| | - | ND HUMAN SERVICES | | | | | FORM APPROVED |
|---------------|-------------------------|---|---------------|--------|--|-----|-----------------------------|
| | | | | | | | AB NO. 0938-0391 |
| | OF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | · · · | | ISTRUCTION | (X3 | B) DATE SURVEY COMPLETED |
| | | | | ° | | | с |
| | | 345061 | B. WING | | | | 10/27/2022 |
| NAME OF PI | ROVIDER OR SUPPLIER | | | STREE | TADDRESS, CITY, STATE, ZIP CODE | I | |
| DOLUTTU | | | | 3100 B | ERWIN ROAD | | |
| PRUITIN | EALTH-DURHAM | | | DUR | IAM, NC 27705 | | |
| (X4) ID | | | ID | | PROVIDER'S PLAN OF CORRE | | (X5) COMPLETION |
| PREFIX TAG | · · · | Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | PREFIX TAG | | (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP | | DATE |
| | | | | | DEFICIENCY) | | |
| | | | | | | | |
| E 000 | Initial Comments | | E 00 | 00 | | | |
| | | | | | | | |
| | | certification survey was | | | | | |
| | facility was found in c | 22 through 10/27/22. The | | | | | |
| | requirement CFR 483 | • | | | | | |
| | Preparedness. Even | | | | | | |
| F 000 | INITIAL COMMENTS | 8 | F 00 | 00 | | | |
| | | | | | | | |
| | A recertification and | complaint survey was | | | | | |
| | | 0/2022 through 10/27/2022. | | | | | |
| | | resulted in immediate | | | | | |
| | | E Jeopardy was identified at 684 at a scope and severity | | | | | |
| | | tuted Substandard Quality of | | | | | |
| | Care. | | | | | | |
| | | | | | | | |
| | | began on 7/27/22 and was | | | | | |
| | conducted. | 2. An extended survey was | | | | | |
| | conducted. | | | | | | |
| | The following intakes | were investigated | | | | | |
| | NC00192562, NC001 | 192689, NC00191451, | | | | | |
| | - | 193685, NC00190458, | | | | | |
| | NC00192220,NC001 | 92549 and NC00192664. | | | | | |
| | Six of the 29 complai | nt allegations were | | | | | |
| | | ng in deficiencies (F550, | | | | | |
| | F561, F677, F684, F6 | | | | | | |
| F 550 | Resident Rights/Exer | rcise of Rights | F 5 | 50 | | | 11/21/22 |
| SS=D | CFR(s): 483.10(a)(1) | (2)(b)(1)(2) | | | | | |
| | §483.10(a) Resident | Rights | | | | | |
| | | ght to a dignified existence, | | | | | |
| | self-determination, ar | nd communication with and | | | | | |
| | - | nd services inside and | | | | | |
| | - | cluding those specified in | | | | | |
| | this section. | | | | | | |
| | | | | | דודו ה | | |
| | | SUPPLIER REPRESENTATIVE'S SIGNATUF | ΣE | | TITLE | | (X6) DATE 11/17/2022 |
| Election | cally Signed | | | | | | 11/17/2022 |

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.

| | - | ID HUMAN SERVICES MEDICAID SERVICES | | | | FORM | APPROVED 0. 0938-0391 |
|--------------------------|--|---|--------------------|-----|--|-------------------|----------------------------|
| STATEMENT (| DF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | · / | | E CONSTRUCTION | (X3) DATE COMP | SURVEY LETED |
| | | 345061 | B. WING | | | | C 27/2022 |
| 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 .SC IDENTIFYING INFORMATION) | ID PREFI TAG | х | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY) | | (X5) COMPLETION DATE |
| F 550 | §483.10(a)(1) A facilit with respect and dign resident in a manner a promotes maintenanch her quality of life, reco individuality. The facil promote the rights of §483.10(a)(2) The faci access to quality care severity of condition, a must establish and m practices regarding tra- provision of services of residents regardless of §483.10(b) Exercise of the resident has the rights as a resident of or resident of the Unit §483.10(b)(1) The fac resident can exercise interference, coercion from the facility. §483.10(b)(2) The res free of interference, c reprisal from the facili rights and to be suppor exercise of his or her subpart. This REQUIREMENT by: Based on observatio and staff interviews, t resident rights, failed | y must treat each resident ity and care for each and in an environment that we or enhancement of his or ognizing each resident's ity must protect and the resident. We regardless of diagnosis, or payment source. A facility aintain identical policies and ansfer, discharge, and the under the State plan for all of payment source. | F | 550 | Corrective action for the residents four to be affected by the deficient practice. In-servicing was conducted by the Director of Health Services (DHS) on | | |

Facility ID: 923197

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| | S FOR MEDICARE & | | | | | 10. 0938-03 |
|--------------------------|------------------------|--|---------------------|--|-----------------------------------|---------------------------|
| | CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | | TE SURVEY MPLETED |
| | | 345061 | B. WING | | 1 | C 0/27/2022 |
| NAME OF P | ROVIDER OR SUPPLIER | · | | STREET ADDRESS, CITY, STATE, ZIP C | CODE | |
| PRUITTHE | ALTH-DURHAM | | | 3100 ERWIN ROAD DURHAM, NC 27705 | | |
| | | | | , | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC | FION SHOULD BE THE APPROPRIATE | (X5) COMPLETIO DATE |
| F 550 | Continued From page | e 2 | F 550 | D | | |
| | | | | 10/08/22 with NA #3 and N | lurse #12 on | |
| | Findings included: | | | providing privacy to reside | | |
| | | | | providing activities of daily | | |
| | | ed to the facility on 4/15/22 | | The education included the | • | |
| | • | hat included a history of type | | curtains around the resider | | |
| | 2 diabetes meilitus, n | ypertension, hypothyroidism, | | providing care and waiting from the resident or staff m | | |
| | anu asunna. | | | a closed door before enter | | |
| | A review of Resident | #86's quarterly minimum | | room. | ing a resident | |
| | | d 8/26/22 revealed Resident | | | | |
| | was cognitively intact | | | Corrective action for other | residents | |
| | | | | having the potential to be a | affected by the | |
| | During an observatio | n on 10/13/22 at 10:23 am | | same deficient practice. | | |
| | | Resident #86's room door | | | | |
| | | viding activities of daily living | | All residents have the pote | | |
| | | #3 stated patient care when | | affected by the alleged def | • | |
| | | 1 door, however Nurse # 12 | | In-servicing was conducted | - | |
| | | bom door. Resident #86 was | | Director of Health Services | · / | |
| | | er body exposed and privacy d while room door was open. | | the Clinical Competency C (CCC) to all employees on | | |
| | | she was doing covid testing | | and specifically their right t | • | |
| | and gestured with ha | č | | 11/08/22 through 11/14/22 | | |
| | | ne room. NA #3 again stated | | educated by 11/21/22 will I | | |
| | "patient care" and Nu | rse #12 then closed room privacy curtain at that time. | | prior to their next schedule | | |
| | | - | | All new hires will receive e | | |
| | | iducted on 10/13/22 at 10:39 | | Resident Rights, specifical | - | |
| | | 6 and she indicated she did | | resident s right to privacy | during their | |
| | | e walked in room while she are. She stated, "I did not | | general orientation. | | |
| | | like I don't have no privacy, | | Systemic changes made to | ensure that | |
| | | d". Resident #86 indicated | | the deficient practice will n | | |
| | | ull the privacy curtain while | | | · | |
| | giving ADL care. | | | Director of Health Services Department Managers will | | |
| | An interview was con | nducted on 10/13/22 at 11:10 | | employees knocking on re- | | |
| | | he indicated she should | | and waiting for response fr | | |
| | | curtain but forgot to pull it. | | and/or employee prior to e | | |
| | | č 1 | | resident⊡s room to ensure | | |

Facility ID: 923197

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| | | | | E CONSTRUCTION | | |
|---------------|-------------------------|--|---------------|--|-------|--------------------|
| | OF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | . , | | · · · | E SURVEY PLETED |
| | | | A. BUILDING | | | С |
| | | 345061 | B. WING | | | 0 /27/2022 |
| | ROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP CODE | 1 10 | 2112022 |
| | | | | 3100 ERWIN ROAD | | |
| PRUITTHE | EALTH-DURHAM | | | DURHAM, NC 27705 | | |
| (X4) ID | SUMMARY ST | ATEMENT OF DEFICIENCIES | ID | PROVIDER'S PLAN OF CORRECT | ON | (X5) |
| PRÉFIX TAG | | Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | PREFIX TAG | (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY) | | COMPLETION |
| F 550 | Continued From page | e 3 | F 550 | | | |
| | During an interview o | n 10/13/22 at 11:20 am with | | being provided during Activities of [| Daily | |
| | | ted she did not hear NA #3 | | Living (ADL) care. This review will d | | |
| | | she was not aware that | | for 5 residents 3 times a week for 4 | | |
| | | covered. She indicated she | | and then 5 residents monthly times | 3 | |
| | | or Resident response before | | months to ensure privacy is being | | |
| | she entered room. | | | provided during Activities of Daily L (ADL) care. | iving | |
| | On 10/13/22 at 1:06 p | om an interview was | | (ADL) care. | | |
| | | irector of Nursing (DON), | | Plans to monitor its performance to | make | |
| | | rse #12 was a new Nurse | | sure that the solutions are sustaine | | |
| | and new to the facility | y. She indicated Nurse # was | | | | |
| | in orientation, and be | lieved it was a cultural | | The Director of Health Services (DI | , | |
| | | t understand what was | | report findings of the employees by | | |
| | | aid patient care. The DON | | knocking on doors and waiting for r | | |
| | | she should have knocked on | | and/or employee response to ensur | | |
| | room before opening | o be instructed to come in | | privacy is maintained to the Quality Assurance Performance Improvem | | |
| | | xpectation that the privacy | | (QAPI) for review and revision mon | | |
| | | nile providing ADL care. | | months or until substantial compliant achieved. | | |
| | | vith the Administrator on | | | | |
| | | she indicated she was | | | | |
| | | and NA #3 not providing | | Date of compliance: 11/21/22 | | |
| | | #86 while she was receiving | | | | |
| | | ated Nurse #12 was in g a task. She further | | | | |
| | indicated it was her e | • | | | | |
| | | s room doors and waited for | | | | |
| | | eeding and privacy curtains | | | | |
| | to be pulled while pro | viding ADL care. | | | | |
| F 561 | Self-Determination | | F 56 | 1 | | 11/21/22 |
| SS=E | CFR(s): 483.10(f)(1)- | (3)(8) | | | | |
| | §483.10(f) Self-deteri | mination. | | | | |
| | , | right to and the facility must | | | | |
| | promote and facilitate | e resident self-determination | | | | |
| | | sident choice, including but | | | | |
| | not limited to the righ | ts specified in paragraphs (f) | | | | |

Facility ID: 923197

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| | - | ID HUMAN SERVICES MEDICAID SERVICES | | | | FORM | APPROVED 0. 0938-0391 |
|--------------------------|---|---|------------------------|---|--|-------------------------------|----------------------------|
| STATEMENT (| DF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULT A. BUILDI | | NSTRUCTION | (X3) DATE SURVEY COMPLETED | |
| | | 345061 | B. WING | | | | C 27/2022 |
| NAME OF PI | ROVIDER OR SUPPLIER | | -1 | STRE | ET ADDRESS, CITY, STATE, ZIP CODE | | |
| | | | | 3100 | ERWIN ROAD | | |
| PRUITTHE | EALTH-DURHAM | | | DUR | HAM, NC 27705 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | × | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | | (X5) COMPLETION DATE |
| F 561 | (1) through (11) of this §483.10(f)(1) The rest activities, schedules (waking times), health care services consists assessments, and pla applicable provisions §483.10(f)(2) The rest choices about aspect facility that are signified §483.10(f)(3) The rest vith members of the original community activities to facility. §483.10(f)(8) The rest participate in other activities to facility. §483.10(f)(8) The rest participate in other activities to facility. Shased on record revision interviews, the facility preference for a show to allow residents the their assigned room vito covid-19 outbreak ((FR esident #54, and Rest residents reviewed for Findings included: 1.Resident #92 was a 9/13/22. Review of the facility. | s section. ident has a right to choose including sleeping and care and providers of health ent with his or her interests, an of care and other of this part. ident has a right to make s of his or her life in the cant to the resident. ident has a right to interact community and participate in both inside and outside the ident has a right to trivities, including social, nity activities that do not ts of other residents in the T is not met as evidenced ew, staff and resident failed to honor a resident's ver (Resident #92) and failed right to choose to leave while the facility was in a Resident #13, Resident #20, esident #26) for 5 of 7 r choices. | F | tt C((# tt S o s a C | Corrective action for the residents four o be affected by the deficient practice. On 11/16/22 the facility Social Workers SW) informed residents #92, #13, #20 54 and #26 of their Resident Rights at he current Covid-19 guidelines. Specifically, their right to choose Activit of Daily Living (ADL) care including howers and/or bed baths, dining, activities, and leaving their rooms durin Covid-19 outbreak. | , nd ies | |
| | | nt dated 9/18/22 indicated | | c | Corrective action for other residents | | |

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| | | ND HUMAN SERVICES | | | PRINTED: 12 FORM API OMB NO. 09 | PROVE |
|---------------|---|---|---------------|---|---------------------------------------|-----------------|
| | DF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | . , | E CONSTRUCTION | (X3) DATE SURVEY COMPLETED | |
| | | 345061 | B. WING | | C 10/27/2 |)22 |
| NAME OF P | ROVIDER OR SUPPLIER | • | | STREET ADDRESS, CITY, STATE, ZIP CODE | • | |
| PRUITTHE | EALTH-DURHAM | | | 3100 ERWIN ROAD DURHAM, NC 27705 | | |
| (X4) ID | SUMMARY ST | ATEMENT OF DEFICIENCIES | ID | PROVIDER'S PLAN OF CORREC | CTION | (X5) |
| PREFIX TAG | | Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | PREFIX TAG | (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY) | | IPLÉTIO DATE |
| F 561 | Continued From page | e 5 | F 561 | 1 | | |
| | the assessment was in process. The resident was assessed as cognitively intact. Resident's Activity of Daily Living (ADL) was assessed as | | | having the potential to be affected same deficient practice. | l by the | |
| | requiring total dependent | dence of one person for t did not exhibit rejection of | | All residents have the potential to affected by the alleged deficient p The Activity Director held a reside council meeting on 11/11/22 to re | ent | |
| | the resident received | 9/13/22 to 10/11/22 revealed complete bed baths on | | Resident Rights Self-Determina current Covid-19 guidelines relate Resident Activities of Daily Living | ed to (ADL) | |
| | 10/5/22, and 10/7/22 partial bed baths on 9 | 3/22, 9/28/22, 10/4/22, . Resident #92 received 9/24/22, 9/26/22, 9/27/22, /as no documentation of the | | care including showers and/or be dining, activities, and leaving their during a Covid-19 outbreak. All al oriented residents that did not atte | r rooms ert and | |
| | resident receiving an | | | given a copy of Resident Rights Determination and the current Co guidelines on Resident Activities a | Self vid-19 | |
| | Resident #92's sched | duled shower days were first shift (7:00 AM- 3:00 | | Dining. Letters were mailed on 11 those residents with designated F Representatives who are not aler oriented. | /17/22 to Resident | |
| | at 12:30 PM, Resider | n and interview on 10/10/22 nt #92 was observed sitting | | In-servicing was conducted by the | | |
| | observed to be well g indicated he was goin | elchair. Resident was proomed and clean. Resident ng out of the facility for a | | Director of Health Services (DHS) Clinical Competency Coordinator to all employees on 11/08/22 thro | (000) | |
| | not receive any show the facility (9/13/22). | . Resident #92 stated he did vers since his admission to Resident indicated he nree times a week. Resident | | 11/21/22 on the current Covid-19 guidelines and resident rights to self-determination. Employees no educated by 11/21/22 will be educ | cated | |
| | shower, he was infor | he requested staff for a med that due to COVID-19 y, the residents were not | | prior to their next scheduled shift. Education on the current Covid-19 | | |
| | offered showers. | | | guidelines and Resident Rights to Self-Determination will occur duri | ng new | |
| | Nurse Aide (NA) #6 s | on 10/12/22 at 10:40 AM, stated she was frequently ent and worked the first shift | | hire orientation for all employees. Systemic changes made to ensur | | |
| | (7:00 AM - 3:00 PM). | | | the deficient practice will not recu | r. | |

Facility ID: 923197

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| TATEMENT (| DF DEFICIENCIES CORRECTION | MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | , <i>i</i> | | E CONSTRUCTION | (X3) DATE SURVEY COMPLETED | |
|--------------------------|-------------------------------|---|-------------------|-----|---|-------------------------------|----------------------------|
| | | 345061 | B. WING | | | | C 10/27/2022 |
| NAME OF PI | ROVIDER OR SUPPLIER | • | | S | TREET ADDRESS, CITY, STATE, ZIP CODE | • | |
| PRUITTHE | EALTH-DURHAM | | | 3 | 100 ERWIN ROAD | | |
| | | | | D | URHAM, NC 27705 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | TATEMENT OF DEFICIENCIES TY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREF TAG | | PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY) |) BE | (X5) COMPLETION DATE |
| F 561 | Continued From page | e 6 | Í F | 561 | | | |
| | | rs every Thursday during | | | | | |
| | | cated the resident was totally | | | The Activity Director will review Resi | dent | |
| | | g and needed a shower bed. | | | Rights | | |
| | NA #6 stated residen | ts who needed a bariatric | | | Covid-19 guidelines on Activities of [| Daily | |
| | | er bed for showers needed | | | Living (ADL) care including showers | | |
| | | sement floor for showers in | | | and/or bed baths, dining, activities, a | | |
| | - | n that could accommodate | | | leaving their rooms during a Covid-1 | | |
| | | e bariatric shower chair. | | | outbreak during the Resident Counc | 11 | |
| | | sidents could not be offered shower rooms could not | | | meetings for the next 2 months. | | |
| | | wer bed or a bariatric shower | | | The Administrator and/or Social Wor | kor | |
| | chair. NA #6 indicate | | | | (SW) will interview 6 residents twice | | |
| | | y, NAs were made aware by | | | week for 4 weeks then, 6 residents v | | |
| | | t the residents could not | | | for 4 weeks to review understanding | - | |
| | - | d hence could not be taken | | | resident rights to self-determination | | |
| | downstairs. NA #6 fu | rther indicated the resident | | | the current Covid-19 guidelines rega | rding | |
| | required 2-person ph | - | | | Resident Activities of Daily Living (A | | |
| | showers and there w | | | | care including showers and/or bed b | | |
| | | odate the resident request. | | | dining, activities, and leaving their ro | oms | |
| | | nt was offered a complete | | | during a Covid-19 outbreak. | | |
| | bed bath or partial be | ed bath instead. | | | Diana ta magnitan ita nanfarmagna ta n | | |
| | During on interview of | on 10/13/22 at 2:03 PM, NA | | | Plans to monitor its performance to r sure that the solutions are sustained | | |
| | - | occasionally assigned to | | | The Administrator and/or Social Wor | | |
| | | the first. NA #1 stated due to | | | (SW) will report findings of the twice | | |
| | | in the facility, residents who | | | weekly and weekly resident and staf | f | |
| | | o the large shower room on | | | interviews. These findings will be bro | | |
| | the basement floor w | | | | to the monthly Quality Assurance | U | |
| | residents were offere | d a bed bath instead. | | | Performance Improvement (QAPI) | | |
| | | | | | meeting for review and revision mon | | |
| | | on 10/12/22 at 11:00 AM, | | | 3 months or until substantial complia | ince | |
| | | was the unit supervisor. | | | is achieved. | | |
| | | ed Resident #92 was offered | | | | | |
| | | bed bath almost daily. Nurse | | | Date of compliance: 11/21/22 | | |
| | #3 indicated to assist | r and offer shower would | | | | | |
| | | e the floor. This would mean | | | | | |
| | | ort staff and other residents' | | | | | |
| | | | 1 | | 1 | | 1 |

Facility ID: 923197

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| | - | ID HUMAN SERVICES MEDICAID SERVICES | | | | FOR | M APPROVED D. 0938-0391 |
|--------------------------|---|---|--------------------|----|---|-----------|----------------------------|
| STATEMENT | DF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | PLE CONSTRUCTION G | (X3) DATE | E SURVEY PLETED |
| | | 345061 | B. WING | | | | C / 27/2022 |
| NAME OF P | ROVIDER OR SUPPLIER | | • | | STREET ADDRESS, CITY, STATE, ZIP CODE | • | |
| | | | | | 3100 ERWIN ROAD | | |
| PRUITTHI | EALTH-DURHAM | | | | DURHAM, NC 27705 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY) | BE | (X5) COMPLETION DATE |
| F 561 | had 3-5 NAs assigned but usually the floor h who could be provide were offered showers offered bed baths. During an interview of Director of Nursing (D unaware of any policy residents would not b the COVID-19 outbreat there was adequate s offer showers to the m expected residents to showers as scheduled During an interview of Administrator indicate stated all residents an appropriate personal and could take the resi needed. All residents on shower days and a Staff were available to required care as need 2. Resident #26 was a 8/31/2022 with diagno diabetes mellitus, and An interview with Resi her room on 10/11/20 interview, Resident #2 staff due to the currer facility, she was unab the dining room and did m Resident #26 further in | d during 1st and 2nd shift ad only 3 NA's. Residents d showers in their rooms and other residents were n 10/12/22 at 11:15 AM, the OON) stated that she was y that indicated that e offered showers due to ak. The DON further stated thatf available if needed to esident. DON stated she be offered and given d and as requested. n 10/13/22 at 3:06 PM, the ed there was a policy that nd staff could wear the protective equipment (PPE) sidents to showers as should be offered showers as needed when requested. to assist the residents with ded. admitted to the facility on oses of heart failure, d non-Alzheimer's dementia. dident #26 was conducted in 22 at 9:05 A.M. During the 26 indicated she was told by nt Covid-19 outbreak in the le to leave her room to sit in | F | 56 | 51 | | |

Facility ID: 923197

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| | - | ID HUMAN SERVICES MEDICAID SERVICES | | | | | FORM APPR 18 NO. 0938 | ROVED |
|--------------------------|---|---|--------------------|----|--|----------|----------------------------|----------------------|
| STATEMENT (| DF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | LE CONSTRUCTION | |) DATE SURVEN COMPLETED | |
| | | 345061 | B. WING | | | | C 10/27/202 | 2 |
| NAME OF PI | ROVIDER OR SUPPLIER | L | I | | 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 PREFI TAG | | PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY) | LD BE | COMPI | (5) LETION ITE |
| F 561 | Meeting, with the survey was held on 10/12/20 meeting the residents #13, Resident #20, Re #26) each confirmed facility staff they were until two weeks after to test in the facility had An interview was comher room on 10/13/22 interview, Resident #7 when the facility had a result, staff told her di Covid-19 outbreak sta allowed to eat in the cigroup activities, or lead An interview was common 10/13/2022 at 11:42 Final Nurse #9 indicated with began two weeks price (IP) spoke with staff with was responsible for the facility. During the IP provided staff with was responsible for the outbreak when their rooms. An interview was compreventionist (IP) on During the interview, fill on the facility. During the staff with was responsible for the outbreak when their rooms. | vey a Resident Council veyor and four residents, 22 at 2:30 P.M. During the a in attendance (Resident esident #54, and Resident they had been told by all a unable to leave their room the last positive Covid-19 been identified. ducted with Resident #13 in a to 11:30 A.M. During the 13 indicated two weeks ago a positive Covid-19 test ue to the facility being in a atus they would not be dining room, participate in ave their rooms. ducted with Nurse #9 on P.M. During the interview, hen the Covid-19 outbreak or, the Infection Preventionist when the positive cases of ied and indicated residents poms due to the outbreak in a interview, she indicated the all the latest updates and elling staff at the conclusion residents were able to leave ducted with the Infection 10/12/2022 at 4:36 P.M. the IP indicated when the | F | 56 | | | | |
| (X4) ID PREFIX TAG | SUMMARY ST (EACH DEFICIENC REGULATORY OR L Continued From page over, and she was ab During the onsite surv Meeting, with the surv was held on 10/12/20 meeting the residents #13, Resident #20, R #26) each confirmed facility staff they were until two weeks after test in the facility had An interview was com- her room on 10/13/22 interview, Resident # when the facility had a result, staff told her du Covid-19 outbreak sta allowed to eat in the o group activities, or lead An interview was com- 10/13/2022 at 11:42 F Nurse #9 indicated wi began two weeks prio (IP) spoke with staff w Covid-19 were identiff were to stay in their ro the facility. During the IP provided staff with was responsible for te of the outbreak when their rooms. An interview was com- Preventionist (IP) on During the interview, facility was in a Covid | Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | PREFI | IX | DURHAM, NC 27705 PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY) | LD BE | | OMPI |

If continuation sheet Page 9 of 98

| CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION | OMB NO. 0938-0391 (X3) DATE SURVEY |
|---|---------------------------------------|
| AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | COMPLETED |
| 345061 B. WING | 10/27/2022 |
| NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE | |
| PRUITTHEALTH-DURHAM 3100 ERWIN ROAD DURHAM, NC 27705 | |
| (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIDEFICIENCY) | BE COMPLETION |
| F 561 Continued From page 9 help prevent the spread of the virus F 561 An interview was conducted with the Director of Nursing (DON) on 10/13/2022 at 1.15 P.M. The DON indicated if staff told residents to stay in their rooms, the staff had misunderstood the newest Covid-19 guidance. The DON further indicated residents who have tested negative for Covid-19 have no restrictions to their movements and are allowed outside of their rooms. An interview was conducted with the Administrator on 10/13/2022 at 12:15 P.M. During the interview, the Administrator indicated residents were allowed to leave their rooms and eat in the dining room. The Administrator stated there have been no positive cases on second floor and residents who resided on the third floor, where positive Covid-19 cases had been identified, had been asked not to enter the second floor to limit the spread of the Covid-19 outbreak. The Administrator indicated staff needed to explain the risks of exposure to residents and allow the residents to leave their rooms. F 580 F 580 Notify of Changes (Injury/Decline/Room, etc.) SS=K CFR(s): 483.10(g)(14)(1)-(iv)(15) S483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (ii) A significant change in the resident's physical, mental, or psychosocial status (that is, a | 11/21/22 |

Facility ID: 923197

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| | - | ID HUMAN SERVICES MEDICAID SERVICES | | | | FORM | M APPROVED 0. 0938-0391 | | | |
|--------------------------|---|---|--------------------|-----|---|-------------------|----------------------------|--|--|--|
| STATEMENT | DF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | E CONSTRUCTION | (X3) DATE COMP | SURVEY PLETED | | | |
| | | 345061 | B. WING | | | | C 27/2022 | | | |
| NAME OF P | ROVIDER OR SUPPLIER | | • | 5 | STREET ADDRESS, CITY, STATE, ZIP CODE | <u> </u> | - | | | |
| PRUITTHI | 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 PREFI TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY) | ЗE | (X5) COMPLETION DATE | | | |
| F 580 | status in either life-the clinical complications (C) A need to alter trea a need to discontinue treatment due to adve commence a new for (D) A decision to tran resident from the faci §483.15(c)(1)(ii). (ii) When making noti (14)(i) of this section, all pertinent informati- is available and provi- physician. (iii) The facility must a resident and the reside when there is- (A) A change in room as specified in §483. (B) A change in resid State law or regulation (e)(10) of this section (iv) The facility must r update the address (r phone number of the representative(s). §483.10(g)(15) Admission to a comp that is a composite di §483.5) must disclose its physical configural locations that compris part, and must specifi room changes betwe- under §483.15(c)(9). | a, mental, or psychosocial reatening conditions or); eatment significantly (that is, an existing form of erse consequences, or to m of treatment); or sfer or discharge the lity as specified in fication under paragraph (g) the facility must ensure that on specified in §483.15(c)(2) ded upon request to the also promptly notify the lent representative, if any, or roommate assignment I0(e)(6); or ent rights under Federal or ns as specified in paragraph ecord and periodically mailing and email) and | F | 580 | | | | | | |

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| | | ND HUMAN SERVICES MEDICAID SERVICES | | | | FOF | ED: 12/06/20 RM APPROVE IO. 0938-039 |
|--------------------------|---------------------------|---|--------------------|-----|---|-------|--|
| | DF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | · / | | CONSTRUCTION | | TE SURVEY MPLETED |
| | | 345061 | B. WING | | | 1 | C 0/27/2022 |
| NAME OF PI | ROVIDER OR SUPPLIER | | | S | TREET ADDRESS, CITY, STATE, ZIP CODE | | |
| PRUITTHE | EALTH-DURHAM | | | 3 | 100 ERWIN ROAD | | |
| | | | | D | URHAM, NC 27705 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | TATEMENT OF DEFICIENCIES DY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFI TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY) | BE | (X5) COMPLETION DATE |
| F 580 | Continued From pag | e 11 | F | 580 | | | |
| | | view, staff interviews, | | | Corrective action for the residents for | und | |
| | physician assistant a | nd physician interview, the | | | to be affected by the deficient practice | | |
| | facility failed to notify | pen wound to a resident's | | | Resident #293 no longer resides in th | e | |
| | right leg on 7/27/22 t | hat deteriorated in condition of 3 residents (Resident | | | facility. | ~ | |
| | | otification of change. This | | | Corrective action for other residents | | |
| | , | physician evaluation of the | | | having the potential to be affected by | the | |
| | | cian ordered treatments to | | | same deficient practice. | | |
| | | /22 the wound was assessed | | | | | |
| | by Nurse #7 with a fo | oul odor and on 8/13/22 | | | All residents have the potential to suff | er a | |
| | | physician of the wound, a | | | serious adverse outcome because of | the | |
| | | nt's condition, and the | | | failure to | - 1 | |
| | physician ordered for | | | | address/communicate/report/docume | nt | |
| | | spital. Resident #293 was al for septicemia (blood | | | identification/condition/status/size/app | oara | |
| | poisoning, especially | caused by bacteria or their elitis (inflammation of the | | | nce of a wound on a weekly basis. | Jeala | |
| | | ction) related to right leg | | | The Director of Health Services (DHS |) | |
| | wound. | | | | initiated 100% body audits on all resid | | |
| | | | | | within the facility on 10/20/22. The au | dit | |
| | | began on 7/27/22 when the | | | was completed on 10/21/22. There we | | |
| | | the physician of the open | | | no new skin integrity issues identified | by | |
| | | ident #293's right leg. The | | | comparing the known (current) skin | | |
| | | was removed on 10/22/22 vided an acceptable credible | | | integrity (wounds) on the wound mana report in the electronic medical record | - | |
| | | ate jeopardy removal. The | | | those residents currently in house to t | | |
| | | t of compliance at a scope | | | body audits completed on 10/20/2022 | | |
| | | ctual harm with potential for | | | The Director of Health Services (DHS | | |
| | more than minimal h | arm that is not immediate | | | and/or Nurse Managers have reviewe | | |
| | jeopardy) to ensure r | | | | the wound audits conducted on 10/20 | | |
| | | ective and to complete staff | | | 21/2022 and reviewed the documenta | | |
| | education. | | | | to ensure residents with skin impairme | | |
| | Findings included: | | | | had a physician □s order for treatment affected areas, physician notification a | | |
| | | | | | documentation of the | | |
| | Resident #293 was a | admitted to the facility on | | | condition/status/size/appearance of th | ne | |
| | 6/8/22. | | | | wound. | | |
| | | | | | The Director of Health Services (DHS |) | |

Event ID: GOU111

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| TATEMENT | OF DEFICIENCIES | MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA | (X2) MULTIF | LE CONSTRUCTION | (X3) DA | 10. 0938-03 TE SURVEY |
|--------------------------|------------------------|---|---------------------|--|------------|---------------------------|
| ND PLAN OF | CORRECTION | IDENTIFICATION NUMBER: | A. BUILDING | B | CON | MPLETED |
| | | 345061 | B. WING | | | С |
| | ROVIDER OR SUPPLIER | 345061 | B. WING | STREET ADDRESS, CITY, STATE, ZIP CODE | 1 | 0/27/2022 |
| NAME OF P | ROVIDER OR SUPPLIER | | | 3100 ERWIN ROAD | | |
| PRUITTHI | EALTH-DURHAM | | | DURHAM, NC 27705 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY) | HOULD BE | (X5) COMPLETIO DATE |
| F 580 | Continued From page | 12 | | | | |
| 1 000 | | | F 58 | and/or Nurse Managers began | aducation | |
| | | progress note dated 7/27/22 Nurse # 11 read in part | | to the Nurses on 10/20/22 regar | | |
| | | n open wound to his right | | weekly skin observations, docu | - | |
| | | ers were found. Wound was | | physician order and physician n | | |
| | packed with normal s | aline, damp to dry sterile | | When a new skin impairment is | noted, the | |
| | | with sterile gauze secured by | | Nurse will complete the wound | | |
| | , - | essing). Resident tolerated | | documentation in the electronic | | |
| | well. | | | record that includes description | | |
| | During a telephone in | nterview on 10/11/22 at 5:48 | | measurement of area and conta physician/physician extender fo | | |
| | - · | ne indicated, on 7/27/22 she | | regarding newly identified skin | orders, | |
| | 1 · | stant (NA) #4 asked for | | impairments and/or worsening s | kin | |
| | - | care to Resident #293. She | | impairments for wound treatment | | |
| | | went to turn the Resident, | | This includes the observations a | | |
| | she observed an ope | n area on the Resident's | | measurements are necessary a | sa | |
| | | out 1/2 inch in diameter and | | monitoring tool to determine if the | | |
| | - | dicated she cleaned the | | any changes in the wound that | | |
| | | ssing on it and looked at the | | require a change in the treatme | • | |
| | | lid not see any other areas | | On 10/20/22 and 10/21/22 the E | | |
| | | dy. She indicated she o Nurse #1 who was in the | | Health Services (DHS) and Nur Managers educated the Certifie | | |
| | | d Nurse #1 informed her she | | Assistants (CNA) on daily skin c | - | |
| | - | Physician know about the | | during personal care. This educ | | |
| | | ing. Nurse #11 indicated | | includes notification to the nurse | | |
| | she asked Nurse #1 i | f she wanted her to | | skin impairment and/or new dre | ssing | |
| | | or get orders and she stated | | noted on resident⊡s skin. The 0 | | |
| | | er she would take care of it | | Nursing Assistant will obtain a p | • • | |
| | and instructed her to | put a dressing on the | | diagram at the beginning of thei | | |
| | wound. | | | from the nursing station on each | | |
| | On 10/13/22 at 3:45 p | om an interview was | | maintain in their possession thro their shift. The Certified Nursing | - | |
| | - | e #1. She denied being | | (CNA) will utilize a body diagrar | | |
| | | of Resident #293 having | | resident daily during resident ca | | |
| | - | 22. She indicated she had | | nurse notification of skin integrit | | |
| | - | Resident having any wounds | | The Certified Nursing Assistant | - | |
| | in July. | | | circle the area of the body on th | | |
| | | | | diagram noting where the skin in | | |
| | | 7/27/22 through 8/12/22 the physician was notified | | issue is with a pen / pencil and i nurse regarding skin integrity is | | |
| | I rovoolod no ovidonee | | 1 | purco rodording okin intogrity io | | 1 |

Facility ID: 923197

If continuation sheet Page 13 of 98

| | OF DEFICIENCIES | MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA | (X2) MULTIP | PLE CONSTRUCTION | OMB NO (X3) DATE S | |
|--------------------------|--------------------------|---|---------------------|--|--|---------------------------|
| ND PLAN OF | FCORRECTION | IDENTIFICATION NUMBER: | A. BUILDING | G | COMPL | LETED |
| | | | | | | 2 |
| | | 345061 | B. WING | | 10/2 | 27/2022 |
| NAME OF P | ROVIDER OR SUPPLIER | - | | STREET ADDRESS, CITY, STATE, Z | P CODE | |
| עדדעוסס | | | | 3100 ERWIN ROAD | | |
| PRUITIN | EALTH-DURHAM | | | DURHAM, NC 27705 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN (EACH CORRECTIVE / CROSS-REFERENCED 1 DEFICIE | ACTION SHOULD BE TO THE APPROPRIATE | (X5) COMPLETIO DATE |
| F 580 | Continued From page | e 13 | F 58 | 30 | | |
| | | ght leg wound first identified | 1.00 | Nurse will complete a bo | dy observation on | |
| | | nent orders were in place, | | all residents the Certified | - | |
| | and no wound asses | • | | Assistant (CNA) has ide | • | |
| | | bund were completed. | | skin integrity issues and for treatment orders. | | |
| | A review of Nursing p | progress note dated 8/12/22 | | The Clinical Competenc | v Coordinator | |
| | | e #7 read in part, Resident # | | (CCC) was notified on 1 | | |
| | | ve an open wound on right | | Licensed Nursing Home | - | |
| | leg (calf) with a foul-s | smelling odor, and some | | (LNHA), to add the educ | ation regarding | |
| | - | ervations left in wound care | | the body diagrams and u | | |
| | and Physician book f | or evaluation. | | body diagram for each r | - | |
| | | | | nurse notification of skin | | |
| | On 10/11/22 at 4:10 | | | the general orientation of | f the Certified | |
| | | e #7, and she indicated she | | Nursing Assistant. | to one una that | |
| | | vorked on 8/12/22. She | | Systemic changes made | | |
| | | rted by NA #4 who was t #293 that he had blood on | | the deficient practice wil | mot recur. | |
| | • | ated she went to check the | | On 10/21/22 The Licens | ed Nursing Home | |
| | | ed a bandage wrapped on | | Administrator (LNHA) no | | |
| | | 7 indicated the bandage had | | of Health Services (DHS | | |
| | no date on it and whe | - | | Leadership to review the | | |
| | bandage, she observ | red wound to right calf that | | observations (weekly for | cus observation), | |
| | | drainage. She indicated she | | in the electronic medical | record under | |
| | | to be to the bone. Nurse #7 | | observation section, to v | | |
| | | nd of her shift and she had | | identified have physiciar | | |
| | | itten note in Physician book | | treatment orders are wri | - | |
| | that is left at the nurs | | | monitored for changes v | - | |
| | - | sician returned to facility, and nerbally on the phone on | | weeks then monthly the The Clinical Competenc | | |
| | 8/13/22. | a verbally on the phone on | | (CCC) was notified on 1 | | |
| | | | | Licensed Nursing Home | - | |
| | Review of electronic | medical record revealed on | | (LNHA) to add the skin o | | |
| | 8/12/22 a SBAR (situ | ation, background, | | documentation in the ele | | |
| | assessment, resident | t evaluation) communication | | record education to the | | |
| | form was completed | - | | for Nurses upon hire wit | | |
| | | read in part a change in | | the nurse who identifies | | |
| | | n 8/12/22 was a wound to | | issue completes the wou | | |
| | | s evaluated to have drainage | | documentation, physicia | | |
| | and toul smell. The re | esponsible party (RP) was | | initiates treatment per pl | nvsician order and | |

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| STATEMENT C | S FOR MEDICARE & PF DEFICIENCIES CORRECTION | MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | 1 ° <i>î</i> | E CONSTRUCTION | (X3) DAT | O. 0938-039 E SURVEY PLETED | |
|--------------------------|---|--|---------------------|--|--|-----------------------------------|--|
| | | | | | С | | |
| | | 345061 | B. WING | | 10 | /27/2022 | |
| 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 PREFIX TAG | PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY) | HOULD BE | (X5) COMPLETION DATE | |
| F 580 | notified. A review of hospital re Resident #293 preser ill-appearing, in acute and had a wound to t covered. On exam it v SIRS (Systemic Inflar exaggerated defense noxious stressor like inflammation) criteria intravenous fluids and (magnetic resonance right lower leg was do MRI along posterolate and toward the poste sinus tract to bone wi A telephone interview at 10:15 am with the it was indicated she re facility and did not ha indicated she did not wounds on Resident any. On 10/12/22 at 10:28 was conducted with the Resident #293, and h no longer worked at t access to Resident #2 he was not aware of l | 4:50 pm, and Physician ecords read, in part, inted to hospital on 8/13/22 e distress, had diffuse pain, the right lower leg that was was noted Resident meet mmatory Response, an e response of the body to a infection and/or and was started on d antibiotics. On 8/15/22 MRI imaging) of Resident #293's one, and results revealed eral (situated on the side rior aspect) upper leg with ith osteomyelitis. was conducted on 10/12/22 Physician Assistant (PA) and no longer worked in the we access to her notes. She recall personally seeing any #293 or being informed of am a telephone interview he primary Physician of he indicated as of 9/17/22, he the facility and no longer had 293's records. He indicated Resident #293 having any vas not able to access the | F 580 | | alth und Nurse that they liscuss unds and wound e to make ined. eto make ined. ort will be ssurance PI) ctor of w and until ved. | | |
| | - | n 10/13/22 at 1:06 pm with ng (DON) she indicated the nd when a wound was | | | | | |

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| | - | D HUMAN SERVICES MEDICAID SERVICES | | | | FORM | M APPROVED 0. 0938-0391 |
|--------------------------|--|---|--------------------|-----|---|-------------------|----------------------------|
| STATEMENT | OF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | LE CONSTRUCTION | (X3) DATE COMF | SURVEY PLETED |
| | | 345061 | B. WING | | | | C 27/2022 |
| NAME OF P | ROVIDER OR SUPPLIER | | | : | STREET ADDRESS, CITY, STATE, ZIP 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 SC IDENTIFYING INFORMATION) | ID PREFI TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY) | 3E | (X5) COMPLETION DATE |
| F 580 | identified was to notif Responsible party (Ri treatment of the wour transcribe the order ir indicated the nursing wounds identified in th book to notify the wou she reviewed the acti and 24-hour report to abnormal findings. S aware Resident #293 During an interview o the Administrator it wa when a new wound w the Physician, get orce notify the family. She expectation skin obse weekly and documen The Administrator wa jeopardy on 10/21/22 On 10/21/22 the facili credible allegation of removal: Identify those recipier are likely to suffer, a s because of the nonco Resident #293 no lon 7/27/22 Nurse #11 nc lower leg, applied dre physician. On 8/12/22 to posterior right lower placed in physician an books without verbal | y the Physician and P), get an order for ad from the Physician and a the computer. She also staff should put any new he wound communication and nurse. She indicated vity report in the computer see if any report included he indicated she was not had any wounds in July. In 10/13/22 at 5:10 pm with as indicated her expectation ras identified was to notify lers to treat the wound, and of further indicated it was her ervations were to be done ted in the computer. Is notified of immediate at 11:11 am. Ity provided the following Immediate Jeopardy hts who have suffered, or serious adverse outcome | F | 580 | | | |

Facility ID: 923197

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| | - | ID HUMAN SERVICES MEDICAID SERVICES | | | | FORM | APPROVED 0. 0938-0391 |
|--------------------------|---|---|---------------------|-----|---|------|----------------------------|
| STATEMENT (| DF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | CONSTRUCTION | | LETED |
| | | 345061 | B. WING _ | | | | C 27/2022 |
| 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 SC IDENTIFYING INFORMATION) | ID PREFIX TAG | x | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | | (X5) COMPLETION DATE |
| F 580 | orders and an x-ray to dated 8/13/22 identifie femoral shaft. Upon th Physician regarding th the Physician transfer Emergency room. The diagnosis to Hospital the right lower leg. Nemployed by this facil The Director of Health body audits on all res 10/20/22 to be done to no new skin integrity if comparing the known (wounds) on the wour electric medical recor body audits complete Actions taken by the f process or system fai adverse outcome from action will be complete The Director of Health Managers have review completed by the Nur 10/20-21/22, and revi ensure residents with order for treatment to notification. The Director Nurse Managers review integrity impairments documentation includ physician of any chan impairment status. | for antibiotics, wound care oright lower leg. X-ray ed lytic lesion to distal he Nurse's notification to the he Right leg X-ray results rred the resident #293 to the e Residents admitting was rule out osteomyelitis to lurse #11 is no longer lity. In Services initiated 100% idents within the facility on by the Nurses. There were issues identified by (current) skin integrity hd manager report, in the d, currently in house to the d on 10/20/2022. Facility to alter to alter the lure to prevent a serious in reoccurring and when the ted. In Services and/or Nurse wed the wound body audit ses, conducted on ewed the documentation to skin impairments had an areas and Physician ctor of Health Services and ewed residents with skin to ensure weekly | F | 580 | | | |

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| | - | ID HUMAN SERVICES MEDICAID SERVICES | | | | FORM | APPROVED 0. 0938-0391 |
|--------------------------|--|--|-------------------|-----|---|-----------|----------------------------|
| STATEMENT (| DF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | E CONSTRUCTION | (X3) DATE | |
| | | 345061 | B. WING | | | | C 27/2022 |
| 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 I CROSS-REFERENCED TO THE APPROPR DEFICIENCY) | BE | (X5) COMPLETION DATE |
| F 580 | 10/20/22 regarding we documentation in the same. When a new sl nurse will complete th the electronic medica description and meas the physician/physicia regarding newly ident and/or worsening skir treatment orders. This and measurements a monitoring tool to dete changes in the wound change in the treatment The Clinical Compete notified on 10/21/22 b Home Administrator to and documentation in education to the Nurs hire with emphasis that the skin integrity issue documentation, physi treatment per physicia integrity. Any Nurse wa after 10/21/22 until the The Director of Health Managers educated to Assistants on daily sk care. This education in nurse of any skin imp dressing noted on res On 10/20/22 and 10/2 Services and Nurse M | cation to the Nurses, on eekly skin observations and electronic health record of kin impairment is noted, the ne wound documentation in I record that includes urement of area and contact an extender for orders, ified skin impairments in impairments for wound is includes the observations re necessary as a ermine if there are any d that would require a ent plan. Incy Coordinator was by the Licensed Nursing the electronic health record e general orientation upon at the nurse who identifies e completes the wound cian notification, initiates an order for changes in skin will not be allowed to work ey receive the education. In Services and Nurse he Certified Nursing in checks during personal ncludes notification to the airment and/or new | F | 580 | | | |

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| DEPART CENTER | FORM | FORM APPROVED OMB NO. 0938-0391 | | | | | |
|--------------------------|---|---|--------------------|-----|---|-----------|----------------------------|
| STATEMENT (| DF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | E CONSTRUCTION | (X3) DATE | |
| | | 345061 | B. WING | | | | C / 27/2022 |
| NAME OF P | ROVIDER OR SUPPLIER | | • | S | STREET ADDRESS, CITY, STATE, ZIP CODE | | |
| | | | | 3 | 3100 ERWIN ROAD | | |
| PRUITTHE | EALTH-DURHAM | | | C | DURHAM, NC 27705 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | х | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY) | BE | (X5) COMPLETION DATE |
| F 580 | notification to the nurs and/or new dressing r Certified Nursing Assi body diagram at the b the nursing station on their possession throu assistant will utilize a resident daily during r notification of skin inte Nursing Assistant will on the body diagram, with a pen / pencil and integrity issue. The N observation on reside assistance have ident issues and notify phys The Clinical Compete notification of skin inte orientation of the Cert Any Certified Nursing to work after 10/21/202 education regarding the utilization of a body di daily for nurse notifica The Clinical Compete notified by the Licens Administrator on 10/2 responsible for ensuri prior to the start of an Certified Nursing Assi 10/21/22. On 10/21/22 The Licen | se of any skin impairment noted on resident's skin. The stant will obtain a paper beginning of their shift from a each unit and maintain in ughout the day. The Nursing body diagram for each resident care, for nurse egrity issues. The Certified circle the area of the body, with the skin integrity issue d notify nurse regarding skin urse will complete body ints the certified nursing tified with new skin integrity sician for treatment orders. ncy Coordinator was 2 by the Licensed Nursing to add the education agrams and utilization of a h resident daily for nurse egrity issues to the general tified Nursing Assistant. Assistant will not be allowed 2 until they receive the he Body diagrams and tagram for each resident ation of skin integrity issues. Incy Coordinator/RN was ed Nursing Home 1/22, that they are ing education is completed y Licensed Nurse and/or stant working the floor after | F | 580 | | | |

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| | - | ID HUMAN SERVICES MEDICAID SERVICES | | | | FOF | RM APPROVED IO. 0938-0391 |
|--------------------------|---|---|--------------------|-----|--|----------|------------------------------|
| STATEMENT | DF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | E CONSTRUCTION | (X3) DAT | TE SURVEY MPLETED |
| | | 345061 | B. WING | | | 1 | 0/27/2022 |
| NAME OF P | ROVIDER OR SUPPLIER | I | | ; | STREET ADDRESS, CITY, STATE, ZIP 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 SC IDENTIFYING INFORMATION) | ID PREFI TAG | | PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY) | D BE | (X5) COMPLETION DATE |
| F 580 | Services and/or Nurs weekly skin observatio observation), in the e under observation se identified have physic orders are written, wo changes weekly for for thereafter. Alleged date of imme 10/22/22 On 10/27/22 the cred jeopardy was validate Record reviews and i which verified the aud Interview with the Mir revealed skin assess Nurse Assistants (NA and if there is an issu NA notifies the charge documents, notifies the order if needed. MD notify the responsible A review of the audits orders were reviewed were corrected. A review of the educa education was provid credible allegation. Interviews with staff in educated by facility th issues with skin to ch assesses resident's s wound nurse, Physici | ing Leadership to review the ons (weekly focus lectronic medical record ction, to validate all areas cian notification, treatments bund is monitored for our weeks then monthly diate jeopardy removal: ible allegation of immediate ed by onsite verification. nterviews were conducted dits were completed. nimum data set (MDS) Nurse ments were completed daily.) complete a skin audit daily e with a resident's skin, the e nurse who then ne Physician, and obtains S Nurse also indicated they party (RP)/family. | F | 580 | | | |

Facility ID: 923197

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| | | ID HUMAN SERVICES MEDICAID SERVICES | | | | FORM | APPROVED 0.0938-0391 |
|--------------------------|--|--|---------------------|-------------------------------------|--|-------------------|----------------------------|
| STATEMENT (| DF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | PLE CONSTRUCTION G | _ | (X3) DATE COMP | |
| | | 345061 | B. WING _ | | | | 27/2022 |
| NAME OF PI | ROVIDER OR SUPPLIER | | - I | STREET ADDRESS, CITY, S | 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 PREFIX TAG | (EACH CORR | R'S PLAN OF CORRECTION ECTIVE ACTION SHOULD BE ENCED TO THE APPROPRIA DEFICIENCY) | | (X5) COMPLETION DATE |
| | body audit sheet for a skin and notifying the any skin issues. Interview was conduct 10/27/2022 at 11:12 at do full skin audits on areas, including reduct and audits were turner reviews and signs off given to DON. Nurse anything observed, th assess wound, inform transcribe any order i information in wound treatment nurse chec any new areas on ski Interviews with staff re provided. The immediate jeopar 10/22/2022 was valid Notice Requirements CFR(s): 483.15(c)(3) Notice Before a facility transt | any issues with a resident's charge nurse if observes at the with Wound Nurse on an who indicated NAs had to every shift. If identified any ess, they notify the nurse ed into the nurse who the skin audit and skin audit as review audit sheets and if ney are to do a SBAR, n Physician and RP, and n computer. Nurses put communication book and ks the book every day for n that were identified. evealed that education was rdy removal date of ated on 10/27/22. Before Transfer/Discharge -(6)(8) before transfer. fers or discharges a | F 5 | | | | 11/21/22 |
| | the reasons for the m language and manne facility must send a correpresentative of the Long-Term Care Omb (ii) Record the reason | and the resident's ne transfer or discharge and ove in writing and in a r they understand. The opy of the notice to a Office of the State oudsman. | | | | | |

Event ID: GOU111

Facility ID: 923197

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| | MENT OF HEALTH AN S FOR MEDICARE & I | ID HUMAN SERVICES MEDICAID SERVICES | | | | FORM | APPROVED 0. 0938-0391 |
|--------------------------|---|---|--------------------|-----|--|-------------------|----------------------------|
| STATEMENT | DF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | E CONSTRUCTION | (X3) DATE COMP | SURVEY PLETED |
| | | 345061 | B. WING | | | | C 27/2022 |
| NAME OF P | ROVIDER OR SUPPLIER | | • | | STREET ADDRESS, CITY, STATE, ZIP 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 .SC IDENTIFYING INFORMATION) | ID PREFI TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY) | | (X5) COMPLETION DATE |
| F 623 | accordance with para and (iii) Include in the noti paragraph (c)(5) of th §483.15(c)(4) Timing (i) Except as specified (c)(8) of this section, f discharge required un made by the facility ai resident is transferred (ii) Notice must be ma before transfer or disc (A) The safety of indiv be endangered under this section; (B) The health of indiv be endangered, under this section; (C) The resident's hea allow a more immedia under paragraph (c)(1 (D) An immediate tran required by the reside under paragraph (c)(1 (E) A resident has not days. §483.15(c)(5) Conten notice specified in para must include the follor (i) The reason for trai (ii) The location to wh transferred or dischar (iv) A statement of the | graph (c)(2) of this section; ce the items described in is section. of the notice. d in paragraphs (c)(4)(ii) and the notice of transfer or oder this section must be t least 30 days before the d or discharged. ade as soon as practicable charge when- viduals in the facility would r paragraph (c)(1)(i)(C) of viduals in the facility would r paragraph (c)(1)(i)(D) of alth improves sufficiently to ate transfer or discharge, 1)(i)(B) of this section; of tresided in the facility for 30 ts of the notice. The written ragraph (c)(3) of this section wing: nsfer or discharge; of transfer or discharge; mich the resident is ged; e resident's appeal rights, ddress (mailing and email), | F | 623 | 3 | | |

Facility ID: 923197

If continuation sheet Page 22 of 98

| | MENT OF HEALTH AN S FOR MEDICARE & I | D HUMAN SERVICES | | | | FORM | : 12/06/2022 APPROVED . 0938-0391 |
|--------------------------|--|---|---------------------|-------------------------------|---|-------------------|---|
| STATEMENT (| DF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | · · · | CONSTRUCTION | | (X3) DATE COMP | SURVEY LETED |
| | | 345061 | B. WING | | _ | (10/: | C 27/2022 |
| NAME OF P | ROVIDER OR SUPPLIER | | ST | REET ADDRESS, CITY, STA | TE, ZIP CODE | | |
| DDUUTTU | | | 31 | 00 ERWIN ROAD | | | |
| PRUITIN | EALTH-DURHAM | | D | URHAM, NC 27705 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | (EACH CORREC CROSS-REFEREN | PLAN OF CORRECTION TIVE ACTION SHOULD BE CED TO THE APPROPRIA EFICIENCY) | | (X5) COMPLETION DATE |
| F 623 | receives such requess to obtain an appeal for completing the form a hearing request; (v) The name, address telephone number of Long-Term Care Omb (vi) For nursing facility and developmental di disabilities, the mailing telephone number of the protection and add developmental disabil C of the Development and Bill of Rights Act codified at 42 U.S.C. (vii) For nursing facilit disorder or related dis email address and tel agency responsible for advocacy of individua established under the for Mentally III Individu §483.15(c)(6) Change If the information in the effecting the transfer must update the recip as practicable once the becomes available. §483.15(c)(8) Notice if In the case of facility of the administrator of the written notification prior to the State Survey Ag State Long-Term Care | ts; and information on how irm and assistance in and submitting the appeal s (mailing and email) and the Office of the State budsman; / residents with intellectual sabilities or related g and email address and the agency responsible for vocacy of individuals with lities established under Part tal Disabilities Assistance of 2000 (Pub. L. 106-402, 15001 et seq.); and y residents with a mental sabilities, the mailing and ephone number of the or the protection and ls with a mental disorder Protection and Advocacy uals Act. | F 623 | | | | |

If continuation sheet Page 23 of 98

| STATEMENT (| DF DEFICIENCIES CORRECTION | MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | · , | | | (X3) DAT | O. 0938-039 E SURVEY PLETED |
|--------------------------|-------------------------------|---|-------------------|-----|---|----------|-----------------------------------|
| | | 345061 | B. WING | | | 10 | C /27/2022 |
| NAME OF PI | ROVIDER OR SUPPLIER | | | s | STREET ADDRESS, CITY, STATE, ZIP CODE | | |
| | | | | 3 | 100 ERWIN ROAD | | |
| PRUITTHE | EALTH-DURHAM | | | 6 | DURHAM, NC 27705 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREF TAG | | PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY) | BE | (X5) COMPLETION DATE |
| F 623 | Continued From page | e 23 | Í - | 623 | | | |
| 1 020 | | ne transfer and adequate | Г | 023 | | | |
| | | dents, as required at § | | | | | |
| | 483.70(I). | aento, ao requireu al 9 | | | | | |
| | | Γ is not met as evidenced | | | | | |
| | by: | | | | | | |
| | Based on record rev | iew and staff interview the | | | Corrective action for the residents for | ound | |
| | facility failed to provid | de written notice of discharge | | | to be affected by the deficient practic | e. | |
| | | or 4 of 4 residents discharge | | | | | |
| | | dent #39. Resident #443, | | | The Ombudsman was sent a written | | |
| | Resident #193, and F | Resident #194). | | | notice of discharge/transfer to the ho | | |
| | The findings included | 1: | | | for resident #39, #443, #193 and #19 11/9/2022. | 94 on | |
| | _ | | | | | | |
| | 1.Resident #39 was a | | | | Corrective action for other residents | | |
| | readmitted on 9/14/2 | | | | having the potential to be affected by same deficient practice. | ' the | |
| | | te dated 9/12/22, revealed | | | | | |
| | Resident #39 was se | • | | | All residents have the potential to be | | |
| | | ent #39 returned to facility on 9 discharged on 9/20/22 to | | | affected by the same deficient practic The Licensed Nursing Home | je. | |
| | | ry tract infection and sexual | | | Administrator (LNHA) in-serviced the | | |
| | · · | d did not return to facility. | | | Social Worker (SW) on the requirement | | |
| | | | | | provide written notice of all discharge | | |
| | During a telephone ir | nterview on 10/13/22 at 11:43 | | | including hospital transfers/discharge | | |
| | | n stated the previously | | | the Ombudsman on 11/8/2022. The | | |
| | | an to the county had left in | | | in-service also included the initiation | | |
| | | n office had sent out a letter | | | monthly log to record discharges/trar | nsfers | |
| | to all facilities assigned | | | | on daily. | | |
| | | ackup person (ombudsman | | | Per the 2567 the Ombudsman s off | | |
| | name) would be for the | - | | | indicated they last received any copy | | |
| | | man further stated she had y of discharge notices from | | | discharge notices from the facility sin June 2022. On 11/9/2022 the License | | |
| | the facility since June | | | | Nursing Home Administrator (LNHA) | | |
| | | | | | conducted an 100% audit of all | | |
| | During an interview o | on 10/12/22 at 5:23 PM the | | | discharges/transfers to the hospital fi | rom | |
| | - | she was responsible for | | | 06/01/2022 | | |
| | | opy notification of discharges | | | time there were 162 discharges/trans | | |
| | - | Administrator indicated the | | | and 162 were not sent to the | | |
| | county currently did r | not have an Ombudsman | | | Ombudsman. On 11/09/2022 the 162 | > | |

Facility ID: 923197

| | DF DEFICIENCIES CORRECTION | MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | . , | E CONSTRUCTION | | E SURVEY IPLETED |
|--------------------------|--------------------------------|---|---------------------|---|---------------|---------------------------|
| | | 345061 | B. WING | | 1(| C D/27/2022 |
| NAME OF PF | ROVIDER OR SUPPLIER | 1 | | STREET ADDRESS, CITY, STATE, ZIP CODE | | |
| | | | | 3100 ERWIN ROAD | | |
| PRUITTHE | ALTH-DURHAM | | | DURHAM, NC 27705 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY) | SHOULD BE | (X5) COMPLETIO DATE |
| F 623 | Continued From page | - 24 | E cor | | | |
| 1 025 | | | F 623 | | | |
| | 0 | the notification of discharge. she was unaware as to | | discharges/transfers were faxe Ombudsman. | eu lo lNe | |
| | whom to send the co | | | Education will be provided in r | new hire | |
| | | | | orientation for any new Social | | |
| | 2.Resident # 443 was | s admitted on 8/4/22. | | (SW) hired regarding the proc | | |
| | | | | notifying the Ombudsman of a | | |
| | Review of nursing no | te dated 08/25/2022, | | discharge/transfer. | | |
| | | 43 went out to a cancer | | | | |
| | | nt today. Resident did not | | Systemic changes made to en | | |
| | - | vas sent to hospital for | | the deficient practice will not re | ecur. | |
| | iurther evaluation dire | ectly from the appointment. | | The Administrator contacted th | ne facility | |
| | During a telephone in | nterview on 10/13/22 at 11:43 | | Ombudsman on 11/8/2022 and | • | |
| | | stated the previously | | instructed to fax notifications of | | |
| | | in to the county had left in | | transfers/discharges monthly. | - | |
| | - | office had sent out a letter | | The Social Worker (SW) will in | nitiate a log | |
| | to all facilities assigned | ed to the county area | | on the 1st day of each month | | |
| | | ickup person (ombudsman | | discharges/transfers. Each da | | |
| | name) would be for th | - | | discharges/transfers will be do | | |
| | | man further stated she had | | on the log and reviewed during | • | |
| | the facility since June | y of discharge notices from | | department managers meeting | | |
| | the facility since June | ; 2022. | | held Monday □ Friday. On Mo Social Worker (SW) will add th | | |
| | During an interview of | n 10/12/22 at 5:23 PM the | | discharges/transfers from Satu | | |
| | - | she was responsible for | | Sunday. | | |
| | | ppy notification of discharges | | Plans to monitor its performan | ce to make | |
| | • | Administrator indicated the | | sure that the solutions are sus | | |
| | • • | not have an Ombudsman | | | | |
| | | the notification of discharge. | | The Social Worker (SW) will re | | |
| | | she was unaware as to | | analysis of the transfer/discha | | |
| | | py of discharge charge. | | the Quality Assurance Perform | | |
| | 3. Resident #193 wa 7/7/22. | is readmitted to the facility on | | Improvement (QAPI) Committee for review and revision monthl | | |
| | 111122. | | | months or until substantial cor | • | |
| | Review of a nurse's r | note dated 7/24/22 revealed | | achieved. | | |
| | | ound to be unresponsive and | | | | |
| | was sent to the hospi | - | | Date of compliance: 11/ | 21/22 | |
| | | | 1 | · · | | 1 |

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| | - | ID HUMAN SERVICES MEDICAID SERVICES | | | | FORM | APPROVED 0. 0938-0391 |
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| STATEMENT (| DF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | LE CONSTRUCTION | (X3) DATE COMP | SURVEY LETED |
| | | 345061 | B. WING | | | | C 27/2022 |
| NAME OF PI | ROVIDER OR SUPPLIER | | | | STREET ADDRESS, CITY, STATE, ZIP CODE | <u></u> | |
| PRUITTHE | EALTH-DURHAM | | | | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION) | ID PREFI TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY) | | (X5) COMPLETION DATE |
| F 623 | 7/24/22 and did not re During a telephone in AM, the Ombudsman assigned Ombudsman June 2022. The main to all facilities assigned regarding who the ba name) would be for th documents. Ombudsm not received any copy the facility since June During an interview of Administrator stated as sending the letter / co to the Ombudsman. A county currently did n and was not sending Administrator stated as whom to send the cop 4. Resident #194 was 7/27/22. Review of a nurse's n Resident #194 was se evaluation due to wor Resident #194 was di 8/22/22 and did not re During a telephone in | eturn to the facility. terview on 10/13/22 at 11:43 stated the previously n to the county had left in office had sent out a letter ed to the county area ckup person (ombudsman nem to submit any man further stated she had y of discharge notices from 2022. n 10/12/22 at 5:23 PM the she was responsible for the notification of discharges Administrator indicated the ot have an Ombudsman the notification of discharge. she was unaware as to by of discharge charge. a admitted to the facility on ote dated 8/22/22 revealed ent to the hospital for sening alert mental status. Escharged to the hospital on eturn to the facility. terview on 10/13/22 at 11:43 | F | 623 | | | |
| | AM, the Ombudsman assigned Ombudsma June 2022. The main to all facilities assigned | stated the previously n to the county had left in office had sent out a letter ed to the county area ckup person (ombudsman | | | | | |

| | - | ID HUMAN SERVICES MEDICAID SERVICES | | | | FORM | D: 12/06/2022 MAPPROVED D. 0938-0391 |
|--------------------------|---|---|---------------------|------------------------------------|--|-------------------|--|
| STATEMENT | OF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | CONSTRUCTION | | (X3) DATE COMF | SURVEY PLETED |
| | | 345061 | B. WING | | _ | | C 27/2022 |
| NAME OF P | ROVIDER OR SUPPLIER | | s | TREET ADDRESS, CITY, ST | ATE, ZIP CODE | | |
| PRUITTH | 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 | (EACH CORREC CROSS-REFEREN | B PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY) | | (X5) COMPLETION DATE |
| F 623 | documents. The Oml had not received any from the facility since During an interview of Administrator stated as sending the letter / co to the Ombudsman. A county currently did n and was not sending Administrator stated as whom to send the cop Notice of Bed Hold Pe CFR(s): 483.15(d)(1)(§483.15(d) Notice of B §483.15(d)(1) Notice nursing facility transfe the resident goes on the nursing facility must p the resident or reside specifies- (i) The duration of the any, during which the return and resume resi facility; (ii) The reserve bed p plan, under § 447.40 (iii) The nursing facilit bed-hold periods, whi paragraph (e)(1) of th resident to return; and (iv) The information s of this section. | budsman further stated she copy of discharge notice June 2022. In 10/12/22 at 5:23 PM the she was responsible for py notification of discharges administrator indicated the ot have an Ombudsman the notification of discharge. She was unaware as to by of discharge charge. Dicy Before/Upon Trnsfr (2) bed-hold policy and return- before transfer. Before a ers a resident to a hospital or therapeutic leave, the provide written information to int representative that e state bed-hold policy, if resident is permitted to sidence in the nursing ayment policy in the state of this chapter, if any; y's policies regarding ch must be consistent with is section, permitting a d pecified in paragraph (e)(1) | F 623 | | | | 11/21/22 |

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| | | D HUMAN SERVICES MEDICAID SERVICES | | | | FORM | APPROVED 0.0938-0391 | |
|--------------------------|--|---|---------|---|---|---|-------------------------|--|
| STATEMENT | OF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | CONSTRUCTION | (X3) DATE COMP | SURVEY LETED | |
| | | 345061 | B. WING | | | | C 27/2022 | |
| NAME OF P | ROVIDER OR SUPPLIER | | | ST | IREET ADDRESS, CITY, STATE, ZIP CODE | | | |
| | | | | 31 | 00 ERWIN ROAD | | | |
| PRUITH | EALTH-DURHAM | | | D | URHAM, NC 27705 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION S | | PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE | | | | |
| F 625 | hospitalization or ther facility must provide to resident representative specifies the duration described in paragrap This REQUIREMENT by: Based on staff interve facility failed to provide 2 residents discharge #39 and Resident #29 The findings included 1.Resident #39 was a 7/28/22 and discharge 9/20/22. The diagnos dementia. The admissi (MDS) dated 7/14/22, cognition was impaired Review of nursing not AM, documented Eme (EMS) arrived at 06:2 resident called, and s hospital. Responsible writer unable to leave box being full. The rest at the time of the surve A telephone interview at 9:40 AM with the rest facility had not offered the bed hold policy. An interview was con AM with Nurse #1 wh Emergency Medical S | apeutic leave, a nursing o the resident and the re written notice which of the bed-hold policy oh (d)(1) of this section. is not met as evidenced iews and record review, the re the bed hold policy to 2 of d to the hospital (Resident 22). : idmitted to the facility on ed to the hospital on es included diabetes, and sion Minimum Data Set indicated Resident #39 ed. ite dated 9/20/2022 at 10:38 ergency Medical Services 0 AM and stated that he needed to go to the Party (RP) was called and message due to voicemail sident remained hospitalized | F | 625 | Corrective action for the residents four to be affected by the deficient practice. Resident #39 did not return to the facili from the hospital as she was discharge home with daughter. Resident #292 did not return to the faci from the hospital and was discharged to another skilled nursing facility. Corrective action for other residents having the potential to be affected by the same deficient practice. The Director of Health Services (DHS) and/or Nurse Managers conducted in-servicing with all licensed nurses regarding including the Bed Hold proce on 11/8/22. When a resident is discharge to the hospital, the nurse responsible for initiating the emergency transfer to the hospital will copy and place the origina bed hold authorization form with the discharge paperwork and place documents inside the INTERACT (Interventions to Reduce Acute Care Transfers) Acute Care Transfer Checkl folder. Medical Records will upload a copy of the bed hold authorization form the electronic medical record. | ty ed ility o ne ess ged or I | | |

Facility ID: 923197

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| | | | | | | 0938-03 |
|---------------|---|--|---------------|---|-------------------|-----------|
| | OF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | (X3) DATE COMF | SURVEY |
| | | | A. BUILDING | 3 | | <u>^</u> |
| | | 345061 | B. WING | | | C |
| | ROVIDER OR SUPPLIER | 343001 | | STREET ADDRESS, CITY, STATE, ZIP CODE | 10/ | 27/2022 |
| NAIVIE OF P | ROVIDER OR SUPPLIER | | | | | |
| PRUITTHE | EALTH-DURHAM | | | 3100 ERWIN ROAD DURHAM, NC 27705 | | |
| (X4) ID | SUMMARY ST | ATEMENT OF DEFICIENCIES | ID | PROVIDER'S PLAN OF CORRECT | ION | (X5) |
| PREFIX TAG | (EACH DEFICIENC | Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | PREFIX TAG | (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY) | DBE | COMPLETIO |
| F 625 | Continued From page | e 28 | F 62 | 25 | | |
| | | insfer packet which included | | The Administrator conducted in-ser | vicina | |
| | | nd instruction, face sheet | | on 11/17/22 to the Social Worker (S | 0 | |
| | | agnoses. Nurse #1 stated | | Director of Health Services (DHS), | | |
| | she called the RP an | hour after resident left, | | Financial Counselor (FC) and Depa | irtment | |
| | | old policy. The RP stated she | | Managers regarding the bed hold | | |
| | | before and they would see if | | process. The Social Worker (SW), | | |
| | | ning when she got to the | | Financial Counselor and/or Departr | nent | |
| | hospital. The nurse d | | | Manager will place a call to the | race to | |
| | | ed hold policy had been d to the resident and/or | | Responsible Party following dischart the hospital within 24 hours of the ti | | |
| | responsible person. | | | and provide a written copy of the be | | |
| | | | | via mail and document in the reside | | |
| | An interview was con | ducted on 10/13/22 at 11:55 | | electronic medical record that such | notice | |
| | AM, the Director of N | ursing (DON) stated | | was sent. | | |
| | standard process was | s for the bed hold policy to | | | | |
| | | nsfer packet and the nurse | | Education will be provided in new h | | |
| | would go over the inf | | | orientation for any new licensed nur | | |
| | resident/responsible | person at time of discharge. | | Administrator, Medical Records, So | | |
| | An interview was can | ducted on 10/13/22 at 10:00 | | Worker (SW), Director of Health Se | | |
| | AM, the Administrato | | | (DHS), Financial Counselor (FC) ar Department Managers hired regard | | |
| | | family or resident being | | procedure for bed holds. | | |
| | | hold policy. She stated the | | | | |
| | business office mana | | | Systemic changes made to ensure | that | |
| | | review bed hold policy on | | the deficient practice will not recur. | | |
| | admission. The disch | | | | | |
| | | ger/social worker would also | | Discharges to the hospital will be | _ | |
| | | policy if the family/resident | | documented on the hospital dischar | | |
| | was present and able placement to the facil | e to make decision for return | | and discussed daily during the more | - | |
| | • | iny. Imitted to the facility on | | IDT meeting Monday through Frida review all residents discharged to the | | |
| | | inoses including cerebral | | hospital were given a copy of the be | | |
| | infarction, hemiplegia | | | authorization form was sent with the | | |
| | | stive heart failure, asthma, | | resident to the hospital, Social Wor | | |
| | and a chronic kidney | | | (SW) placed follow-up call and writt | | |
| | | | | copy to resident and/or Responsible | | |
| | | cal record reveled Resident | | (RP) within 24 hours regarding his/ | ner bed | |
| | #292 was able to ma | | | on hold at the facility. | | |
| | minimum data set (M | DS) was completed. | | | | |

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| CENTERS FOR MI | EDICARE & I | D HUMAN SERVICES MEDICAID SERVICES | | | | | FORM OMB NC |): 12/06/2022 1 APPROVED 0: 0938-0391 |
|---|---|--|--------------------|-----|--|---|-------------------|---|
| STATEMENT OF DEFICIEN AND PLAN OF CORRECTIO | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ` ´ | | CONSTRUCTION | | (X3) DATE COMP | LETED |
| | | 345061 | B. WING | | | | | 27/2022 |
| NAME OF PROVIDER OR | SUPPLIER | | | ST | TREET ADDRESS, CITY, STATE | , ZIP CODE | | |
| PRUITTHEALTH-DUP | RHAM | | | | 100 ERWIN ROAD URHAM, NC 27705 | | | |
| | ACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | x | (EACH CORRECTIN CROSS-REFERENCE | AN OF CORRECTION /E ACTION SHOULD BE D TO THE APPROPRIA ICIENCY) | | (X5) COMPLETION DATE |
| A review read in p hospital a notified. On 10/11 conducte and it wa notice at Resident On 10/13 conducte and she bed hold packet a informati (RP) at ti On 10/13 conducte indicateo family or policy. S would ca policy on discharg social wo policy if t to make | Art Resident and Physician (22 at 9:25 A ed with Resid as indicated so bout the facilit t # 292 transf (3/22 at 11:55 ed with the Di indicated the policy to be nd the nurse on with the ra- ime of discha (3/22 at 10:49 ed with the Act there was n resident beir he stated the ill family/reside admission. So orker would a the family/resis the decision. | rogress note dated 8/29/22 #292 was transported to the n and responsible party was AM an interview was ent # 292's family member he did not receive written ty's bed hold policy when erred to the hospital. AM an interview was rector of Nursing (DON), standard process is for the included in the transfer would go over the esident/responsible party rge or telephone call. AM an interview was dministrator, and she o documentation of the ng informed of the bed hold Business office manager lent and review the bed hold She indicated the usiness office manager lso go over the bed hold ident was present and able | F | 525 | Plans to monitor its pe sure that the solutions The Administrator and Health Services (DHS analysis of the hospita the Quality Assurance Improvement (QAPI) of review and revision m until substantial comp Date of compliance: | s are sustained. d/or Director of b) will report the al discharge log to e Performance Committee for ionthly x 3 months | o s or | |

If continuation sheet Page 30 of 98

| TATEMENT | OF DEFICIENCIES CORRECTION | MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | · , | | CONSTRUCTION | | | |
|--------------------------|--|---|--------------------|-----|--|----------|----------------------------|--|
| | | 345061 | B. WING | | | | | |
| | ROVIDER OR SUPPLIER | | • | 310 | REET ADDRESS, CITY, STATE, ZIP CODE 00 ERWIN ROAD JRHAM, NC 27705 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFI TAG | x | PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY) | IOULD BE | (X5) COMPLETION DATE | |
| F 626 F 626 SS=D | Permitting Residents CFR(s): 483.15(e)(1) §483.15(e)(1) Permit facility. A facility must establi on permitting residen after they are hospita therapeutic leave. The following. (i) A resident, whose leave exceeds the be State plan, returns to room if available or in availability of a bed in resident- (A) Requires the serve and (B) Is eligible for Meck services or Medicaid nursing facility servic (ii) If the facility that of who was transferred returning to the facility facility, the facility mu- requirements of para discharges. §483.15(e)(2) Readm distinct part. When the returns is a composit § 483.5), the resident to an available bed in composite distinct par- previously. If a bed is at the time of return, f | to Return to Facility ((2) ting residents to return to ish and follow a written policy its to return to the facility alized or placed on ise policy must provide for the hospitalization or therapeutic ed-hold period under the the facility to their previous mmediately upon the first in a semi-private room if the vices provided by the facility; dicare skilled nursing facility es. determines that a resident with an expectation of cy, cannot return to the ust comply with the graph (c) as they apply to hission to a composite he facility to which a resident it must be permitted to return in the particular location of the or the particular location of the is not available in that location the resident must be given to that location upon the first | | 626 | | | 11/21/22 | |

If continuation sheet Page 31 of 98

| TATEMENT (| DF DEFICIENCIES CORRECTION | MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ` <i>`</i> | | | (X3) DAT | O. 0938-039 E SURVEY IPLETED |
|--------------------------|-------------------------------|---|--------------------|-----|--|----------|------------------------------------|
| | | 345061 | B. WING | | | | С |
| | | 545061 | D. WING | | | 10 |)/27/2022 |
| 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 PREFI TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY) | ЗE | (X5) COMPLETION DATE |
| F 626 | Continued From page | - 21 | | ~~~ | | | |
| F 020 | | | F | 626 | | | |
| | | Γ is not met as evidenced | | | | | |
| | by: Based on family into | rview, staff interviews and | | | Corrective action for the residents fou | und | |
| | | cility failed to permit the | | | to be affected by the deficient practice | | |
| | | discharged to the hospital | | | | - | |
| | (Resident #39 and #2 | | | | Resident #39 is no longer here to corr | ect | |
| | (| ; | | | the alleged deficiency. Resident was | | |
| | The findings included | 1: | | | discharged home with daughter. | | |
| | 1.Resident #39 was a | admitted to the facility on | | | Resident #292 is no longer here to cor | rrect | |
| | 7/28/22 and discharg | • | | | the alleged deficiency. Resident was | | |
| | - | ses included diabetes, | | | discharged to another skilled nursing | | |
| | | e sclerosis, deep venous | | | facility. | | |
| | | /delusional disorder, and | | | | | |
| | | sion Minimum Data Set | | | Corrective action for other residents | | |
| | | , indicated Resident #39 ed and required extensive | | | having the potential to be affected by t same deficient practice. | ne | |
| | assistance with activi | - | | | same dencient practice. | | |
| | | des of daily living. | | | All residents have the potential to be | | |
| | Care plan dated 9/2/2 | 22 identified the problem as | | | affected by the alleged deficient practi | ce. | |
| | | mentia with behaviors and a | | | The Administrator completed an audit | | |
| | | allucinations, anxiety and | | | 11/17/22 of all discharges/transfers to | | |
| | | tive behaviors problems as | | | hospital for the last 30 days, no other | | |
| | - | false statements- stating that | | | residents were denied readmission to | the | |
| | | ner after receiving anisole | | | facility. | | |
| | | 1 without allowing nursing to | | | | | |
| | | nent. Family stated she has | | | On 11/17/22 the PruittHealth Senior N | | |
| | | sexual and physical assault | | | Consultant (SNC) in-serviced the Dire | | |
| | by man and woman, | - | | | of Health Services (DHS), Administrat | | |
| | | ts poisoned. On 9/19/22 the | | | Social Worker, and Unit Manager on the | ne | |
| | | ty to let Administrator know | | | Regulation of permitting residents to | ad | |
| | | 10 to 14 times a day stating a | | | return to the facility according to the be | ea | |
| | | e in the building has been | | | hold policy. | | |
| | - | and to kill her and called 911 The goal included Resident | | | On 11/8/22, the Director of Health | | |
| | #39 would not harm s | | | | Services (DHS) and/or Nurse Manage | rs | |
| | | Psych referral as needed, | | | in-serviced all nurses on the Bed-hold | 13 | |
| | | ges to physician/physician | | | policy related to discharges and hospi | tal | |
| | | practitioner (MD/PA/NP) as | | | stays. All residents are allowed to retu | | |

Facility ID: 923197

If continuation sheet Page 32 of 98

| TATEMENT (| OF DEFICIENCIES | MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA | (X2) MULTIPL | E CONSTRUCTION | (X3) DAT | O. 0938-03 E SURVEY |
|--------------------------|---|---|---------------------|--|----------------------|---------------------------|
| id plan of | CORRECTION | IDENTIFICATION NUMBER: | A. BUILDING | | COMPLETED | |
| | | 345061 | B. WING | | 10 | C)/27/2022 |
| NAME OF PI | ROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP CODE | | - |
| | ALTH-DURHAM | | | 3100 ERWIN ROAD | | |
| Romine | | | | 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 SHO CROSS-REFERENCED TO THE APP DEFICIENCY) | OULD BE | (X5) COMPLETIC DATE |
| F 626 | Continued From page | e 32 | F 626 | | | |
| | | would be redirected to facts. | 1 020 | according to the Bed-hold policy. | | |
| | AM, documented em | te dated 9/20/2022 at 10:38 ergency medical service) AM and stated that resident | | Systemic changes made to ensur the deficient practice will not recu | | |
| | called and stated "sh vaginal was burning. | e needed help that her EMS escorted to resident stated she needed to go to | | All nurses are required to follow t bed-hold policy and allow resider return from the hospital or therap | nts to | |
| | the hospital. EMS wa psych issues and this | is told that resident had s behavior is ongoing. | | leave. The Admission Director wi the Administrator and/or Director | ll keep of Health | |
| | | least twice a week. The and writer unable to leave email box being full. | | Service (DHS) informed of a resid status while in the hospital and the expected date of return to the fact | ieir cility. The | |
| | at 9:40 AM, the daug was denied access to | v was conducted on 10/12/22 hter stated that her mother o return to the facility on d the facility liaison and | | Admissions Director will follow-up Case Manager at assigned hospi each hospital discharge on an an return date. | ital for | |
| | administrator told the not return to the facili | hospital Resident #39 could ity to due to her sexual | | Discharges to the hospital will be documented on the hospital disch | narge log | |
| | needed to be done be | rchological evaluation efore she could return. The (RP) further stated the | | and discussed daily during the m IDT meeting Monday through Frid review all residents discharged to | day to | |
| | but the night shift nur | eared for return on 9/20/22, se told the hospital social already been given to | | hospital and their anticipated retu by the Administrator and/or Direc Health Services (DHS). The Adm | tor of | |
| | another resident. The contacted the facility | e hospital caseworker on 9/23/22 and was | | will audit discharges/transfers to hospital to ensure the resident re | the turns to | |
| | | ogy evaluation had been lent #39 was again ready for The RP further stated | | the facility when medically cleare will occur weekly for 4 weeks the monthly times one. | | |
| | Resident #39 remain facility denial for return | s in the hospital due to rn. The RP stated she | | Ongoing education will be provide | | |
| | return to facility and i | 9 was inappropriately denied t was the obligation of the dent #39 with obtaining | | newly hired Director of Health Se Administrator, Social Worker, Lic Nurse⊡s, and Unit Managers dur | ensed | |
| | - | assistance and medication | | general orientation. | - | |
| | | | | Plans to monitor its performance | to make | |

Event ID: GOU111

Facility ID: 923197

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| | - | D HUMAN SERVICES MEDICAID SERVICES | | | FORM | D: 12/06/2022 MAPPROVED D. 0938-0391 |
|--------------------------|-------------------------------|--|---------------------|---|-------------------|--|
| STATEMENT (| DF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | · / | E CONSTRUCTION | (X3) DATE COMP | SURVEY PLETED |
| | | 345061 | B. WING | | | C 27/2022 |
| NAME OF PI | ROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP CODE | • | |
| DOLUTTU | | | | 3100 ERWIN ROAD | | |
| PRUITINE | EALTH-DURHAM | | | 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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY) | BE | (X5) COMPLETION DATE |
| F 626 | Continued From page | | F 62 | - | | |
| | | was conducted on 10/12/22 y Nurse Liaison stated she | | sure that the solutions are sustained. | | |
| | had spoken with the h | nospital case manager at the | | The Administrator and/or Director of | | |
| | time of Resident #39' | | | Health Services (DHS) will report the | | |
| | | e resident was unable to | | analysis of the hospital discharge log | to | |
| | | Illegation. She added the rmed her of a report from | | the Quality Assurance Performance Improvement (QAPI) Committee for | | |
| | | Resident #39 continued to | | review and revision monthly x 3 month | ns or | |
| | make allegations of s | taff poisoning her at the | | until substantial compliance is achieve | | |
| | | sident #39 was denied | | | | |
| | | e Nurse Liaison further | | Date of compliance: 11/21/22 | | |
| | | e hospital case managers to ical evaluation on the | | | | |
| | | irther discussion would be | | | | |
| | | urn. The Nurse Liaison | | | | |
| | | follow-up with the hospital | | | | |
| | | status of Resident #39 to | | | | |
| | | would be appropriate. The | | | | |
| | administrator and cor | dent #39 was made by the | | | | |
| | | porate onice. | | | | |
| | An interview was con | ducted on 10/13/22 at 10:00 | | | | |
| | AM, the Administrator | stated she did not have any | | | | |
| | | direct discussion from the | | | | |
| | | ent #39 continued to make | | | | |
| | her. She stated Resid | specific staff would poison | | | | |
| | | t calls to 911 was a problem | | | | |
| | | not meet her behavior | | | | |
| | - | vould need to be stable | | | | |
| | | e she could return. She did | | | | |
| | | et her needs due to her | | | | |
| | | isoning her and providing | | | | |
| | | fused. She stated she did resident would not be | | | | |
| | accepted for return af | | | | | |
| | | as not aware of the follow-up | | | | |
| | - | n the liaison that the resident | | | | |
| | was ready for return a | at this time. She had not | | | | |

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| | | | ()(0) | | | 10.0938-039 |
|--------------------------|--------------------------|--|-------------|---------------------------------------|----------------------------|----------------------|
| | OF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | E CONSTRUCTION | · · · | TE SURVEY MPLETED |
| | | | A. BUILDING | | | С |
| | | 345061 | B. WING | | 1 | 0/27/2022 |
| NAME OF P | ROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP CODI | | 0/21/2022 |
| | | | | 3100 ERWIN ROAD | | |
| PRUITTHE | EALTH-DURHAM | | 1 | DURHAM, NC 27705 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORF (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION S REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE AI DEFICIENCY) DEFICIENCY | | SHOULD BE | (X5) COMPLETIOI DATE | |
| F 626 | Continued From page | - 24 | F 000 | | | |
| F 020 | Continued From page | | F 626 | | | |
| | | r discussion with anyone at | | | | |
| | | no documentation with the ng informed of Resident | | | | |
| | #39's return to the fac | 0 | | | | |
| | | omy. | | | | |
| | Telephone interview | was conducted on 10/13/22 | | | | |
| | | pital Case Manager (CM) | | | | |
| | | was admitted on 9/20/22 for | | | | |
| | urinary tract infection | as well as psychological | | | | |
| | issues. The resident | was treated in the ED and | | | | |
| | | n to the facility. The Case | | | | |
| | | to the facility around 7 PM | | | | |
| | | cility nurse and prepare | | | | |
| | - | ident return, Nurse #10 on | | | | |
| | - | s informed the resident was | | | | |
| | | return. The CM was told the urn because the bed was | | | | |
| | | en to another resident. CM | | | | |
| | | o see if they had spoken with | | | | |
| | | hold and the daughter | | | | |
| | - | spoken with anyone from | | | | |
| | - | the bed hold policy. CM | | | | |
| | | ility around 2 AM, to discuss | | | | |
| | transfer back and aga | ain nurse stated there was | | | | |
| | no bed available and | she would have to speak | | | | |
| | | ent about resident not | | | | |
| | | facility Liaison at 6:45 AM | | | | |
| | | ed the resident would not be | | | | |
| | - | esident paranoid/delusion, | | | | |
| | | assault worsening. The | | | | |
| | | e accepted back to the | | | | |
| | facility. The Liaison re | equested a complete | | | | |
| | | ould return to the facility. CM | | | | |
| | | id spoke with the liaison on | | | | |
| | - | I her the resident had been | | | | |
| | | d psychologically for return | | | | |
| | | | | | | |
| | and was again told th | at management decided not | | | | |

Facility ID: 923197

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| | - | D HUMAN SERVICES MEDICAID SERVICES | | | | FORM | APPROVED 0. 0938-0391 | | | |
|---|--|---|---------|--|---------------------------------------|-------------------|--------------------------|--|--|--|
| STATEMENT OF D AND PLAN OF CO | EFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | · / | | E CONSTRUCTION | (X3) DATE COMP | SURVEY LETED | | | |
| | | 345061 | B. WING | | | | C 27/2022 | | | |
| NAME OF PROV | IDER OR SUPPLIER | | | | STREET ADDRESS, CITY, STATE, ZIP CODE | | | | | |
| PRUITTHEAL | TH-DURHAM | | | | 3100 ERWIN ROAD DURHAM, NC 27705 | | | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | | ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | | | | | | |
| no ha ac 30 be he pla ha the ac lim co ret ini ad sir An AM ret sh Ret sh Ret sh An the sh An the ac ac lim co ret ini ad sir An the ac ac lim co ret ini ad sir An the ac ac lim co ret ini ad sir An the ac ac lim co ret ini ad sir An the ac sh ac ac ac sh ac ac ac ac ac ac ac ac ac ac ac ac ac | ad been at hospital of coept resident, they I obday notice and alter een found at this time eld with resident and acement in area near ad been no success. ey were told flat out coepted for return pla nited. CM was not ar ontacting any outside ferences of individua- itial admission. the r djusted and resident nce 9/23/22. In interview was cond M, the Director of Nu ceive a call from the ne received a call from esident #39 was rea ated the resident was sych eval and vagina- nticipated the resident me resident would have om that required iso een given to another boke with the Admini- ould not be acception in the behaviors/accu e police. DON further ave followed up with e resident to determ ould be appropriate telephone interview 12:43 PM, the Nurs | The CM stated the resident due to facility refusal to had not given resident ernate placement had not e. Discussion had been daughter regarding ar daughter, however, there CM further stated because the resident would not be acement options had been ware of the resident e source or making als poisoning her since her nedications had been had been stable for return ducted on 10/13/22 at 11:55 ursing (DON) stated she did e 3rd shift nurse who stated om the hospital stating dy for return. The DON is sent to the hospital for a al discomfort and it was not int would return that evening. Ave needed to return to a valation and that room had resident. DON stated she strator who stated they g the resident back based usation and constant calling er stated the liaison would the hospital and assessed ine whether the resident | F | 626 | | | | | | |

If continuation sheet Page 36 of 98

| | - | ID HUMAN SERVICES MEDICAID SERVICES | FORM APF OMB NO. 093 | | APPROVED 0.0938-0391 | | |
|--------------------------|--|---|-------------------------|-----|--|-------------------|----------------------------|
| STATEMENT (| DF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | E CONSTRUCTION | (X3) DATE COMP | |
| | | 345061 | B. WING | | | | 27/2022 |
| NAME OF PI | ROVIDER OR SUPPLIER | | | | STREET ADDRESS, CITY, STATE, ZIP CODE | <u> </u> | |
| 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 PREFI TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY) | | (X5) COMPLETION DATE |
| F 626 | returned. She told the staff the bed the resid was currently occupie bed available. She sta the DON who stated t until a psych eval was not have another roor placed on isolation sin been put in her previce 2. Resident # 292 adr 8/18/22 and had diag infarction, hemiplegia hypertension, conges and a chronic kidney A review of the medice #292 was able to mak minimum data set (MI Resident # 292 discha and discharged from skilled nursing facility On 10/11/22 at 9:25 a conducted with Resid and it was indicated th Resident # 292 to retu- calling the state agen corporate complaint li An interview was com- pm with the facility ho indicated she was in o resident's return to fac and Resident # 292 d and went to another s indicated she receiver #292 was not returning | e emergency department lent was discharged from ad and there was no other ated she had spoken with the resident could not return a done. She stated she did in that the resident could be noce another resident had ous room. mitted to the facility on noses including cerebral , atrial fibrillation, tive heart failure, asthma, disease. al record reveled Resident ke needs known. No DS) was completed. arged to hospital on 8/29/22 the hospital to another um an interview was ent # 292's family member he facility would not allow urn to the facility due to her cy and the company | F | 626 | | | |

Facility ID: 923197

If continuation sheet Page 37 of 98

| | | MEDICAID SERVICES | | | OMB NO. 0938- | |
|--------------------------|--|---|-------------------------------------|--|-------------------------------|--|
| | OF DEFICIENCIES F CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CO A. BUILDING | | (X3) DATE SURVEY COMPLETED | |
| | | | | | с | |
| | | 345061 | B. WING | | 10/27/2022 | |
| NAME OF P | ROVIDER OR SUPPLIER | • | STR | EET ADDRESS, CITY, STATE, ZIP COD | | |
| PRUITTHE | 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 CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY) | SHOULD BE COMPLI | |
| F 626 | Continued From page | | F 626 | | | |
| | meet Resident's needs. She indicated on 9/1/22 she contacted the hospital case manager and informed her that the facility would not be taking the Resident back due to not being able to meet Resident #292 needs. | | | | | |
| | pm with the Administ Resident #292's fami allegation of neglect compliance line. She to bring Resident # 2 | nducted on 10/13/22 at 12:58 rator and it was indicated ily member made an on the facility to the company indicated it was decided not 92 back because the family ty was not taking care of the | | | | |
| F 636 SS=B | | - | F 636 | | 11/21/2 | |
| | a comprehensive, ac | duct initially and periodically | | | | |
| | A facility must make a assessment of a resi goals, life history and resident assessment by CMS. The assess the following: (i) Identification and c (ii) Customary routine | ent Assessment Instrument. a comprehensive dent's needs, strengths, I preferences, using the instrument (RAI) specified sment must include at least demographic information e. | | | | |
| | (iii) Cognitive pattern (iv) Communication. (v) Vision. (vi) Mood and behavi (vii) Psychological week | ior patterns. | | | | |

Facility ID: 923197

If continuation sheet Page 38 of 98

| | | ND HUMAN SERVICES MEDICAID SERVICES | | | FOR | ED: 12/06/202 RM APPROVEI O. 0938-039 |
|--------------------------|---|---|---------------------|---|------------------------------|---|
| STATEMENT (| OF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | . , | CONSTRUCTION | | E SURVEY IPLETED |
| | | 345061 | B. WING | | 10 | C D/27/2022 |
| NAME OF P | ROVIDER OR SUPPLIER | | s | TREET ADDRESS, CITY, STATE, ZIP COI | | |
| PRUITTH | 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 CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY) | N SHOULD BE E APPROPRIATE | (X5) COMPLETION DATE |
| F 636 | (viii) Physical function (ix) Continence. (x) Disease diagnosis (xi) Dental and nutriti (xii) Skin Conditions. (xiii) Activity pursuit. (xiv) Medications. (xv) Special treatment (xvi) Discharge plann (xvii) Documentation regarding the addition on the care areas trig the Minimum Data Set (xviii) Documentation assessment. The as include direct observations with the resident, as a licensed and nonlicer members on all shifts §483.20(b)(2) When timeframes prescribed chapter, a facility must assessment of a resist timeframes specified through (iii) of this set prescribed in §413.32 apply to CAHs. (i) Within 14 calendate in mental condition. (For "readmission" means following a temporary or therapeutic leave.) (iii)Not less than once This REQUIREMENT | hing and structural problems. a and health conditions. onal status. Ats and procedures. ing. of summary information hal assessment performed gered by the completion of et (MDS). of participation in sessment process must ation and communication well as communication with hsed direct care staff 5. required. Subject to the d in §413.343(b) of this st conduct a comprehensive dent in accordance with the in paragraphs (b)(2)(i) ction. The timeframes 13(b) of this chapter do not r days after admission, ns in which there is no the resident's physical or r purposes of this section, a return to the facility y absence for hospitalization | F 636 | Corrective action for the res | idents found | |

Facility ID: 923197

If continuation sheet Page 39 of 98

| | | MEDICAID SERVICES | | | | B NO. 0938-03 |
|--------------------------|--------------------------|---|---------------------|-------------------------------------|---|---------------------------|
| | DF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | · / | PLE CONSTRUCTION | , , | DATE SURVEY COMPLETED |
| | | 0.15004 | | | | С |
| | | 345061 | B. WING | | | 10/27/2022 |
| NAME OF P | ROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY | , STATE, ZIP 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 | (EACH COR | ER'S PLAN OF CORRECTION RECTIVE ACTION SHOULD BE RENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETIO DATE |
| F 636 | Continued From page | a 30 | F 6 | 36 | | |
| 1 000 | | | FU | | , the deficient practice | |
| | | lete admission Minimum essments within 14 calendar | | | y the deficient practice. s no longer in the facility. | |
| | | nts' admission to the facility | | | n admission assessment | |
| | | (Residents #393, #14, and | | | nent Reference Date | |
| | | sessments were reviewed. | | | 2 and was completed on | |
| | The findings included | 1: | | | | |
| | | | | | admission Minimum Data | |
| | | is admitted to the facility on | | | closed and signed by the | |
| | | tive diagnoses included | | - | se (RN) on 07/14/22, | |
| | diabetes and a histor | y of fails. | | date. | ays after his admission | |
| | Review of Resident # | 393's admission Minimum | | uale. | | |
| | Data Set (MDS) reve | | | Resident #92⊡s | admission Minimum Data | |
| | reference date (ARD, | | | | ssment was in open | |
| | | s 9/18/22. The facility's | | | 2022 and was completed | |
| | | m indicated the due date for | | and closed by th | ne Registered Nurse on | |
| | Resident #393's adm | ission MDS was 9/28/22. | | 10/14/2022, whi | ch was 31 days after his | |
| | | was not signed or dated by | | admission date. | | |
| | the Registered Nurse | | | | | |
| | - | the assessment had been | | | n for other residents | |
| | completed as of the c | date of the review (10/12/22). | | | ntial to be affected by the | |
| | A : | | | same deficient p | practice. | |
| | | ducted on 10/12/22 at 3:35 | | All regidents has | is the notential to be | |
| | - | Administrator. During the strator reported she was | | | ve the potential to be alleged deficient practice. | |
| | | garding multiple MDS | | | dentify other residents | |
| | assessments being c | | | - | ntial to be affected by the | |
| | | | | | practice by an audit | |
| | Upon their request, a | n interview was conducted | | | e Case Mix Coordinator of | |
| | on 10/12/22 at 5:05 F | | | | ent residents to ensure an | |
| | | gional MDS Consultant. | | admission asses | ssment was completed | |
| | | the Administrator reported | | | lar days of the residents \square | |
| | - | ied concerns with MDS | | | e facility per Resident | |
| | | overdue. It was reported the | | | trument (RAI) guidelines. | |
| | facility had staffing ch | | | | completed on 11/16/22. | |
| | Department and coul | | | | esidents noted as affected | |
| | | e all assessments. The | | - | sessments not completed | |
| | Consultant reported of | outside assistance has | | timely. | | |

Facility ID: 923197

| CENTER | S FOR MEDICARE & | MEDICAID SERVICES | | | | IO. 0938-039 |
|--------------------------|---|---|--|---|---|----------------------------|
| | OF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | · · / | PLE CONSTRUCTION G | · · · · | TE SURVEY MPLETED |
| | | 345061 | B. WING | | 1 | C 0/27/2022 |
| NAME OF P | ROVIDER OR SUPPLIER | I | | STREET ADDRESS, CITY, STATE, ZIP | | |
| 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 C (EACH CORRECTIVE AC CROSS-REFERENCED TC DEFICIEN | CTION SHOULD BE THE APPROPRIATE | (X5) COMPLETION DATE |
| F 636 | helped the facility to catch up on "quite a few" assessments. When asked what the anticipated date of compliance was for the MDS assessments to be up to date, the Regional MDS Consultant stated it was "on-going." She added there was a meeting planned for 10/14/22 and she anticipated a date of compliance may be set at that time. 2. Resident #14 was admitted to the facility on 6/21/22. His cumulative diagnoses included | | F 63 | 36 | | |
| | | | | The Regional Clinical Rei Consultant (CRC) in-serv Interdisciplinary Team (ID completion of all Minimum (MDS) assessments acco Resident Assessment Ins guidelines on 11/15/22. C Coordinator will review th Set Section Status daily in assure all assessments a | iced the facility PT) on timely In Data Set ording to the trument (RAI) case Mix e Minimum Data n Matrix Care to | |
| | | | and signed within the time for each assessment type has also been developed Corporate Clinical Reimb and will be used by the M (MDS) nurses to track all type and Assessment Ref (ARD) dates as well as ut Resident Minimum Data S Status Report daily from I | e. A spreadsheet by the Regional ursement Team linimum Data Set assessments for ference Date lilizing the Set (MDS) 3.0 | | |
| | | | Education will be provided orientation for any new Li Assessment Coordinator the timely completion of a Set (MDS) assessments Medicare and Medicaid S guidelines. Systemic changes made | censed Nurse hired regarding Ill Minimum Data per Center for ervices (CMS) | | |
| | During the interview, the facility had identifi assessments being o facility had staffing ch Department and could demands to complete Consultant reported o | the Administrator reported ied concerns with MDS verdue. It was reported the allenges in the MDS | | A spreadsheet has been Regional Corporate Clinic Reimbursement Consulta be used by the Minimum nurses for tracking all ass type and Assessment Ref | not recur. developed by the cal int Team and will Data Set (MDS) sessments for | |

Facility ID: 923197

If continuation sheet Page 41 of 98

| | OF DEFICIENCIES | MEDICAID SERVICES | (X2) MI II TID | PLE CONSTRUCTION | | NO. 0938-039 |
|--------------------------|--|---|---------------------|---|----------------|----------------------------|
| | CORRECTION | IDENTIFICATION NUMBER: | | G | · · · · | OMPLETED |
| | | | A. DOILDING | | | С |
| | | 345061 | B. WING | | | 10/27/2022 |
| NAME OF PI | ROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP | P CODE | |
| | | | | 3100 ERWIN ROAD | | |
| PRUITTHE | EALTH-DURHAM | | | DURHAM, NC 27705 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | REFIX (EACH CORRECTIVE ACTION SHOULD BE | | (X5) COMPLETION DATE |
| F 636 | Continued From page | - 41 | Г. со | | | |
| F 030 | 1.0 | | F 63 | | 411: | |
| | assessments. When date of compliance w | asked what the anticipated | | (ARD) dates as well as un Resident Minimum Data | • | |
| | | p to date, the Regional MDS | | Status Report daily from | , , | |
| | | vas "on-going." She added | | spreadsheet will be utilize | | |
| | | planned for 10/14/22 and | | discussed during the dail | • | |
| | - | e of compliance may be set | | Team meeting. | | |
| | at that time. | | | Plans to monitor its perfo | rmance to make | |
| | | admitted to the facility on | | sure that the solutions are | e sustained. | |
| | | 92's baseline care plan was | | - | | |
| 1 | · · | 2. Review of the admission ndicated the assessment | | The Licensed Nurse Asse | | |
| | was in process and in | | | Coordinator will report the tracking spreadsheet duri | • | |
| | | icomplete. | | Assurance Performance | | |
| | On 10/13/22 at 3:23 I | PM with the Regional MDS | | (QAPI) Committee meetir | • | |
| | Consultant and facilit | | | revision monthly x 3 mon | | |
| | | jional MDS Consultant stated | | substantial compliance is | | |
| | that the assessment | was not completed and was | | | | |
| | | esident's baseline care plan | | Date of compliance: | 11/21/22 | |
| | was completed within | n the 48 hours of admission. | | | | |
| | An interview was con | ducted on 10/12/22 at 5:05 | | | | |
| | PM with the facility's | Administrator and Regional | | | | |
| | | ring the interview, the | | | | |
| | - | d the facility had identified a | | | | |
| | | have been working on which | | | | |
| | | rns. In discussing the MDS | | | | |
| | | he Regional MDS Consultant I staffing challenges in the | | | | |
| | | d could not meet the work | | | | |
| | | all assessments. MDS | | | | |
| | | cilities have been utilized to | | | | |
| | assist this facility. Th | e Regional MDS Consultant | | | | |
| | reported the outside | assistance had helped the | | | | |
| | | "quite a few" assessments. | | | | |
| | | when we started was trying | | | | |
| | | e assessments" and two | | | | |
| | | led to regroup to ensure the | | | | |
| | | ne current assessments eted. The Administrator and | | | | |

If continuation sheet Page 42 of 98

| TATEMENT (| DF DEFICIENCIES CORRECTION | MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | · · · | IPLE CONSTRUCTION | | (X3) DATE SURVEY COMPLETED | |
|--------------------------|---|--|-------------------------------------|--|---|-------------------------------|---------------------------|
| | | 345061 | B. WING | | | C 10/27/2022 | |
| NAME OF PI | ROVIDER OR SUPPLIER | • | | STREET ADDRESS, | CITY, STATE, ZIP CODE | • | - |
| PRUITTHE | ALTH-DURHAM | | 3100 ERWIN ROAD DURHAM, NC 27705 | | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFI TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | | | (X5) COMPLETIO DATE |
| F 636 | Continued From page the Regional MDS Co | e 42 onsultant were asked what | F | 36 | | | |
| | | of completion for all MDS | | | | | |
| F 637 SS=D | Comprehensive Asse CFR(s): 483.20(b)(2) | essment After Signifcant Chg (ii) | F | 37 | | | 11/21/22 |
| | determines, or should there has been a sign resident's physical or purpose of this section means a major declin resident's status that itself without further in implementing standa interventions, that ha one area of the reside requires interdisciplin care plan, or both.) This REQUIREMENT by: | hin 14 days after the facility d have determined, that hificant change in the mental condition. (For on, a "significant change" he or improvement in the will not normally resolve intervention by staff or by rd disease-related clinical s an impact on more than ent's health status, and hary review or revision of the f is not met as evidenced iew and staff interviews, the | | Corrective a | action for the residents fou | nd | |
| | Minimum Data Set (N calendar days after th had been a significar | lete a significant change /IDS) assessment within 14 ne facility determined there It change for 1 of 1 DS reviewed (Resident | | Resident #4 facility. He h assessment | ed by the deficient practice 42 no longer resides in the had a significant change with an Assessment Date (ARD) of 9/8/22 and 0/30/22. | | |
| | The findings included | | | | ction for other residents | h | |
| | 5/29/21 with re-entry Hospice referral was | dmitted to the facility on from a hospital on 9/2/22. A made for Resident #442 on | | same deficie | | ne | |
| | | ve diagnoses included roke) affecting his left | | affected by t The facility v | have the potential to be the alleged deficient praction will identify other residents potential to be affected by t | | |

Event ID: GOU111

Facility ID: 923197

If continuation sheet Page 43 of 98

| STATEMENT (| DF DEFICIENCIES CORRECTION | MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | LE CONSTRUCTION | (X3) DAT | O. 0938-039 E SURVEY IPLETED |
|---------------|-------------------------------|--|---------------|---|-----------------|------------------------------------|
| | | 345061 | B. WING | | C 10/27/2022 | |
| NAME OF PI | ROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP CODE | | |
| | | | | 3100 ERWIN ROAD | | |
| PRUITTHE | EALTH-DURHAM | | | DURHAM, NC 27705 | | |
| (X4) ID | SUMMARY ST | TATEMENT OF DEFICIENCIES | ID | PROVIDER'S PLAN OF COR | RECTION | (X5) |
| PREFIX TAG | | CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | PREFIX TAG | (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY) | | COMPLETION |
| F 637 | Continued From pag | e 43 | F 63 | 17 | | |
| | | #442's significant change | 1 00 | same deficient practice by an a | audit | |
| | Minimum Data Set (N | | | conducted by the Case Mix Co | | |
| | · · | ce date (ARD, the last day of | | 100% of all current residents to | | |
| | |) was 9/8/22. This significant | | significant change assessment | | |
| | | gned/dated on 9/30/22 by the | | completed per RAI guidelines. | | |
| | | N) Assessment Coordinator | | was completed on 11/16/22. The | | |
| | | nent had been completed (28 | | four residents noted as affected | • | |
| | • | #442 returned from the | | significant change assessment | | |
| | hospital and was refe | erred to Hospice). | | completed timely. These four s | • | |
| | An interview was cor | nducted on 10/12/22 at 3:35 | | change assessments will be co 11/21/22. | impleted by | |
| | | Administrator. During the | | 11/21/22. | | |
| | - | strator reported she was | | The Regional Clinical Reimburg | sement | |
| | | egarding multiple MDS | | Consultant (CRC) in-serviced t | | |
| | assessments being o | | | Interdisciplinary Team (IDT) on | | |
| | | - | | completion of all Minimum Data | a Set | |
| | Upon their request, a | an interview was conducted | | (MDS) assessments according | to the | |
| | on 10/12/22 at 5:05 F | • | | Resident Assessment Instrume | | |
| | | egional MDS Consultant. | | guidelines on 11/15/22. Case N | | |
| | - | the Administrator reported | | Coordinator will review the Min | | |
| | | fied concerns with MDS overdue. It was reported the | | Set (MDS) Section Status daily Care to assure all assessments | | |
| | | hallenges in the MDS | | completed and signed within th | | |
| | Department and could | - | | timeframe allotted for each ass | | |
| | - | e all assessments. The | | type. A spreadsheet has also b | | |
| | | outside assistance has | | developed by the Regional Cor | | |
| | helped the facility to | catch up on "quite a few" | | Clinical Reimbursement Team | and will be | |
| | | asked what the anticipated | | used by the Minimum Data Set | · / | |
| | date of compliance w | | | nurses to track all assessments | | |
| | | p to date, the Regional MDS | | and Assessment Reference Da | | |
| | | vas "on-going." She added planned for 10/14/22 and | | dates as well as utilizing the Re Minimum Data Set (MDS) 3.0 S | | |
| | - | te of compliance may be set | | Report daily from Matrix Care. | Jiaius | |
| | at that time. | e el compliance may be set | | | | |
| | | | | Education will be provided in n | ew hire | |
| | | | | orientation for any new License | | |
| | | | | Assessment Coordinator hired | | |
| | | | | the timely completion of all Min | | |
| | | | | Set (MDS) assessments per C | enter for | |

Event ID: GOU111

Facility ID: 923197

If continuation sheet Page 44 of 98

| | DF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | · / | | | E SURVEY PLETED |
|--------------------------|--|---|-------------------------------------|--|---|--------------------|
| | | | | | | С |
| | | 345061 | B. WING | | 10/27/2022 | |
| NAME OF P | ROVIDER OR SUPPLIER | | | 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 LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY) | CTION SHOULD BE COMPL D THE APPROPRIATE DA | |
| F 637 | Continued From page | ≥ 44 | F 63 | Medicare and Medicaid Services guidelines. Systemic changes made to ensu the deficient practice will not rec A spreadsheet has been develo Regional Corporate Clinical Reimbursement Consultant (CR and will be used by the Minimum (MDS) nurses for tracking all assessments for type and Asses Reference Date (ARD) dates as utilizing the Resident Minimum I (MDS) 3.0 Status Report daily for Care. This spreadsheet will be u daily and discussed during the Interdisciplinary Team meeting. Plans to monitor its performance sure that the solutions are susta The Licensed Nurse Assessmer Coordinator will report the analy tracking spreadsheet during the Assurance Performance Improv (QAPI) Committee meeting for revision monthly x 3 months or u substantial compliance is achieved. | ure that cur. ped by the C) Team n Data Set sement well as Data Set orm Matrix utilized e to make ined. t sis of the Quality ement eview and until | |
| F 638 SS=B | | _east Every 3 Months | F 63 | Date of compliance: 11/2 | 1/22 | 11/21/22 |
| | §483.20(c) Quarterly Review Assessment A facility must assess a resident using the quarterly 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 by: | | | | | |

Facility ID: 923197

If continuation sheet Page 45 of 98

| | S FOR MEDICARE & | MEDICAID SERVICES | | LE CONSTRUCTION | OMB N | MAPPROVE O. 0938-039 E SURVEY |
|--------------------------|--|---|---------------------|---|---|-------------------------------------|
| | CORRECTION | IDENTIFICATION NUMBER: | | | | IPLETED |
| | | 345061 | B. WING | | C 10/27/2022 | |
| NAME OF PI | ROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP CODE | | |
| PRUITTHE | ALTH-DURHAM | | | 3100 ERWIN ROAD DURHAM, NC 27705 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY) | HOULD BE | (X5) COMPLETIO DATE |
| F 638 | Continued From pag | | F 63 | | | |
| | facility failed to comp | view and staff interviews, the plete quarterly Minimum Data ents at least every 92 days | | Corrective action for the reside to be affected by the deficient p | | |
| | following the previou within 14 days of the | s MDS assessment and/or Assessment Reference Date f the look-back period) for 13 | | Resident #7 was admitted to the 11/04/20 with reentry on 07/24/2 hospital. The coding for the qua | 21 from a | |
| | of 36 residents whos | e MDS assessments were #7, #60, #3 #40, #4, #1, #2, | | assessment for Resident #7 wa completed on 10/14/22. The as was transmitted to Quality Impr | is sessment ovement | |
| | The findings included | d: | | and Evaluation System (QIES) and showing accepted status. | database | |
| | 11/4/20 with reentry of | s admitted to the facility on on 7/24/21 from a hospital. noses included Alzheimer's ition. | | Resident #60 was admitted to the was admitted to the facility from on 10/26/21. The coding for the assessment for Resident #60 w Assessment Reference Date (A | a hospital quarterly vith an vRD) of | |
| | (MDS) assessments had an Assessment I last day of the look-b | nt's Minimum Data Set revealed a quarterly MDS Reference Date (ARD, the pack period) of 1/27/22. The | | 6/17/22 was completed on 07/1 assessment was transmitted to Improvement and Evaluation Sy (QIES) database and showing a status. | Quality /stem | |
| | on 4/7/22 by the Reg | ator to verify the assessment | | Resident #3 was admitted to the 06/04/19. The coding for the qu assessment for Resident #3 wit Assessment Reference Date (A | arterly h an | |
| | AM with the facility's Regional MDS Const both the MDS Coord Consultant reported to | nducted on 10/12/22 at 10:26 MDS Coordinator and the ultant. During the interview, inator and the Regional MDS the MDS assessment was n signed as completed more | | 8/22/22 was completed on 11/1 assessment was transmitted to Improvement and Evaluation Sy (QIES) database and showing a status. | 0/22. The Quality ystem | |
| | than 14 days after th An interview was cor | ÷ . | | Resident #40 was admitted to the on 4/26/19 with the most recent 5/3/22. The coding for the quark assessment for Resident #40 w | reentry on terly | |
| | interview, the Admini | strator reported she was | | Assessment Reference Date (A 8/9/22 was completed on 9/3/22 | RD) of | |

Event ID: GOU111

Facility ID: 923197

If continuation sheet Page 46 of 98

| TATEMENT (| DF DEFICIENCIES | MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | . , | | (X3) DATI | O. 0938-039 E SURVEY PLETED |
|--------------------------|---|---|---------------------|---|---|-----------------------------------|
| | | 345061 | - B. WING | | C 10/27/202 | |
| NAME OF PI | ROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP CODE | 1 10 | |
| | | | 3 | 3100 ERWIN ROAD | | |
| PRUITTHE | EALTH-DURHAM | | | DURHAM, NC 27705 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY) | HOULD BE | (X5) COMPLETIO DATE |
| F 638 | Continued From pag | e 46 | F 638 | | | |
| | assessments being c | | | assessment was transmitted to Improvement and Evaluation S | • | |
| | on 10/12/22 at 5:05 I | n interview was conducted PM with the facility's gional MDS Consultant. | | (QIES) database and showing a status. | accepted | |
| | During the interview, | the Administrator reported fied concerns with MDS | | Resident #4 was admitted to th 5/3/18. The coding for the quar | • | |
| | assessments being c facility had staffing cl Department and cou | | | assessment for Resident #4 with Assessment Reference Date (# 8/23/22 was completed on 10/1 | ARD) of | |
| | Consultant reported helped the facility to assessments. When | e all assessments. The outside assistance has catch up on "quite a few" asked what the anticipated | | assessment was transmitted to Improvement and Evaluation S (QIES) database and showing a status. | ystem | |
| | Consultant stated it w there was a meeting | vas for the MDS p to date, the Regional MDS vas "on-going." She added planned for 10/14/22 and e of compliance may be set | | Resident #1 was admitted to th 4/11/22. The coding for the qua assessment for Resident #1 wit Assessment Reference Date (A 8/19/22 was completed on 10/1 assessment was transmitted to | rterly th an ARD) of 9/22. The | |
| | 11/4/20 with reentry of Her cumulative diagr | s admitted to the facility on on 7/24/21 from a hospital. noses included Alzheimer's tion. Review of the resident's | | (QIES) database and showing a status. | ystem | |
| | a quarterly MDS had Date (ARD, the last of of 4/21/22. The quar | MDS) assessments revealed an Assessment Reference day of the look-back period) terly MDS dated 4/21/22 was | | Resident #2 was admitted to th 9/3/21. The coding for the quar assessment for Resident #2 wit Assessment Reference Date (# 8/18/22 was completed on 10/1 | terly th an ARD) of | |
| | (RN) Assessment Co | 3/22 by the Registered Nurse bordinator to verify the hpleted (32 days after the | | 8/18/22 was completed on 10/1 assessment was transmitted to Improvement and Evaluation S (QIES) database and showing a status. | Quality ystem | |
| | AM with the facility's Regional MDS Cons | nducted on 10/12/22 at 10:26 MDS Coordinator and the ultant. During the interview, inator and the Regional MDS | | Resident #5 was admitted to th 1/19/21. The coding for the qua assessment for Resident #5 wit | irterly | |

Facility ID: 923197

If continuation sheet Page 47 of 98

| | | MEDICAID SERVICES | | E CONSTRUCTION | (X3) DATE SU | 938-039 |
|--------------------------|--------------------------|---|--|---|--------------|----------------------------|
| | CORRECTION | IDENTIFICATION NUMBER: | . , | | COMPLET | |
| | | | A. BOILDING | | с | |
| | | 345061 | B. WING | | 10/27/ | 2022 |
| NAME OF P | ROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP CODE | 1 | |
| | EALTH-DURHAM | | | 3100 ERWIN ROAD | | |
| FROITIN | | | | DURHAM, NC 27705 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOL | | IOULD BE C | (X5) COMPLETION DATE |
| F 638 | Continued From page | e 47 | F 638 | 3 | | |
| | | n signed as completed more | | 8/18/22 was completed on 10/7/ | 22. The | |
| | than 14 days after the | • | | assessment was transmitted to | | |
| | | | | Improvement and Evaluation Sy | | |
| | | ducted on 10/12/22 at 3:35 | | (QIES) database and showing a | ccepted | |
| | | Administrator. During the strator reported she was | | status. | | |
| | | garding multiple MDS | | Resident #74 was admitted to th | e facility | |
| | assessments being c | | | on 10/14/21 with the most recen | • | |
| | 5 | • | | on 6/15/22. The coding for the q | • | |
| | | n interview was conducted | | assessment for Resident #74 with | th an | |
| A | on 10/12/22 at 5:05 F | • | | ASSESSMENT REFERENCE D | | |
| | | gional MDS Consultant. | | 9/21/22 was completed on 11/6/ | | |
| | | the Administrator reported ied concerns with MDS | | assessment was transmitted to Improvement and Evaluation Sy | • | |
| | - | verdue. It was reported the | | (QIES) database and showing a | | |
| | facility had staffing ch | | | status. | | |
| | Department and could | | | | | |
| | | e all assessments. The | | Resident #26 was admitted to the | | |
| | | outside assistance has | | on 8/31/16. The coding for the q | • | |
| | | catch up on "quite a few" | | assessment for Resident #26 wi | | |
| | date of compliance w | asked what the anticipated | | ASSESSMENT REFERENCE D 4/30/22 was completed on 5/24/ | | |
| | | o to date, the Regional MDS | | assessment was transmitted to | | |
| | | /as "on-going." She added | | Improvement and Evaluation Sy | • | |
| | | planned for 10/14/22 and | | (QIES) database and showing a | | |
| | | e of compliance may be set | | status. | | |
| | at that time. | | | Resident #61 was admitted to th | e facility | |
| | 2-a. Resident #60 wa | is admitted to the facility | | on 11/2/21. The coding for the q | • | |
| | | /26/21. His cumulative | | assessment for Resident #61 w | th an | |
| | | nd stage renal disease | | ASSESSMENT REFERENCE D | | |
| | requiring hemodialysi | IS. | | 6/18/22 was completed on 07/12 | | |
| | Review of the resider | nt's Minimum Data Set | | The assessment was transmitte Quality Improvement and Evaluation | | |
| | | revealed a quarterly MDS | | System (QIES) database and sh | | |
| | | Reference Date (ARD, the | | accepted status. | . | |
| | last day of the look-ba | ack period) of 3/17/22. The | | | | |
| | | 3/17/22 was signed/dated | | Resident #53 was admitted to the | - | |
| | on 4/26/22 by the Re | gistered Nurse (RN) | | on 12/6/19. The coding for the q | uarterly | |

Facility ID: 923197

If continuation sheet Page 48 of 98

| | | ID HUMAN SERVICES MEDICAID SERVICES | | | FOR | ED: 12/06/2022 MAPPROVED O. 0938-0391 |
|--------------------------|---|---|---------------------|---|---|---|
| STATEMENT O | DF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | · , | PLE CONSTRUCTION | | E SURVEY IPLETED |
| | | 345061 | B. WING | | 10 | C)/27/2022 |
| NAME OF PI | ROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP CODE | | |
| PRUITTHE | ALTH-DURHAM | | | 3100 ERWIN ROAD DURHAM, NC 27705 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY) | HOULD BE | (X5) COMPLETION DATE |
| F 638 | was completed (40 d. An interview was con AM with the facility's I Regional MDS Consu- both the MDS Coordi Consultant reported to overdue if it had been than 14 days after the An interview was con PM with the facility's a interview, the Adminis aware of concerns re assessments being of Upon their request, a on 10/12/22 at 5:05 F Administrator and Re During the interview, the facility had identiff assessments being of facility had staffing ch Department and could demands to complete Consultant reported of helped the facility to of assessments. When date of compliance w | ator to verify the assessment ays after the ARD). ducted on 10/12/22 at 10:26 MDS Coordinator and the ultant. During the interview, nator and the Regional MDS he MDS assessment was a signed as completed more e ARD date. ducted on 10/12/22 at 3:35 Administrator. During the strator reported she was garding multiple MDS ompleted late. n interview was conducted PM with the facility's gional MDS Consultant. the Administrator reported ied concerns with MDS verdue. It was reported the hallenges in the MDS d not meet the work e all assessments. The putside assistance has catch up on "quite a few" asked what the anticipated | F 63 | assessment for Resident #53 wi ASSESSMENT REFERENCE D 8/13/22 was completed on 9/15/ assessment was transmitted to Improvement and Evaluation Sy (QIES) database and showing a status. Resident #77 was admitted to th on 5/20/22. The coding for the q assessment for Resident #77 wi ASSESSMENT REFERENCE D 9/8/22 was completed on 9/29/2 assessment was transmitted to Improvement and Evaluation Sy (QIES) database and showing a status. Corrective action for other reside having the potential to be affected same deficient practice. All residents have the potential t affected by the alleged deficient The facility will identify other res having the potential to be affected same deficient practice by an au conducted by the Case Mix Coo 100% of all current residents to quarterly assessment was comp RAI guidelines. This audit was comp | ATE of (2022. The Quality rstem accepted he facility juarterly ith an DATE of 2022. The Quality rstem accepted ents ed by the idents ed by the udit rdinator of ensure a pleted per | |
| | Consultant stated it w there was a meeting she anticipated a date at that time. 2-b. Resident #60 wa from a hospital on 10 | as admitted to the facility /26/21. His cumulative nd stage renal disease | | on 11/16/22. One resident was affected by quarterly assessmer completed timely with the quarter assessment to be completed by The Regional Clinical Reimburs Consultant (CRC) in-serviced th Interdisciplinary Team (IDT) on t | noted as hts not erly 11/21/22. ement e | |

Facility ID: 923197

If continuation sheet Page 49 of 98

| STATEMENT OF | F DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA | | | OMB NO. 0938-03 |
|--------------------------|--------------------------|---|-----------------------------|---|-----------------|
| NAME OF PR | ID PLAN OF CORRECTION | | (X2) MULTIPL A. BUILDING | (X3) DATE SURVEY COMPLETED | |
| NAME OF PR | | 345061 | B. WING | | C 10/27/2022 |
| | OVIDER OR SUPPLIER | • | | STREET ADDRESS, CITY, STATE, ZIP CODE | • |
| | | | | 3100 ERWIN ROAD | |
| PRUITTHE | ALTH-DURHAM | | 1 | DURHAM, NC 27705 | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRC DEFICIENCY) | LD BE COMPLETIC |
| F 638 | Continued From page | ≥ <u>/</u> 9 | F 638 | | |
| | | | 1 000 | | |
| | requiring hemodialysi | IƏ. | | (MDS) assessments according to the | |
| | Review of the resider | nt's Minimum Data Set | | Resident Assessment Instrument (F | |
| | | revealed a quarterly MDS | | guidelines on 11/15/22. Case Mix | |
| | | Reference Date (ARD, the | | Coordinator will review the Minimur | n Data |
| | | ack period) of 6/17/22. The | | Set (MDS) Section Status daily in N | latrix |
| | quarterly MDS dated | 6/17/22 was signed/dated | | Care to assure all assessments are | |
| | on 7/12/22 by the Re | | | completed and signed within the | |
| | | ator to verify the assessment | | timeframe allotted for each assessr | nent |
| | was completed (26 da | ays after the ARD). | | type. A spreadsheet has also been | |
| | A : | durate d. e.e. 40/40/00 et 40:00 | | developed by the Regional and Cor | |
| | | ducted on 10/12/22 at 10:26 | | Clinical Reimbursement Consultant team and will be used by the Minim | |
| | | MDS Coordinator and the ultant. During the interview, | | Data Set (MDS) nurses for tracking | |
| | | nator and the Regional MDS | | assessments for type and Assessm | |
| | | he MDS assessment was | | Reference Date (ARD) dates as we | |
| | | n signed as completed more | | utilizing the Resident Minimum Data | |
| | than 14 days after the | | | (MDS) 3.0 Status Report daily from Care. | |
| | | ducted on 10/12/22 at 3:35 | | | |
| | - | Administrator. During the | | Education will be provided in new h | |
| | | strator reported she was | | orientation for any new Licensed N | |
| | | garding multiple MDS | | Assessment Coordinator hired rega | • |
| | assessments being c | | | the timely completion of all Minimur Set (MDS) assessments per Center | |
| | Upon their request a | n interview was conducted | | Medicare and Medicaid Services (C | |
| | on 10/12/22 at 5:05 F | | | guidelines. | |
| | | gional MDS Consultant. | | | |
| | | the Administrator reported | | Systemic changes made to ensure | that |
| | - | ied concerns with MDS | | the deficient practice will not recur. | |
| | - | verdue. It was reported the | | | |
| | facility had staffing ch | | | A spreadsheet has been developed | by the |
| | Department and could | | | Regional and Corporate Clinical | . |
| | - | e all assessments. The | | Reimbursement Consultant (CRC) | |
| | - | outside assistance has | | and will be used by the Minimum D | ata Set |
| | | catch up on "quite a few" | | (MDS) nurses for tracking all assessments for type and Assessm | ent |
| | date of compliance w | asked what the anticipated | | Reference Date (ARD) dates as we | |
| | | p to date, the Regional MDS | | utilizing the Resident Minimum Data | |

Facility ID: 923197

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION COMPLETED A. BUILDING ____ С 345061 B. WING 10/27/2022 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 638 Continued From page 50 F 638 Consultant stated it was "on-going." She added (MDS) 3.0 Status Report daily from Matrix there was a meeting planned for 10/14/22 and Care. she anticipated a date of compliance may be set at that time. Plans to monitor its performance to make sure that the solutions are sustained. 4. Resident #3 was admitted to the facility on 6/14/19. His cumulative diagnoses included a An analysis of the Minimum Data Set history of cerebrovascular accident (stroke). (MDS) assessment completion tracking sheet will be brought to the monthly Review of the resident's Minimum Data Set **Quality Assurance Performance** Improvement (QAPI) Committee meeting (MDS) assessments revealed a quarterly MDS had an Assessment Reference Date (ARD, the for review and revision monthly x 3 last day of the look-back period) of 8/22/22. The months or until substantial compliance is quarterly MDS dated 8/22/22 was still "in process" achieved. as of the date of the review (10/11/22). This assessment was not signed or dated by the Date of compliance: 11/21/22 Registered Nurse (RN) Assessment Coordinator to verify the assessment had been completed (50 davs after the ARD). 5. Resident #4 was admitted to the facility on 5/3/18. Review of the resident's MDS assessment dated 6/5/22 was as quarterly assessment and was signed as being completed on 6/10/22. A review of Resident #4's most recent guarterly MDS assessment dated 8/23/22 revealed the assessment was in progress and not completed. Further review of the assessment revealed Section Z for signature of Registered Nurse assessment coordinator verifying assessment as complete was noted to be blank and no date entry noted. On 10/13/22 at 3:23 PM with the Regional MDS Consultant and facility MDS nurse were interviewed. The Regional MDS consultant stated that the assessments were incomplete. She added the guarterly assessment was overdue since it has not been completed within 14 days

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

| | - | ID HUMAN SERVICES MEDICAID SERVICES | | | | FORM |): 12/06/2022 APPROVED). 0938-0391 |
|--------------------------|--|---|---------------------|------------------------------------|---|-------------------|---|
| STATEMENT C | DF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | . , | CONSTRUCTION | | (X3) DATE COMP | SURVEY LETED |
| | | 345061 | B. WING | | _ | | C 27/2022 |
| NAME OF PF | ROVIDER OR SUPPLIER | | S | TREET ADDRESS, CITY, ST | ATE, ZIP CODE | | |
| PRUITTHE | ALTH-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 | (EACH CORRE) CROSS-REFERE | S PLAN OF CORRECTION CTIVE ACTION SHOULD B NCED TO THE APPROPRIA DEFICIENCY) | | (X5) COMPLETION DATE |
| F 638 | Continued From page since the ARD date. | ÷51 | F 638 | | | | |
| | of the resident's MDS was a discharge asse being completed on 6 | dmitted on 4/11/22. Review assessment dated 5/23/22 assment and was signed as b/6/22.Resident #1 was Resident #1 did not have a assessment after | | | | | |
| | MDS assessment dat assessment was in pr Further review of the section C (cognitive p section Z (Assessmen signature of Registere coordinator verifying a | atterns) was incomplete and nt administration) for | | | | | |
| | Consultant and facility interviewed. The Reg that the assessment w the quarterly assessm | PM with the Regional MDS y MDS nurse were ional MDS consultant stated was incomplete. She added nent was overdue since it ted within 14 days since the | | | | | |
| | review of the quarterly 8/18/22 revealed the | eadmitted on 9/3/21. A y MDS assessment dated assessment was signed by assessment coordinator to aplete on 10/12/22. | | | | | |
| | Consultant and facility | ional MDS consultant stated | | | | | |

Facility ID: 923197

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| | - | ID HUMAN SERVICES MEDICAID SERVICES | | | | FORM | MAPPROVED 0. 0938-0391 |
|--------------------------|--|--|--------------------|-----|---|-------------------|----------------------------|
| STATEMENT | DF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | E CONSTRUCTION | (X3) DATE COMP | SURVEY PLETED |
| | | 345061 | B. WING | | | | C 27/2022 |
| NAME OF P | ROVIDER OR SUPPLIER | | | 5 | 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 SC IDENTIFYING INFORMATION) | ID PREFI TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY) | BE | (X5) COMPLETION DATE |
| F 638 | Resident #5 was ar of the quarterly MDS revealed the assessm Registered Nurse ass certify that it was com On 10/13/22 at 3:23 F Consultant and facility interviewed. The Registered that the assessments Regional MDS Consultants Regional MDS Consultants A review of Resident MDS assessment was in pr Further review of the section C (cognitive pr section Z (Assessment signature of Registered coordinator verifying at was noted to be bland An interview was com PM with the facility's A MDS Consultant. Du Administrator reporter couple of areas they functured MDS concert concerns identified, the stated the facility had MDS Department and demands to complete nurses from sister fact assist this facility. Th | dmitted on 1/19/21. A review assessment dated 8/18/22 nent was signed by the sessment coordinator to aplete on 10/7/22. PM with the Regional MDS y MDS nurse were ional MDS Consultant stated were completed late. The altant stated Resident #5's apleted on 10/7/22 and 22. readmitted on 6/15/22. #74's most recent quarterly red 9/21/22 revealed the rogress and not completed. assessment revealed atterns) was incomplete and not administration) for ed Nurse assessment assessment as complete (and no date entry noted. ducted on 10/12/22 at 5:05 Administrator and Regional | F | 638 | | | |

Facility ID: 923197

If continuation sheet Page 53 of 98

| | | ID HUMAN SERVICES MEDICAID SERVICES | | | | FORM | APPROVED 0. 0938-0391 |
|--------------------------|---|--|--------------------|------|---|-----------|----------------------------|
| STATEMENT (| OF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA | (X2) MUL | TIPL | LE CONSTRUCTION | (X3) DATE | SURVEY |
| AND PLAN OF | CORRECTION | IDENTIFICATION NUMBER: | A. BUILD | ING | 3 | | |
| | | 345061 | B. WING | | | | C 27/2022 |
| NAME OF P | ROVIDER OR SUPPLIER | | | | 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 PREFI TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY) | | (X5) COMPLETION DATE |
| F 638 | facility to catch up on She stated, "the goal to catch up on the late weeks ago they need facility also kept up th needing to be comple the Regional MDS Co the anticipated date of assessments to be up MDS Consultant state 10. Resident #26 was 8/31/2016. Review of Resident # revealed the resident Data Set (MDS) with a Date (ARD, last day of 4/30/2022. The quarte completed on 5/24/20 An interview with the Clinical Reimburseme the MDS assessment more than 14 days aff An interview with the A Clinical Reimburseme conducted on 10/12/2 Administrator indicate assessments should b required time. 11. Resident #61 was 11/02/2021. Review of Resident # | "quite a few" assessments. when we started was trying a assessments" and two ed to regroup to ensure the e current assessments ted. The Administrator and onsultant were asked what if completion for all MDS to date. The Regional ed it was "on-going." a admitted to the facility on 26's medical record had a quarterly Minimum an Assessment Reference of the assessment period) of erly MDS was signed as 22. MDS Coordinator and the ent Consultant was 2022 at 3:23 P.M. The ent Consultant indicated if was signed as completed ter the ARD date it was late. Administrator and the ent Consultant was 2022 at 5:06 P.M. The ent consultant mos 2022 at 5:06 P.M. The ent consultant mos 2022 at 5:06 P.M. The ent consultant mos | F | 638 | 8 | | |

If continuation sheet Page 54 of 98

| | | - | ID HUMAN SERVICES | | | | FORM | M APPROVED |
|--|-------------|------------------------|-------------------------------|----------|-----|---|-----------|----------------------------|
| A. BUILDING C 345061 B. WING 10/27/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE PRUITTHEALTH-DURHAM 3100 ERWIN ROAD DURHAM, NC 27705 DURHAM, NC 27705 (X4) ID PREFIX SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL ID PREFIX PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE (X5) COMPLETION COMPLETION | STATEMENT (| OF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA | l` í | | | (X3) DATE | SURVEY |
| 345061 B. WING 10/27/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE PRUITTHEALTH-DURHAM 3100 ERWIN ROAD DURHAM, NC 27705 DURHAM, NC 27705 (X4) ID PREFIX SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL ID PREFIX PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE (X5) COMPLETION | AND PLAN OF | CORRECTION | IDENTIFICATION NOMBER. | A. BUILD | ING | i | | |
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| ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X5) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETION | PRUITTH | EALTH-DURHAM | | | | | | |
| PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETION | | | | | | | | |
| TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) DATE | PREFIX | (EACH DEFICIENC) | Y MUST BE PRECEDED BY FULL | PREF | | (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR | | (X5) COMPLETION DATE |
| F 638 Continued From page 54 F 638 | F 638 | Continued From page | 54 | | 639 | 0 | | |
| Data Set (MDS) with an Assessment Reference | 1 000 | | | Г | 030 | 0 | | |
| Date (ARD, the last day of the look-back period) | | Date (ARD, the last d | ay of the look-back period) | | | | | |
| of 6/18/2022. The quarterly MDS was signed as completed on 7/12/2022. | | | | | | | | |
| An interview with the MDS Coordinator and the | | An interview with the | MDS Coordinator and the | | | | | |
| Clinical Reimbursement Consultant was conducted on 10/13/2022 at 3:23 P.M. The | | - | | | | | | |
| Clinical Reimbursement Consultant indicated if | | | | | | | | |
| the MDS assessment was signed as completed | | | | | | | | |
| more than 14 days after the ARD date it was late. | | more than 14 days af | ter the ARD date it was late. | | | | | |
| An interview with the Administrator and the | | | | | | | | |
| Clinical Reimbursement Consultant was conducted on 10/12/2022 at 5:06 P.M. The | | | | | | | | |
| Administrator indicated resident MDS | | | | | | | | |
| assessments should be completed within the required time. | | assessments should l | | | | | | |
| 12. Resident #53 was admitted to the facility on 12/06/2019. | | | admitted to the facility on | | | | | |
| Review of Resident # medical record revealed the | | | | | | | | |
| resident had a quarterly Minimum Data Set | | | | | | | | |
| (MDS) with an Assessment Reference Date (ARD, the last day of the look-back period) of | | | | | | | | |
| 8/13/2022. The quarterly MDS was signed as | | 8/13/2022. The quarter | erly MDS was signed as | | | | | |
| completed on 9/15/2022. | | completed on 9/15/20 |)22. | | | | | |
| An interview with the MDS Coordinator and the | | An interview with the | MDS Coordinator and the | | | | | |
| Clinical Reimbursement Consultant was | | | | | | | | |
| conducted on 10/13/2022 at 3:23 P.M. The Clinical Reimbursement Consultant indicated if | | | | | | | | |
| the MDS assessment was signed as completed | | | | | | | | |
| more than 14 days after the ARD date it was late. | | more than 14 days af | ter the ARD date it was late. | | | | | |
| An interview with the Administrator and the | | An interview with the | Administrator and the | | | | | |
| Clinical Reimbursement Consultant was conducted on 10/12/2022 at 5:06 P.M. The | | - | | | | | | |

Facility ID: 923197

If continuation sheet Page 55 of 98

| | - | D HUMAN SERVICES MEDICAID SERVICES | | | | FORM | MAPPROVED 0. 0938-0391 |
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| STATEMENT (| DF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | CONSTRUCTION | (X3) DATE COMF | SURVEY PLETED |
| | | 345061 | B. WING _ | | | | C 27/2022 |
| NAME OF PI | ROVIDER OR SUPPLIER | | | | IREET ADDRESS, CITY, STATE, ZIP CODE | | |
| PRUITTHE | ALTH-DURHAM | | | | 00 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 | < | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY) | | (X5) COMPLETION DATE |
| F 638 F 642 SS=B | required time. 13. Resident #77 was 5/20/2022. Review of Resident # revealed the resident Data Set (MDS) with a Date (ARD, the last d of 9/8/2022. The quar completed on 9/29/20 An interview with the Clinical Reimburseme conducted on 10/13/2 Clinical Reimburseme the MDS assessment more than 14 days aff An interview with the A Clinical Reimburseme conducted on 10/12/2 Administrator indicate assessments should b required time. Coordination/Certificat CFR(s): 483.20(h)-(j) §483.20(h) Coordinatt A registered nurse mu each assessment with participation of health §483.20(i) Certificatio §483.20(i) Certificatio | ad resident MDS be completed within the admitted to the facility on 77's medical record had a quarterly Minimum an Assessment Reference ay of the look-back period) terly MDS was signed as 122 (21 days after the ARD). MDS Coordinator and the ent Consultant was 2022 at 3:23 P.M. The ent Consultant indicated if was signed as completed ter the ARD date it was late. Administrator and the ent Consultant was 2022 at 5:06 P.M. The ent Consultant was 2022 at 5:06 P.M. The d resident MDS be completed within the ation of Assessment ion. ust conduct or coordinate in the appropriate professionals. n. ered nurse must sign and | F6 | | | | 11/21/22 |
| - | Clinical Reimburseme conducted on 10/12/2 Administrator indicate assessments should b required time. Coordination/Certifica CFR(s): 483.20(h)-(j) §483.20(h) Coordinat A registered nurse mu each assessment with participation of health §483.20(i) Certificatio | ent Consultant was 2022 at 5:06 P.M. The ed resident MDS be completed within the ation of Assessment ion. ust conduct or coordinate in the appropriate professionals. n. ered nurse must sign and | Fé | 642 | | | 11/21/22 |

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| | - | ID HUMAN SERVICES MEDICAID SERVICES | | | | FORM | APPROVED . 0938-0391 |
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| STATEMENT C | DF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | · / | | E CONSTRUCTION | (X3) DATE COMP | SURVEY LETED |
| | | 345061 | B. WING | | | | C 27/2022 |
| NAME OF PF | ROVIDER OR SUPPLIER | | | S | STREET ADDRESS, CITY, STATE, ZIP CODE | 1 10/ | |
| PRUITTHE | ALTH-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 PREFI TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | | (X5) COMPLETION DATE |
| F 642 | Continued From page | > 56 | F | 642 | | | |
| | portion of the assessr | dividual who completes a ment must sign and certify ortion of the assessment. | | | | | |
| | individual who willfully (i) Certifies a material resident assessment penalty of not more th assessment; or (ii) Causes another in and false statement ir | ledicare and Medicaid, an y and knowingly- and false statement in a is subject to a civil money nan \$1,000 for each dividual to certify a material n a resident assessment is ey penalty or not more than | | | | | |
| | constitute a material a | disagreement does not and false statement. is not met as evidenced | | | | | |
| | facility failed to compl assessment within 14 Reference Date (ARD look-back period) for | days of the Assessment | | | Corrective action for the residents four to be affected by the deficient practice. Resident #7 was admitted to the facility 11/04/2020 with reentry on 07/24/2021 from a hospital. The coding for the Ann Assessment for Resident #7 was | ' on | |
| | The findings included | : | | | completed on 10/14/2022. The assessment was transmitted to Quality | | |
| | - | n 7/24/21 from a hospital. oses included Alzheimer's | | | Improvement and Evaluation System (QIES) database and showing accepted status. | d | |
| | (MDS) assessments r had an Assessment F | nt's Minimum Data Set revealed an annual MDS Reference Date (ARD) of larterly MDS had an ARD | | | Corrective action for other residents having the potential to be affected by the same deficient practice. All residents have the potential to be affected by the alleged deficient practice | | |

Event ID: GOU111

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| | | | 0.00 | | | NO. 0938-03 |
|--------------------------|-------------------------------|---|---------------------|--|----------------------------|---------------------------|
| | OF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | . , | LE CONSTRUCTION | · · · · | ATE SURVEY OMPLETED |
| | | | A. BUILDING | · | | С |
| | | 345061 | B. WING | | | |
| | ROVIDER OR SUPPLIER | 343001 | | STREET ADDRESS, CITY, STATE, ZIP COL | | 10/27/2022 |
| | ROVIDER OR SUFFLIER | | | 3100 ERWIN ROAD | | |
| PRUITTHE | EALTH-DURHAM | | | DURHAM, NC 27705 | | |
| | | | | · | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTIOI CROSS-REFERENCED TO THE DEFICIENCY) | N SHOULD BE APPROPRIATE | (X5) COMPLETIO DATE |
| F 642 | Continued From page | e 57 | F 64 | 2 | | |
| | | her review of Resident #7's | | The facility will identify other | residents | |
| | | dicated an annual Minimum | | having the potential to be affe | | |
| | | an assessment reference | | same deficient practice by an | • | |
| | | 2 was still "in process" on | | conducted by the Case Mix C | | |
| | the date of the review | • | | 100% of all current residents | | |
| | assessment was not | signed or dated by the | | Registered Nurse conducted | and | |
| | Registered Nurse (RN | N) Assessment Coordinator | | coordinated each assessmer | it with the | |
| | to verify the assessm | ent had been completed. | | appropriate participation of th | e | |
| | | | | Interdisciplinary Team. This a | | |
| | | ducted on 10/12/22 at 10:26 | | completed on 11/16/22. The | re were no | |
| | | MDS Coordinator and | | residents noted as affected. | | |
| | - | ultant. Upon review of | | | | |
| | | MDS dated 8/31/22, the | | The Regional Clinical Reimbu | | |
| | | d this assessment was late | | Consultant (CRC) in-serviced | | |
| | and had not yet been | completed. | | Interdisciplinary Team (IDT) of a semalation of all Minimum De | - | |
| | An interview was can | ducted on 10/12/22 at 3:35 | | completion of all Minimum Da (MDS) assessments accordir | | |
| | | Administrator. During the | | Resident Assessment Instrun | - | |
| | | strator reported she was | | guidelines on 11/15/22. Case | . , | |
| | | s regarding multiple MDS | | Coordinator will review the M | | |
| | assessments being c | | | Set (MDS) Section Status da | | |
| | | | | Care to assure all assessme | • | |
| | Upon their request. a | n interview was conducted | | completed and signed within | | |
| | on 10/12/22 at 5:05 F | | | timeframe allotted for each as | | |
| | Administrator and Re | gional MDS Consultant. | | type. A spreadsheet has also | | |
| | - | the Administrator reported | | developed by the Regional a | | |
| | | ied concerns with MDS | | Clinical Reimbursement Con | | |
| | | verdue. It was reported the | | team and will be used by the | | |
| | facility had staffing ch | | | Data Set (MDS) nurses for tra | - | |
| | Department and could | | | assessments for type and As | | |
| | | e all assessments. The | | Reference Date (ARD) dates | | |
| | | outside assistance has | | utilizing the Resident Minimu | | |
| | | catch up on "quite a few" | | (MDS) 3.0 Status Report dail | y from Matrix | |
| | | asked what the anticipated | | Care. | | |
| | date of compliance w | o to date, the Regional MDS | | Education will be provided in | new hire | |
| | | as "on-going." She added | | orientation for any new Licen | | |
| | | planned for 10/14/22 and | | Assessment Coordinator, hire | | |
| | | e of compliance may be set | | the timely completion of all M | | |

Facility ID: 923197

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| | | ND HUMAN SERVICES MEDICAID SERVICES | | | PRINTED: 12/06/2022 FORM APPROVED OMB NO. 0938-0391 |
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| STATEMENT | DF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | LE CONSTRUCTION | (X3) DATE SURVEY COMPLETED C |
| | | 345061 | B. WING | | 10/27/2022 |
| NAME OF P | ROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP COD | |
| 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 CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY) | N SHOULD BE COMPLETION |
| F 642 | Continued From page at that time. | e 58 | F 64 | 2 Set (MDS) assessments per of Medicare and Medicaid Servi guidelines. Systemic changes made to enthe deficient practice will not of A spreadsheet has been dever Regional and Corporate Clinic Reimbursement Consultant (Cand will be used by the Minim (MDS) nurses for tracking all assessments for type and Ass Reference Date (ARD) dates utilizing the Resident Minimur (MDS) 3.0 Status Report daily Care. Plans to monitor its performan sure that the solutions are sure An analysis of the Minimum (MDS) assessment completion sheet will be brought to the m Quality Assurance Performan Improvement (QAPI) Commit for review and revision month months or until substantial contactional contaction of the c | ces (CMS) nsure that recur. eloped by the cal CRC) team hum Data Set sessment as well as m Data Set y from Matrix nce to make stained. Data Set on tracking honthly ice tee meeting hy x 3 |
| F 655 SS=B | - | -(3) | F 65 | Date of compliance: 11 | 1/21/22 |
| | Planning §483.21(a) Baseline §483.21(a)(1) The fa | sive Person-Centered Care Care Plans cility must develop and e care plan for each resident | | | |

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| | | ID HUMAN SERVICES MEDICAID SERVICES | | | | FORM | APPROVED 0. 0938-0391 |
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| STATEMENT | DF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | E CONSTRUCTION | (X3) DATE COMP | SURVEY LETED |
| | | 345061 | B. WING | | | | C 27/2022 |
| NAME OF P | ROVIDER OR SUPPLIER | | • | 5 | 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 SC IDENTIFYING INFORMATION) | ID PREFI TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY) | | (X5) COMPLETION DATE |
| F 655 | that includes the instr effective and person- that meet professional The baseline care pla (i) Be developed within admission. (ii) Include the minimu necessary to properly including, but not limit (A) Initial goals based (B) Physician orders. (C) Dietary orders. (C) Dietary orders. (C) Dietary orders. (C) Dietary orders. (C) Dietary orders. (E) Social services. (F) PASARR recomm §483.21(a)(2) The fact comprehensive care plan if the compre- (i) Is developed within admission. (ii) Meets the requirer (b) of this section (exc this section). §483.21(a)(3) The fact resident and their rep of the baseline care point (ii) A summary of the dietary instructions. (iii) Any services and administered by the fac on behalf of the faciliti (iv) Any updated infor of the comprehensive | uctions needed to provide centered care of the resident al standards of quality care. In must- in 48 hours of a resident's um healthcare information care for a resident ted to- d on admission orders. endation, if applicable. cility may develop a plan in place of the baseline rehensive care plan- n 48 hours of the resident's ments set forth in paragraph cepting paragraph (b)(2)(i) of cility must provide the resentative with a summary plan that includes but is not if the resident. resident's medications and treatments to be acility and personnel acting | F | 655 | | | |

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| | | ND HUMAN SERVICES MEDICAID SERVICES | | | FOR | D: 12/06/202 MAPPROVE D. 0938-039 |
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| | DF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | · · / | LE CONSTRUCTION | COM | E SURVEY PLETED |
| | | 345061 | B. WING | | | /27/2022 |
| NAME OF PI | ROVIDER OR SUPPLIER | | | 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 LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE / DEFICIENCY) | SHOULD BE | (X5) COMPLETION DATE |
| F 655 | Continued From page | e 60 | F 65 | 5 | | |
| | family interview, and failed to provide the r | | | Corrective action for the resid to be affected by the deficient | | |
| | | summary of the baseline esidents reviewed for care and Resident #94) | | Resident #46 no longer reside facility. | | |
| | Findings included: | | | On 11/15/2022 the Interdiscipli (IDT) held a care plan review r resident #92 and he was provi | meeting with ded a copy | |
| | 1.Resident #46 was a 8/22/22. | admitted to the facility on | | of his Comprehensive Care Pla Summary. | an | |
| | Resident #46 was ca | dated 8/22/22 revealed re planned for behavior vity of Daily Living (ADL) ler, and mobility. | | Corrective action for other resi having the potential to be affect same deficient practice. | | |
| | | Set (MDS) five-day admission 29/22 revealed Resident #46 hitively. | | The current Social Worker (SV employment January 2022 and aware that each admission wa a copy of his/her baseline care residents were reviewed for | d was not is to receive | |
| | Resident #46's repre- resident was admitte | on 10/10/22 at 2:10 PM, sentative indicated that the d to the facility 8 weeks ago. ntative stated he does not | | documentation of providing the and/or Responsible Party a co baseline care plan and none w | py of the | |
| | recollect having recein documentation provide admission to the facility | led to him after resident's | | On 11/15/2022 the Clinical Reimbursement Consultant (C in-serviced the Interdisciplinar (IDT) on providing the resident | y Team | |
| | Social Worker stated the time of Resident i unsure if any docume plan was provided to | on 10/13/22 at 1:57 PM the she was unavailable during #46's admission and was entation of the baseline care the resident's | | Responsible Party (RP) with a baseline care plan to include a minimum healthcare information necessary to care for the resident the 48-hour Post-Acute Care (| copy of the at a on lent during PAC) | |
| | Director of Nursing (| on 10/13/22 at 5:10 PM, the DON) indicated she was e care plan was reviewed | | meeting that is held within 48-l admission. The Social Worker document in the medical recor baseline care plan meeting wa a copy given to the resident ar | (SW) will d that the as held, and | |

Facility ID: 923197

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DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION COMPLETED A. BUILDING ____ С 345061 B. WING 10/27/2022 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 655 Continued From page 61 F 655 with the resident's representative and a copy of Responsible Party (RP) during the the care plan was provided to them. The DON 48-hour Post-Acute Care (PAC) meeting. stated she thought MDS staff were responsible for care plan meetings and documentation. Education will be provided in new hire orientation for any new Social Worker On 10/13/22 at 3:23 PM with the Regional MDS (SW) hired regarding the procedure for Consultant and facility MDS nurse were providing each admission with a copy of interviewed. The Regional MDS consultant stated his/her baseline care plan. the baseline care plan was completed by different Systemic changes made to ensure that departments within 48 hours of admission, the deficient practice will not recur. however the MDS staff were not responsible for setting up any meeting or providing The Social Worker (SW) will audit each documentation to residents and family members admission for documentation that a copy for baseline care plans. The MDS department of the baseline care plan was provided to was only responsible for setting up the resident and/or the Responsible Party interdisciplinary team meetings with the resident (RP) during the 48-hour Post-Acute Care or family for quarterly, annual and any change in (PAC) meeting. This audit will be resident's care plan. conducted daily x 4 weeks then three times a week x 4 weeks then once a week During an interview on 10/13/22 at 5:10 PM the x 4 weeks. Administrator did not identify the staff responsible to conduct and provide baseline care plan Plans to monitor its performance to make documents to the residents or their sure that the solutions are sustained. representatives. The Administrator stated the The Social Worker (SW) will report the resident's representative should be provided with analysis of the baseline care plan the written summary of the baseline care plan delivery/documentation audit to the and should be completed within 48 hours of **Quality Assurance Performance** admission to the facility. Improvement (QAPI) Committee monthly for review and revision x 3 months or until 2. Resident #92 was admitted to the facility on substantial compliance is achieved. 9/13/22. Date of compliance: 11/21/22 Review of the care plan dated 9/13/22 revealed the resident was care planned for Activity of Daily Living (ADL) decline, falls, medical conditions, and behaviors. Review of the admission Minimum Data Set (MDS) dated 9/18/22 indicated the resident was

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

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| | - | D HUMAN SERVICES MEDICAID SERVICES | | | | FORM | M APPROVED 0. 0938-0391 |
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| STATEMENT C | DF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | PLE CONSTRUCT G | | (X3) DATE SURVEY COMPLETED | |
| | 345061 B. WING | | | | C / 27/2022 | | |
| | | | | STREET ADDRE | ESS, CITY, STATE, ZIP CODE | | |
| PRUITTHE | ALTH-DURHAM | | | DURHAM, NO | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI> TAG | | PROVIDER'S PLAN OF CORRECTION ACH CORRECTIVE ACTION SHOULD DSS-REFERENCED TO THE APPROPR DEFICIENCY) | 3E | (X5) COMPLETION DATE |
| F 655 F 657 SS=D | assessed as cognitive During an interview of Resident #92 stated h received care plan do him after his admissic During an interview of Social Worker stated plan meeting with the member in the preser indicated she was uns was provided to the re- member. During an interview of Administrator stated shad a meet and greet and the resident's fam resident was admitted Administrator indicate plan meeting and no of to the resident or the Administrator was una responsible to conduct meeting and provide of resident's responsible stated the resident or should be provided w the baseline care plan within 48 hours of adr Care Plan Timing and CFR(s): 483.21(b)(2)(0 §483.21(b) Comprehe §483.21(b)(2) A comp- be- (i) Developed within 7 | ely intact. In 10/10/22 at 12:30 PM, he does not recollect having cumentation provided to on to the facility. In 10/13/22 at 1:57 PM the she had a baseline care resident and resident family doe of the Administrator. She sure if any documentation esident or his family In 10/13/22 at 5:10 PM, the she and the Social Worker meeting with the resident hily member when the at to the facility. The di t was not a base line care documentation was provided family member. The able to identity the staff at the baseline care plan documentation to resident or a party. The Administrator resident's representative ith the written summary of an and should be completed mission to the facility. Revision i)-(iii) ensive Care Plans orehensive care plan must if days after completion of | F6 | | | | 11/21/22 |
| | (i) Developed within 7 the comprehensive as | | | | | | |

Facility ID: 923197

If continuation sheet Page 63 of 98

| | - | ID HUMAN SERVICES MEDICAID SERVICES | | | | FOR | ED: 12/06/202 MAPPROVE O. 0938-039 |
|--------------------------|--|---|-------------------|--------------|---|----------------|--|
| | TEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA DPLAN OF CORRECTION UMBER: | | , í | CONSTRUCTION | (X3) DATE SURVEY COMPLETED | | |
| | | 345061 | B. WING | | | 10 | C)/27/2022 |
| NAME OF PF | ROVIDER OR SUPPLIER | I | I | S | TREET ADDRESS, CITY, STATE, ZIP CODE | | |
| PRUITTHEALTH-DURHAM | | | | | 100 ERWIN ROAD JURHAM, NC 27705 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREF TAG | | PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY) | SHOULD BE COMP | |
| F 657 | Continued From page | e 63 | F | 657 | | | |
| | | terdisciplinary team, that | | | | | |
| | includes but is not lim | | | | | | |
| | (A) The attending phy | /sician. | | | | | |
| | | e with responsibility for the | | | | | |
| | resident. | | | | | | |
| | (C) A nurse aide with resident. | responsibility for the | | | | | |
| | | and nutrition services staff. | | | | | |
| | | ticable, the participation of | | | | | |
| | | esident's representative(s). | | | | | |
| | • | be included in a resident's | | | | | |
| | | participation of the resident | | | | | |
| | | resentative is determined | | | | | |
| | not practicable for the | e development of the | | | | | |
| | resident's care plan. | staff or professionals in | | | | | |
| | | ined by the resident's needs | | | | | |
| | or as requested by th | - | | | | | |
| | | ised by the interdisciplinary | | | | | |
| | | ssment, including both the | | | | | |
| | comprehensive and c | uarterly review | | | | | |
| | assessments. | - : | | | | | |
| | | is not met as evidenced | | | | | |
| | by: Based on resident in | terview, staff interviews, and | | | Corrective action for the residents for | ound | |
| | | ility failed to the facility failed | | | to be affected by the deficient practic | | |
| | to allow the Resident | the right to participate in | | | | | |
| | | 28 residents reviewed for | | | Resident #43 was admitted to the fact | cility | |
| | care planning (Reside | ent #43). | | | on 08/25/2021 and readmitted on 10/21/2021. The Interdisciplinary Tea | am | |
| | Findings included: | | | | (IDT) held a care plan meeting on 10/25/2022 with resident to review h | er | |
| | | ed to the facility on 8/25/21 | | | current comprehensive care plan. | | |
| | | cluding chronic congestive | | | | | |
| | | rillation, peripheral vascular | | | Corrective action for other residents | (the | |
| | disease, and chronic | | | | having the potential to be affected by same deficient practice. | / ine | |
| | | #43's comprehensive care st reviewed on 5/24/22. | | | The current Minimum Data Set (MDS | 5) | |

Facility ID: 923197

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| | | | | | | 0938-03 |
|---|-----------------------|---|---------------------|--|--------|---------------------------|
| TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA ND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | . , | LE CONSTRUCTION | (X3) DATE S COMPL | | |
| | | | A. BUILDING | | с | |
| | | 345061 | B. WING | | | 7/2022 |
| NAME OF PF | ROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP CODE | 1 10/2 | |
| | | | 3100 ERWIN ROAD | | | |
| PRUITTHE | ALTH-DURHAM | | | 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 CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY) | LD BE | (X5) COMPLETIO DATE |
| | | | | DEFICIENCY | | |
| F 657 | Continued From page | e 64 | F 65 | 7 | | |
| | | | | nurse began employment Septemb | er | |
| | A review of Resident | #43's annual minimum data | | 2022 and initiated the care plan rev | | |
| | set (MDS) dated 8/8/2 | 22 revealed Resident was | | process to include resident and/or | | |
| | cognitively intact. | | | Responsible Party (RP) participation | n. | |
| | During an interview w | rith Resident #43 on | | As of 11/10/2022, the Minimum Da | ta Set | |
| | 10/10/22 at 11:25 am | it was indicated she has not | | (MDS) nurses reviewed all resident | ts for | |
| | | ing since admitting to the | | documentation of a comprehensive | | |
| | | Resident #43 indicated | | plan meeting with the resident and | | |
| | | e a care plan meeting to go | | Responsible Party (RP) and 23 of 9 | | |
| | over her care. | | | been done. The remaining resident | | |
| | . | | | have a care plan meeting schedule | d to | |
| | | ducted with Administrator urse on 10/13/22 at 12:58 | | review his/her care by 11/21/22. | | |
| | - | ed they were re-structuring | | The Minimum Data Set (MDS) nurs | | |
| | | is since hiring new staff in | | and/or the Social Worker (SW) hav | | |
| | | partments as they current | | completed and mailed care plan m | | |
| | process was not adec | quate. | | letters to all residents and/or Response Party (RP) notifying them of schedu | | |
| | During an interview w | ith the Social Worker (SW) | | care plan meeting date and time ar | | |
| | | n it was indicated follow up | | care plans already scheduled by | | |
| | | had a care plan meeting | | 11/21/2022. If by 11/21/22 the facili | ty has | |
| | | ary team (IDT), but the | | not heard from the resident and/or | | |
| | | n individually and have | | Responsible Party (RP), the Minim | | |
| | | g care and medications with | | Data Set (MDS) nurses and/or the | | |
| | | indicated she was the only | | Worker (SW) will follow up with a p | | |
| | | nent for a while and they | | call to schedule a care plan meetin | | |
| | | nother SW and they have | | Interdisciplinary Team is to review | | |
| | | conduct care plan meetings /orker indicated Resident # | | care plan during the care plan mee | | |
| | | this month for a care plan | | with the resident and/or Responsib (RP). | | |
| | meeting. | | | Systemic changes made to ensure | that | |
| | | ducted on 10/13/22 at 5:06 | | the deficient practice will not recur. | | |
| | | ator and she indicated she | | | | |
| | | o have care plan meetings | | The Case Mix Coordinator will sche | | |
| | quarterly and as need | iea. | | the comprehensive care plan meet | - | |
| | | | | each resident as assigned quarterly annually and with a significant char | | |

Event ID: GOU111

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If continuation sheet Page 65 of 98

| | - | ND HUMAN SERVICES MEDICAID SERVICES | | | FORM APPROVE OMB NO. 0938-039 |
|--------------------------|-------------------------------|---|---------------------|--|--|
| | DF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | · · / | LE CONSTRUCTION | (X3) DATE SURVEY COMPLETED C |
| | | 345061 | B. WING | | 10/27/2022 |
| NAME OF P | ROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP CODE | 1 |
| | | | | 3100 ERWIN ROAD | |
| PRUITIN | ALTH-DURHAM | | | DURHAM, NC 27705 | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY) | ULD BE COMPLETION |
| F 657 | Continued From pag | e 65 | F 65 | distribute the care plan letter invitation the resident and/or Responsible P (RP). The Case Mix Coordinator will discuss the assigned care plans diduring the Interdisciplinary Team (meeting. The Interdisciplinary Team will review each care plan during the plan meeting with the resident and Responsible Party (RP). The Social Worker (SW) will review document via a log all scheduled or plan meetings weekly x 4 weeks a monthly x 3 months ensuring care are conducted quarterly, annually a significant change with the reside and/or Responsible Party (RP). In-servicing was conducted on 11/with the Interdisciplinary Team (ID the Regional Clinical Reimbursem Consultant (CRC) on the care plan meeting process to include mailing plan invitation letters quarterly, and with a significant change and including the resident and/or Responsive care plan. Plans to monitor its performance the sure that the solutions are sustain. Results of the monitoring/log will b presented by the Social Worker (Sthe Quality Assurance Performance Improvement (QAPI) Committee m for review and revision x 3 months substantial compliance is achieved. | arty /ill aily IDT) m (IDT) he care I/or the w and care nd then plans and with ent 15/2022 T) by ent by ent by g care nually ponsible o make ed. we SW) to ce nonthly o or until d. |
| | | solete Event ID: GO | | Date of compliance: 11/21/2 | <u> </u> |

Event ID: GOU111

Facility ID: 923197

If continuation sheet Page 66 of 98

| TATEMENT (| OF DEFICIENCIES | MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA | (X2) MULTIP | LE CONSTRUCTION | (X3) DAT | E SURVEY |
|--------------------------|---|---|---------------------|--|---|----------------------------|
| | ND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | A. BUILDING | | · · · | PLETED |
| | | | D 1/11/2 | | | С |
| | | 345061 | | | 10 | /27/2022 |
| NAME OF P | ROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP CODE 3100 ERWIN ROAD | | |
| PRUITTHE | EALTH-DURHAM | | | 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 CORREC (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPR DEFICIENCY) | JLD BE | (X5) COMPLETION DATE |
| | ADL Care Provided fo CFR(s): 483.24(a)(2) | or Dependent Residents | F 67 | 7 | | 11/21/22 |
| | out activities of daily I services to maintain g personal and oral hyg This REQUIREMENT by: Based on observatio record review the faci resident's fingernails residents dependent Living (ADL) care (Re Findings included: Resident #91 was ad 9/19/22 with diagnose (an injury) of C1/C2 c (bone(s) in the spinal respiratory failure with obstructive pulmonary degeneration. Review of the Admiss (MDS) assessment da Resident #91 was ass | is not met as evidenced ns, staff interviews and lity failed to assure were trimmed for 1 of 7 on staff for Activity of Daily esident #91). mitted to the facility on es that included Subluxation ervical (the neck) vertebrae column), Chronic | | Corrective action for the residents to be affected by the deficient prace Resident # 91 had his fingernails of and trimmed on 10/12/2022 by a C Nurse Aide (CNA). Resident is not facility currently. Corrective action for other resident having the potential to be affected same deficient practice. All dependent residents have the p to be affected by the alleged defici practice. On 11/17/22, Director of H Services (DHS), completed a 1009 of all dependent residents to ensur fingernails are trimmed. 32 of 63 dependent residents were noted w fingernails needing to be trimmed a | tice. certified in the ts by the ootential ent Health % audit re | |
| | Activities of Daily Livi | o-two-person assistance ng (ADL) care. an dated 9/15/22 revealed | | were trimmed on 11/17/22. Systemic changes made to ensure the deficient practice will not recur | | |
| | Resident #91 was can ADL decline. Goal inc needs would be met a maximized within con | re planned for potential for dicated the resident's ADL and independence potential estraints of the disease. d providing assistance with and encouraging the | | Education began on 11/17/22 by th Director of Health Services (DHS) Nurse Managers for the Certified N Assistants (CNA) and Licensed Nu ensuring dependent resident⊡s fin are trimmed accordingly. Educatio be completed by 11/21/22. Any Li | ne and/or Jursing Irses on gernails n is to | |

Facility ID: 923197

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| | OF DEFICIENCIES | MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA | (X2) MULTIF | PLE CON | STRUCTION | (X3) D. | NO. 0938-039 ATE SURVEY |
|------------------------------|---|--|---------------------|---|--|---|----------------------------|
| ND PLAN OF | ND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | A. BUILDING | | | COMPLETED | |
| | | | B. WING | | | С | |
| | | 040001 | | STREE | T ADDRESS, CITY, STATE, ZIP CODE | I | 10/27/2022 |
| NAME OF PROVIDER OR SUPPLIER | | | | | RWIN ROAD | | |
| PRUITTHE | EALTH-DURHAM | | | | AM, NC 27705 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | | PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPR DEFICIENCY) | JLD BE | (X5) COMPLETION DATE |
| F 677 | Continued From page | 967 | F 67 | 77 | | | |
| | During an observation Resident #91 was observation of reside resident with approxin fingernails (10 of 10 fic color debris under the was asked if he liked Resident # 91 did not question. On 10/10/22 at 1:08 F observed during lunch lunch in his room and lunch tray consisted of as part of his meal. The eating these foods wit fingernails (10 of 10 fit with black color debris under them. During an interview of Nurse Aide (NA) #6 in to the resident. NA #6 #91 required extensiv one-person physical a The NA stated the resident. Unless the resident of bath. Unless the resident when the assigned nu fingernails and toenai further stated she had resident and had not | n on 10/10/22 at 10:51AM, served lying in bed. nt's fingers revealed mately one-inch-long ingernails). There was black e nails. When the resident his fingernails trimmed, respond to surveyor's PM, Resident #91 was h. Resident was eating his was able to feed self. The of corn bread and fried okra he resident was observed th his hands. The resident's ingernails) were observed is and had food particles n 10/12/22 at 10:28 AM, ndicated she was assigned of further indicated Resident re to total assistance with assist for ADL care. NA #6 sidents' fingernails and d after a shower or a bed lent was a diabetic patient, urse would trim the ls of the resident. NA #6 d provided a bed bath to the noticed the resident's | | Nu no be the Th an Din au trir tw x 1 Pla su Th rep fin Pe Co rev co | urses and/or certified nursing ass t completing education by 11/21 required to complete education e start of his/her next scheduled the Nurse managers, weekend ma d/or weekend nursing superviso rector of Health Services (DHS) dit 5 dependent residents for fin- mmed 3 times a week x 4 weeks to times a week x 4 weeks, then 1 month or until compliance is act ans to monitor its performance to re that the solutions are sustained the Director of Health Services (D port the analysis of the trimming gernails audit to the Quality Assis erformance Improvement (QAPI) committee monthly for review and vision x 3 months or until substa mpliance is achieved. ate of compliance: 11/21/2 | /22 will prior to shift. anager r, or will gernails a, then weekly chieved. of urance ntial | |
| | | - | | | | | |

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| | | ND HUMAN SERVICES MEDICAID SERVICES | | | | ED: 12/06/202 RM APPROVE IO. 0938-039 |
|--------------------------|--|---|--|--|-------------------------------|---|
| | DF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | (X3) DATE SURVEY COMPLETED | |
| | | 345061 | B. WING | | 1 | C 0/27/2022 |
| NAME OF P | ROVIDER OR SUPPLIER | • | STRE | EET ADDRESS, CITY, STATE, ZIP CO | | |
| PRUITTHI | EALTH-DURHAM | | | ERWIN ROAD RHAM, NC 27705 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY | ON SHOULD BE | (X5) COMPLETION DATE |
| F 677 | resident's nails shoul the resident was offe offered a shower. Nur resident if he would lit trimmed and the resid Nurse #3 indicated sh resident's fingernails Nurse #3 stated the r the facility on 10/8/22 resident had a declin under hospice care. During an interview of Director of Nursing (I resident's fingernails trimmed as needed, w offered a shower or a unless the resident w NA could trim resider the resident was a dia nurse was responsible fingernails and toena resident's fingernails and cleaned by staff could also be placed his toenails could be Quality of Care CFR(s): 483.25 § 483.25 Quality of car applies to all treatme facility residents. Bas assessment of a residents | nt's fingernails stated the d have been trimmed when red a bed bath or when urse #3 then asked the ike his fingernails to be dent responded "sure". he would ensure the were trimmed and cleaned. resident was readmitted to 2 from the hospital. The e in health and was placed on 10/12/22 at 11:00 AM, The DON), she indicated the and toenails should be when the resident was a bed bath. She indicated twas a diabetic resident, the nts' fingernails or toenails. If abetic, then the assigned le for trimming both ils. The DON stated the should have been trimmed as needed. The resident on the podiatrist list so that trimmed. | F 677 | | | 11/21/22 |

Event ID: GOU111

Facility ID: 923197

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| | | ID HUMAN SERVICES MEDICAID SERVICES | | | PRINTED: 12/06 FORM APPRO OMB NO. 0938- | OVE |
|---|--|--|--|---|---|-------|
| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | (X3) DATE SURVEY COMPLETED | |
| | | 345061 | B. WING _ | | C 10/27/2022 | 2 |
| NAME OF PI | ROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STAT | E, 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 LSC IDENTIFYING INFORMATION) | ID PREFI TAG | PROVIDER'S P X (EACH CORRECT CROSS-REFERENC | LAN OF CORRECTION (X5) IVE ACTION SHOULD BE COMPLE EED TO THE APPROPRIATE DATI FICIENCY) | ETION |
| F 684 | by: Based on record rev physician assistant at facility failed to identii residents (Resident # wound on Resident's were no orders for we 8/12/22 Nurses failed body observations the observations and me Nurse # 7 noted an o leg with foul smelling and, Nurse #7 failed address/communicate condition/status/size/ On 8/13/22 Resident and Resident #293 w #293 required treatm osteomyelitis related Immediate Jeopardy Nurse #11 identified a posterior right leg, an services were not pro- Jeopardy was remove facility provided an ac of immediate jeopard remain out of complia | sidents' choices. F is not met as evidenced iew, staff interviews, nd physician interviews, the fy/assess a wound for 1 of 3 4293). Nurse #11 identified a right leg on 7/27/22. There bund care. From 7/27/22 to I to complete the weekly at included wound asurements. On 8/12/22 pen wound to posterior right odor with some bleeding | F | Corrective action for to be affected by the Resident #293 no lor facility. Corrective action for having the potential t same deficient practi All residents have the affected by the allege The Director of Healt initiated 100% body a within the facility on no new skin integrity comparing the known integrity (wounds) on report, in the electric currently in house to completed by the nut 10/20-21/2022. The Director of Healt and/or Nurse Manag the wound audit core 10/20-21/22 and revi documentation to en- skin impairments had | r the residents found deficient practice. nger resides in the other residents to be affected by the ice. e potential to be ed deficient practice. th Services (DHS) audits on all residents 10/20/22. There were issues identified by n (current) skin n the wound manager medical record, the body audits rses on th Services (DHS) ers have reviewed ducted on iewed the sure residents with | |
| | minimal harm that is ensure monitoring an in-serviced. Findings included: | not immediate jeopardy) to | | Services (DHS) and reviewed residents w identified on their 10, body audits to ensure treatment order in pla notification, and docu condition/status/size, wound. | vith skin impairments /20/22 and 10/21/22 e the resident had a ace, physician ument of the | |

Event ID: GOU111

Facility ID: 923197

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| | | ND HUMAN SERVICES MEDICAID SERVICES | | | PRINTED: 12/06/20 FORM APPROV OMB NO. 0938-03 |
|--------------------------|--|--|---------------------|--|---|
| STATEMENT | | | · · / | E CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
| | | 345061 | B. WING | | C 10/27/2022 |
| NAME OF P | ROVIDER OR SUPPLIER | | | 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 LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY) | OULD BE COMPLETIC |
| F 684 | AG REGULATORY OR LSC IDENTIFYING INFORMATION) | | F 684 | The Director of Health Services (and/or Nurse Managers began e to the Nurses on 10/20/22 regard weekly skin observations and documentation in the electronic h record of same. When a new skii impairment is noted, the Nurse w complete the wound documentat electronic medical record that ind description and measurement of contact the physician/physician e for orders, regarding newly ident impairments and/or worsening sk impairments for wound treatment This includes the observations an measurements are necessary as monitoring tool to determine if the any changes in the wound that w require a change in the treatment The Clinical Competency Coordii (CRC) was notified on 10/21/22 f Licensed Nursing Home Adminis (LNHA) to add the skin observation | ducation ding nealth n vill ion in the cludes area and extender ified skin kin t orders. nd a ere are yould t plan. nator by the trator ons and |
| | computer. An interview with Nur 10/13/22 at 1:43 pm, recall doing skin obse on 7/15/22 and 7/29/2 when she did skin ob off she completed the EMAR and document computer. A review of Nursing p at 7:24 pm by Nurse | be documented in the rse #7 was conducted on it was indicated she did not ervations on Resident # 293 22. She further indicated servations, she would sign e skin observation on the t the skin observation in the progress note dated 7/27/22 #11 read in part Resident ound to his right leg. No | | record education to the nurse ge orientation upon hire with empha the nurse who identifies the skin issue completes the wound documentation, physician notifica initiates treatment per physician new / changes in skin integrity. On 10/20/22 and 10/21/22 the Di Health Services (DHS) and Nurs Managers educated the Certified Assistant (CNA) on daily skin che during personal care. This educa includes notification to the nurse skin impairment and/or new dres noted on resident□s skin. The Certified | sis that integrity ation, order for rector of e Nursing ecks tion of any sing |

Facility ID: 923197

If continuation sheet Page 71 of 98

| - | | MEDICAID SERVICES | | | OMB NO. 0938-0 | |
|--------------------------|--|---|--|---|--|--|
| | OF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | (X3) DATE SURVEY COMPLETED | |
| | | 345061 | B. WING | | C 10/27/2022 | |
| NAME OF PI | ROVIDER OR SUPPLIER | L | | 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 CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY) | DULD BE COMPLÉTI | |
| F 684 | Continued From page | e 71 | F 684 | | | |
| r 004 | treatment orders wer with normal saline, da covered with sterile g Resident tolerated we side following cleanin bowel movement. An interview was man with NA #4, and she working one night, (h exact date) with Nurs about the wound to F Nurse #11 put a band During a telephone in pm with Nurse #11 it she assisted NA #4 p living (ADL) care on F they went to turn the open wound on Resid about 1/2 inch in diar She indicated she clead dressing on it. She in Resident's skin and co on Resident. Nurse # the time, and Nurse # the time, and Nurse # wound Physician kno morning. Nurse #11 #1 if she wanted her orders and she stated would take care of it dressing on the wour | e found. Wound was packed amp to dry sterile gauze, and auze secured by kerlix. ell. Repositioned off right ag and linen change after de on 10/11/22 at 4:33 pm indicated she recalled owever could not recall the e #11 and reported to her tesident's right leg and dage on it. terview on 10/11/22 at 5:48 was indicated on 7/27/22 provide activities of daily Resident #293 and when Resident, she observed an dent's right leg that was neter and 2 inches long. eaned the wound and put a dicated she observed lid not see any other wounds #11 indicated she reported #1 who was in the facility at #1 stated she would let the w about the wound the next indicated she asked Nurse to measure the wound or get d Nurse #1 informed her she and instructed her to put a nd. | F 684 | Nursing Assistant (CNA) will obta paper body diagram at the beginn their shift from the nursing station unit and maintain in their possess throughout the day. The Nursing will utilize a body diagram for each resident daily during resident card nurse notification of skin integrity The Certified Nursing Assistant (C circle the area of the body, on the diagram, with the skin integrity iss a pen / pencil and notify nurse of integrity issue. The Nurse will cor body observation on residents the Certified Nursing Assistants (CNA identified with new skin integrity is and notify physician for treatment The Clinical Competency Coordin (CCC) was notified on 10/21/2022 Licensed Nursing Home Administ (LNHA), to add the education of t diagrams and utilization of a body for each resident daily for nurse notification of skin integrity issues general orientation of the Certified Nursing Assistant (CNA). Any Ce Nursing Assistant (CNA) will not the allowed to work after 10/21/22 un receive the education of the Body diagrams and utilization of a body for each resident daily for nurse notification of skin integrity issues general orientation of the Body diagrams and utilization of a body for each resident daily for nurse notification of skin integrity issues Systemic changes made to ensure | hing of on each sion assistant th e, for issues. CNA) will e body sue with skin nplete e A) have ssues corders. hator 2 by the trator he Body y diagram s to the d ertified be til they y diagram | |
| | Resident #293 had n | e #1, and she indicated | | the deficient practice will not recu On 10/21/22 The Director of Heal Services (DHS) notified the Wour and the Nurse Practitioner (NP) to | th nd Nurse | |

Facility ID: 923197

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| (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345061 | A. BUILDING | | (X3) DATE SURVEY COMPLETED C |
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| | | OTDEET ADDEEDO OITV OTATE JID OODE | 10/27/2022 |
| | | STREET ADDRESS, CITY, STATE, ZIP CODE | |
| | | 3100 ERWIN ROAD DURHAM, NC 27705 | |
| Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY) | LD BE COMPLETIC |
| e 72 Its and to document any he wound communication in nurse's desk. Nurse #1 recall the conversation with terly minimum data set revealed cognition assessed. Further review of sident #293 was able to nd required extensive son physical assist with bed ersonal hygiene, bathing, and o help with eating. Resident identified on this MAR for Resident #293 was initialed by Nurse #2 vation was completed; nation was found to verify it pm an interview was e #2, and it was indicated he ng a skin observation on /22. He indicated he did not g a wound. last revised on 8/12/22 93 had a potential for v related to decreased a, and obesity. A goal was for | F 684 | with wounds and both parties will si weekly wound manager report. On 10/21/22 The Licensed Nursing Administrator (LNHA) notified the D of Health Services (DHS) and/or Nu Leadership to review the weekly sk observations (weekly focus observation section, to validate all a identified have physician notification treatments orders are written, wour monitored for changes weekly for fo weeks then monthly thereafter. Plans to monitor its performance to sure that the solutions are sustaine The facility wound manager report or brought to the monthly Quality Assu Performance Improvement (QAPI) Committee meeting by the Director Health Services for review and revisimonthly x 3 months or until substar compliance is achieved. Date of compliance: 11/21/22 | Home virector ursing in ation), der areas n, id is our make d. will be urance of sion itial |
| | ts and to document any he wound communication in nurse's desk. Nurse #1 recall the conversation with terly minimum data set revealed cognition assessed. Further review of sident #293 was able to nd required extensive son physical assist with bed rsonal hygiene, bathing, and o help with eating. Resident identified on this MAR for Resident #293 was initialed by Nurse #2 vation was completed; ntation was found to verify it om an interview was #2, and it was indicated he ng a skin observation on /22. He indicated he did not g a wound. last revised on 8/12/22 93 had a potential for related to decreased | ts and to document any he wound communication in nurse's desk. Nurse #1 recall the conversation with terly minimum data set revealed cognition assessed. Further review of sident #293 was able to nd required extensive son physical assist with bed rsonal hygiene, bathing, and o help with eating. Resident identified on this MAR for Resident #293 was initialed by Nurse #2 vation was completed; ntation was found to verify it om an interview was #2, and it was indicated he ng a skin observation on /22. He indicated he did not g a wound. last revised on 8/12/22 93 had a potential for related to decreased , and obesity. A goal was for se from development of nterventions included y care, report open, sore areas to nurse, diet as | F 684ts and to document any the wound communication in nurse's desk. Nurse #1 recall the conversation withF 684with wounds and both parties will si weekly wound manager report. On 10/21/22 The Licensed Nursing Administrator (LNHA) notified the D of Health Services (DHS) and/or NL Leadership to review the weekly sk observations (weekly focus observa- in the electronic medical record und observation section, to validate all a identified have physician notification treatments orders are written, wour monitored for changes weekly for for weeks then monthly thereafter.MAR for Resident #293 was initialed by Nurse #2 vation was found to verify itThe facility wound manager report to brought to the monthly Quality Assu Performance Improvement (QAPI) Committee meeting by the Director Health Services for review and revi- monthly x 3 months or until substar compliance is achieved.22. He indicated he did not g a wound.gal a potential for rrelated to decreased , and obesity. A goal was for se from development of therventions included y care, report open, sore areas to nurse, diet as |

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| | | D HUMAN SERVICES MEDICAID SERVICES | | | | FORM | APPROVED 0. 0938-0391 | |
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| STATEMENT (| DF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | CONSTRUCTION | (X3) DATE SURVEY COMPLETED | | |
| | | 345061 | B. WING | | | | C 27/2022 | |
| NAME OF P | ROVIDER OR SUPPLIER | | | | REET ADDRESS, CITY, STATE, ZIP CODE | | | |
| PRUITTHE | EALTH-DURHAM | | | | 00 ERWIN ROAD JRHAM, NC 27705 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY) | | (X5) COMPLETION DATE | |
| F 684 | and as needed, use p for offloading. An interview was made with NA #4 and she in to Resident # 293 on she came to work on and while doing her ro Resident and saw dra noted a bandage on h she reported her findi A review of Nursing p at 10:00 pm by Nurse 293 was found to hav leg (calf) with a foul-s bleeding noted. Obse and Physician book for On 10/11/22 at 4:10 p conducted with Nurse was the Nurse that we indicated it was repor to Resident # 293 tha sheets. She indicated and observed a banda leg. Nurse #7 indicated on it and when she re observed wound to rig greenish drainage. Sh the wound to be to the was the end of her sh During a follow up inte clarified that on 8/12/2 with a dressing on Re | episodes, provide sistance with care rounds sillows as tolerated/indicated de on 10/11/22 at 4:33 pm ndicated she was assigned 8/12/22. She indicated when the 11pm shift on 8/12/22 bunds she went to check sinage on his sheets and his right leg. She indicated ngs to Nurse #7. rogress note dated 8/12/22 #7 read in part Resident # e an open wound on right melling odor, and some rvations left in wound care or further evaluation. | F 6 | 84 | | | | |

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| | - | ID HUMAN SERVICES MEDICAID SERVICES | | | | FORM | M APPROVED 0. 0938-0391 |
|--------------------------|--|---|---------|--|---------------------------------------|-------------------|----------------------------|
| STATEMENT (| DF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | , í | | E CONSTRUCTION | (X3) DATE COMF | SURVEY PLETED |
| | | 345061 | B. WING | | | | C 27/2022 |
| NAME OF P | ROVIDER OR SUPPLIER | L | | 5 | 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 PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | | | |
| F 684 | smelling bloody green on the sheet. Review of electronic in 8/12/22 a SBAR (situ assessment, resident Nurse #7 communical change in condition s was wound to right le Wound was evaluated smell. The responsibl 8/13/22 at 4:50 pm, at A review of Nursing p at 1:28 pm by Nurse a Physician, and receiv wound to right leg due osteomyelitis. The ord Doxycycline (an antib infections) 200 milligr day for 7 days, and w solution and Santyl of lab orders for a Comp metabolic panel for M was notified." A review of Nursing p at 6:37 pm by Nurse a #293 sent to emerger evaluation due to wou uncontrolled pain per | nish colored drainage was medical record revealed on ation, background, evaluation) completed by tion form read in part a ymptoms or signs observed g, and it started on 8/12/22. d to have drainage and foul e party (RP) was notified on nd Physician notified. rogress note dated 8/13/22 #7 read in part, "Spoke to ed an order for x-ray of e to pain and to rule out ders were transcribed for iotic to treat bacterial ams (mg) by mouth twice a round care orders for Dakin's intment daily. Also received olete blood count and basic londay 8/15/22. The RP | F | 684 | | | |
| | (T) was 97.3, pulse (F was 18, blood pressu oxygen level was 100 done and results of ri further assessment w tomography (CT)/mag | P) was 134, respirations (R) re (B/P) was 120/72, and 0% on room air. X-ray was ght leg findings suggest | | | | | |

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| | - | ID HUMAN SERVICES MEDICAID SERVICES | | | | FOR | M APPROVED 0. 0938-0391 | |
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| STATEMENT | OF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | | (X3) DATE SURVEY COMPLETED | | |
| | | 345061 | B. WING | | | 10 | C / 27/2022 | |
| NAME OF P | ROVIDER OR SUPPLIER | | • | | STREET ADDRESS, CITY, STATE, ZIP 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 PREFI TAG | | PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY) | BE | (X5) COMPLETION DATE | |
| F 684 | A review of physician orders received to cle saline pat dry, apply I gauze, and cover with dressing once daily. On 10/11/22 at 3:21 p | nurse. orders revealed on 8/13/22 ean right leg with normal Dakin's solution, moistened n calcium alginate and dry | F | 684 | 4 | | | |
| | was called on 8/13/22 of Resident #293's we indicated she informe Physician. On 10/11/22 at 4:10 p conducted with Nurse returned to work on 8 the Resident and then Physician. She indica x-ray of right leg, anti stated she went back the shift and Residen receiving pain medica Physician back and re Resident to hospital f rule out osteomyelitis called the DON and F above information. During an interview o Nurse #9, it was indic assigned to Resident Nurse #7 send Resid Nurse #9 also indicat Resident #293 on 8/1 | 2 and Nurse #7 informed her ound to right leg. She ed Nurse #7 to call the om an interview was e #7, and she indicated she info 22 and went to check on in went and called the ited she received orders for biotics, and blood work. She into Resident's room later in | | | | | | |
| | Nurse #7 stated she I | | | | | | | |

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| | | D HUMAN SERVICES MEDICAID SERVICES | | | FORM | M APPROVED 0. 0938-0391 | |
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| STATEMENT O | OF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA | (X2) MUL | TIPL | LE CONSTRUCTION | (X3) DATE SURVEY | |
| AND PLAN OF | CORRECTION | IDENTIFICATION NUMBER: | A. BUILDI | NG . | · | | PLETED |
| | | 345061 | B. WING | | | | C / 27/2022 |
| NAME OF PI | ROVIDER OR SUPPLIER | | | : | STREET ADDRESS, CITY, STATE, ZIP CODE | 1 10, | 2172022 |
| PRUITTHE | ALTH-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 PREFI TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY) | BE | (X5) COMPLETION DATE |
| | Continued From page notify the Physician b wound the evening be was informed by Nurs order on 8/13/22 to se for evaluation. Nurse seen a wound on the and had only observe Nurse #7 while she di wound. She indicated Residents right calf, a muscle. She indicate bloody drainage on th she did not recall doir Resident #293. She ir observation was on th completed weekly. S supposed to sign off of observation of the ski document in the obse computer. Nurse #9 ir Resident #293 having On 10/12/22 at 10:28 was conducted with th Resident #293, and h no longer worked at th access to Resident #2 he recalled the call fro concerning Resident's gave Nurse #7 orders remember exactly wh sent Resident to the h | a 76 a a 76 b a cause she had found the affore. She indicated she had not and Resident to the hospital # 9 indicated she had not Resident prior to 8/13/22 d the wound on 8/13/22 with a the treatment to the she observed the wound on nd she could see the d it had a small amount of the bandage. She indicated had a small amount of the bandage. She indicated had a skin observation on the EMAR and was to be the also indicated they were on the EMAR once the n was completed and rvation section in the indicated she did not recall any wounds. am a telephone interview the primary Physician of the indicated as of 9/17/22, he indicated he sit indicated on Nurse #7 on 8/13/22 a wound. He indicated he sit of the primary Physician of the indicated he indicated he sit of the indicated he indicated he | | 684 | DEFICIENCY) | IATE | DATE |
| | further about Residen During an interview of NA #10 it was indicate #293 on occasion and | ed he did not recall anything t #293. n 10/11/22 at 4:04 pm with ed she worked with Resident d last worked with Resident l Resident would barely let | | | | | |

| | - | D HUMAN SERVICES MEDICAID SERVICES | | | | FORM | 2: 12/06/2022 1 APPROVED 2: 0938-0391 |
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| STATEMENT C | DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | · / | PLE CONSTRUCTION | | (X3) DATE SURVEY COMPLETED | |
| | | 345061 | B. WING | | | (10/: | ; 27/2022 |
| NAME OF PF | 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) | 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 BE NCED TO THE APPROPRIA DEFICIENCY) | | (X5) COMPLETION DATE |
| F 684 | often refuse to be turn She indicated she not Resident refused care Resident #293 had a and buttocks. She indi- what was under the b A telephone interview at 10:15 am with the F it was indicated she lo and did not have acce indicated she did not wounds on Resident a During an interview of the DON she indicate wound was identified and RP, get an order from the Physician an computer. She also in should put any new w wound communication nurse. She indicated report in the compute if anything was report She indicated she wa until 8/13/22 and after performance improve included education to body audits, skin asse manner, to ensure res care to promote optim decrease the occurrer wounds, education o and they did wound c 8/24/22 as part of the | as difficult to turn, would hed, bathed, or touched. tified the nurses when as NA #10 indicated bandage on back of his leg licated she did not know andages. Twas conducted on 10/12/22 Physician Assistant (PA) and onger worked in the facility ess to her notes. She recall personally seeing any #293. In 10/13/22 at 1:06 pm with d the process for when a was to notify the Physician for treatment of the wound ad transcribe the order in the adicated the Nursing staff younds identified in the in book to notify the wound she reviews the activity r and 24-hour report to see ed of any abnormal findings. s not aware of this incident r this occurred, she did a ment plan (PIP) which Nursing staff on completing essments in a timely sidents are provided quality hum outcomes and ince of new acquired f doing skin observations, hecks on the residents on PIP. | F 68 | | | | |
| | During an interview of | n 10/13/22 at 5:10 pm with | | | | | |

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| | - | ID HUMAN SERVICES MEDICAID SERVICES | | | | FOR | M APPROVED D. 0938-0391 | |
|--------------------------|--|--|--------------------|-----|---|-------------------------------|----------------------------|--|
| STATEMENT (| DF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | LE CONSTRUCTION | (X3) DATE SURVEY COMPLETED | | |
| | | 345061 | B. WING | | | | C / 27/2022 | |
| NAME OF P | ROVIDER OR SUPPLIER | | | | 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 PREFI TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY) | BE | (X5) COMPLETION DATE | |
| F 684 | the Administrator it was expectation when a n was to notify the Phys wound, and notify the indicated it was her e were to be done week computer. A review of hospital e records read in part F hospital on 8/13/22 ill distress, had diffuse p right lower leg, that w signs were as follows B/P-105/63. On exam systemic inflammator and was started on in antibiotics. On 8/15/2 right lower leg was do MRI along posterolate tract to bone with oster The Administrator wa jeopardy on 10/20/22 On 10/22/22 the facili credible allegation of removal: Identify those recipier are likely to suffer, a s because of the nonco Resident #293 no lon 7/27/22 Nurse #11 no lower leg, applied dre physician, her superv | as indicated it was her ew wound was identified sician, get orders to treat the family. She further xpectation skin observations kly and documented in the mergency department Resident #293 presented to -appearing, in acute bain, and had a wound to the as covered. Resident's vital T-99.6, P-119, R-20, it was noted Resident meet y response (SIRS)criteria travenous fluids and 2 MRI of Resident #293's one, and results revealed eral upper leg with sinus eomyelitis. s notified of immediate at 6:07 pm. ty provided the following Immediate Jeopardy hts who have suffered, or serious adverse outcome empliance. ger resides in the facility. On the wound to posterior right ssing but failed to notify isor and did not report off to aff. From 7/27/22 to 8/12/22 | F | 684 | 4 | | | |

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| | | D HUMAN SERVICES MEDICAID SERVICES | | | | FORM | APPROVED 0. 0938-0391 |
|--------------------------|--|--|---------------------|----|---|-------------------------------|----------------------------|
| STATEMENT (| DF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | CONSTRUCTION | (X3) DATE SURVEY COMPLETED | |
| | | 345061 | B. WING | | | | C 27/2022 |
| NAME OF PI | ROVIDER OR SUPPLIER | | | | TREET ADDRESS, CITY, STATE, ZIP CODE | | |
| PRUITTHE | EALTH-DURHAM | | | | 100 ERWIN ROAD URHAM, NC 27705 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION) | ID PREFIX TAG | (| PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | | (X5) COMPLETION DATE |
| F 684 | and measurements or status for this same p Nurse noted an open lower leg with foul sm bleeding noted, the N communication in the book for further evalu address/communicate condition/status/size/a On 8/13/22 nurse spo orders were obtained care orders with an x- 8/13/22 identified lytic was transferred to the Room. The Residents Hospital was rule out no longer employed b The Director of Health body audits on all res 10/20/22. There were identified by comparin integrity (wounds) on in the electric medicat to the body audits cor 10/20-21/2022. All residents have the adverse outcome as a address/communicate identification/condition the wound on a week Actions taken by the f process or system fai | uded wound observation f the resident's skin integrity eriod of time. On 8/12/22 wound to posterior right elling odor with some urse placed a written Physician and Wound Care ation and failed to e/report/document the appearance of the wound. We with physician and new for antibiotics and wound tray to right leg. X-ray dated e lesion, and resident #293 e Hospital Emergency a dmitting diagnosis to the osteomyelitis. Nurse #11 is by this facility. In Services initiated 100% idents within the facility on no new skin integrity issues ing the known (current) skin the wound manager report, I record, currently in house mpleted by the nurses on the potential to suffer a serious a result of the failure to e/report/document the n/status/size/appearance of ly basis. | F 6 | 84 | | | |

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| | | ID HUMAN SERVICES MEDICAID SERVICES | | | | FOR | M APPROVED D. 0938-0391 |
|--------------------------|---|--|--------------------|-----|---|-------------------------------|----------------------------|
| STATEMENT C | OF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | · , | | E CONSTRUCTION | (X3) DATE SURVEY COMPLETED | |
| | | 345061 | B. WING | | | | C / 27/2022 |
| NAME OF P | ROVIDER OR SUPPLIER | | | S | STREET ADDRESS, CITY, STATE, ZIP CODE | | |
| | | | | 3 | 3100 ERWIN ROAD | | |
| PRUITINE | ALTH-DURHAM | | | 0 | DURHAM, NC 27705 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | x | PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY) | BE | (X5) COMPLETION DATE |
| F 684 | Continued From page | 80 | F | 684 | | | |
| | Managers have review conducted on 10/20-2 documentation to ensi- impairments had an of The Director of Health Managers reviewed re- impairments identified 10/21/22 body audits treatment order in pla- and document of the condition/status/size/a The Director of Health Managers began edu 10/20/22 regarding we documentation in the same. When a new sl Nurse will complete th the electronic medica description and meas the physician/physicia regarding newly ident and/or worsening skir treatment orders. This and measurements a monitoring tool to dete changes in the wound change in the treatmet The Clinical Compete notified on 10/21/22 b | 21/22 and reviewed the sure residents with skin order for treatment to areas. In Services and Nurse esidents with skin d on their 10/20/22 and to ensure the resident had a ce, physician notification, appearance of the wound. In Services and/or Nurse cation to the Nurses on eekly skin observations and electronic health record of kin impairment is noted, the ne wound documentation in I record that includes urement of area and contact an extender for orders, ified skin impairments in impairments for wound s includes the observations re necessary as a ermine if there are any d that would require a ent plan. | | | | | |
| | and documentation in education to the Nurs hire with emphasis the the skin integrity issue | o add the skin observations the electronic health record e general orientation upon at the nurse who identifies e completes the wound | | | | | |
| | documentation, physi | cian notification, initiates | | | | | |

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| | OF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | · · / | PLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED | | |
|--|---|--|---------------------|--|---|--|--|
| | | 345061 | B. WING | | C 10/27/2022 | | |
| NAME OF PR | ROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP COL | | | |
| PRUITTHE | ALTH-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 | PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY) | N SHOULD BE COMPLETIC E APPROPRIATE DATE | | |
| F 684 Continued From page 81 treatment per physician order for new / changes | | an order for new / changes | F 68 | 34 | | | |
| | in skin integrity. Any work after 10/21/22 u education. | Nurse will not be allowed to ntil they receive the | | | | | |
| On 10/21/22 The Director of Health Services notified the Wound Nurse and the Nurse Practitioner to meet weekly to discuss and revi all residents with wounds. | urse and the Nurse /eekly to discuss and review | | | | | | |
| On 10/20/22 and 1 | | 21/22 the Director of Health | | | | | |
| | Certified Nursing Assi during personal care. | Anagers educated the istants on daily skin checks This education includes | | | | | |
| | and/or new dressing r Certified Nursing Assi | se of any skin impairment noted on resident's skin. The istant will obtain a paper | | | | | |
| | the nursing station on | peginning of their shift from each unit and maintain in ughout the day. The Nursing | | | | | |
| | resident daily during r | body diagram for each resident care, for nurse egrity issues. The Certified | | | | | |
| | Nursing Assistant will on the body diagram, | circle the area of the body, with the skin integrity issue d notify nurse regarding skin | | | | | |
| | observation on reside | urse will complete body ents the certified nursing ified with new skin integrity | | | | | |
| | The Clinical Compete | sician for treatment orders. ncy Coordinator was 2 by the Licensed Nursing | | | | | |
| | Home Administrator, tregarding the Body di | | | | | | |
| | | egrity issues to the general | | | | | |

If continuation sheet Page 82 of 98

| | MENT OF HEALTH AN S FOR MEDICARE & I | ID HUMAN SERVICES MEDICAID SERVICES | | | | FORM | MAPPROVED 0. 0938-0391 | |
|--------------------------|--|---|--------------------|-----|--|-------------------------------|----------------------------|--|
| STATEMENT | DF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | , , | | LE CONSTRUCTION | (X3) DATE SURVEY COMPLETED | | |
| | | 345061 | B. WING | | | | C 27/2022 | |
| 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 SC IDENTIFYING INFORMATION) | ID PREFI TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY) | | (X5) COMPLETION DATE | |
| F 684 | education regarding ti utilization of a body di daily for nurse notifica The Clinical Compete notified by the License Administrator on 10/2 responsible for ensuri prior to the start of an Certified Nursing Assi 10/21/22. On 10/21/22 The Lice Administrator notified Services and/or Nursi weekly skin observation observation), in the el under observation ser- identified have physic orders are written, wo changes weekly for for thereafter. Date when corrective 10/22/22. On 10/27/22 the credi jeopardy was validate Record reviews and in which verified the aud Interview with the Min- revealed skin assessi Nurse Assistants (NA and if there is an issu NA notifies the charge documents, notifies th | he Body diagrams and iagram for each resident ation of skin integrity issues. Incy Coordinator/RN was ed Nursing Home 1/22, that they are ing education is completed y Licensed Nurse and/or stant working the floor after ensed Nursing Home the Director of Health ing Leadership to review the ons (weekly focus lectronic medical record ction, to validate all areas ian notification, treatments bund is monitored for bur weeks then monthly action will be completed: the allegation of immediate ed by onsite verification. Interviews were conducted lits were completed. imum data set (MDS) Nurse ments were completed daily.) complete a skin audit daily e with a resident's skin, the e nurse who then ne Physician, and obtains S Nurse also indicated they | F | 684 | 4 | | | |

Facility ID: 923197

If continuation sheet Page 83 of 98

| | - | ID HUMAN SERVICES MEDICAID SERVICES | | | | FORM | APPROVED 0. 0938-0391 | |
|--------------------------|--|--|---------------------|-----|---|-------------------------------|----------------------------|--|
| STATEMENT C | DF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | CONSTRUCTION | (X3) DATE SURVEY COMPLETED | | |
| | | 345061 | B. WING | | | | C 27/2022 | |
| NAME OF PF | ROVIDER OR SUPPLIER | | · · | | IREET ADDRESS, CITY, STATE, ZIP CODE | - | | |
| PRUITTHE | ALTH-DURHAM | | | | 000 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 | < | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY) | | (X5) COMPLETION DATE | |
| F 684 | orders were reviewed were corrected. A review of the educated education was provid credible allegation. Interview was conduct at 10:18 am who indice educated by facility the issues with skin to che assesses resident's se wound nurse, Physical Interview was conduct at 10:22 am who indice completing a daily bo with a resident's skin nurse if observes any Interview was conduct 10/27/2022 at 11:12 at do full skin audits on a areas, including reduct and audits were turner reviews and signs off given to DON. Nurse anything observed, the assess wound, inform transcribe any order i information in wound treatment nurse checc any new areas on skit Interviews with staff re provided. | revealed all residents' and any discrepancies the diameter of the staff on 10/27/2022 cated they had been nat NAs are to report any arge nurse. The Nurse then kin and documents, notifies an and RP/family. The dwith staff on 10/27/2022 cated knowledge of dy audit sheet for any issues and notifying the charge skin issues. The dwith Wound Nurse on am who indicated NAs had to every shift. If identified any ess, they notify the nurse ed into the nurse who the skin audit and skin audit s review audit sheets and if ney are to do a SBAR, n Physician and RP, and n computer. Nurses put communication book and ks the book every day for n that were identified. | F 6 | 584 | | | | |
| | The immediate jeopa | rdy removal date of | | | | | | |

If continuation sheet Page 84 of 98

| | S FOR MEDICARE & | | | | | MB NO. 0938-03 |
|--------------------------|--|---|---------------------|--|--|------------------------------|
| | OF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | PLE CONSTRUCTION | () | X3) DATE SURVEY COMPLETED |
| | | | A. BUILDIN | G | | |
| | | 345061 | B. WING | | | C |
| | ROVIDER OR SUPPLIER | 343001 | | | | 10/27/2022 |
| | | | | STREET ADDRESS, CITY, STATE, ZIP CODE 3100 ERWIN ROAD | | |
| PRUITTHE | EALTH-DURHAM | | | DURHAM, NC 277 | 705 | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | (EACH C | VIDER'S PLAN OF CORRECTION CORRECTIVE ACTION SHOULD BE EFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
| F 684 | Continued From page | - 94 | | | | |
| F 004 | - 15 | | F 6 | 34 | | |
| F 000 | 10/22/2022 was valid | | | | | 44/04/00 |
| F 686 SS=G | | event/Heal Pressure Ulcer | F 6 | 30 | | 11/21/22 |
| 33-6 | CFR(5). 403.23(b)(1) | (1)(11) | | | | |
| | §483.25(b) Skin Integrity | | | | | |
| | §483.25(b)(1) Pressure ulcers. | | | | | |
| | Based on the comprehensive assessment of a | | | | | |
| | resident, the facility n | | | | | |
| | (i) A resident receives | s care, consistent with | | | | |
| | professional standard | ls of practice, to prevent | | | | |
| | • | loes not develop pressure | | | | |
| | | vidual's clinical condition | | | | |
| | | ey were unavoidable; and | | | | |
| | | essure ulcers receives | | | | |
| | | and services, consistent | | | | |
| | with professional star | vent infection and prevent | | | | |
| | new ulcers from deve | - | | | | |
| | | is not met as evidenced | | | | |
| | by: | | | | | |
| | | ns, staff interviews, Nurse | | Corrective a | ction for the residents found | I |
| | Practitioner interview | , and record review, the | | to be affected | by the deficient practice. | |
| | | le the necessary care and | | | | |
| | · · | re ulcer including failure to | | | no longer resides in the | |
| | complete weekly skin | | | facility. | | |
| | | d. The facility failed to | | 0 | the franchistic is the | |
| | | cer before it was significant | | - | tion for other residents | |
| | | n (7/10/22). Three days later slough, debris, and necrosis. | | same deficier | otential to be affected by the | ; |
| | On 8/3/22, the wound | | | | | |
| | | age three. The wound | | All residents | have the potential to be | |
| | | ate. On 10/11/22, a nurse | | | ne alleged deficient practice | |
| | | wound and did not seek | | | . . | |
| | medical attention. Th | is was for 1 of 3 residents | | The Director | of Health Services (DHS) | |
| | | e ulcer prevention and | | | % body audits on all residen | |
| | treatment (Resident # | <i>‡</i> 83). | | | ility on 10/20/22. There wer | |
| | | | | 🛛 no new skin i | ntegrity issues identified by | |
| | The findings included | | | | e known (current) skin | |

Event ID: GOU111

Facility ID: 923197

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| | OF DEFICIENCIES | MEDICAID SERVICES | | PLE CONSTRUCTION | | NO. 0938-039 DATE SURVEY |
|---------------|------------------------|--|---------------|--|---------------|-----------------------------|
| | CORRECTION | IDENTIFICATION NUMBER: | · / | G | · · · | OMPLETED |
| | | | A. BUILDING | | | С |
| | | 345061 | B. WING | | | 10/27/2022 |
| NAME OF PI | ROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP CO | DE | 10/21/2022 |
| | | | | 3100 ERWIN ROAD | | |
| PRUITTHE | EALTH-DURHAM | | | DURHAM, NC 27705 | | |
| (X4) ID | | ATEMENT OF DEFICIENCIES | ID | PROVIDER'S PLAN OF C | | (X5) |
| PREFIX TAG | | Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | PREFIX TAG | (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY | E APPROPRIATE | COMPLETIOI DATE |
| F 686 | Continued From page | e 85 | F 68 | 36 | | |
| | | | | integrity (wounds) on the wo | und manager | |
| | Resident #83 was init | tially admitted to the facility | | report, in the electric medica | | |
| | | nitted to the facility on | | currently in house to the bod | | |
| | | ncluded sacral pressure | | completed by the nurses on | | |
| | ulcer, type two diabet | | | 10/20-21/2022. | | |
| | | d right leg above knee | | | | |
| | amputations, and mu | scle weakness. | | The Director of Health Servio | | |
| | - | | | and/or Nurse Managers have | | |
| | | m data set (MDS) dated dent #83 was at risk for | | the wound audit conducted of 10/20-21/22 and reviewed the | | |
| | pressure ulcer develo | | | documentation to ensure res | | |
| | | e time of assessment. | | skin impairments had an ord | | |
| | | | | treatment to areas. The Dire | | |
| | Weekly skin assessm | ent documentation was not | | Services (DHS) and Nurse M | | |
| | provided. | | | reviewed residents with skin identified on their 10/20/22 a | impairments | |
| | A wound note by Nur | se #1 dated 7/10/22 | | body audits to ensure the res | | |
| | revealed Resident #8 | 3 had a new sacral wound, | | treatment order in place, phy | /sician | |
| | and she was started of | on supplements to promote | | notification, and document o | | |
| | - | vound had a light amount of | | condition/status/size/appear | ance of the | |
| | | nd was noted to have the | | wound. | | |
| | - | ents: length 2.5 centimeters | | | (= | |
| | (cm), width 4.5 cm, a | nd depth 0.3 cm. | | The Director of Health Servic | | |
| | A physician order for | wound treatment dated | | and/or Nurse Managers beg to the Nurses on 10/20/22 or | | |
| | | wound treatment dated sacral wound with normal | | observations and documenta | - | |
| | | nser and pat dry. Apply Medi | | electronic health record of sa | | |
| | | bed and cover with a dry | | new skin impairment is noted | | |
| | dressing once daily. | , | | will complete the wound doc | | |
| | | | | the electronic medical record | | |
| | | ote by Nurse Practitioner | | description and measuremen | | |
| | | 2 revealed Resident #83 | | contact the physician/physic | | |
| | | ew sacral wound. Resident | | for orders, newly identified s | | |
| | | /e staff assistance with | | impairments and/or worsenir | | |
| | | ne commands, and was not | | impairments for wound treat | | |
| | | licated the wound exhibited | | This includes the observation | | |
| | | and debris. Therefore, depth imated to be 0.4 cm. The | | measurements are necessar monitoring tool to determine | - | |
| | i uie wound was est | a.eu io de 0.4 011. 1116 | 1 | | n ulere ale | |

Facility ID: 923197

If continuation sheet Page 86 of 98

| | | ND HUMAN SERVICES MEDICAID SERVICES | | | FOR | D: 12/06/20 MAPPROVE D. 0938-039 | |
|--------------------------|------------------------|---|---------------------|---|-------------|--|--|
| | DF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | |
| | | 345061 | B. WING | | 10 | C / 27/2022 | |
| NAME OF PI | ROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP CODE | | | |
| | | | | 3100 ERWIN ROAD | | | |
| PRUITTHE | EALTH-DURHAM | | | DURHAM, NC 27705 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY) | HOULD BE | (X5) COMPLETIO DATE | |
| F 686 | Continued From pag | e 86 | F 686 | | | | |
| | was 5.8 cm. There w | as a presence of necrotic and a mild amount of | | require a change in the treatme | ent plan. | | |
| | , , , | plan was to apply topical | | The Clinical Competency Coord | dinator | | |
| | | would promote debridement. | | (CCC) was notified on 10/21/22 | | | |
| | | d use of an air mattress to | | Licensed Nursing Home Admin | | | |
| | | ading of the resident's | | (LNHA) to add the skin observa | | | |
| | - | n, as well as repositioning. | | documentation in the electronic | | | |
| | | origin of the pressure ulcer | | record education to the Nurse g | | | |
| | as in-house and mar | ked "no" for unavoidable. | | orientation upon hire with emph | | | |
| | | eta hu ND #1 datad 8/2/22 | | the nurse who identifies the skill | n integrity | | |
| | | ote by NP #1 dated 8/3/22 | | issue completes the wound | ootion | | |
| | indicated the sacral v | arance. It was noted to be a | | documentation, physician notific initiates treatment per physiciar | | | |
| | | injury and measured length | | new / changes in skin integrity. | | | |
| | | , and depth 0.2 cm. There | | new / changes in skin integrity. | | | |
| | was a mild amount o | - | | On 10/20/22 and 10/21/22 the [| Director of | | |
| | | formed. It was noted that | | Health Services (DHS) and Nur | se | | |
| | | ould continue as well as | | Managers educated the Certifie | | | |
| | nutritional support me | easures. | | Assistant (CNA) on daily skin cl | hecks | | |
| | | | | during personal care. This educ | cation | | |
| | | plan, revised on 8/4/22, | | includes notification to the nurse | | | |
| | | a for pressure ulcers. The | | skin impairment and/or new dre | • | | |
| | • | it #83's pressure ulcer to | | noted on resident s skin. The (| | | |
| | | ations. Interventions included | | Nursing Assistant (CAN) will ob | | | |
| | · · | lcer for signs and symptoms | | paper body diagram at the begi | - | | |
| | practitioner of any ch | the physician or nurse | | their shift from the nursing station unit and maintain in their posse | | | |
| | treatments as ordere | | | throughout the day. The Certifie | | | |
| | | ч. | | Assistant (CAN) will utilize a bo | 0 | | |
| | A wound note by NP | #1 dated 8/10/22 indicated | | for each resident daily during re | | | |
| | - | d was deteriorating. The was | | care, for nurse notification of sk | | | |
| | | idate and measurements | | issues. The Certified Nursing A | ••• | | |
| | were as follows: leng | th 6cm, width 5 cm, and | | (CNA) will circle the area of the | | | |
| | | sident was noted to be | | the body diagram, with the skin | | | |
| | | ers and urinary diversion with | | issue with a pen / pencil and no | - | | |
| | catheter placement v | vas addressed. | | integrity issue. The Nurse will c | | | |
| | | | | body observations on residents | | | |
| | | #1 dated 8/24/22 indicated | | Certified Nursing Assistant (CN | | | |
| | Resident #83's woun | d healing demonstrated | | identified with new skin integrity | / Issues | | |

Facility ID: 923197

If continuation sheet Page 87 of 98

| | | | | | FO | ED: 12/06/202 RM APPROVE NO. 0938-039 |
|--|---|---|---|---|---|---|
| OF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | (X3) DA | TE SURVEY MPLETED | |
| | 345061 | B. WING _ | | | C 10/27/2022 | |
| ROVIDER OR SUPPLIER | | | ST | REET ADDRESS, CITY, STATE, ZIP CODE | • | |
| EALTH-DURHAM | | | | | | |
| (EACH DEFICIENC | Y MUST BE PRECEDED BY FULL | ID PREFIX TAG | ĸ | (EACH CORRECTIVE ACTION SHOU | LD BE | (X5) COMPLETIO DATE |
| Continued From page | e 87 | F | 586 | | | |
| slight deterioration fro | om previous assessments. | | | and notify physician for treatment o | rders. | |
| wound measurement cm, width 5 cm, and indicated Resident #4 positioning and trans Review of MDS docu #83 was hospitalized A physician's order d Resident #83 was or for her stage three pr The quarterly MDS d Resident #83 was se She required extensi mobility and had a st ulcer. She was noted care and a pressure | ts were as follows: length 6.5 depth 0.2 cm. NP #1 83 remained dependent for fers. Immentation revealed Resident from 9/1/22 - 9/5/22. ated 9/5/22 revealed dered a low air loss mattress ressure ulcer. ated 9/12/22 revealed everely cognitively impaired. ve staff assistance with bed age three unhealed pressure I to receive pressure ulcer reducing device for the bed. | | | (CCC) was notified on 10/21/2022 I Licensed Nursing Home Administra (LNHA), to add the education on the diagrams and utilization of a body of for each resident daily for nurse notification of skin integrity issues to general orientation of the Certified Nursing Assistant (CNA). Any Certi Nursing Assistant (CNA) will not be allowed to work after 10/21/22 until receive the education on the Body diagrams and utilization of a body of for each resident daily for nurse notification of skin integrity issues. | by the tor e Body liagram o the fied they liagram | |
| Review of a wound n indicated the wound stable in appearance of exudate, and the n follows: length 6.5 cm cm. It was noted that significant improvement changed. A physician's order d revealed cleanse sac cleanser, pat dry, app dressings, and secur times a week. | ote by NP #1 dated 9/14/22 was again deteriorating, but . There was a mild amount neasurements were as n, width 7 cm, and depth 0.2 there was a lack of ent and treatments were ated 9/14/22 for wound care cral wound with wound ply two hydrocolloid e with bordered gauze three | | | Services (DHS) notified the Wound and the Nurse Practitioner (NP) to a weekly to discuss and review all re- with wounds. On 10/21/22 The Licensed Nursing Administrator (LNHA) notified the D of Health Services (DHS) and/or No Leadership to review the weekly sk observations (weekly focus observa in the electronic medical record und observation section, to validate all a identified have physician notification treatments orders are written, wour monitored for changes weekly for for | Nurse meet sidents Home pirector ursing in ation), der areas n, at is | |
| | S FOR MEDICARE & DF DEFICIENCIES CORRECTION ROVIDER OR SUPPLIER EALTH-DURHAM SUMMARY ST (EACH DEFICIENC REGULATORY OR Continued From pag slight deterioration from There was a mild and wound measurement cm, width 5 cm, and indicated Resident #4 positioning and trans Review of MDS docu #83 was hospitalized A physician's order d Resident #83 was or for her stage three pu The quarterly MDS d Resident #83 was se She required extensis mobility and had a st ulcer. She was noted care and a pressure The resident weighed Review of a wound m indicated the wound stable in appearance of exudate, and the r follows: length 6.5 cm cm. It was noted that significant improvem changed. A physician's order d revealed cleanse sac cleanser, pat dry, ap dressings, and secur times a week. | CORRECTION IDENTIFICATION NUMBER: IDENTIFICATION NUMBER: 345061 ROVIDER OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 87 slight deterioration from previous assessments. There was a mild amount of exudate, and the wound measurements were as follows: length 6.5 cm, width 5 cm, and depth 0.2 cm. NP #1 indicated Resident #83 remained dependent for positioning and transfers. Review of MDS documentation revealed Resident #83 was hospitalized from 9/1/22 - 9/5/22. A physician's order dated 9/5/22 revealed Resident #83 was ordered a low air loss mattress for her stage three pressure ulcer. The quarterly MDS dated 9/12/22 revealed Resident #83 was severely cognitively impaired. She required extensive staff assistance with bed mobility and had a stage three unhealed pressure ulcer. She was noted to receive pressure ulcer care and a pressure reducing device for the bed. The resident weighed 179 pounds. Review of a wound note by NP #1 dated 9/14/22 indicated the wound was again deteriorating, but stable in appearance. There was a mild amount of exudate, and the measurements were as follows: length 6.5 cm, width 7 cm, and depth 0.2 cm. It was noted that there was a lack of significant improvement and treatments were changed. A physician's order dated 9/14/22 for wound care revealed cleanse sacral wound with wound cleanser, pat dry, apply two hydrocolloid dressings, and secure with bordered gauze three | S FOR MEDICARE & MEDICAID SERVICES OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLA IDENTIFICATION NUMBER: (X2) MULT A. BUILDIN A. BUILDIN SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREEP (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREEP TAG Continued From page 87 slight deterioration from previous assessments. There was a mild amount of exudate, and the wound measurements were as follows: length 6.5 cm, width 5 cm, and depth 0.2 cm. NP #1 indicated Resident #83 remained dependent for positioning and transfers. F 6 Review of MDS documentation revealed Resident #83 was hospitalized from 9/1/22 - 9/5/22. A physician's order dated 9/5/22 revealed Resident #83 was ordered a low air loss mattress for her stage three pressure ulcer. The quarterly MDS dated 9/12/22 revealed Resident #83 was severely cognitively impaired. She required extensive staff assistance with bed mobility and had a stage three unhealed pressure ulcer. She was noted to receive pressure ulcer care and a pressure reducing device for the bed. The resident weighed 179 pounds. Review of a wound note by NP #1 dated 9/14/22 indicated the wound was again deteriorating, but stable in appearance. There was a mild amount of exudate, and the measurements were as follows: length 6.5 cm, width 7 cm, and depth 0.2 cm. It was noted that there was a lack of significant improvement and treatments were changed. A physician's order dated 9/14/22 for wound care revealed cleanse sacral wound with wound cleanser, pat dry, apply two hydrocolloid dressings, and secure with bordered gauze three times a week. | S FOR MEDICARE & MEDICAID SERVICES OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE (A. BUILDING | S FOR MEDICARE & MEDICAID SERVICES OF DEFICIENCIES (11) PROVIDERSUPPLENCILA DENTIFICATION NUMBER (X2) MULTIPLE CONSTRUCTION A BULDING A BULDING | MENT OF HEALTH AND HUMAN SERVICES FO SFOR MEDICARE & MEDICALS SERVICES OMB 1 CORRECTION (X1) PROVIDERSIVEPLERCLA LIDENTIFICATION NUMBER (X2) MULTIPLE CONSTRUCTION A BUILDING (X3) DC CONDER OR SUPPLER 345061 INVID (X2) MULTIPLE CONSTRUCTION A BUILDING (X3) DC CONDER OR SUPPLER 3100 ERVIN ROAD 100 100 CO SUMMAY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTON SOLLD BE CONSERVENCE TO THE APPROPRIATE DEFICIENCY) PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTON SOLLD BE CONSERVENCE TO THE APPROPRIATE DEFICIENCY) Continued From page 87 slight deterioration from previous assessments. There was a mild amount of exudate, and the wound measurements were as follows: length 6.5 cm, width 5 cm, and depth 0.2 cm, NP #1 indicated Resident #83 remained dependent for positioning and transfers. F 686 and notify physician for treatment orders. The Clinical Competency Coordinator (CCC) was notified m 9//122 revealed Resident #83 was ordered to allow air loss mattress for her stage three pressure ulcer. F 686 and notify physician for treatment orders. The Clinical Competency Coordinator (LNFA), to add the deficient practice will not recur. The Clinical Competency Coordinator (CCC) was notified on 102/1202 by the Licensed Nursing Home Administrator (LNFA) to add to def 91/22 revealed Resident #83 was ordered cognitively impaired. She required extensi |

Facility ID: 923197

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| | OF DEFICIENCIES | MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA | (X2) MULTIF | LE CONS | TRUCTION | | B NO. 0938-03 |
|--------------------------|---|---|---------------------|----------------------------|---|--------------------------------|---------------------------|
| AND PLAN OF | CORRECTION | IDENTIFICATION NUMBER: | A. BUILDING | | | | COMPLETED |
| | | | | 3. WING | | | С |
| | | 345061 | B. WING | | | | 10/27/2022 |
| NAME OF P | ROVIDER OR SUPPLIER | | | | ADDRESS, CITY, STATE, ZIP CO | DDE | |
| PRUITTHI | EALTH-DURHAM | | | | AM, NC 27705 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | | PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TH DEFICIENCY | ON SHOULD BE HE APPROPRIATE | (X5) COMPLETIO DATE |
| F 686 | Continued From page | e 88 | F 68 | 36 | | | |
| | pressure ulcer, and the | | | | ins to monitor its perform | ance to make | |
| | continued. There was | | | e that the solutions are s | | | |
| | | rements were as follows: | | | e 114 | , | |
| | length 4.5 cm, width | 3 cm, and depth 0.3 cm. | | | e facility wound manager ought to the monthly Qua | | |
| | A Physical Therapy (| PT) progress note dated | | | rformance Improvement | | |
| | | sident #83 was noted to be | | Co | mmittee meeting by the I | Director of | |
| | | articipated in rolling to her | | | alth Services (DHS) for r | | |
| | | ioned with pillows to promote There was a large red patch | | | ision monthly x 3 months ostantial compliance is ac | | |
| | | al wound and the resident | | Sur | ostantial compliance is at | Jilleveu. | |
| | | ne area was assessed by | | Da | te of compliance: | 11/21/22 | |
| | | th the nail tip to surrounding | | | | | |
| | | onse from the resident. It was ned if this was due to | | | | | |
| | confusion or poor set | | | | | | |
| | A PT prograss note of | lated 9/27/22 revealed | | | | | |
| | | oted to be supine in bed. The | | | | | |
| | | in rolling to her side and was | | | | | |
| | | ows to promote offloading of | | | | | |
| | - | creased redness around the | | | | | |
| | Resident #83's sensa | e therapist questioned ation. | | | | | |
| | A physician's order d | ated 9/28/22 revealed sacral | | | | | |
| | wound care daily and | d as needed for soiled or | | | | | |
| | | order further indicated to | | | | | |
| | | /ith wound cleanser, pat dry, vith Dakin's solution moist | | | | | |
| | | as to be covered with a dry | | | | | |
| | | not an order for calcium | | | | | |
| | indicated the sacral v assessed and it was | - | | | | | |
| | | anged from a stage three to | | | | | |
| | stage four pressure u | ulcer. NP #1 suggested | | | | | |

If continuation sheet Page 89 of 98

| | - | D HUMAN SERVICES MEDICAID SERVICES | | | | | FORM |): 12/06/2022 MAPPROVED). 0938-0391 |
|--------------------------|---|--|-------------------|-----|-----------------------------------|--|-------------------|--|
| STATEMENT C | DF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | · , | | CONSTRUCTION | | (X3) DATE COMP | SURVEY LETED |
| | | 345061 | B. WING | | | _ | | C 27/2022 |
| NAME OF PF | ROVIDER OR SUPPLIER | | | S | TREET ADDRESS, CITY, ST | ATE, 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 PREF TAG | | (EACH CORRE) CROSS-REFEREI | PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY) | | (X5) COMPLETION DATE |
| F 686 | and body habitus. The drainage and an incre- present. A debrideme wound measurements cm, width 4cm, and de A PT progress note da Resident #83 was not complained of back pa PT session. Resident after she was reposition promote offloading of A wound note by Nurs- revealed Resident #83 ulcer with moderate d tissue present, and th were documented: ler depth 1 cm. Treatment solution daily. A PT note dated 9/29/ was repositioned to he session for optimal wo around the wound wa Review of documenta was hospitalized from The medication admint dated 10/1/22 - 10/12, was in the facility 10/7 was not documented | ge pillow to optimize (Resident #83's immobility ere was a mild amount of ase in necrotic tissue was nt was performed, and the s were as follows: length 5 epth 1 cm. ated 9/28/22 revealed ed to be supine in bed. She ain and participated in the #83 stated she felt better oned with a pillow to weight. Se #1 dated 9/28/22 3 had a stage four pressure rainage. There was necrotic e following measurements ngth 5cm, width 4 cm, and at orders included Dakin's /22 revealed Resident #83 er side at the end of the bund pressure relief. Skin s noted to be red. tion revealed Resident #83 10/1/22 - 10/6/22. histration record (MAR) /22 revealed Resident #83 1/22 - 10/12/22. Wound care on 10/8/22. /10/22 11:42 AM revealed | F | 686 | | | | |
| | Resident #83 was in t | bea iying on her back. | | | | | | |

Facility ID: 923197

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| | - | ID HUMAN SERVICES MEDICAID SERVICES | | | | FORM | M APPROVED 0. 0938-0391 |
|--------------------------|--|--|--|-----|---------------------------------------|-----------|----------------------------|
| STATEMENT O | DF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | E CONSTRUCTION | (X3) DATE | |
| | | 345061 | B. WING | | | | C 27/2022 |
| NAME OF PI | ROVIDER OR SUPPLIER | | | S | STREET ADDRESS, CITY, STATE, ZIP CODE | | |
| | | | | 3 | 3100 ERWIN ROAD | | |
| PRUITIHE | EALTH-DURHAM | | | 0 | DURHAM, NC 27705 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | | | | (X5) COMPLETION DATE |
| F 686 | Resident #83 was in I right hip. An observation on 10 the resident was in be An interview was con 10/11/22 at 3:17 PM. #83 developed a press received dressing cha refused care. The trea performed wound car responsible when the absent. During an observation Nurse #7 was observ care for Resident #83 under her right hip. D cleansing solution we bedside table. Reside an unreadable (smea brown exudate. Nurse and commented on th odor from the wound. wound with Dakin's so packed the wound wit applied a foam dressi mattress was set to n of 350 pounds. Resid catheter at the time o During an interview w 3:55 PM, she stated so orders before providir did not know who was | /10/22 1:20 PM revealed bed with a pillow under her /10/22 at 4:00 PM revealed ed lying on her back. ducted with Nurse #8 on Nurse #8 stated Resident soure ulcer in July 2022 and anges daily, unless she atment nurse typically e, but nurses were treatment nurse was n on 10/11/22 at 3:55 PM, ed providing pressure ulcer 5. The resident had a pillow ressing supplies and re placed on the resident's ent #83's sacral dressing had red) date and was wet with e #7 removed the dressing he strong presence of an Nurse #7 cleansed the olution-soaked gauze, th calcium alginate, and ng. Resident #83's air ormal pressure for a weight ent #83 did not have a f the observation. | F | 686 | | | |
| | Resident #83's air ma | attress and was not sure of ided pressure ulcer care for | | | | | |

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| | - | ID HUMAN SERVICES MEDICAID SERVICES | | | | FORM | M APPROVED 0. 0938-0391 |
|--------------------------|--|---|--------------------|--|---------------------------------------|------------------------------|----------------------------|
| STATEMENT C | OF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | E CONSTRUCTION | (X3) DATE SURVE COMPLETED | |
| | | 345061 | B. WING | | | | C 27/2022 |
| NAME OF PF | ROVIDER OR SUPPLIER | | 1 | S | 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 SC IDENTIFYING INFORMATION) | ID PREFI TAG | PREFIX (EACH CORRECTIVE ACTION SHOULD BE | | | |
| F 686 | Resident #83. There is performed wound car An interview was con 10/11/22 at 3:55 PM. mostly calm. She reconneeded. If the resider soiled, he would notify An interview was con 10/11/22 at 4:03 PM. developed a pressure going to the hospital. return, she had a sma About a week later, the assessed, and treatmed dressing changes and further explained nursisettings on the air matt settings on the air matt he air mattress should for Resident #83. Resise hospitalized several to treatments. Nurse #1 weeks ago. During an interview we 4:32 PM, she stated F lie flat. The NA stated and repositioned even An observation on 10 Resident #83 was in 1 Appeared calm when her. The air mattress setting, normal presson An interview and observation on states | was no odor when she last e. ducted with NA#9 on He stated Resident #83 was eived incontinence care as nt's dressing was loose or y the nurse. ducted with Nurse #1 on She stated Resident #83 e ulcer in July 2022 after At the time of the resident's all red area on her back. he area was open, it was bents were ordered including d an air mattress. Nurse #1 ses should adjust the fittress. Nurse #1 indicated id not be set at 350 pounds sident #83 has been imes causing interruptions in last saw Resident #83 two with NA #4 on 10/11/22 at Resident #83 did not like to Resident #83 was turned by 2 hours. /12/22 at 7:34 AM revealed bed lying on her back. staff were engaging with was set to 160/200-pound ure. | F | 686 | | | |
| | | on 10/12/22 at 8:05 AM. ht #83 had recently been | | | | | |

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| | | ID HUMAN SERVICES MEDICAID SERVICES | | | | FORM | APPROVED 0. 0938-0391 |
|--------------------------|--|--|--|-----|--------------------------------------|-----------|----------------------------|
| STATEMENT (| DF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | | (X3) DATE | |
| | | 345061 | B. WING | | | | C 27/2022 |
| 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 SC IDENTIFYING INFORMATION) | ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | | | | (X5) COMPLETION DATE |
| F 686 | hospitalized. She indi the air mattress shoul weight to promote opt assessed the wound a treatment with Dakin's Nurse #1 was presen odor when the dressin not been notified of an day. The NP was unside teriorated and state previous notes. NP # would see the resider back and to reduce pre- cooperative with the option positioned on her back assessment and treat An observation on 10 Resident #83 was in B the head of the bed side During a follow up inter had deteriorated since she would need to rev- indicated Resident #8 assessed by the hosp infection preventionis hospitalization (10/1/2 infected at the time of surgical debridement An observation on 10 Resident #83 was in B the head of the bed side hospitalization (10/1/2) | cated pressure settings on Id reflect the resident's timal wound healing. NP #1 and determined the s solution should continue. t and noted there was some ing was removed. NP #1 had in odor from the previous ure if the wound had ed she would need to review 1 indicated physical therapy int to help keep her off her ressure. Resident # 83 was care that was provided and ek after the pressure ulcer timent was completed. /12/22 at 10:50 AM revealed bed lying on her back with lightly elevated. /12/22 at 10:70 AM revealed bed lying on her back with lightly elevated. erview on 10/12/22 at 12:45 e was unsure if the wound e her last assessment, and view previous notes. NP #1 33's pressure ulcer had been bital's general surgeon and t during her recent 22 - 10/6/22). It was not f that assessment and was not needed. /12/22 at 1:17 PM revealed bed lying on her back with lightly elevated. | F | 686 | | | |

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| | - | ID HUMAN SERVICES | | | | FORM | / APPROVED | |
|------------|--------------------------|---|--|------|--|--------------------|--------------|--|
| | | MEDICAID SERVICES | | | | OMB NO. 0938-0391 | | |
| | DF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | ECONSTRUCTION | (X3) DATE COMP | SURVEY | |
| | | | A. BUILDI | NG _ | | | | |
| | | 345061 | B. WING | | | | C 27/2022 | |
| NAME OF PI | ROVIDER OR SUPPLIER | | | S | STREET ADDRESS, CITY, STATE, ZIP CODE | 1 10/ | | |
| | | | | 3 | 100 ERWIN ROAD | | | |
| PRUITTHE | EALTH-DURHAM | | | D | DURHAM, NC 27705 | | | |
| (X4) ID | SUMMARY ST | ATEMENT OF DEFICIENCIES | ID PROVIDER'S PLAN OF CORRECTION | | | | (X5) | |
| PREFIX | | | PREFIX (EACH CORRECTIVE ACTION SHOULD BE | | | COMPLETION DATE | | |
| TAG | REGULATORT OR L | SC IDENTIFYING INFORMATION) | TAG | | CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | | | |
| | | | 1 | | | | | |
| F 686 | Continued From page | 93 | F | 686 | | | | |
| | 1 3 | | | | | | | |
| | During an interview w | /ith nurse aide (NA) #2 on | | | | | | |
| | | she stated she turned | | | | | | |
| | - | bath before lunch and | | | | | | |
| | | ack. NA #2 stated Resident | | | | | | |
| | #83 did not want a pil | low under her. | | | | | | |
| | An observation on 10 | /13/22 at 9:58 AM revealed | | | | | | |
| | Resident #83 was lyir | ng on her back with the head | | | | | | |
| | of the bed slightly ele | vated. | | | | | | |
| | An interview was con | ducted with Physical | | | | | | |
| | | 10/13/22 at 11:30 AM. She | | | | | | |
| | stated she received a | | | | | | | |
| | | four pressure ulcer. She | | | | | | |
| | - | ident for wound healing | | | | | | |
| | | obility for optimal relief of | | | | | | |
| | • | indicated she had seen the | | | | | | |
| | - | in the day and stated it | | | | | | |
| | | the last time she saw it. rejected any treatments | | | | | | |
| | that were provided in | | | | | | | |
| | | | | | | | | |
| | | /13/22 at 12:15 PM revealed | | | | | | |
| | Resident #83 was lyir | ng in bed on her back. | | | | | | |
| | During an interview w | vith the Director of Nursing | | | | | | |
| | | p interview with Nurse #1 on | | | | | | |
| | | I, the DON stated nurses | | | | | | |
| | should provide pressu | ure ulcer care as ordered. | | | | | | |
| | | #1 confirmed nurses should | | | | | | |
| | verify settings on air r | nattress beds. | | | | | | |
| | During an interview w | vith the Administrator on | | | | | | |
| | - | she stated wound care | | | | | | |
| | | s ordered and bed settings | | | | | | |
| | should be correct and | | | | | | | |
| F 759 | Free of Medication Er | rror Rts 5 Prcnt or More | F | 759 | | | 11/21/22 | |
| SS=D | | | | | | | | |

If continuation sheet Page 94 of 98

| | - | ID HUMAN SERVICES MEDICAID SERVICES | | | PRINTED: 12/06/2 FORM APPROV OMB NO. 0938-03 | |
|--------------------------|---|---|-------------------------|---|--|--|
| | F DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULT A. BUILDIN | (X3) DATE SURVEY COMPLETED C | | |
| | | 345061 | B. WING | | 10/27/2022 | |
| NAME OF PF | ROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP COL | | |
| PRUITTHE | ALTH-DURHAM | | | 3100 ERWIN ROAD DURHAM, NC 27705 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY) | N SHOULD BE COMPLETIN E APPROPRIATE DATE | |
| F 759 | Continued From page | 94 | F7 | 59 | | |
| | CFR(s): 483.45(f)(1) | | | | | |
| | §483.45(f) Medication | | | | | |
| | The facility must ensu | | | | | |
| | percent or greater; | tion error rates are not 5 is not met as evidenced | | | | |
| | by: Based on observatio record review, the fac | ns, staff interviews, and ility failed to have a | | Corrective action for the residue to be affected by the deficient | | |
| | medication error rate | | | | | |
| | | cation errors out of 30 ig in a medication error rate idents (Resident #40) | | Nurse #8 was immediately in administration of medications and Levemir FlexTouch pen | s via a g-tube | |
| | observed during med | ication pass. | | aware of medication errors. | | |
| | The findings included | : | | On 10/26/22 the Pharmacy C observed a medication pass | | |
| | 1. On 10/12/21 at 8:0 | | | residents, totaling 25 medica | | |
| | observed as she prep | ared medications for astrostomy tube (G-Tube) to | | administered by Nurse #8. T identified issues related to th | | |
| | Resident #40. The m | nedications included, in part: 0 milligrams (mg) / 5 ml | | deficiency. | | |
| | gabapentin (an antise separate medication (| eizure medication) put into a (med) cup with | | Corrective action for other re having the potential to be affered | | |
| | ml oxycodone (an opi | ater and 2.5 ml of 5 mg / 5 ioid pain medication) also | | same deficient practice. | | |
| | ml water. The medica | | | All residents receiving medic gastrostomy tube (g-tube) ar | nd Levemir | |
| | administration also in milligrams (mg) tablet anti-hypertensive med | | | FlexTouch pen have the pote risk for the alleged deficiency | | |
| | of famotidine (a medi | | | All licensed nurses have bee by the Director of Health Ser | | |
| | reduce secretions). N | rolate (a medication used to Nurse #8 was observed as | | and/or the Clinical Competer Coordinator (CCC) on follow | ing the | |
| | | ets together, placed them in added approximately 10 | | medication administration of FlexTouch pen and medication | | |

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DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION COMPLETED A. BUILDING С 345061 B. WING 10/27/2022 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 759 Continued From page 95 F 759 ml of water into the med cup to dissolve the administration via a g-tube per pol0icy. crushed tablets. This education was completed on 11/21/22. Any Licensed Nurses not Nurse #8 was observed as she brought the completing education by 11/21/22 will be medications into Resident #40's room for required to complete education prior to administration on 10/12/21 at 8:25 AM. The the start of his/her next scheduled shift. nurse connected a syringe to the resident's G-tube and first poured the oxycodone mixed with The Pharmacy Consultant will continue to water into the syringe followed by the gabapentin educate nursing and make any mixed with water. The crushed tablets mixed with recommendations monthly regarding water were administered last followed by 15 ml of medication administration via a g-tube plain water. Plain water flushes were not and Levemir FlexTouch pens. observed to be given prior to the first administration of the medications or between the All new hired nurses will receive the medications being administered via G-tube. medication administration via g-tube and Levemir FlexTouch pen education during A review of Resident #40's current orders orientation. included the following, in part: "During medication administration times, flush tube with 15 milters Systemic changes made to ensure that water before and after medications and 5 milters the deficient practice will not recur. with each medication" (Start date 5/16/22). The Director of Health Services (DHS), Clinical Competency Coordinator (CCC) An interview was conducted on 10/12/22 at 9:30 AM with Nurse #8. During the interview, the and/or Pharmacy Consultant will observe medication concerns identified during the med medication administration via a g-tube for administration observation for Resident #40 were five nurses three times a week x 4 weeks, discussed. When discussing the resident's once a week x 4 weeks, then monthly medications being crushed then administered times 3 months or until compliance is together and failure to flush the G-tube as achieved. indicated by the physician's order, the nurse stated she was aware of the orders. However, The Director of Health Services (DHS), Nurse #8 stated she felt Resident #40 could best Clinical Competency Coordinator (CCC) tolerate the medications as she had administered and/or Pharmacy Consultant will observe them. medication administration via a Levemir FlexTouch pen for five nurses three times An interview was conducted on 10/12/22 at 3:35 a week x 4 weeks, once a week x 4 PM with the facility's Administrator and Regional weeks, then monthly times 3 months or Nurse Consultant. During the interview, concerns until compliance is achieved. identified during the medication administration

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

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| | - | ID HUMAN SERVICES MEDICAID SERVICES | | | | FORM | M APPROVED D. 0938-0391 |
|--------------------------|--|---|--------------------|------|---|-------------------------------|----------------------------|
| STATEMENT | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | CONSTRUCTION | (X3) DATE SURVEY COMPLETED | |
| AND FLAN OF | CORRECTION | IDENTIFICATION NOMBER. | A. BUILDI | NG _ | | | C |
| | | 345061 | B. WING | | | | 0 /27/2022 |
| NAME OF P | ROVIDER OR SUPPLIER | 1 | | S | TREET ADDRESS, CITY, STATE, ZIP CODE | <u> </u> | |
| PRUITTH | EALTH-DURHAM | | | | 100 ERWIN ROAD | | |
| | | | | D | URHAM, NC 27705 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFI TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY) | 3E | (X5) COMPLETION DATE |
| F 759 | observation were disc Consultant stated she administered via G-tu medication at a time we between each medica An interview was con PM with the facility's I During the interview, aware of the med pass disappointed in the re DON reported the fact to administer one mer- with a water flush give medication. She also medications were sup tube differently than the needed to be a physic the meds needed to be 2. On 10/12/21 at 8:0 observed as she prep administration to Ress these medications were resident, the nurse pri administration. Nurse withdrew a Levemir F pen from the medicat the pen, and turned the units of insulin in prep The nurse did not prir #8 was observed as set the resident's right up The manufacturer's F for the Levemir Flex T "Instructions for Use." | cussed. The Regional a was aware meds be were to be given one with water flushes in ation. ducted on 10/13/22 at 12:10 Director of Nursing (DON). the DON stated she was as observations and was esults. When asked, the sility staff had been educated dication at a time via G-tube en between each b stated that if the oposed to be instilled via he usual practice, there cian's order specifying how be administered. 6 AM, Nurse #8 was bared medications for ident #40 via G-tube. After are administered to the epared the insulin for e #8 was observed as she lexTouch prefilled insulin ion cart, placed a needle on the dose selector to select 8 baration for the injection. The the insulin pen. Nurse she injected the insulin into oper arm. full Prescribing Information bouch pen included ' These instructions ben needed to be primed | F | 759 | Plans to monitor its performance to ma sure that the solutions are sustained. The Director of Health Services and/or Clinical Competency Coordinator (CC will report to the Quality Assurance Performance Improvement Committee (QAPI) x 3 months for review and revis monthly x 3 months or until substantia compliance is achieved. Date of compliance: 11/21/22 | r the C) sion | |

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| DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES | | | | | | | | PRINTED: 12/06/2022 FORM APPROVED OMB NO. 0938-0391 | |
|---|--|---|--|-------------------------------------|-------------------------------|---|--|---|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED | | | |
| | | 345061 | B. WING | | _ | C 10/27/2022 | | | |
| NAME OF PROVIDER OR SUPPLIER | | | | s | STREET ADDRESS, CITY, ST | ATE, ZIP CODE | | - | |
| PRUITTHEALTH-DURHAM | | | | 3100 ERWIN ROAD DURHAM, NC 27705 | | | | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | | ID PREF TAG | | (EACH CORRE) CROSS-REFEREI | B PLAN OF CORRECTION CTIVE ACTION SHOULD B NCED TO THE APPROPRIA DEFICIENCY) | | (X5) COMPLETION DATE | |
| F 759 | Continued From page 97 | | F | 759 | | | | | |
| | Continued From page 97 An interview was conducted on 10/12/22 at 9:30 AM with Nurse #8. During the interview, the medication concerns identified during the med administration observation for Resident #40 were discussed. When asked about priming the Levemir FlexTouch insulin pen, the nurse stated she normally did prime the pen but acknowledged she did not prime it this time. An interview was conducted on 10/13/22 at 12:10 PM with the facility's Director of Nursing (DON). During the interview, the DON stated she was aware of the med pass observations and was disappointed in the results. When asked, the DON stated the Levemir insulin pen needed to be primed with 2 units of insulin prior to each use. | | | F 759 | | | | | |

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