not recur: sacral area. On 5/6/2019, the Director of Health a.During the treatment of the right heel and left Services (DHS), Unit Managers, the lateral foot wounds. Nurse #5 washed her hands Clinical Competency Coordinator and the and donned clean gloves to remove the old Treatment Nurse reviewed all residents dressing. After she removed the old dressing, the with wounds using the weekly wound nurse removed the gloves, washed her hands report to ensure treatments were being and donned clean gloves to apply medication to done as ordered by the physician. On

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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 345061 B. WING 05/02/2019 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 880 Continued From page 36 F 880 the wounds. After applying the medication, the 5/3/2019, Nurse #5 was educated on nurse was observed removing the gloves, cross contamination during wound washing her hands and donning clean gloves to dressing change. On 5/6/2019, education apply the new dressing. After the nurse applied for other nurses (charge nurses and Unit the new dressing, Nurse #5 reached her right Managers/Supervisors) was initiated by pocket, pulled out the scissors, and cut the extra the DHS and the Clinical Competency gauze from the dressing on the right heel and left Coordinator for all licensed nurses on foot, and put the scissors back in her pocket. cross contamination during wound dressing changes. The education will be b.During the treatment of the sacrum wound, completed by 5/25/2019. Charge Nurses, Nurse #5 washed her hands and donned clean Unit Managers/Supervisors who have not gloves to remove the old dressing. After she completed the education will not be removed the old dressing, the nurse removed the allowed to work until they are educated. gloves and donned clean gloves, without washing All newly hired charge nurses, Unit her hands, to apply medication to the wounds. Managers/Supervisors will be educated After applying the medication, the nurse was on cross contamination during wound observed removing the gloves, washing her dressing changes during new hire orientation by the Clinical Competency hands and donning clean gloves to apply the new Coordinator and/or the Director of Health dressing. After the nurse applied the new dressing, Nurse #5 reached her right pocket, Services. The Director of Health Services pulled out the black marker, wrote the date on and/or the Clinical Competency dressing and placed the marker back. Coordinator will observe the nurses perform a return a return demonstration. On 5/1/19 at 4:30 PM, during an interview, Nurse #5 indicated that she followed the clean technique Plans to monitor its performance to make in wound treatment, as well as infection control sure that solutions are sustained: policy and used personal protective equipment. She was aware that it is required to wash her The Director of Health Services and the hands between changing gloves during the **Clinical Competency Coordinator will** procedure of wound treatment. The nurse observe treatment nurses daily for 5 days, confirmed that it is not appropriate to touch the then weekly for 4 weeks and, then scissors or highlighter in her pocket with monthly until 6 consecutive months of contaminated gloves. compliance are sustained. The Director of Health Services will report any areas of On 5/2/19 at 2:35 PM, during an interview, Nurse non-compliance to the Quality Assurance #7, infection control nurse, confirmed that the and Performance Improvement staff must wash hands prior to use clean gloves, committee monthly for further regardless of performing procedure. She recommendations until 6 consecutive indicated that she provided mandatory infection months of compliance are sustained.

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		ID HUMAN SERVICES MEDICAID SERVICES			FORM	D: 06/10/2019 MAPPROVED D. 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		05/02/2019		
NAME OF PI	ROVIDER OR SUPPLIER	•		TREET 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 CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 880	individual reeducation explained that in Janu demonstrated the skil including clean techn hygiene. On 5/2/19 at 2:55 PM Director of Nursing ex infection control polic	entation, annually, plus n as needed. The nurse uary 2019, all the employees lls, according to checklist, ique and proper hand l, during an interview, the spected the staff to follow	F 880			

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Facility ID: 923197

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