PRINTED: 06/03/2025 FORM APPROVED OMB NO. 0938-0391

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		345538	B. WING			1	С
		345536	D. WING_			05/	08/2025
NAME OF PE	ROVIDER OR SUPPLIER			8	STREET ADDRESS, CITY, STATE, ZIP CODE		
PRUITTHE	ALTH-RALEIGH			2	2420 LAKE WHEELER ROAD		
				ı	RALEIGH, NC 27603		
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	,	Y MUST BE PRECEDED BY FULL	PREFIX		(EACH CORRECTIVE ACTION SHOULD B		COMPLETION DATE
TAG	REGULATORY OR L	LSC IDENTIFYING INFORMATION)	TAG		CROSS-REFERENCED TO THE APPROPRIA	AIE.	DATE
			+		,		
F 000	INITIAL COMMENTS		F(000)		
	The survey team ent	ered the facility on 5/5/25 to					
	-	nvestigation. The survey					
		on 5/5/25 and 5/6/25 with					
	additional information	obtained remotely on					
		survey team returned to					
		onsite validation of the					
	immediate jeopardy re	emoval plans. Therefore,					
	the exit date was 5/8/	25. Event ID# 8UDP11.					
	The following intakes						
	NC00226025, NC002	28700, and NC00230033.					
	Intake NC00230033 r	esulted in immediate					
	jeopardy.						
	3 of the 5 complaint a	llegations resulted in					
	deficient practice.						
	Immediate Jeopardy	was identified at:					
	OFD 400 40 11 F0	200					
	_	600 at a scope and severity					
	(J)	204 -t and					
	_	684 at a scope and severity					
	(J)	con at a seems and according					
	_	689 at a scope and severity					
	(J)						
	The tags F600 F684	, and F689 constituted					
	Substandard Quality						
	Sabstandard Quality	o. 34.0.					
	Immediate Jeonardy I	began on 4/25/25 and was					
		5/8/25 and for F684 and					
	F689 on 5/7/25.	5.5,25 and 151 1 50 1 and					
	A partial extended sur	rvev was conducted					
F 600		-	F	600			5/22/25
SS=J				500			5,22,20
00-0	σ. π. σ., που. πετα (π.) (π.)						
	8483.12 Freedom from	m Abuse, Neglect, and					
	Exploitation						
LABODATORY	DIRECTOR'S OR BROVINER/S	SLIPPLIER REPRESENTATIVE'S SIGNATURE	1		TITI F		(X6) DATE

ABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE

05/27/2025

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

Electronically Signed

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION G	(X3) DATE SU COMPLE	
		345538	B. WING		C 05/05	3/2025
	ROVIDER OR SUPPLIER	1		STREET ADDRESS, CITY, STATE, ZIP CODE 2420 LAKE WHEELER ROAD RALEIGH, NC 27603	1 05/00	72023
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 600	neglect, misappropriand exploitation as a includes but is not licorporal punishmen any physical or cher treat the resident's right is 8483.12(a) The facil \$483.12(a) The facil \$483.12(a) (1) Not use physical abuse, corpinvoluntary seclusion. This REQUIREMENT by: Based on record reresident, Contracted and the Physician, the resident physician, the resident serviewed fapproximately 4:30 to the facility from a contracted transport flipped backwards lated the van. Resident and her back sustain wheelchair backrest user's back) hit the form transport Driver was clinical assessment resident if she was a cupright, secured the continued the trip bareported during the contracted Transport Driver not the factor of the transport Driver not the transport Dr	e right to be free from abuse, fation of resident property, defined in this subpart. This mited to freedom from t, involuntary seclusion and mical restraint not required to medical symptoms. ity must- se verbal, mental, sexual, or poral punishment, or	F 60	" Address how the corrective act be accomplished for those resident found to have been affected by the deficient practice: Upon return from her appointment of 4/25/25 Resident #1 was evaluated Nurse at the facility, was provided Tramadol due to resident reports of The Nurse contacted the Medical D (MD) related to the resident reports pain and obtained an order to trans the resident to the Emergency Department for additional evaluation. "Address how the facility will ide other residents having the potential affected by the same deficient practice. The facility had 22 residents who have between 4/1/25 and 5/6/25. The Direction of Nursing (DON) reviewed documentation to ensure that each resident was assessed by a license	pon by the pain. poctor of port n. entify to be tice: ad falls rector	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SUPPLIER OF COMPLETE OF							
			A. BOILDI			, ا	
		345538	B. WING			1	08/2025
NAME OF P	ROVIDER OR SUPPLIER		•	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
DDI IITTUI	EALTH-RALEIGH			24	120 LAKE WHEELER ROAD		
PRUITIN	EALIN-KALEIGN			R	ALEIGH, NC 27603		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 600	resident suffering a far Transport Driver left informed staff of the rated a 10 out of 10 (possible) in her neck reported they had ne like that before and the crying out. Opioid particles administered but it would be partment (ED) at a resident was identified superior endplate (flat vertebra) of the L1 (lux vertebra). Disregard to be clinically assess the resident had a high further injury. The Condecision to withhold in staff to be notified of assessment to be connecessary care the recare and extended the suffered severe paint deliberate actions take Transport Driver consumed in the contracted transport Resident #1 assesses professional prior to be in the contracted transport geopardy was removed facility implemented a allegation of immediate allegation of immediate and the suffered severe paint deliberate actions take transport Driver consumediate Jeopardy Contracted Transport Driver consumediate Jeopardy was removed facility implemented a allegation of immediate allegation of immediate allegation of immediate and the suffered severe paint deliberate actions take the contracted transport Driver consumediate Jeopardy was removed facility implemented and allegation of immediate allegation of immediate and the suffered severe paint deliberate actions take the suffered severe p	information about the all. After the Contracted the facility, the resident fall and complained of pain with 10 being the worst pain , shoulders, and back. Staff ver seen Resident #1 in pain hat she was moaning and ain medication was as not effective to relieve the reas transferred to the hospital rated in the Emergency approximately 7:32 PM. The red with a fracture at the at surface at the top of each umbar spine region, first ing the need for Resident #1 sed for injury prior to moving gh likelihood of resulting in contracted Transport Driver's information essential for the in order for a clinical mpleted to determine the resident required delayed the time period the resident without treatment. These is sen by the Contracted	F	600	nurse for injury following a fall, and non-medical staff notified staff who wer qualified to perform clinical assessmen prior to the resident being moved, discrepancies were corrected during the audit on 5/6/25. "Address what measures will be purinto place or systemic changes made to ensure that the deficient practice will not recur: All facility staff members were re-educated regarding the policy and procedure for identification and prevent of abuse, neglect and misappropriation including examples of what constitutes neglect, by each Department Supervisor designee on 5/6/25. Staff who did not receive this education on 5/6/25 receive the training prior to working their next shift, by their respective Supervisor. The ducation has been added to the Gene Orientation of any newly hired staff members. All facility staff members received education on the facility policy to not members. All facility staff members received education on the facility policy to not members. All facility staff members received education on the facility policy to not members. All facility staff members received education on the facility policy to not members. All facility staff members received education on the facility policy to not members. All facility staff members received education on the facility policy to not members. All facility staff members received education on the facility policy to not members. All facility staff members received education on the facility policy to not members.	t e t c t o t o t o t o t o t o t o t o t o	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ` ′		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
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		345538	B. WING			l	08/2025
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
DDIUTTU	TALTIL DAL FIGU			24	120 LAKE WHEELER ROAD		
PRUITIH	EALTH-RALEIGH			R	ALEIGH, NC 27603		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 600	immediate jeopardy) completed and monit are effective. The findings included The tag is cross-reference F684: Based on reconstaff, resident, Contrac Company, and the Platransport Driver failed assessed for injury by prior to moving the restransportation van an staff of the fall in order clinically assessed for Resident #1 returned approximately 5:30 pwheelchair had flipped transported back to the Transport Driver lifted from the floor and ret Resident #1 suffered (with 10 being the wood of the complete transported back to the Resident #1 suffered (with 10 being the wood of the complete transported the complete transported the complete transported back to the Resident #1 suffered (with 10 being the wood of the complete transported back to the Resident #1 suffered (with 10 being the wood of the complete transported back to the Resident #1 suffered (with 10 being the wood of the complete transported back to the Resident #1 suffered (with 10 being the wood of the complete transported back to the Resident #1 suffered (with 10 being the wood of the complete transported back to the Resident #1 suffered (with 10 being the wood of the complete transported back to the Resident #1 suffered (with 10 being the wood of the complete transported back to the complete transported bac	an minimal harm that is not to ensure education is oring systems put into place I: renced to: rd review, interviews with	F	600	On 5/6/25 100% of the facility s Transport Drivers received training relato ensuring the resident is assessed by qualified professional in the event the foccurs during transportation and prior to moving the resident. Per the policy, the should move to the side of the road and call 911 for resident assessment by a qualified professional. Per policy, the facility Transport Driver will notify the facility of any fall that occurs during transport. The facility s Transport Driver training was provided by the facility Maintenance Director on 5/6/25. Newly hired facility Transportation Drive will be provided training related to ensuring the resident is assessed by a qualified professional in the event the foccurs during transportation and prior to moving the resident. Per the policy, the should move to the side of the road and call 911 for resident assessment by a qualified professional. Per policy, the facility Transport Driver will notify the facility Transport Driver will notify the facility of any fall that occurs during transport, provided by the Maintenance	er all o ey all o er	
	transferred to the hos identified with a fracti (flat surface at the top (lumbar spine region, high likelihood of furti resident after a fall pr of injury and not infor treatment for the resi	spital where she was ure at the superior endplate of of each vertebra) of the L1 first vertebra). There was a her injury from moving a rior to a clinical assessment ming staff of the fall delayed dent. This deficient practice residents reviewed for			Director. Drivers for the vendor who is providing contracted transportation services received training related to assessing the resident for injury prior to moving the resident, by notifying 911 so a qualified professional will assess the resident ar notifying the facility of falls by calling the facility after calling 911. Vendor training	ne nd e	
	An initial report comp	leted by the Administrator			also included examples of what constitutes abuse and neglect. The		

STATEMENT OF DEFICIENCIES (X1 AND PLAN OF CORRECTION		` IDENTIFICATION NUMBER:		JLTIPLE CONSTRUCTION DING		(X3) DATE SURVEY COMPLETED	
		345538	B. WING _			C 05/08/2025	
NAME OF PR	ROVIDER OR SUPPLIER	1		STREET ADDRESS, CITY, STATE, ZIP C	ODE I	03/00/2023	
				2420 LAKE WHEELER ROAD			
PRUITTHE	ALTH-RALEIGH			RALEIGH, NC 27603			
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F 600	an allegation of negled Transport Driver was individual. The report Resident #1 was transport the facility by the Conafter Resident #1 retifallen in the van and Contracted Transport #1's paperwork to the of an incident during sent to the ED for extendity was notified the acute fracture related on 4/25/25. During an interview with 1:05 pm she stated the Resident #1's fall on she immediately were revealed that Reside panicked, "like talking rambling". She indichesitant to report when revous like not look she asked her about back from dialysis. An interview was coram with Resident #1 entire ride back to the	State Agency on 5/01/25 for ect. The Contracted noted as the accused tindicated on 4/25/25 asported from dialysis back to intracted Transport Driver and urned she reported she had had back pain. The tid Driver returned Resident enurse and made no report transport. The resident was aluation. On 5/01/25 the nat Resident #1 sustained and to the fall during transport. With Nurse #2 on 5/05/25 at that after she was notified of 4/25/25 by Nurse Aide #1 at to assess the resident. She int #1 appeared to be giall over the place and ated the resident seemed at happened, "almost ing at her [Nurse #2]" when what happened on the ride inducted on 5/08/25 at 9:01 who revealed that during the efacility after the fall on eed Transport Driver kept	F 6	vendor provided documents NHA on 5/7/25. Newly hire transport drivers for this verprovided this training, by the transportation company own designee, prior to being asset transportation trips for the foresidents. The Maintenance Director, will audit 10 instances where secured in a transport van a ensure the resident chair is fastened in the transport versident and take appropriate follow Weekly transportation audit fastening resident chairs in vehicle will continue after 3 ensure ongoing compliance. The DON, or designee, will per month, to ensure that the assessed for fall by a qualif professional prior to the resimoved, for 3 months. The address any concerns that during audits and take apprup action. Monthly audits verside and the apprup action. Monthly audits verside and the service of compliance. "Indicate how the facility in the resident of the professional prior to the resident of the resident of the professional prior to the prof	d contract ndor will be e contracted ner, or signed facility or designee, n a resident is at the facility to securely chicle weekly, will address any during audits up action. Its for securely the transport months, to e. audit 10 falls ne resident was fied sident being facility will are identified ropriate follow will continue ngoing		
	allegation of neglect Resident #1 was rev	mitted on 5/1/25 for an related to the 4/25/25 fall for lewed with the Administrator m. The Administrator was		monitor its performance to solutions are sustained: The Maintenance Director vanalysis of the transportation	will present the		

PRÉFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 600 Continued From page 5 unable to state why she completed and submitted the initial report for neglect but she stated it was not neglect on the role of the facility. She stated PREFIX TAG PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DAT PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DAT Safety/fastening audit compliance percentage to the Nursing Home Administrator (NHA) at the Quality	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED	
NAME OF PROVIDER OR SUPPLIER PRUITTHEALTH-RALEIGH STREET ADDRESS, CITY, STATE, ZIP CODE 2420 LAKE WHEELER ROAD RALEIGH, NC 27603 (X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 600 Continued From page 5 unable to state why she completed and submitted the initial report for neglect but she stated it was not neglect on the role of the facility. She stated STREET ADDRESS, CITY, STATE, ZIP CODE 2420 LAKE WHEELER ROAD RALEIGH, NC 27603 F 600 PREFIX TAG F 600 CROSS-REFERENCED TO THE APPROPRIATE DAT F 600 Safety/fastening audit compliance percentage to the Nursing Home Administrator (NHA) at the Quality		345538	345538 B. WING		
RALEIGH, NC 27603 REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) DEFICIENCY DEFICIEN		IER	2420 LAKE WHEELER ROAD	, , ,	
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 600 Continued From page 5 unable to state why she completed and submitted the initial report for neglect but she stated it was not neglect on the role of the facility. She stated PREFIX TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE OF THE APPROPRIATE DATE O	PRUITTHEALTH-RALEIGH		RALEIGH, NC 27603		
unable to state why she completed and submitted the initial report for neglect but she stated it was not neglect on the role of the facility. She stated safety/fastening audit compliance percentage to the Nursing Home Administrator (NHA) at the Quality	PREFIX (EACH DE	FICIENCY MUST BE PRECEDED BY FULL	EFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SI FORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE AF	HOULD BE	(X5) COMPLETION DATE
Interfacility continued, resident #1 s fail and injury had occurred but she did not feel the facility was responsible for the actions of the Contracted Transport Driver. The Administrator further stated that she did not identify anything, on their end, that the facility would have done differently. On 5/05/25 at 4:51 pm the Administrator was notified of immediate jeopardy. The facility provided the following Immediate Jeopardy removal plan: Identify those recipients who have suffered, or are likely to suffer, a serious adverse outcome as a result of the noncompliance: On 4/25/25 Resident #1 had a fall in the Contracted Transport Driver moved the resident prior to having the resident assessed for injuries by a qualified professional. Upon return to the facility hursing staff of the fall in order for the resident to be clinically assessed for injuries from the fall. On 4/25/25 at 5:30 p.m., Resident #1 reported to Nurse #2 that her back was hurting and stated that her wheelchair flipped back in the contracted transportation van, the driver forgot to lock her wheelchair down, and she bumped her head. Nurse #2 went directly to evaluate Resident #1 and identified that the resident was tearful and reported pain.	unable to state the initial report on the facility con had occurred the responsible for Transport Driv stated that she end, that the facility produced from the facility produced from the facility produced from the facility those are likely to sure a result of the Contracted Transport of the staff the remote feel good the facility the Contracted from the staff the remote feel good the facility as On 4/25/25 at Nurse #2 that that her wheel transportation wheelchair downse #2 went and identified for the staff the remote feel good that the staff that her wheel transportation wheelchair downse #2 went and identified for the staff the remote feel good that the staff the remote feel good the staff th	why she completed and submitted to for neglect but she stated it was the role of the facility. She stated firmed Resident #1's fall and injury but she did not feel the facility was the actions of the Contracted er. The Administrator further edid not identify anything, on their acility would have done differently. 4:51 pm the Administrator was ediate jeopardy. vided the following Immediate oval plan: recipients who have suffered, or ffer, a serious adverse outcome as noncompliance: sident #1 had a fall in the ensport Driver moved the resident the resident assessed for injuries professional. Upon return to the tracted Transport Driver informed sident wanted to go to bed and did but he failed to notify the facility if the fall in order for the resident to sessed for injuries from the fall. 5:30 p.m., Resident #1 reported to the back was hurting and stated chair flipped back in the contracted van, the driver forgot to lock her we, and she bumped her head. directly to evaluate Resident #1	safety/fastening audit compliance percentage to the Nursing Hom Administrator (NHA) at the Quality Assumed and the resident #11 fall in the resident #11 fall in order for the resident #11 that the resident was burden the facility of the fall in order for the resident #11 that the resident was tearful and injury but she did not feel the facility was or the actions of the Contracted ver. The Administrator further e did not identify anything, on their facility would have done differently. safety/fastening audit compliance percentage to the Nursing Hom Administrator (NHA) at the Qual Assurance and Performance Improvement Committee meeting until three consecutive months of compliance is maintained and the quarterly the quarterly the facility would have done differently. safety/fastening audit compliance percentage to the Nursing Hom Administrator (NHA) at the Qual Assurance and Performance Improvement Committee meeting until three consecutive months of compliance is maintaining the acceptable correction related to transportation Percentage to the Nursing Hom Administrator at the Quality Assurance and Performance Improvement Committee meeting until three consecutive months of compliance is maintaining the acceptable correction related to transportation Percentage to the Nursing Hom Administrator (NHA) at the Quality Assurance and Performance Improvement Committee meeting until three consecutive months of compliance is maintaining the acceptable correction related to ransportation Percentage to the Nursing Hom Administrator (NHA) at the Quality Assurance and Performance Improvement Committee meeting until three consecutive months of compliance is maintaining the acceptable correction related to ransportation Percentage to the Nursing Hom Administrator at the Quality Assurance and Performance Improvement Committee meeting until three consecutive months of compliance is maintaining the acceptable correction related to fall assessment audit compliance is maintaining the acceptable correction related to fall assessment	e lity ng monthly of hen enance ementing plan of ion sis of the ce e eurance til three nce is hereafter. elementing plan of	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION IG	(XX	B) DATE SURVEY COMPLETED
		345538	B. WING			C 05/08/2025
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 2420 LAKE WHEELER ROAD RALEIGH, NC 27603	I	05/06/2025
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 600	Continued From pag	ge 6	F 6	00		
	of Resident #1, which was given Tramadol Nurse #2 contacted (MD) for Resident # complained of pain is shoulder. The MD president #1 to the Efor evaluation. Nurse Medical Services (EED and Resident #1 Nurse #2 contacted to report the incident contracted van, the the MD order to transpace Resident #1 remained a Cat Scan on 4/25/acute diagnosis. Du pain at the Hospital,	a neurological assessment th was normal. Resident #1 for pain at 5:45 p.m. for pain. the primary Medical Doctor 1 to report the resident n her back, neck and provided an order to transport the resident (ED) the #2 called Emergency MS) for transportation to the left for the ED at 6:45 p.m. the Responsible Party (RP) that occurred in the resident report of pain and sport the resident to the ED. ed in the Hospital undergoing 25 with negative results for the to continued complaints of the Hospital completed an childentified a lumbar 1				
	Director contacted the Company Owner on 5:45pm to report Resident #1 stated hand she hit her head Transportation Comstatement to the Fac Contracted Transpoemail from the Contracted Transpowith the Contracted Transpowith the Contracted Transpowith the Contracted	ion Management (HIM) ne Contracted Transportation 4/25/25 at approximately sident #1's allegation that ner wheelchair flipped back d. On 4/25/25 the Contracted pany Owner provided a cility in an email from the reacted Transportation scribed an interview that the retation Company Owner had Transport Driver following the with Resident #1. Per the				

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345538	B. WING		C 05/08/2025
	ROVIDER OR SUPPLIER		2	TREET ADDRESS, CITY, STATE, ZIP CODE 420 LAKE WHEELER ROAD RALEIGH, NC 27603	1 00/00/2020
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETION
F 600	Contracted Transport Resident #1's wheel causing her to fall at The Contracted Dristopped, asked Resher chair upright and The Contracted Transport Transport of Transport of Transport to moving the facility Transportation Composes and the Director of Nurse and the Director of Nu	ortation Company Owner, the ort Driver reported that elchair tilted backwards and hitting her head and back. It is she was OK, sat do returned her to the facility. Insport Driver stated Resident that she was OK. Per the ortation Company Owner, the ort Driver did not follow the ort Driver was terminated due or and is ineligible for rehire. Ising (DON) will review all the last 30 days to verify that the last 3	F 600		

C 05/08/2025
1 00/00/2020
ECTION (X5) OULD BE COMPLETION PROPRIATE DATE
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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345538	B. WING		05/08/2025	
	ROVIDER OR SUPPLIER	1		STREET ADDRESS, CITY, STATE, ZIP CODE 2420 LAKE WHEELER ROAD RALEIGH, NC 27603	1 00:00:2020	
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F 600	working their next shrespective Department Competency Coording tracking to ensure the training. This training general orientation for 5/6/25. On 5/6/25 100% of fore-education provides regarding the facility resident after a fall usexamined by a licensinjuries. Department education for their restaff who did not conwill have the training their next shift, provided tracking to ensure the training. This training general orientation for 5/6/25. On 5/6/25 100% of the will receive training the event the fall occuprior to moving the resident assessment of the second tracking to ensure the training. This training general orientation for 5/6/25.	the training provided prior to hift, provided by their ent Supervisor. The Clinical mator will be responsible for at 100% of staff receive the g will be provided during or all newly hired staff after acility staff received ad by the Administrator policy not to move the ntil he/she has been sed nurse for possible to Supervisors will provide this espective staff on 5/6/25. All inplete this training on 5/6/25 a provided prior to working ded by their respective sor. The Clinical mator will be responsible for at 100% of staff receive the g will be provided during or all newly hired staff after the facility's transport drivers related to ensuring the by a qualified professional in curs during transportation and esident. Per the policy, they side of the road and call 911	F 600			

PRINTED: 06/03/2025 FORM APPROVED OMB NO. 0938-0391 (X3) DATE SURVEY

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345538	B. WING			1	09/2025
	ROVIDER OR SUPPLIER			s 2	TREET ADDRESS, CITY, STATE, ZIP CODE 420 LAKE WHEELER ROAD RALEIGH, NC 27603	<u> </u> U5/	08/2025
(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 600	provided training relations assessed by a qualevent the fall occurs of prior to moving the reshould move to the sifor resident assessment professional. Per podriver will notify the faduring transport provide Director. Alleged date of imme 5/08/25 Onsite validation of the facility ceased used company that provide Resident #1 on 4/25/24 A review of the facility revealed an audit of fawas completed by the outlined in their remover review for documental assessed the resident and that non-medical to perform a clinical aresident being moved identified. Review of the contract company's education staff had completed eregarding the notification.	ansportation drivers will be ted to ensuring the resident lifted professional in the during transportation and sident. Per the policy, they de of the road and call 911 ent by a qualified licy, the facility transport acility of any fall that occurs ded by the Maintenance diate jeopardy removal: The immediate jeopardy removal: T	F	600			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED			
		345538	B. WING _			C 05/08/2025
	ROVIDER OR SUPPLIER	l		STREET ADDRESS, CITY, STATE, ZIP CODE 2420 LAKE WHEELER ROAD RALEIGH, NC 27603	•	03/00/2023
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE. DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 600	911. Further review documentation review transportation commoderation commoderation review transportation commoderation review transportation completed this training transportation comprior to being assign facility residents. The Administrator of contracted transportation currently used for the training of the facility policy for included transportation was provincluded transportation was provincluded transportation facility policy for included how to identify and example sign-in sheets were completed by all facility policy for included composition. This training to ensure training. This training eneral orientation 5/6/25. A review of the facility focus to not move a examined by a lice.	an related incident after calling	F6			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED		
		345538	B. WING _			C 05/08/2025
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 2420 LAKE WHEELER ROAD RALEIGH, NC 27603		00/00/2020
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 600	Clinical Competency responsible for track staff receive the train provided during genthired staff after 5/6/2. Review of the education sheets for the facility reviewed regarding occur during transport that the resident wall qualified professions move the transportation facility of any falls the Newly hired facility of any falls the Newly hired facility to provided training relist assessed by a quevent the fall occurs prior to moving the should move to the for resident assessional. Per professional. Per professional. Per professional productor.	cluding contracted staff. The y Coordinator will be king to ensure that 100% of ning. This training will be eral orientation for all newly 25. ation materials and sign-in y transportation staff were the procedure if a fall should bot. The education included as to be assessed by a labefore moving a resident, to a staff were to notify the nat occur during transports. Transportation drivers will be atted to ensuring the resident alified professional in the aduring transportation and resident. Per the policy, they side of the road and call 911	F 6	00		
	staff and contracted education was receinneglect education we examples, and repo	facility staff to confirm that ved regarding abuse and which included definitions and rting of resident neglect. ducted on 5/08/25 with the in staff who confirmed				
		oleted regarding management ng transports including not				

` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
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	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 2420 LAKE WHEELER ROAD RALEIGH, NC 27603				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PREFIX (EACH CORRECTIVE ACTION SHO		(X5) COMPLETION DATE		
F 684	medical professional, facility, and abuse an examples of neglect. The facility's immedia 5/08/25 was validated	hout being assessed by reporting incidents to the d neglect which included attended	F 6			5/22/25		
SS=J	applies to all treatment facility residents. Bas assessment of a resident residents received accordance with proferactice, the compreherance plan, and the resident, and the resident, Contracted and the Physician, the Driver failed to have I injury by a qualified per the resident following van and to notify the in order for the resident for injuries from the facility on 4/25/25 and notified staff that backwards while being facility and the Contral her and her wheelchare turned her to the facility of a 10 out of the facility and the facility of the facility and the Contral her and her wheelchare turned her to the facility and the facility of the facility and the Contral her and her wheelchare turned her to the facility and the facility of the facility and the Contral her and her wheelchare turned her to the facility and the contral her to the facil	ndamental principle that nt and care provided to ed on the comprehensive dent, the facility must ensure treatment and care in essional standards of nensive person-centered		" Address how corrective action accomplished for those residents for have been affected by the deficient practice: Upon return from her appointment 4/25/25 Resident #1 was evaluated Nurse at the facility, was provided Tramadol due to resident reports of The Nurse contacted the Medical E (MD) related to the resident reports pain and obtained an order to trans the resident to the Emergency Department for additional evaluation." Address how the facility will ide other residents having the potential	on I by the I pain. Director S of Sport			

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CENTER	3 FOR WEDICARE &	WEDICAID SERVICES				OIVID INC	7. 0930 - 0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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		345538	B. WING _				08/2025
NAME OF P	ROVIDER OR SUPPLIER			S1	TREET ADDRESS, CITY, STATE, ZIP CODE	·	
				24	20 LAKE WHEELER ROAD		
PRUITIH	EALTH-RALEIGH			R	ALEIGH, NC 27603		
(X4) ID	SUMMARY ST	TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION	,	
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F 684	Continued From page	e 14	F	584			
		nsferred to the hospital			affected by the same deficient practice	•	
	where she was identi			anotice by the came denotern practice	•		
		at surface at the top of each			The facility had 22 residents who had f	alls	
		umbar spine region, first			between 4/1/25 and 5/6/25. The Direct		
	, , ,	s a high likelihood of further			of Nursing (DON) reviewed		
		resident after a fall prior to a			documentation to ensure that each		
		of injury and not informing			resident was assessed by a licensed		
	I .	ed treatment for the resident.			nurse for injury following a fall, and		
	This deficient practice	e affected 1 of 3 residents			non-medical staff notified staff who we	re	
	reviewed for accident	ts (Resident #1).			qualified to perform clinical assessmen	ıt	
					prior to the resident being moved,		
	Immediate Jeopardy	began on 4/25/25 when			discrepancies were corrected at the tin	ıе	
	I .	assessed by a medical			of the audit, which was conducted on		
	1 -	y prior to being moved			5/6/25.		
	_	contracted transport van.					
	1	was removed on 5/07/25			" Address what measures will be pu		
	1	emented an acceptable			into place or systemic changes made to		
	credible allegation of				ensure that the deficient practice will no	ot	
		will remain out of compliance			recur:		
		severity level of D (no actual			All facility atoff manual and manipus		
	that is not immediate	or more than minimal harm			All facility staff members received education on the facility policy to not m	101/0	
		ed and monitoring systems			the resident after a fall until he/she has		
	put into place are effe	~ -			been examined by a licensed nurse for		
	put into place are end	couve.			possible injuries, provided by each		
	The findings included	y .			Department Supervisor, or designee, or	'n	
	The initiality included	••			5/6/25. Staff who did not receive this		
	Resident #1 was adm	nitted to the facility on			education on 5/6/25 received the training	na	
	I .	es which included a left			prior to working their next shift, by their	•	
		utation, right below the knee			respective Supervisor. This education		
	amputation, and depe	_			has been added to the General		
	·	-			Orientation of any newly hired staff		
	The Minimum Data S	Set (MDS) quarterly			members.		
	I .	29/25 revealed Resident #1					
	had severe cognitive	impairment. Resident #1			On 5/6/25 100% of the facility□s		
		ent upon staff for transfers and used			Transport Drivers received training rela		
	I .	a wheelchair for mobility. Resident #1 was not			to ensuring the resident is assessed by		
	T	the use of opioid pain			qualified professional in the event the f		
	medication.				occurs during transportation and prior t	:0	

Facility ID: 990762

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345538	B. WING _			C 05/08/2	2025	
NAME OF P	ROVIDER OR SUPPLIER	<u> </u>		STREET ADDRE	ESS, CITY, STATE, ZIP CODE	1 05/00/2	2023	
	101.02.1 01.1 001.1 2.2.1				HEELER ROAD			
PRUITTHE	ALTH-RALEIGH							
				RALEIGH, NO	27603			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES OY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(E	PROVIDER'S PLAN OF CORRECTION ACH CORRECTIVE ACTION SHOULD I DSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE CC	(X5) DMPLETION DATE	
F 684	Continued From pag	e 15	F6	84				
F 684	The nursing progress dated 4/25/25 at 6:54 returned from her dia approximately 5:30 p. Transport Driver repowas hurting and she #2 noted that staff er Resident #1 to bed a crying out that her be explained that her while being transport because the Contract lock the wheelchair of Resident #1 reported for her back from top the back, neck, and administered the as (opioid pain medicati noted the Medical Doreceived an order to emergency department of that EMS (emergency department) and that EMS (emergency department) and that Reside pain while Nurse #2 notified her Respons reported that Reside hospital at 6:45 pm. Review of the Control Nurse #2 administered (mg) tablets for pain 5:45 pm.	s note written by Nurse #2 4 pm revealed Resident #1 alysis appointment at 5 pm and the Contracted 5 ported that Resident #1's back 6 wanted to go to bed. Nurse 6 putered the room to assist 7 and she started moaning and 8 and she started moaning	F 6	moving the should me call 911 from the qualified facility of transport training will be proposed facility. The facility of transport training the color of transport training the should me call 911 from transport training facility af provided 5/7/25. Notivers for training, in the call 911 from the color of training, in the call 911 from the call 911 f	or the vendor who is providing ed transportation services training related to assessing for injury prior to moving the by notifying 911 so a qualified and will assess the resident at the facility of falls by calling the feer calling 911. The vendor adocumentation to the NHA of Newly hired contract transport or this vendor will be provided by the contracted transportation.	vers a fall to ney nd e the d nd the the the this		
	at 1:05 pm with Nurs	w was conducted on 5/05/25 te #2 who was assigned to /25 when she returned from		company	y owner, or designee, prior to signed transportation trips for			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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		345538	B. WING _			05/0	08/2025
NAME OF PR	ROVIDER OR SUPPLIER	•	STREET ADDRESS, CITY, STATE, ZIP CODE		TREET ADDRESS, CITY, STATE, ZIP CODE	-	
				2	420 LAKE WHEELER ROAD		
PRUITTHE	ALTH-RALEIGH			R	RALEIGH, NC 27603		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
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F 684	Continued From page	e 16	F	684			
	the dialysis appointme	ent. Nurse #2 stated she					
		ation when the Contracted			The Maintenance Director, or designee	,,	
		oached the desk with			will audit 10 instances when a resident		
		dialysis communication book			secured in a transport van at the facility	/ to	
	and reported that Res	sident #1's back hurt and			ensure the resident chair is securely		
	she wanted to go to b	oed. Nurse #2 stated the			fastened in the transport vehicle weekly	у,	
	Contracted Transport	Driver left the dialysis			for 12 weeks. The facility will address	any	
	communication book	at the desk and left the			concerns that are identified during audi	ts	
	facility. Nurse #2 stat	ted that at no time did the			and take appropriate follow up action.		
		Driver report that Resident			Weekly transportation audits for secure	•	
		ipped backwards during the			fastening resident chairs in the transpo	rt	
		ty or that Resident #1 had hit			vehicle will continue after 3 months, to		
	the floor of the van. N				ensure ongoing compliance.		
		ian and they discussed the				_	
		diology testing but they			The DON, or designee, will audit 10 fal		
		send Resident #1 to the	per month, to ensure that the resider			vas	
		pain was all over. She			assessed for fall by a qualified		
		as medicated with pain			professional prior to the resident being		
	medication but she w				moved, for 3 months. The facility will		
	continued to cry out v	Nurse #2 stated she notified			address any concerns that are identifie		
	the Director of Nursin				during audits and take appropriate folloup action. Monthly audits will continue		
	the Director of Naisin	ig of the incident.			after 3 months, to ensure ongoing		
	Resident #1 was inte	rviewed on 5/08/25 at 9:01			compliance.		
		had some difficulty talking			Compilation.		
		cause she was so upset by			" Indicate how the facility plans to		
		sident #1 stated when the			monitor its performance to make sure t	hat	
		Driver went to take a turn or			solutions are sustained:	1141	
		er wheelchair tip backwards					
	•	ng she could see was the			The Maintenance Director will present	the	
	ceiling of the van. Re	-			analysis of the transportation		
		Driver pulled the van over			safety/fastening audit compliance		
	and came to check or	· · · · · · · · · · · · · · · · · · ·			percentage to the Nursing Home		
	(Resident #1) was ok	ay." Resident #1 stated she			Administrator (NHA) at the Quality		
		nything at that time, she			Assurance and Performance		
	stated she felt "confu	sed and in shock". Resident			Improvement Committee meeting mon	ihly	
	#1 stated that someh	ow the Contracted Transport			until three consecutive months of		
		ck her and her wheelchair up			compliance is maintained and then		
	from the floor while sl	he was still sitting in it and			quarterly thereafter. The Maintenance		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345538	B. WING				C 08/2025	
NAME OF D	ROVIDER OR SUPPLIER	0.000			TREET ADDRESS, CITY, STATE, ZIP CODE	05/	06/2025	
NAME OF T	NOVIDER OR SOLT LIER							
PRUITTHE	ALTH-RALEIGH				420 LAKE WHEELER ROAD			
				R	RALEIGH, NC 27603			
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 684	Continued From page	e 17	F 6	684				
F 684	put her and the whee Resident #1 stated th Driver then hooked he and drove her back to stated when she got he was at least 10 out of staff what happened by the Contracted Train An attempt to intervie Driver on 5/07/25 was. The Director of Nursin on 5/05/25 at 2:08 pm at the facility when the Driver brought Reside appointment on 4/25/notified by Nurse #2 contracted Trailready left the facility obtain a statement. The Health Information Director to contact the Company and report DON stated she was Contracted Transport van incident when he facility. An interview with the on 5/05/25 at 2:21 pm contacted the Contracted the Contract	Ichair back upright. The Contracted Transport The wheelchair to the floor The facility. Resident #1 The pack to the facility her pain The sold to tell the when she was transported ansport Driver. The Contracted Transport The DON stated she was The DON stated she was The Contracted Transport The the was transport The the was transport The DON stated she was The DON stated she was The the was transport The the was transport The the the was The DON stated she was The the was transport The the was The the was transport The the the was The the was The the was The the was The was transport The the the was The the was The the was The was transport The the the was The the was The was The was The the was The was The was The the was The was The was The the was Th	F	584	Director is responsible for implementing and maintaining the acceptable plan of correction related to transportation safety/fastening. The DON will present the analysis of the fall assessment audit compliance percentage to the Nursing Home Administrator at the Quality Assurance and Performance Improvement Committee meeting monthly until three consecutive months of compliance is maintained and then quarterly thereafted. The DON is responsible for implementiand maintaining the acceptable plan of correction related to fall assessment and documentation. 1. Completion Date: 5/22/25	er.		
	Transportation Comparison the Contracted 1	any obtained the statement Fransport Driver and the information to the facility.						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		345538	B. WING _			C 05/08/2025	
	ROVIDER OR SUPPLIER		,	STREET ADDRESS, CITY, STATE, ZIP CODE 2420 LAKE WHEELER ROAD RALEIGH, NC 27603	•	30.00.2020	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF COF ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 684	provided the facility the company which Contracted Transporegarding the incide Resident #1 was pid approximately 4:30 facility by the Contracted that as he over backwards caucher head and back, that the Contracted stopped, asked the the wheelchair uprig and returned Reside further noted that he to the facility managhim not to tell anyor to get anyone in troconcluded that the was terminated due not securing Resident negligence. A telephone intervie at 1:56 pm with the Company's Office Mad provided the farregarding the incident this time they had in provide.	nsportation Company with a written statement from included a statement from the out Driver dated 4/25/25 cent. The statement revealed cked up on 4/25/25 at pm for transport back to the acted Transport Driver. He took off, the wheelchair tilted using Resident #1 to fall hitting The statement further noted Transport Driver immediately resident if she was okay, set ght, secured it to the van floor, ent #1 to the facility. He e wanted to report the incident gement but Resident #1 asked the because she did not want tuble. The statement Contracted Transport Driver to not reporting the incident, ent #1's wheelchair, and gross www as conducted on 5/05/25 Contracted Transportation flanager who revealed they cility with the information ent with Resident #1 and at to further information to	F6				
	facility contacted EN emergent transport they arrived at the fand symptoms lister	ted 4/25/25 revealed the MS for Resident #1's to the hospital at 6:40 pm and acility at 6:54 pm. The signs d on the report indicated acute The resident stated she was					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	PLE CONSTRUCTION G	, ,	(X3) DATE SURVEY COMPLETED			
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	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 2420 LAKE WHEELER ROAD RALEIGH, NC 27603	!	03/00/2023		
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F 684	the pain. Staff indica 2 tramadol prior to E the facility with Resident arrived at the hospit Review of the hospit through 5/01/25 revein the emergency roapproximately 7:32 the transportation vachest, abdominal, attomography (CT) sowithout intravenous 4/26/25 at 4:45 am whospital record furth #1continued to repo 4/29/25 a magnetic was performed on 4 fracture at the super height loss (a less scompressed). Resid surgical intervention back to the facility of discharge activity leand she was prescrimedication) 5 mg tafor moderate or sevelidocaine 4% pain particular to Resident #1 on 4/25 through 11:00 pm shwent to Resident #1 was crying out every she had never seen before. NA #3 state	she was unable to describe ated Resident #1 had received EMS arrival. EMS departed dent #1 at 7:11 pm and al at 7:27 pm. tal record dated 4/25/25 ealed Resident #1 was seen om provider on 4/25/25 at pm after sustaining a fall in an with reports of head, neck, and back pain. A computed an of the cervical spine contrast was completed on with no acute findings. The er noted that Resident rt "pain all over" and on resonance imaging (MRI) //29/25 which showed a rior endplate of L1 without evere fracture that is not fully ent #1 did not require any s and was stable for transfer in 5/01/25. Resident #1's vel was noted "as tolerated" bed oxycodone (opioid pain blet every 4 hours as needed ere pain for 5 days and a	F 6	84				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED		
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	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 2420 LAKE WHEELER ROAD RALEIGH, NC 27603	1 00/00/2	2020
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F 684	Continued From page 20 why the Contracted Transport Driver did not		F 6	84		
	_	ed to Resident #1 when he				
	NA #1 she revealed 4/25/25 when Resid NA #1 stated the Cocame to the nursing that Resident #1 had was not feeling good was visibly upset an room Resident #1 rethe transport van. N Nurse #2. NA #1 state Driver had the "audaher face and not say happened to Reside	on 5/05/25 at 1:50 pm with that she was working on ent #1 returned from dialysis. Intracted Transport Driver station desk and he reported dibeen "crying like this and di". She stated Resident #1 di when she was back in her eported what had occurred on A #1 immediately notified ated the Contracted Transport acity to stand right in front of yone word about what ent #1 in the van when it was I was in extreme pain."				
	pm with the Physicial the medical provided years at the facility. Resident #1 should being moved since to Driver was not able been injured at the toworsened an injury. The spoke with Nurse obtain in-house radio He stated they discut was at the bedside of Resident #1's pain to they made the decist the hospital for the toworsened pain through	an who revealed he had been of for Resident #1 for over 3. The Physician indicated that have been assessed before the Contracted Transport to know if Resident #1 had ime and it could have. The Physician stated when the Physician stated when the was to cology testing for Resident #1. It is sed that since the nurse she was best to determine the was best to determine the evel and current status so the sion to send the resident to the esting because of the hout her body. The Physician was "very sharp and alert"				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ` ′	PLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED		
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F 684	He stated Resident her cognition and sp source of information. A follow-up interview at 1:15 pm with the Contracted Transpo 911 when Resident backwards and he stacility. During an interview the Administrator sh the incident occurred Transport Driver did staff at the facility with from the dialysis appetated the Contracted have had Resident stacility. On 5/05/25 at 4:51 protified of immediated The facility provided Jeopardy removal publication of the noncomplete o	er chronic and acute illnesses. #1 was normally very clear in beech and she was a reliable in. was conducted on 5/08/25 DON who stated the incident to the incident to the incident to the incident to any incident to any incident. The Administrator incident to the incident to any the in	F 6	84			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	IPLE CONSTRUCTION IG	, ,	(X3) DATE SURVEY COMPLETED		
		345538	B. WING _			C 05/08/2025	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 2420 LAKE WHEELER ROAD RALEIGH, NC 27603	•	00/00/2020	
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F 684	not feel good but he nursing staff of the five clinically assessed on 4/25/25 at 5:30 p. Nurse #2 that her be that her wheelchair transportation van, to wheelchair down, and wheelchair down, and identified that the reported pain. Nurse #2 went direct and identified that the reported pain. Nurse #2 completed of Resident #1, whice was given Tramado was given Tramado was given Tramado for Resident #1 to the Effort evaluation. Nurse Medical Services (ED and Resident #1 Nurse #2 contacted to report the incident contracted van, the the MD order to transport Resident #1 remains a CT Scan on 4/25/2 acute diagnosis. Durse was stated to the MD order to transport the diagnosis. Durse was stated to the MD order to transport the diagnosis. Durse was stated to the MD order to transport the diagnosis. Durse was stated to the MD order to transport the MD order to transport the diagnosis. Durse was stated to the MD order to transport the diagnosis. Durse was stated to the MD order to transport the MD order	ge 22 It wanted to go to bed and did If ailed to notify the facility It all in order for the resident to It and for injuries from the fall. It an earn of the contracted It an eurological assessment It an eurological assessment It for pain at 5:45 p.m. for pain. If or pain at 5:45 p.m. for pain. If the primary Medical Doctor If to report the resident If in her back, neck and If an order to transport If the resident ED at 6:45 p.m. If the Responsible Party (RP) If that occurred in the It resident report of pain and It is pain and the primary design and It is pain and the primary design and If the resident in her back, neck and If the primary design and the primary design and It is pain and the primary design and the primary des	F6	84			
	MRI on 4/29/25 which fracture.	ch identified a lumbar 1 ion Management (HIM)					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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F 684	Continued From page 23		F	684				
	T	the Contracted Transportation						
		on 4/25/25 at approximately						
		Resident #1's allegation that						
		l her wheelchair flipped back						
		ad. On 4/25/25 the Contracted						
		mpany Owner provided a						
	-	acility in an email from the						
		ortation Company Owner. The						
		ntracted Transportation						
	Company Owner of							
	Contracted Transp							
	with the Contracted							
		incident on 4/25/25 with Resident #1. Per the						
		ortation Company Owner, the						
		ort Driver reported that						
		elchair tilted backwards						
	_	and hit her head and back.						
		iver reported he immediately						
	1	esident #1 if she was OK, sat						
		nd returned her to the facility.						
		ansport Driver stated Resident						
		that she was OK. Per the ortation Company Owner, the						
		ort Driver did not follow the						
	·	911 to assess the resident for						
		ng the resident and not						
		of the fall. The Contracted						
		mpany Owner reported that the						
		ort Driver was terminated due						
		e and is ineligible for rehire.						
		rsing (DON) will review all						
		he last 30 days to verify that all						
		sessed by a licensed nurse for						
		all and non-medical staff						
		vere qualified to perform clinical						
		to the resident being moved.						
		nplete an investigation for any						
	concerns that are i	dentified and take appropriate						

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F 684	investigation. The Aresponsibility to ens follow-up are completed in the process or system from the adverse outcome from the action will. The facility will have residents to be assessed accident and for nor staff who are qualified assessments for injuresident being move. The Administrator sportation Com	deed upon the results of the administrator will assume ure the investigation and eted. The entity will take to alter the ailure to prevent a serious of occurring or recurring, and be complete: The effective systems in place for essed in the event of an in-medical staff to notify facility ed to perform clinical ury following a fall prior to the	F 68-	4		
	appointment transport for all contract transports from the fate and transports from the fate and	vendor who will be utilized for ortation will provide training port drivers who transport acility starting on 5/6/25. ided by the Contract for Supervisors and will to assess the resident for g the resident and the the facility of falls by calling e of the fall after calling 911. contracted transport drivers fendor sends to the facility will mpleted prior to being tion trips for the facility documentation will be inistrator by the Contracted pany Owner or Designee to a facility. Newly hired contract this vendor will be provided				

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F 684	Continued From page	e 25	F 68	4		
	this training by the Co Company Owner or E assigned transportation residents. On 5/6/25 100% of fare-education provided regarding the facility of resident after a fall undexamined by a licens injuries. Department education for their resistaff who did not commowill have the training their next shift, provided Department Supervisions Competency Coordination tracking to ensure that training. This training	contracted Transportation Designee prior to being on trips for the facility cility staff received d by the Administrator colicy not to move the ntil he/she has been ed nurse for possible Supervisors will provide this spective staff on 5/6/25. All plete this training on 5/6/25 provided prior to working led by their respective				
	will receive training resident is assessed the event the fall occuprior to moving the reshould move to the sifor resident assessment professional. Per podriver will notify the faduring transport. The training was provided Director on 5/6/25. Newly hired facility traprovided training relais assessed by a quar	by a qualified professional in urs during transportation and sident. Per the policy, they de of the road and call 911				

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	TIPLE CONSTRUCTION NG		(X3) DATE COMP	SURVEY LETED
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F 684	should move to the secont assessment of the secont assessment of the second of the sec	esident. Per the policy, they ide of the road and call 911 ent by a qualified olicy, the facility transport acility of any fall that occurs ided by the Maintenance ediate jeopardy removal: the immediate jeopardy mpleted as follows: documentation revealed an elast 30 days was d in their removal plan. The w for documentation that a seed the resident for injury eat non-medical staff notified form a clinical assessment being moved. No concerns ediated transportation and documentation revealed all education on 5/06/25. The otification of 911 to assess a prior to moving, and to my van related incident after cation was verified by sign-in vice locations. Newly hired vers for this vendor will be	F	584			

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	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP 2420 LAKE WHEELER ROAD RALEIGH, NC 27603	CODE	03/06/2023
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F 684			F	684		
		ntion company the facility nsportation effective 5/05/25.				
	I .	The state of the s				
	sign-in sheets were reducation was provided completed on resider education included nearly fall until the resident licensed nurse for poor The Clinical Competer responsible for tracking staff receive the train	ency Coordinator will be ng to ensure that 100% of ing. This training will be aral orientation for all newly				
	sign-in sheets were retransportation staff in education included to be assessed by a quevent of a fall during resident until the resinjury, and to notify the Newly hired facility the provided training relations assessed by a quatevent the fall occurs prior to moving the reshould move to the stor resident assessm professional. Per podriver will notify the fall occurs will notify the fall occurs for resident assessm professional.	education materials and eviewed regarding the facility the event of a fall. The call 911, a resident was to alified professional in the transport, not to move the dent had been assessed for the facility of the incident. The ansportation drivers will be ted to ensuring the resident lified professional in the during transportation and esident. Per the policy, they ide of the road and call 911 ent by a qualified plicy, the facility transport acility of any fall that occurs ided by the Maintenance				

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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F 684	staff, facility transpor facility staff to confirm	lucted on 5/08/25 with facility tation staff, and contracted	F 684			
F 689 SS=J	5/07/25 was validated Free of Accident Haze CFR(s): 483.25(d)(1) §483.25(d) Accidents The facility must ens §483.25(d)(1) The re	ards/Supervision/Devices (2)	F 689		5/22/25	
	supervision and assist accidents. This REQUIREMENT by: Based on record revision, Contracted and the Physician, the resident was safely stransport van during appointment back to Contracted Transport Resident #1's wheeld manufacturer's instructure resident #1's wheeld landing with the back support structure for of the van. Resident	esident receives adequate stance devices to prevent I is not met as evidenced iew and interviews with staff, Transportation Company, e facility failed to ensure a ecured in the contracted the return trip from an the facility. On 4/25/25 the to Driver failed to secure chair in accordance with the ctions prior to departing with dialysis clinic. During travel, chair flipped backwards crest of wheelchair (the the user's back) on the floor #1 remained in the e fall resulting in her head		" Address how corrective action will accomplished for those residents foun have been affected by the deficient practice: The facility has observed Resident #1 being correctly secured prior to transportation to an appointment, in a transport vehicle, following her fall in the contracted transport vendor transport vehicle on 4/25/25. " Address how the facility will identificated by the same deficient practices."	d to he fy be	

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F 689	Continued From page	÷ 29	F 6	889			
	hitting the van floor are impact when the back floor. Resident #1 su 10 (with 10 being the neck, shoulders, and resident was moaning they had never seen before. The resident hospital where she wat the superior endplate each vertebra) of the first vertebra). Reside on 5/01/25 and contin medication to control practice affected 1 of accidents (Resident #1 lmmediate jeopardy be Contracted Transport Resident #1's wheeld system in the transport jeopardy was remove facility implemented a allegation of immediate facility will remain out	and her back sustaining krest of the wheelchair hit ffered pain rated a 10 out of worst pain possible) in her back. Staff reported the g and crying out and that Resident #1 in pain like that was transferred to the as identified with a fracture ate (flat surface at the top of L1 (lumbar spine region, ent #1 returned to the facility aued to need opioid pain her pain. This deficient 3 residents reviewed for		The facility had 18 alert and o residents who had transportat transport vehicle between 4/7/5/6/25. Social Services interv 18 residents related to whether safely secured during transport No residents reported any incitately were not safely secured of transport. The facility identified 5 resident transportation in a transport vehicle to between 4/7/25 and 5/6/25, we alert and oriented. The facility a skin note and pain assessmenthese 5 residents, conducted Director of Nursing, Assistant Nursing or Licensed Nurse, or No areas of concern were identified during these evaluations. "Address what measures we into place or systemic change ensure that the deficient practirecur:	ion in a /25 and iewed the er they we rt on 5/6/2 idents who during hts who ha ehicle ho were n / complete ent for by the Director of n 5/6/25 . ntified will be put s made to	re 5. en ad ot ed	
	potential for more tha immediate jeopardy)	n minimal harm that is not to ensure education is		On 5/6/25 100% of the facility		ad	
	are effective.	oring systems put into place		Transport Drivers received tra to securing wheelchairs in the vehicle. Training uses the Su	transport		
	The findings included			and Secure Program and inclured return demonstration of safely	securing	a	
		etailed instructions for		wheelchair. The facility □s Tra			
		were noted to identify the		Driver training was provided b	-	ity	
		the vehicle designed for		Maintenance Director on 5/6/2	25.		
	securing wheelchairs	, position the wheelchair in					
	the designated secure	ement area, connect the floor anchor points, and		Newly hired facility Transporta will be provided training relate		rs	

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F 689	Continued From page	÷ 30	F 68	39			
	then to the wheelchai at the front and two a minimum of four tie-dinstructions further not to ensure the wheelch the occupant was prodriving. Resident #1 was adm 3/24/22 with diagnose above the knee ampuamputation, and dependent upon wheelchair mobility. If or pain or for the use	r's securement points (two t the rear of the chair) with a cown points. The coted to tighten the tie-downs nair was firmly secured and perly restrained before set that to the facility on the se which included a left station, right below the knee endence on dialysis. et (MDS) quarterly 29/25 revealed Resident #1 impairment. Resident #1		securing wheelchairs in the tra vehicle, using the Sure-Lok Sa Secure Program including a re demonstration of safely securing wheelchair, by the Maintenanc prior to providing transportation to a resident. Drivers for the vendor who is procontracted transportation serving received training related to safe a wheelchair, using the Q-Stra Training Video, including a return demonstration of safely securing wheelchair. The vendor proving documentation to the NHA on the Newly hired contract transport this vendor will be provided the QRT Training Video, including demonstration of safely securing wheelchair, by the contracted	fe and turn ng a e Director, n services roviding ces ely securing int QRT urn ng a ded 5/7/25. drivers for e Q-Straint a return		
	for ibuprofen (a nonst medication used to re	eroidal anti-inflammatory lieve pain and inflammation) blet; administer 2 tablets		transportation company owner designee, prior to being assign transportation trips for the faciliresidents.	ed		
	for tramadol (opioid p tablet; administer 2 ta hours as needed. Review of the April 20	ysician order dated 4/04/25 ain medication) 50 mg blets for left hip pain every 6 025 Medication d (MAR) and pain monitoring		The Maintenance Director, or of will audit 10 instances when a secured in a transport van at the ensure the resident chair is secfastened in the transport vehicle for 12 weeks. The facility will a concerns that are identified during the second of the sec	resident is ne facility to curely le weekly, address any		
	revealed Resident #1 tramadol 11 times and and her pain level val through 4/24/25.	was administered the PRN d the PRN ibuprofen 2 times ried from 0 to 7 from 4/01/25 note dated 4/25/25 at 6:54		and take appropriate follow up Weekly transportation audits for fastening resident chairs in the vehicle will continue after 3 monensure ongoing compliance. Indicate how the facility plants	action. or securely transport onths, to		

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F 689	returned from her dia approximately 5:30 p Contracted Transport reported back pain at Nurse #2 further note moaning and crying of Resident #1 explaine flipped backwards who to the facility from dia the Contracted Trans wheelchair down. Rescore of 10 out of 10 neck all the way down sides, and both shoul administered as need #2 further noted that out in pain and was to further evaluation by services). Review of the Contron Resident #1 was admitablets for pain on 4/2 medication was signed. A telephone interview at 1:05 pm with Nurse Resident #1 on 4/25/2 returned from the dia stated she was sitting.	#2 revealed Resident #1 lysis appointment at m and it was reported by the t Driver that Resident #1 had nd wanted to go to bed. d that Resident #1 began but that her back hurt and d that her wheelchair had nile being transported back lysis. Resident #1 reported port Driver forgot to lock the sident #1 reported a pain for her back from top of n the back, neck on both lders. Resident #1 was ded pain medication. Nurse Resident #1 continued to yell ransferred to the hospital for EMS (emergency medical lled Drug Record revealed ninistered 2 tramadol 50 mg 25/25 at 5:45 pm and the	F 68		present the nce ne surance t ntil three ance is thereafter. esponsible ing the elated to	
	desk with Resident # Resident #1's back h bed. Nurse #2 stated Driver left the dialysis desk and left the facil	1 and he reported that urt and she wanted to go to d the Contracted Transport s communication book at the lity. Nurse #2 stated she e Aide (NA) #1 that Resident				

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F 689	the room. She stated be panicked, "like tall rambling". She indice hesitant to report who nervous like not look she asked her about back from dialysis. It the Contracted Transwheelchair to the varitipped back and she Resident #1 reported and described it as rescheded the stated she contained to arrive stated Resident #1 was transhe had such severe stated Resident #1 was transhed to cry out ambulance to arrive. time did the Contract that Resident #1 had Nurse #2 stated she Nursing of the incide Review of the hospitathrough 5/01/25 reveinformation. Resident emergency room on in the transportation neck, chest, abdomir resident was also no oxygen level) and was oxygen via nasal car she had received parand her pain scale w	and she immediately went to all Resident #1 appeared to king all over the place and atted the resident seemed at happened, "almost ing at her [Nurse #2]" when what happened on the ride esident #1 did tell her that sport Driver did not lock the infloor and the wheelchair hit the floor. Nurse #2 stated I pain from the neck down eally bad, everything hurt. In acted the physician and insferred to the hospital since pain all over her body. She was medicated with pain was in such pain and while waiting for the Nurse #2 stated that at no led Transport Driver report in the floor of the van. In the floor of the van. In the floor dated 4/25/25 aled the following	F 68	39			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
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F 689	intracranial findings without intravenous 4/26/25 at 4:45 am hospital record furth #1continued to repo 4/29/25 a magnetic was performed on 4 fracture at the supe height loss (a less scompressed). Residure at the facility of discharge activity lewas prescribed addincluded oxycodone mg tablet every 4 hor severe pain for 5 patch daily. Review of the MAR Resident #1 receive for moderated to sepain level varied frothrough 5/06/25. To discontinued on 5/00 During an interview the Rehabiliation M Resident #1 had be therapy on 5/02/25 significant across home the sepain for 5 patch daily. Review of the MAR Resident #1 had be therapy on 5/02/25 significant across home the sepain level varied from the rehabiliation of the sepain for 5/02/25 significant across home the sepain f	25 at 4:41 am with no acute . A CT of the cervical spine contrast was completed on with no acute findings. The ner noted that Resident ort "pain all over" and on resonance imaging (MRI) l/29/25 which showed a rior endplate of L1 without severe fracture that is not fully dent #1 did not require any as and was stable for transfer on 5/01/25. Resident #1 had a evel noted "as tolerated" and itional pain medication which e (opioid pain medication) 5 ours as needed for moderate days and a lidocaine 4% pain for May 2025 revealed ed the as needed oxycodone evere pain 9 times and her on 0 through 8 from 5/01/25 the as needed oxycodone was	F 68			

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F 689	Continued From page	e 34	F 6	89		
	what happened. Resigetting into the transpore someone from the diagive her something a Driver was talking wit closed the doors and drive away. Resident did not realize that the Driver had not hooke floor. She stated he something and she fand then the only this ceiling of the van. Recontracted Transport and came to check of the Contracted Transport and continued to get back to the facility he of 10. Resident #1 stated during the pain continued to get back to the facility he of 10. Resident #1 stated and that "I okay" but when she goain was so bad that staff what happened had pain from the inchard to describe just her body." The Director of Nursi on 5/05/25 at 2:08 pr present at the facility	sident #1 stated she recalled cortation van and recalled alysis center came out to nd the Contracted Transport th them. She stated he then got in the van and began to t #1 stated at that time she e Contracted Transport d her wheelchair to the van went to take a turn or elt her chair tip backwards ng she could see was the		09		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED		
		345538	B. WING		C	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 2420 LAKE WHEELER ROAD RALEIGH, NC 27603	05/08/2025	
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION	
F 689	went to find the Co had already left the asked the Health Ir Director to contact Company and report of the company and report of the contact of the contact of the incident that in the HIM Director's Transportation Confrom the Contracted Transportation Company provided The Contracted Transport of the company which contracted Transport of the transportation where for travel when from the dialysis contacted the incident that in the transport of the transport of the the transport of the the transport of the without realizing her the transport Driver rewheelchair tilted on Resident #1 to fall is statement further in Transport Driver im resident if she was upright, secured it if	age 35 2 of the incident and when she intracted Transport Driver he facility. The DON stated she information Management (HIM) the Contracted Transportation wit Resident #1's incident. Inducted with the HIM Director pm. She reported she racted Transportation sted by the DON and reported volved Resident #1 on 4/25/25. Itated the Contracted inpany obtained the statement downward that information to the facility. Insportation Company with a written statement from the included a statement from the port Driver dated 4/25/25 ent. The Contracted Transport was loading Resident #1 into van and was about to secure he was distracted by a person enter. He noted that he as doing to get something from the did lysis center, then he at the doors, and took off the had not secured Resident the floor. The Contracted ported that as he took off, the ver backwards causing hitting her head and back. The oted that the Contracted imediately stopped, asked the okay, set the wheelchair to the van floor, and returned facility. He further noted that	F 68	39		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345538	B. WING		C 05/08/2025	
NAME OF PROVIDER OR SUPPLIER PRUITTHEALTH-RALEIGH			STREET ADDRESS, CITY, STATE, ZIP CODE 2420 LAKE WHEELER ROAD RALEIGH, NC 27603		1 00/00/2020	
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE COMPLETION	
F 689	management but R tell anyone because anyone in trouble. Driver stated Reside and he left Resider statement conclude Transport Driver was reporting the incide wheelchair, and grown at 1:56 pm with the Company's Office M had provided the faregarding the incide this time they had reprovide. An attempt to intervite at 1:12 pm with Nurassigned to Reside 3:00 pm shift on 4/2 Resident #1 had not leaving the facility for 5/05/25 at 1:18 assigned to Reside 3:00 pm through 11 when she went to Freturned from dialys something was wro Resident #1's face, stated Nurse #2 was	the incident to the facility esident #1 asked him not to a she did not want to get. The Contracted Transport ent #1 reported she was okay at #1 at the facility. The ed that the Contracted as terminated due to not not, not securing Resident #1's pass negligence. We was conducted on 5/05/25 Contracted Transportation Manager who revealed they cility with the information ent with Resident #1 and at no further information to	F 68	9		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345538	B. WING _				08/2025
NAME OF PROVIDER OR SUPPLIER PRUITTHEALTH-RALEIGH				2420 L	TADDRESS, CITY, STATE, ZIP CODE AKE WHEELER ROAD IGH, NC 27603	<u>, ou</u>	00/2020
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFII TAG	(PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 689	Continued From page	e 37	F	889			
	and her whole body we Resident #1 was cryitouched and she had pain like that. An interview was compm with NA #4 who reassigned to Resident the resident well. NA Contracted Transport down the hall in her wishe stated Resident #	#1 on 4/25/25 but she knew #4 stated she did see the Driver pushing Resident #1 wheelchair on 4/25/25 and #1 was sitting "slumped					
	lower body close to the wheelchair and her not the chair. She report be upset and in pain sitting in the wheelch looked at her when the she tried to speak to was wrong but the Co	apright in the chair with her the front edge of the eck resting on the back of ed Resident #1 appeared to because of the way she was air and the way Resident #1 arey went by. NA #4 stated Resident #1 and ask what contracted Transport Driver wheelchair down the hall					
	NA #1 she revealed the 4/25/25 when Residen NA #1 stated the Corcame to the nursing signature that Resident #1 had was not feeling good was visibly upset and room Resident #1 reput Transport Driver did not not right and that her she had hit her head Resident #1 was cryical.	n 5/05/25 at 1:50 pm with hat she was working on nt #1 returned from dialysis. Itracted Transport Driver station desk and he reported been "crying like this and". She stated Resident #1 when she was back in her ported that the Contracted not put her wheelchair in the wheelchair tipped back and and back. NA #1 stated ng saying she was in so mediately told Nurse #2 who					

		IDENTIFICATION NUMBER:		PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		345538	B. WING _			C 05/08/2025	
NAME OF PROVIDER OR SUPPLIER PRUITTHEALTH-RALEIGH			STREET ADDRESS, CITY, STATE, ZIP CO. 2420 LAKE WHEELER ROAD RALEIGH, NC 27603	•	310012023		
(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)	ON SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 689	pm with the Physician the medical provider years at the facility. It some diffuse left hip provided in the medical provider years at the facility. It some diffuse left hip provided in the medical provided in the medical provided in the medical provided in the provided i	ducted on 5/08/25 at 12:34 n who revealed he had been for Resident #1 for over 3 He stated Resident #1 had pain prior to the 4/25/25 hal use of opioid pain sician stated Resident #1 alert" and he would see her t the facility to manage her esses. He stated Resident clear in her cognition and a reliable source of was conducted with the 15 pm who revealed the Driver should have checked int #1's wheelchair was before he left the dialysis n 5/05/25 at 2:29 pm with revealed she had initiated the incident for Resident #1 e incident did occur and that acted Transportation driver. The Administrator d Transport Driver was e Resident #1's wheelchair an floor prior to driving. the following Immediate	F6	89			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	PLE CONSTRUCTION G		COMPLETED		
		345538	B. WING _			C 05/08/2025	
NAME OF PROVIDER OR SUPPLIER PRUITTHEALTH-RALEIGH				STREET ADDRESS, CITY, STATE, ZIP CODE 2420 LAKE WHEELER ROAD RALEIGH, NC 27603		03/00/2023	
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F 689	are likely to suffer, a a result of the nonco. The Contracted Tran secure Resident #1' the Contracted Tran 5:30 pm Resident # her back was hurting wheelchair flipped be the driver forgot to look she bumped her head Nurse #2 went direct and identified that the reported pain. Nurse #2 completed of Resident #1, which was given Tramadol Nurse #2 contacted (MD) for Resident # complained of pain is shoulder. The MD processed Resident #1 to the Efor evaluation. Nurse Medical Services (ED and Resident #1 Nurse #2 contacted to report the inciden contracted van, the the MD order to transplained in the hospital,	ents who have suffered, or a serious adverse outcome as ompliance: Insport Driver failed to safely swheelchair to the floor of sportation Van. On 4/25/25 at 1 reported to Nurse #2 that g and stated that her ack in the transportation van, bock her wheelchair down, and	F 6	89			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X		L IDENTIFICATION NUMBER:		X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345538	B. WING				C (08/2025	
NAME OF P	ROVIDER OR SUPPLIER	0.0000		STR	REET ADDRESS, CITY, STATE, ZIP CODE	05/	00/2025	
				242	0 LAKE WHEELER ROAD			
PRUITTHE	EALTH-RALEIGH			RA	LEIGH, NC 27603			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 689	Continued From page fracture. The Health Information Director contacted the Company Owner on 5:45pm to report the the Contracted Transthe wheelchair flipped by 4/25/25 the Contraction Company Owner. To Transportation Company Owner. To Transportation Company Owner had Transport Driver followith Resident #1. To Contracted Transport Evident #1's the Contracted Transport Evident #1's wheel causing her to fall and The Contracted Drivestopped, asked Resident #1's wheel causing her to the fall and The Contracted Drivestopped, asked Resident #1's wheel causing her to the fall and The Contracted Drivestopped, asked Resident #1's wheel causing her to the fall and The Contracted Drivestopped, asked Resident #1's wheel causing her to the fall and The Contracted Drivestopped, asked Resident #1's was of the Contracted Driver state him that she was Often Transport Driver did securing a passenger Transportation Component Driver did securing a passenger Transportat	ion Management (HIM) ne Contracted Transportation 4/25/25 at approximately Resident #1's allegation that sport Driver failed to secure Resident #1 stated her ack and she hit her head. On ted Transportation Company atement to the facility in an racted Transportation he email from the Contracted pany Owner described an outracted Transportation d with the Contracted owing the incident on 4/25/25 The email stated that the rt Driver confirmed he did not s wheelchair to the floor. Per sport Driver reported that chair tilted backwards and hit her head and back. er reported he immediately ident #1 if she was OK, sat cured her properly and acility. The Contracted ted Resident #1 reported to K. Per the Contracted pany Owner, the Contracted pany Owner, the Contracted pany Owner reported that the rt Driver was terminated due		689				
		and is ineligible for rehire.						
		Director identified all						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C 2420 LAKE WHEELER ROAD RALEIGH, NC 27603	•	3/00/2023	
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL IR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 689	using the facility tra Social Worker will is residents on this lis Mental Status (BIM Social Services will residents to identify transport driver fail wheelchair in the tr interviews will be concerns that are is follow-up action ba investigation. The responsibility to en follow-up are comp The facility licenses Note and Pain Ass BIMS of less than transportation in th potential injury which transportation. Rea Assessment will be results will be repo the DON. The faci investigation for an and take appropria the results of the in will assume respon investigation and for Specify the action of process or system adverse outcome f when the action will	iders within the last 30 days insportation calendar. The dentify alert and oriented it using the Brief Interview for IS) score of 10 and above. Interview alert and oriented any incident where the ed to safely secure the ansportation van. These completed on 5/6/25 and the red to the facility Administrator birector of Nursing (DON). The ean investigation for any dentified and take appropriate sed upon the results of the Administrator will assume sure the investigation and leted. If any the east 7 days to identify the may have occurred during sults of the Skin Note and Pain a completed on 5/6/25 and the red to the Administrator and/or lity will complete an y concerns that are identified the follow-up action based upon vestigation. The Administrator is sibility to ensure the ollow-up are completed.	F	689			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		345538	B. WING _			C 05/08/2025	
NAME OF PROVIDER OR SUPPLIER PRUITTHEALTH-RALEIGH			STREET ADDRESS, CITY, STATE, ZIP CODE 2420 LAKE WHEELER ROAD RALEIGH, NC 27603		00/00/2020		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR ((EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 689	was responsible for as of 5/5/25. The fa outside vendor utilizatransportation. The Administrator's Transportation Comneed for education appointment transportation appointment transportation of transportation of the Contract Transportation of 5/6/25. The Contract Transportation using the manufactivideo and will include afely securing a will contracted transport vendor sends to the	use of the outside vendor who transportation of Resident #1 cility has one additional ted for appointment poke with the Contracted upany Owner regarding the land documentation on 5/6/25. Vendor who will be utilized for ortation will provide go for all contract transport art residents from the facility Training will be provided by cortation Vendor Supervisors curer's instructional Training de a return demonstration of meelchair. Effective 5/6/25 all the drivers this Transportation de facility will have this training peing assigned transportation esidents. Training	F	DEFICIENCY)			
	Company Owner or the facility. Newly have for this vendor will be Contracted Transport Designee prior to be trips for the facility have demonstration of sa On 5/6/25 100% of will receive compete securing wheelchair transport driver train	e Contracted Transportation Designee to be maintained at hired contract transport drivers he provided this training by the hortation Company Owner or heing assigned transportation hesidents, including a return hefely securing a wheelchair. The facility's transport drivers hency training related to hir in the van. The facility's hing was provided by the hired Director on 5/6/25. Training					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	PLE CONSTRUCTION G	, ,	(X3) DATE SURVEY COMPLETED		
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	ROVIDER OR SUPPLIER	ı		STREET ADDRESS, CITY, STATE, ZIP CODE 2420 LAKE WHEELER ROAD RALEIGH, NC 27603	<u> </u>	00/00/2020	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R 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 689	a return demonstration wheelchair. Newly hired facility to provided this training demonstration of sa prior to being sched trips, provided by the Alleged date of imm 5/07/25. Onsite validation of removal plan was considered transportation services or concerns regarding services. Review of the facility revealed interviews residents who had a utilized transportation service skin/pain assessment residents with a BIM 7 days. No concerns The Administrator we the facility ceased uncompany that provice Resident #1 on 4/25. Review of the facility sign-in sheets were education was proviprovided resident training t	rer's instructions and includes from of safely securing a ransportation drivers will be g and include a return fely securing a wheelchair, uled to provide transportation a Maintenance Director. The immediate jeopardy removal: The immediate jeopardy peopleted as follows: The immediate jeopardy peopleted problems and the safety of transportation The immediate jeopardy peopleted problems and the safety of transportation The immediate jeopardy peopleted problems and the safety of transportation The immediate jeopardy peopleted problems and the safety of transportation The immediate jeopardy peopleted problems and the safety of transportation The immediate jeopardy peopleted problems and the safety of transportation The immediate jeopardy peopleted problems and the safety of transportation The immediate jeopardy peopleted problems and the safety of transportation The immediate jeopardy peopleted problems and the safety of transportation The immediate jeopardy peopleted problems and the safety of transportation The immediate jeopardy peopleted problems and the safety of transportation peopleted problems and the safety of transportation peopleted problems and the safety of transportation peopleted peopl	F6	89			

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NAME OF PROVIDER OR SUPPLIER PRUITTHEALTH-RALEIGH				STREET ADDRESS, CITY, STATE, ZI 2420 LAKE WHEELER ROAD RALEIGH, NC 27603	P CODE	03/00/2023
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFII TAG	PROVIDER'S PLAN (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETION DATE
F 689	guidelines for securir transportation and in demonstration of sechired facility transport the educational video demonstration of saf prior to being schedutrips, and will be provided company's education. The facility provided company's education The documentation of safely stransporting resident included a manufaction how to properly secutive van floor and a reeducation was verified hired contract transport be provided this train. Transportation Comparior to being assigned facility residents, included safely securing a very safely safely securing a very safely securing a very safely securing a very safely safely securing a very safely securing a very safely s	r regarding manufacturer and a resident for cluded a return curing a wheelchair. Newly station drivers will be provided to which will include a return ely securing a wheelchair, alled to provide transportation wided by the Maintenance. The contracted transportation of documentation for review. The evealed that all staff at both and completed video and written securing a wheelchair when so on 5/06/25. The education curer instructional video on the aresident wheelchair to enturn demonstration. The end by sign-in sheets. Newly cort drivers for this vendor will be any Owner or Designee and transportation trips for the auding a return demonstration wheelchair. Infirmed this was the only action company the facility insportation effective 5/05/25. Inducted on 5/08/25 with and the Maintenance are education was provided instration was completed.	F	589		

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
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		345538	B. WING _		05/08/2025	
NAME OF PR	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
PRIJITTHE	ALTH-RALEIGH			2420 LAKE WHEELER ROAD		
FROITINE	ALITI-NALLIOIT			RALEIGH, NC 27603		
(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 BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION TE DATE	