STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345061	A. BUILDING _____ B. WING _____	C 06/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEALTH-DURHAM	3100 ERWIN ROAD DURHAM, NC 27705

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F 000	INITIAL COMMENTS A complaint investigation was conducted onsite from 6/10/2025 to 6/11/2025. Additional information was obtained offsite on 6/13/2025. Therefore, the exit date was to 6/13/2025. Event ID # YJ1711. The following intakes were investigated: NC00230836, NC00230736, NC00230369, and NC00230229. Four (4) of the 6 allegations resulted in deficiency.	F 000		
F 580 SS=G	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the	F 580		7/4/25

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 06/27/2025

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F 580	Continued From page 1 resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on record review, and staff, responsible party (RP), Hospice Nurse, and Physician interviews, the facility failed to notify the provider of a change in condition and x-ray results after a fall for one (Resident #1) of three residents reviewed for notification of falls. Resident #1 fell on 5/17/2025 and the facility failed to notify the provider of pain and a new inability to bear weight. X-ray results obtained midday on 5/19/2025 were not relayed to the on-call provider until after hours on 5/19/2025. Resident #1 sustained an acute impacted left femoral neck fracture (an acute impacted left femoral neck fracture is a break in the upper part of the thigh bone (femur), specifically at the neck, where it connects to the ball of the hip joint). Findings	F 580	Corrective action for the residents found to be affected by the deficient practice. The facility failed to notify the Provider(s) and Responsible Party (RP) of a fall, change in condition and x-ray results for Resident #1 in a timely manner and failed to effectively communicate pending x-ray results between shifts for follow up. The MD Provider was notified of fall on 05/19/2025 and Hospice provider was notified of fall on 05/20/2025, change of condition on 05/20/2025 and x-ray results on 5/20/2025. The facility notified the Responsible Party (RP) of fall on 05/20/2025, change of condition on 05/20/2025 and x-ray results on	

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F 580	Continued From page 2 included: Resident #1 was admitted to the facility on 3/28/2025 with diagnoses of history of cerebral vascular accident, hemiplegia, hemiparesis, and lung cancer. Hemiplegia is paralysis on one side while hemiplegia is weakness on one side of the body. Resident #1 started receiving Hospice services on 3/31/2025. Documentation on a timesheet for Nurse Aide (NA) #1 revealed she worked at the facility from 7:18 AM to 10:53 PM on 5/17/2025. Documentation on the corresponding nursing schedule revealed NA #1 was assigned to care for Resident #1 during that time period. NA #1 was interviewed on 6/10/2025 at 11:54 AM. NA #1 revealed the following information. Resident #1 had a fall on 5/17/2025. NA #1 heard Resident #1 fall, and she told Nurse #4. Nurse #4 was interviewed on 6/10/2025 at 6:41 PM and revealed the following information. Nurse #4 worked the 7:00 AM to 7:00 PM shift on 5/17/2025. Resident #1 fell on 5/17/2025 while trying to go to the bathroom. Nurse #4 did full range of motion assessments of all her limbs and took the vital signs of Resident #1. Nurse #4, with the assistance of NA #1, helped Resident #1 up off the floor and into her wheelchair. Nurse #4 was so busy with a new admission, helping residents eat, changing incontinence briefs, and administering medications that she was not able to document anything in the electronic medical record. Nurse #4 also stated that she forgot to notify anybody about the fall but, Resident #1 was without injury or pain after the fall on 5/17/2025.	F 580	5/20/2025. Resident #1 was sent to Duke University Medical Center for treatment following fall on 05/20/2025; was readmitted to facility on 06/04/2025; discharged to another Skilled Nursing Facility on 06/06/2025. Nurse #4 was reported to the North Carolina Board of Nursing for substantiated allegation of neglect on 05/23/2025 and employment terminated on 05/25/2025. Corrective action for other residents having the potential to be affected by the same deficient practice. All current residents have the potential to be affected by these deficient practices. Falls, associated change-in-condition and x-ray orders will be audited for the past ten (10) days for timely notification to Provider(s), RP and Oncoming-Shift Nurse by the Director of Health Services (DHS), Clinical Competency Coordinator (CCC), Unit Manager (UM), Unit Coordinator (UC), Infection Preventionist (IP), Nurse Navigator/Senior Care Partner (NN/SCP), Case Mix Director (CMD), Case Mix Coordinator (CMC), Senior Nurse Consultant (SNC) or Administrator, by 07/03/2025. . Systemic changes made to ensure that the deficient practice will not recur. Licensed nursing staff education regarding notifying the provider; identifying change in condition requiring medical evaluation and treatment; communication to effectively provide treatment will be provided by the Director of Health Services (DHS), Clinical Competency	

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F 580	Continued From page 3 There was no documentation in Resident #1's electronic medical record of any fall, assessments, or notification of physician or family on 5/17/2025 for the 7:00 AM to 7:00 PM shift. An interview was conducted with the Responsible Party (RP) #1 for Resident #1 on 6/10/2025 at 2:06 PM. RP #1 provided the following information. RP #1, her husband, and her children went to visit Resident #1 on the morning of 5/18/2025. RP #1 barely got down the hallway when she was stopped by NA #1. NA #1 explained that she had not yet assisted Resident #1 out of bed and to get dressed. NA #1 said she knew that RP #1 would like to take Resident #1 outside. NA #1 then told RP #1 that Resident #1 fell yesterday (5/17/2025) but she was fine. RP #1 remarked to NA #1 that nobody had called to tell her about the fall. RP #1 went to see Resident #1 and to ask her about the fall. RP #1 stated that she and her husband were trying to help Resident #1 to get up, but it seemed like she was in pain, and she could not bear any weight. This was a change for Resident #1 because although she was weak on her left side she had always been able to stand. RP #1 revealed she assisted Resident #1 in dressing and then asked her about the fall she had on the previous day. Resident #1 told RP #1 that she was trying to get to the bathroom, and she twisted her left foot and fell. Resident #1 told RP #1 she did not hit her head. Resident #1 told RP #1 that a nurse and a nurse aide put her back into bed. RP #1 indicated Resident #1 seemed very sore and was protecting her left side. RP #1 stated she and her husband took Resident #1 to the bathroom, but Resident #1 was not able to stand or bear any weight. RP #1 indicated Resident #1 required her husband to pick her up and hold her to get on and	F 580	Coordinator (CCC), Unit Manager (UM), Unit Coordinator (UC), Infection Preventionist (IP), Nurse Navigator/Senior Care Partner (NN/SCP), Case Mix Director (CMD), Case Mix Coordinator (CMC), Senior Nurse Consultant (SNC) or Administrator by 07/04/2025. Any staff that have not completed the education will be removed from the schedule and will be educated prior to returning to work. New staff will be educated on the fall notification process during new hire orientation. All residents will falls will be audited three (3) x weekly for 4 weeks, then two (2) times weekly x 4 weeks, then one (1) x weekly for 4 weeks) by the Director of Health Services (DHS), Clinical Competency Coordinator (CCC), Unit Manager (UM), Unit Coordinator (UC), Infection Preventionist (IP), Nurse Navigator/Senior Care Partner (NN/SCP), Case Mix Director (CMD), Case Mix Coordinator (CMC), Senior Nurse Consultant (SNC) or Administrator, or until compliance maintained. Plans to monitor its performance to make sure that the solutions are sustained. An AdHoc Quality Assurance Performance Improvement (QAPI) review will be held by 07/04/2025 to review the Plan of Correction (POC). The Director of Health Services (DHS) 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	

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F 580	Continued From page 4 off the toilet and back into the wheelchair. RP #1 then went to the nurse's desk and spoke to Nurse #4. RP #1 told Nurse #4 that Resident #1 told her she fell last night and she was now in pain. RP #1 said Nurse #4 acted like she didn't know what RP #1 was talking about. Nurse #4 told RP #1 that Resident #1 had not mentioned anything about a fall or pain to her. Nurse #4 stated she would check and see if Resident #1 fell last night and confirmed she did not see anything about a fall in the electronic medical record. Nurse #4 went down to Resident #1's room and gave her pain medication but did not do any assessment or do anything else for Resident #1. RP #1 revealed she told Nurse #4 that Resident #1 was unable to bear weight on her left side and Nurse #4 kept acting like she didn't know what she was talking about or with any concern. Resident #1 told RP #1 that Nurse #4 was the nurse who was in the room last night after the fall. RP #1 did take Resident #1 outside to get some air but Resident #1 seemed very sore anytime they moved her, and she required more assistance than usual. Nurse #4 was interviewed on 6/10/2025 at 6:41 PM. Nurse #4 confirmed she worked the 7:00 AM to 7:00 PM shift on 5/18/2025. Nurse #4 stated that RP #1 came to the desk on the morning of 5/18/2025 and told her Resident #1 was having back pain. Nurse #4 stated that Resident #1's fall that occurred on 5/17/2025 was not discussed at all with RP #1. Nurse #4 stated that Resident #1 was not injured so there was no reason to tell RP #1 about the fall. Nurse #4 confirmed she administered an ordered dose of Oxycodone to Resident #1 on the morning of 5/18/2025. Nurse #4 confirmed she did not do any documentation or notification of a physician on 5/18/2025 because she was too busy with nursing duties.	F 580	until three consecutive months of compliance is maintained and then quarterly thereafter beginning July 2025. Date of compliance: 07/04/2025	

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F 580	Continued From page 5	F 580		

RP #1 was interviewed on 6/10/2025 at 2:06 PM and revealed the following information. On the morning of 5/19/2025 RP #1 had concerns for Resident #1, so she sent a text message to Hospice Nurse #1 first thing in the morning. RP #1 told Hospice Nurse #1 that Resident #1 had a fall on 5/17/2025 and she was in pain. Hospice Nurse #1 told RP #1 that Resident #1 was the first person she would visit that day. RP #1 could see on 5/19/2025 in a video call to Resident #1 that she was in a lot of pain and was guarding her left side.

Documentation in a Hospice Nurse as needed visit note dated 5/19/2025 at 1:46 PM revealed, "Received message from [RP #1] that [Resident #1] had a fall over the weekend. Arrived [Resident #1's] room, [Resident #1] was sleeping. Called out her name and [Resident #1] woke up without difficulty. Asked [Resident #1] about the fall, [Resident #1] narrated saying, "I called for someone to help me to bathroom, but no one came, I did not want to pee on myself, so I got up using my cane, but my left foot got caught and I tripped over and fell on my left side. I lay there until an aide came to help me up." [Resident #1] had an unwitnessed fall on Saturday 5/17/2025, consulted facility nurse for details but [Nurse #3] stated that he had no report of the fall from previous shift. Since then, she has complained of pain of 5 to 8 on numerical scale. [Resident #1] able to assist in turning, but pain prohibits turning to left side of body. [Resident #1] left leg and foot had no bruising, swelling, or hotness. [Resident #1] left side is the weak side from history of [Cerebral Vascular Accident]. Asked the facility provider [MD #1 (Physician)] for further management. Provider did an assessment and

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F 580	Continued From page 6	F 580		

ordered STAT (immediate) X-ray of left leg and hip. Called Mobile service for STAT x-ray and collaborated with facility nurse for pain medication, to start with [as needed] acetaminophen. [Resident #1] was slightly tachycardic in 111-113 beats/minute with oximetry, oxygen saturation initially was 88 % on room air then after repositioning it came up to 93 %. (Tachycardia is a medical condition characterized by a rapid heart rate, typically defined as a resting heart rate of over 100 beats per minute.) Called family for update, to call Hospice and not to wait next time there was a concern."

Hospice Nurse #1 was interviewed on 6/10/2025 at 5:20 PM. Hospice Nurse #1 revealed she was the case manager for Resident #1. Hospice Nurse #1 stated that on 5/19/2025 RP #1 sent her a text notifying her that Resident #1 had a fall over the weekend on 5/17/2025. Hospice Nurse #1 revealed she went to the facility, assessed Resident #1, and immediately contacted MD #1 (Physician), who was in the building. MD #1 looked at Resident #1 and ordered a STAT x-ray. Hospice Nurse #1 called mobile x-ray. Hospice Nurse #1 confirmed she asked Nurse #3 about Resident #1's fall on 5/17/2025 but he was unaware of the fall and did not see any documentation in the electronic medical record about the fall.

MD #1 (Physician) was interviewed on 6/11/2025 at 8:06 AM and revealed the following information. MD #1 was doing his rounds at the facility on 5/19/2025 when a nurse approached him and asked him to look at Resident #1. MD #1 did an assessment of Resident #1 and noted her left leg was shorter and was externally rotated.

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F 580	Continued From page 7	F 580		

MD #1 was certain that Resident #1 had a fracture, so he ordered a STAT x-ray of her left hip and made sure that Resident #1 had pain medication ordered and available. MD #1 requested to be contacted when the results of the x-ray came back for further orders. MD #1 expected a provider to be notified of any acute findings at the time they were available. MD #1 explained that Resident #1 was not one of his patients but for any change in condition; including x-ray results of a fracture, a provider should be notified to obtain additional orders. MD #1 confirmed notification was a key piece in the provision of care.

Nurse #3 was interviewed on 6/10/2025 at 2:53 PM and provided the following information. Nurse #3 worked from 7:00 AM to 3:00 PM on 5/19/2025. Nurse #3 was told by Hospice Nurse #1 that Resident #1 had a fall on 5/17/2025 and that MD #1 had ordered a STAT x-ray of her left hip.

Documentation on the x-ray results dated 5/19/2025 revealed Resident #1 had sustained an acute impacted left femoral neck fracture. The x-ray results were faxed to the facility at 2:50 PM on 5/19/2025.

Nurse #2 was interviewed on 6/10/2025 at 2:38 PM and revealed the following information. Nurse #2 worked from 3:00 PM to 11:00 PM on 5/19/2025. Nurse #2 stated she was not aware at the start of her shift that Resident #1 had a fall over the weekend. Nurse #2 explained that she was also the facility wound care nurse and that at some point in her shift, she went to the fax machine to fax wound care orders. Nurse #2 went through all the faxes that were on the fax

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F 580	Continued From page 8	F 580		

machine, and she noted the x-ray results for Resident #1. Nurse #2 did not know anything had happened to Resident #1. Nurse #2, at some point in the shift, went to Resident #1 to ask her why she had an x-ray because she was alert and oriented. Resident #1 told Nurse #2 she fell a few days ago. The on-call provider told Nurse #2 to follow up with the regular provider in the morning. Nurse #2 took her vital signs and did a pain assessment. Nurse #2 was alerted by the nurse aides that Resident #1 was in extreme pain when they turned her for incontinence care. Nurse #2 stated she gave pain medication to Resident #1. Nurse #2 explained that when Resident #1 first arrived at the facility she was weak and could not get up to go to the bathroom. Gradually Resident #1 gained strength and confidence and used her cane to go to the bathroom. Resident #1 was continent of bowel and bladder, but staff had to keep reminding her that she needed to ask for help to go to the bathroom so she would not fall. Nurse #2 noted it was a change for Resident #1 to be incontinent and to be provided with incontinent care by the nurse aides. Nurse #2 called the on-call physician with the x-ray results because it was after hours on 5/19/2025. The on-call provider asked if Resident #1 was stable. Nurse #2 told the on-call provider that Resident #1 was stable and was only in pain when she was moved or turned for incontinent care.

Documentation in a nursing progress note dated 5/20/2025 at 12:09 AM written by Nurse #2 revealed the following information. Resident #1 fell a few days ago and was in pain when she was turned from side to side. Resident #1 received medication for breakthrough pain in the left hip area. The left hip x-ray results were received, and Resident #1 was noted to have an acute

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F 580	Continued From page 9	F 580		

impacted left femoral hip neck fracture. The after-hours provider was contacted. The after-hours provider stated that if the resident was stable, to follow up in the morning with the nurse practitioner.

Nurse #2 was interviewed again on 6/11/2025 at 1:31 PM. Nurse #2 conceded that Nurse #3 may have told her Resident #1 had a fall and to watch out for the x-ray results at the change of shift on 5/19/2025. Nurse #2 reiterated that she became aware of the x-ray results at an unknown time and she had many responsibilities that day as the wound care nurse for the facility.

An interview was conducted with NA #6 on 6/11/2025 at 8:57 AM and the following information was provided. NA #6 was assigned to care for Resident #1 on 5/19/2025 from 3:00 PM until 7:00 AM on 5/20/2025. Resident #1 told NA #6 that she fell on Saturday. NA #6 asked her what happened because she was alert and oriented. Resident #1 told him she was trying to go to the bathroom and her foot twisted, and she fell. Resident #1 told NA #6 that a nurse and a nurse aide picked her up and put her in bed. NA #6 asked if RP #1 was called and Resident #1 said no. NA #6 called another nurse aide for help to provide incontinent care for her because she was in pain when she was moved. NA #6 stated he left the room to immediately tell Nurse #2 that Resident #1 had a fall over the weekend and she was in pain. Nurse #2 told NA #6 that there was no documentation in the electronic record of a fall sustained by Resident #1 over the weekend. NA #6 returned to Resident #1's room and told her that if she needed a bed pan to call him because he could not help her out of bed to the bathroom like he usually did. NA #6 said Resident #1 was

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	345061	A. BUILDING _____ B. WING _____	C 06/13/2025

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F 580	Continued From page 10	F 580		

crying in pain and he had to roll her little by little to provide incontinent care for her. NA #6 revealed he told Nurse #5 that Resident #1 had a fall and was in pain when moved.

Nurse #5 was interviewed on 6/11/2025 at 7:27 AM and revealed the following information. Nurse #5 worked the 11:00 PM to 7:00 AM shift that ended on 5/20/2025. Nurse #5 revealed she notified the nurse practitioner in the morning on 5/20/2025 that the x-ray results were received by the facility and Resident #1 had an acute impacted left femoral neck fracture.

Documentation in the nursing progress notes dated 5/20/2025 at 7:25 AM written by Nurse #5 revealed the nurse practitioner gave a verbal order to send Resident #1 to the emergency room for a left femoral neck fracture.

The documentation on Resident #1's hospital discharge summary dated 5/28/2025 revealed Resident #1 underwent surgery to repair her femur fracture.

An interview was conducted on 6/13/2025 at 1:11 PM with the current interim Director of Nursing (DON), who initiated employment with the facility on 5/27/2025. The DON explained she was made aware of the facility investigation for Resident #1 by the previous Administrator at the start of her employment. The DON stated she expected that the nursing staff would assess a resident who fell, and if there was a serious medical issue to contact the provider and herself. The DON elaborated that each nursing station had directions at the desk for what steps needed to be taken when a resident falls, including assessment, notification of provider, and charting.

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	345061	A. BUILDING _____ B. WING _____	C 06/13/2025

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F 580	Continued From page 11 The facility provided a draft plan of correction for past non-compliance that was not acceptable to the state agency due to a lack of measures put into place for audits and monitoring of compliance.	F 580		
F 600 SS=G	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on record review, and staff, resident, responsible party (RP), Hospice Nurse, Physician, and Medical Director interviews, the facility failed to provide ongoing assessments after a fall; failed to identify a change in condition that required medical evaluation and treatment; failed to notify a provider of a change in condition; failed to identify one leg shorter than the other and external leg rotation required medical evaluation and treatment; failed to communicate effectively to provide treatment; and failed to notify a provider of fracture x-ray fax results upon	F 600	Corrective action for the residents found to be affected by the deficient practice. The facility failed to ensure that staff provided ongoing assessment after fall; identify change in condition requiring medical evaluation and treatment; failed to communicate effectively to provide treatment for Resident #1. The provider was notified of fall on 05/20/2025, change of condition on 05/20/2025 and x-ray results on 5/20/2025. The facility notified the	7/4/25

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F 600	Continued From page 12 receipt for one (Resident #1) of three residents reviewed for abuse and/or neglect. Resident #1 sustained an acute impacted left femoral neck fracture. (an acute impacted left femoral neck fracture is a break in the upper part of the thigh bone (femur), specifically at the neck, where it connects to the ball of the hip joint). Findings included: This tag is cross referred to: F580: Based on record review, and staff, responsible party (RP), Hospice Nurse, and Physician interviews, the facility failed to notify the provider of a change in condition and x-ray results after a fall for one (Resident #1) of three residents reviewed for notification of falls. Resident #1 fell on 5/17/2025 and the facility failed to notify the provider of pain and a new inability to bear weight. X-ray results obtained midday on 5/19/2025 were not relayed to the on-call provider until after hours on 5/19/2025. Resident #1 sustained an acute impacted left femoral neck fracture. (An acute impacted left femoral neck fracture is a break in the upper part of the thigh bone (femur), specifically at the neck, where it connects to the ball of the hip joint.) F684: Based on record review, and staff, responsible party (RP), resident, Hospice Nurse, Physician, and Medical Director interviews the facility failed to provide ongoing assessments after a fall; failed to identify the change in condition required medical evaluation and treatment; failed to identify one leg shorter than the other and external leg rotation required medical evaluation and treatment; and failed to communicate effectively to provide treatment for one (Resident #1) of three residents reviewed for	F 600	Responsible Party (RP) of fall on 05/20/2025, change of condition on 05/20/2025 and x-ray results on 5/20/2025. Resident #1 was sent to Duke University Medical Center for treatment following fall on 05/20/2025 and was readmitted to facility on 06/04/2025. Resident #1 discharged to another Skilled Nursing Facility on 06/06/2025. Nurse #4 was reported to the North Carolina Board of Nursing for substantiated allegation of neglect on 05/23/2025 and employment terminated on 05/25/2025. Corrective action for other residents having the potential to be affected by the same deficient practice. All current residents have the potential to be affected by these deficient practices. Fall assessment, change-in-condition and communication will be audited for the past ten (10) days for timely notification and treatment, to Provider(s), RP and Oncoming-Shift Nurse by the Director of Health Services (DHS), Clinical Competency Coordinator (CCC), Unit Manager (UM), Unit Coordinator (UC), Infection Preventionist (IP), Nurse Navigator/Senior Care Partner (NN/SCP), Case Mix Director (CMD), Case Mix Coordinator (CMC), Senior Nurse Consultant (SNC) or Administrator, by 07/03/2025. Systemic changes made to ensure that the deficient practice will not recur. Licensed Nursing education regarding ongoing assessment; identifying change in condition requiring medical evaluation	

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	345061	A. BUILDING _____ B. WING _____	C 06/13/2025

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F 600	Continued From page 13 assessment after a fall. Resident #1 sustained an acute impacted left femoral neck fracture (an acute impacted left femoral neck fracture is a break in the upper part of the thigh bone (femur), specifically at the neck, where it connects to the ball of the hip joint). Findings included:	F 600	and treatment; communication to effectively provide treatment will be provided by the Director of Health Services (DHS), Clinical Competency Coordinator (CCC), Unit Manager (UM), Unit Coordinator (UC), Infection Preventionist (IP), Nurse Navigator/Senior Care Partner (NN/SCP), Case Mix Director (CMD), Case Mix Coordinator (CMC), Senior Nurse Consultant (SNC) or Administrator and completed by 07/03/2025. Any staff that have not completed the education will be removed from the schedule and will be educated prior to returning to work. New staff will be educated on the fall notification process during new hire orientation. All residents will falls will be audited for ongoing assessment; identifying change in condition requiring medical evaluation and treatment, and communication to provide treatment, weekly x twelve (12) weeks by the Director of Health Services (DHS), Clinical Competency Coordinator (CCC), Unit Manager (UM), Unit Coordinator (UC), Infection Preventionist (IP), Nurse Navigator/Senior Care Partner (NN/SCP), Case Mix Director (CMD), Case Mix Coordinator (CMC), Senior Nurse Consultant (SNC) or Administrator or until compliance maintained. Plans to monitor its performance to make sure that the solutions are sustained. An AdHoc Quality Assurance Performance Improvement (QAPI) review will be held by 7/3/2025 to review the Plan of Correction (POC). The DHS will present the analysis of the	

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F 600	Continued From page 14	F 600	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 thereafter beginning July 2025. Date of compliance: 07/04/2025	
F 607 SS=D	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(5)(ii)(iii) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, §483.12(b)(4) Establish coordination with the QAPI program required under §483.75. §483.12(b)(5) Ensure reporting of crimes occurring in federally-funded long-term care facilities in accordance with section 1150B of the Act. The policies and procedures must include but are not limited to the following elements. §483.12(b)(5)(ii) Posting a conspicuous notice of employee rights, as defined at section 1150B(d)(3) of the Act.	F 607		7/4/25

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F 607	Continued From page 15 §483.12(b)(5)(iii) Prohibiting and preventing retaliation, as defined at section 1150B(d)(1) and (2) of the Act. This REQUIREMENT is not met as evidenced by: Based on record review, and staff and a resident interview, the facility failed to immediately notify the Administrator of an abuse allegation made by a resident for one (Resident #2) of three residents reviewed for abuse investigations. Findings included: Documentation on the facility procedures for Reporting Patient Abuse, Neglect, Exploitation, Mistreatment, and Misappropriation of Property dated as last reviewed on 11/15/2024 revealed the following statement. Any allegations, suspicion, or identified occurrence identified involving patient abuse, neglect, exploitation, mistreatment, and misappropriation of property, including injuries of an unknown source, should be immediately reported to the Administrator of the provider entity. Resident #2 was admitted to the facility on 4/3/2025 with diagnoses of schizophrenia, depression, dementia, and bipolar disorder. Documentation on a quarterly Minimum Data Set assessment dated 5/16/2025 revealed Resident #2 was cognitively intact, always incontinent of bowel and bladder, and required substantial assistance with toileting hygiene. Resident #2 was interviewed on 6/10/2025 at 10:28 AM. Resident #2 revealed Nurse Aide (NA) #2 came into her room to provide incontinent care one evening. Resident #2 further revealed NA #2	F 607	Corrective action for the residents found to be affected by the deficient practice. The facility failed to ensure staff implemented the abuse policy and procedure for Resident #2 in a timely manner. Resident #2 Allegation of Abuse reported to NCDHHS by Administrator on 05/01/2025. Physician notified on 05/01/2025. Responsible Party notified of allegation on 05/01/2025. Durham Police Department notified and visited Resident #2 on 05/01/2025. Adult Protective Services notified and visited Resident #2 on 05/02/2025. Skin check performed on 05/06/2025 without any unexpected findings. Corrective action for other residents having the potential to be affected by the same deficient practice. All residents are at risk for this deficient practice. Abuse questionnaire interviews were conducted for all residents at the facility with a Brief Interview for Mental Status score of 10 or higher by the Social Services Director, Licensed nurses, and Administrator on 05/01/2025. Skin audits were completed for all residents by licensed nursing personnel on 05/01/2025 without any adverse response to questions or without any unknown skin issues identified. Activity Director (AD), Director of Health	

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F 607	Continued From page 16 made inappropriate actions of a sexual nature and made an inappropriate comment. Resident #2 stated she told Nurse #7 and Nurse Aide (NA) #8 what had happened to her. Resident #2 did not recall which day she told Nurse #7 or NA #8. Nurse #7 was interviewed on 6/11/2025 at 10:51 AM. Nurse #7 denied Resident #2 told her of the abuse allegation involving NA #2. Nurse #7 said she heard rumors of the abuse allegation made by Resident #2 regarding NA #2 but when she went to the Administrator it was already known to her. Nurse #7 stated Resident #2 was known to fabricate stories and was attention seeking although this may not have been documented in her medical record. Nurse #7 did not recall which day this occurred. NA #8 was interviewed on 6/11/2025 at 11:15 AM. NA #8 provided the following information. NA #8 was assisting Resident #2's roommate to eat lunch when she overheard the Activity Director (AD) #1 talking to Resident #2. Resident #2 told AD #1 that NA #2 inappropriately touched her when he was changing her. NA #8 did not recall what day this occurred. AD #1 then left the room telling Resident #2 she had to tell the Administrator. NA #8 continued assisting residents and performing her nurse aide duties. NA #8 realized at the end of her shift that nothing was happening, and nobody had come to talk to Resident #2 about the allegation she had made earlier. NA #8 went to a person she recognized to be a corporate person and told her she needed to talk to someone about an abuse allegation she heard. The corporate person directed NA #8 to interrupt a meeting the Administrator and the Director of Nursing were having at that time. NA #8 interrupted the meeting and informed the	F 607	Services (DHS) and Administrator educated by Senior Nurse Consultant (SNC) regarding facility policy related to abuse reporting; investigation of patient abuse, neglect, exploitation, mistreatment and misappropriation of property policy with emphasis on timely reporting to agencies on 05/01/2025 and 05/02/2025. Systemic changes made to ensure that the deficient practice will not recur. 100% staff education regarding abuse reporting completed 05/06/2025 by Administrator. New staff will be educated on the Identifying and Reporting of Abuse will be conducted during new employee orientation by the Director of Health Services (DHS), Clinical Competency Coordinator (CCC), Unit Manager (UM), Unit Coordinator (UC), Infection Preventionist (IP), Nurse Navigator/Senior Care Partner (NN/SCP), Case Mix Director (CMD), Case Mix Coordinator (CMC), Human Resources Coordinator, Senior Nurse Consultant (SNC) or Administrator. Three (3) residents with a Brief Interview for Mental Status (BIMS) score of 8 or higher, will be interviewed regarding abuse four (4) x weekly x four (4) weeks; three residents (3) residents, three (3) x weekly x four (4) weeks, then one (1) residents weekly x 4 weeks by Social Services Director (SSD)/Admission Director (AD); Social Services Assistant; Unit Manager; Unit Coordinator; Infection Preventionist (IP), Clinical Competency Coordinator (CCC); Activity Director; Case Mix Director (CMD); Case Mix	

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F 607	Continued From page 17 Administrator of the allegation of abuse Resident #2 told AD #1. AD #1 was interviewed on 6/11/2025 at 11:50 AM. AD #1 stated she entered Resident #2's room to give mail to Resident #2's roommate. Resident #2 stopped AD #1 and said she had something to tell her. Resident #2 relayed to AD #1 an allegation regarding NA #2 inappropriately touching her. AD #1 revealed that NA #8 looked at them from around the privacy curtain while assisting Resident #2's roommate. AD #1 said she told Resident #2 to stop talking so NA #8 would not hear anymore. AD #1 said she left Resident #2's room to tell the Administrator of the allegation of abuse but it slipped her mind as she got busy. AD #1 indicated she remembered on the way home from work the allegation Resident #2 made regarding NA #2. AD #1 decided that in the morning clinical meeting the next day she would inform the Administrator of the allegation made by Resident #2. AD #1 discovered the next morning that the Administrator already was aware of the allegation made by Resident #2 as she had been informed by NA #8 at the end of her shift. The facility's senior Nursing Corporate Consultant was interviewed on 6/11/2025 at 12:27 PM. The Nursing Corporate Consultant confirmed NA #8 came to her and told her she had an allegation of abuse to report. The Nursing Corporate Consultant instructed NA #8 to immediately go to the Administrator and interrupt her meeting to tell her of the abuse allegation. The previous Administrator, whose employment at the facility ended on 6/6/2025, did not respond to requests for an interview.	F 607	Coordinator (CMC); Nurse Navigator; Director of Health Services (DHS) or Administrator to ensure that no allegations of abuse have been made and not reported. Plans to monitor its performance to make sure that the solutions are sustained. An AdHoc Quality Assurance Performance Improvement (QAPI) review will be held by 07/04/2025 to review the Plan of Correction (POC). The DHS 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 thereafter beginning July 2025. Date of compliance 07/04/2025	

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F 607	Continued From page 18 The previous Director of Nursing (DON) was interviewed on 6/13/2025 at 1:27 PM. The previous DON confirmed NA #8 interrupted a meeting she was having with the previous Administrator to report an allegation of abuse Resident #2 had made in her presence. The previous DON confirmed NA #8 brought this information to the previous Administrator at the end of her shift at approximately 3:00 PM. Documentation on an initial investigation report sent to the state offices by the former Administrator faxed on 5/1/2025 at 4:09 PM revealed Resident #2 had made an allegation of abuse against NA #2 for an event occurring on either 4/28/2025 or 4/29/2025. The current Administrator was interviewed on 6/13/2025 at 1:15 PM. The Administrator stated that abuse was not tolerated at the facility. The Administrator confirmed all allegations of abuse must be immediately reported to her so that a full investigation can be completed.	F 607		
F 684 SS=G	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on record review, and staff, responsible	F 684	Corrective action for the residents found	7/4/25

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F 684	Continued From page 19 party (RP), resident, Hospice Nurse, Physician, and Medical Director interviews the facility failed to provide ongoing assessments after a fall; failed to identify the change in condition required medical evaluation and treatment; failed to identify one leg shorter than the other and external leg rotation required medical evaluation and treatment; and failed to communicate effectively to provide treatment for one (Resident #1) of three residents reviewed for assessment after a fall. Resident #1 sustained an acute impacted left femoral neck fracture (an acute impacted left femoral neck fracture is a break in the upper part of the thigh bone (femur), specifically at the neck, where it connects to the ball of the hip joint). Findings included: Resident #1 was admitted to the facility on 3/28/2025 with diagnoses of history of cerebral vascular accident, hemiplegia, hemiparesis, and lung cancer. Hemiplegia is paralysis on one side while hemiplegia is weakness on one side of the body. Resident #1 started receiving Hospice services on 3/31/2025. Documentation on an admission Minimum Data Set assessment dated 4/3/2025 revealed Resident #1 had moderately impaired cognition with a range of motion impairment on one side of the upper and lower extremities. Resident #1 was also assessed as using a cane or a wheelchair. Resident #1 was evaluated as always incontinent of bowel and bladder. It was unknown if Resident #1 had a history of falls with no falls since her admission. Documentation on a timesheet for Nurse Aide (NA) #1) reveale she worked at the facility from 7:18 AM to 10:53 PM on 5/17/2025.	F 684	to be affected by the deficient practice. The facility failed to ensure that staff provided ongoing assessment; identify change in condition requiring medical evaluation and treatment; failed to communicate effectively to provide treatment for Resident #1. The provider was notified of fall on 05/20/2025, change of condition on 05/20/2025 and x-ray results on 5/20/2025. The facility notified the Responsible Party (RP) of fall on 05/20/2025, change of condition on 05/20/2025 and x-ray results on 5/20/2025. Resident #1 was sent to Duke University Medical Center for treatment following fall on 05/20/2025 and was readmitted to facility on 06/04/2025. Resident #1 discharged to another Skilled Nursing Facility on 06/06/2025. Nurse #4 was reported to the North Carolina Board of Nursing for substantiated allegation of neglect on 05/23/2025 and employment terminated on 05/25/2025. Corrective action for other residents having the potential to be affected by the same deficient practice. All current residents have the potential to be affected by these deficient practices. Fall ongoing assessment, identifying change-in-condition and communication will be audited for the past ten (10) days for timely notification and treatment to Provider(s), RP and Oncoming-Shift Nurse by the Director of Health Services (DHS), Clinical Competency Coordinator (CCC), Unit Manager (UM), Unit Coordinator (UC), Infection Preventionist	

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PRUITTHEALTH-DURHAM	3100 ERWIN ROAD DURHAM, NC 27705

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F 684	Continued From page 20 Documentation on the corresponding nursing schedule revealed NA #1 was assigned to care for Resident #1 during that time period. NA #1 was interviewed on 6/10/2025 at 11:54 AM. NA #1 revealed the following information. Resident #1 had a fall on 5/17/2025. NA #1 heard Resident #1 fall, and she told Nurse #4. Any other information would have to be obtained from Nurse #4 and NA #1 declined to make a statement about whether Resident #1 was in pain. NA #1 insinuated she provided the facility with a statement regarding Resident #1's fall on 5/17/2025. The facility provided a statement handwritten by NA #1 on 5/21/2025 regarding the events of 5/17/2025. The documentation on the statement by NA #1 revealed the following information. NA #1 walked into Resident #1's room to collect the evening meal tray. NA #1 noted Resident #1 stood up with her cane. NA #1 requested Resident #1 to wait for her to set the meal tray down before ambulating. NA #1 turned around and she heard Resident #1 fall. NA #1 called for Nurse #4 who stood over Resident #1. NA #1 asked Nurse #4 what to do. Nurse #4 and NA #1 assisted Resident #1 to rise and placed her in bed. Nurse #4 sat in a chair while NA #1 made Resident #1 comfortable in the bed. Nurse #4 then left the room. Nurse #4 was interviewed on 6/10/2025 at 6:41 PM and revealed the following information. Nurse #4 worked the 7:00 AM to 7:00 PM shift on 5/17/2025. Resident #1 fell on 5/17/2025 while trying to go to the bathroom. Nurse #4 did full range of motion assessments of all her limbs and took the vital signs of Resident #1. Nurse #4, with	F 684	(IP), Nurse Navigator/Senior Care Partner (NN/SCP), Case Mix Director (CMD), Case Mix Coordinator (CMC), Senior Nurse Consultant (SNC) or Administrator, by 7/3/2025. Systemic changes made to ensure that the deficient practice will not recur. Licensed Nursing education regarding ongoing assessment; identifying change in condition requiring medical evaluation and treatment; communication to effectively provide treatment will be provided by the Director of Health Services (DHS), Clinical Competency Coordinator (CCC), Unit Manager (UM), Unit Coordinator (UC), Infection Preventionist (IP), Nurse Navigator/Senior Care Partner (NN/SCP), Case Mix Director (CMD), Case Mix Coordinator (CMC), Senior Nurse Consultant (SNC) or Administrator and completed by 07/04/2025. Any staff that have not completed the education will be removed from the schedule and will be educated prior to returning to work. New staff will be educated on the fall notification process during the new hire orientation. All residents will falls will be audited for ongoing assessment; identifying change in condition requiring medical evaluation and treatment, and communication to provide treatment, weekly x twelve (12) weeks by the Director of Health Services (DHS), Clinical Competency Coordinator (CCC), Unit Manager (UM), Unit Coordinator (UC), Infection Preventionist (IP), Nurse Navigator/Senior Care Partner (NN/SCP), Case Mix Director (CMD),	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345061	A. BUILDING _____ B. WING _____	C 06/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEALTH-DURHAM	3100 ERWIN ROAD DURHAM, NC 27705

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F 684	Continued From page 21 the assistance of NA #1, helped Resident #1 up off the floor and into her wheelchair. NA #1 wheeled Resident #1 to the bathroom. Resident #1 stood up, pivoted, and sat on the commode. After finishing, Resident #1 stood, pivoted, and sat in the wheelchair. NA #1 then helped Resident #1 back to the bed, where Resident #1 stood, pivoted, and sat on the bed. Nurse #4 was adamant that Resident #1 was fine and in no pain. Nurse #4 was so busy with a new admission, helping residents eat, changing incontinence briefs, and administering medications that she was not able to document anything in the electronic medical record. Nurse #4 also stated that she forgot to document or notify anybody about the fall but, Resident #1 was without injury or pain after the fall on 5/17/2025. The facility provided a statement handwritten by Nurse #4 on 5/21/2025 regarding the events of 5/17/2025. The documentation on the statement revealed the following information. Nurse #4 was called to Resident #1's room by NA #1 because the resident had fallen. When Nurse #4 arrived, Resident #1 was sitting up against the nightstand by her bed. Resident #1 stated that she fell while going to the bathroom. Resident #1 had one leg flat, and one leg off the floor. Nurse #4 asked Resident #1 to move her arms and legs and she complied. Nurse #4 took the vital signs of Resident #1. NA #1 assisted Resident #1 into the wheelchair and took her to the bathroom. Resident #1 stood up holding onto the rail in the bathroom and NA #1 put her back into the wheelchair. NA #1 assisted Resident #1 back into bed. Resident #1 did not complain of pain. There was no documentation in Resident #1's electronic medical record of any fall,	F 684	Case Mix Coordinator (CMC), Senior Nurse Consultant (SNC) or Administrator, or until compliance maintained. Plans to monitor its performance to make sure that the solutions are sustained. An AdHoc Quality Assurance Performance Improvement (QAPI) review will be held by 7/03/2025 to review the Plan of Correction (POC). The Director of Health Services (DHS) 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 thereafter beginning July 2025. Date of compliance: 07/04/2025	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345061	A. BUILDING _____ B. WING _____	C 06/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEALTH-DURHAM	3100 ERWIN ROAD DURHAM, NC 27705

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F 684	Continued From page 22	F 684		

assessments, or notification of physician or family on 5/17/2025 for the 7:00 AM to 7:00 PM shift.

Resident #1 was interviewed over the phone on 6/11/2025 at 3:31 PM. Resident #1 confirmed she remembered what happened when she fell on 5/17/2025 in the evening. Resident #1 stated she was going to the bathroom with her cane when her foot twisted causing her to fall. Resident #1 added that eventually someone came to assist her but not right away. Resident #1 stated she was picked up off the floor and placed back into bed. Resident #1 indicated the nurse did not do any assessment of her arms or legs nor take any vital signs. Resident #1 denied she was taken to the bathroom after the fall. Resident #1 was able to confirm the fall caused her pain but was not able to elaborate on that.

Nurse #2 was interviewed on 6/10/2025 at 2:38 PM. Nurse #2 confirmed she worked from 7:00 PM to 11:00 PM on 5/17/2025. Nurse #2 stated she had no knowledge on 5/17/2025 that Resident #1 had fallen on the previous shift. Nurse #2 stated that she did recall that Resident #1 took her nighttime medication, had no complaints, and went to sleep.

Documentation on the physician orders revealed Resident #1 had an order initiated on 4/8/2025 for 5 milligrams (mg) of Oxycodone to be administered as one tablet by mouth every 4 hours as needed for moderate pain at a level of 4 to 6 out of 10. Oxycodone is a prescription opioid pain medication used to relieve severe pain.

Documentation on a controlled drug record for Resident #1 revealed Nurse #2 removed one dose of the ordered oxycodone at 9:15 PM on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345061	A. BUILDING _____ B. WING _____	C 06/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEALTH-DURHAM	3100 ERWIN ROAD DURHAM, NC 27705

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 23	F 684		

5/17/2025. There was no corresponding documentation on the MAR to confirm the dose was administered to Resident #1.

Nurse #2 was interviewed again on 6/11/2025 at 1:31 PM. Nurse #2 revealed the nurse aides came to her to tell her on 5/17/2025 that Resident #1 was in pain when they provided care. Nurse #2 confirmed she gave Resident #1 her ordered oxycodone pain medication at her request.

Nurse #5 was interviewed on 6/11/2025 at 7:27 AM. Nurse #5 confirmed she worked the 11:00 PM to 7:00 AM shift beginning on 5/17/2025 and ending on 5/18/2025. Nurse #5 stated she was not informed on 5/17/2025 that Resident #1 had a fall earlier that evening. Nurse #5 indicated Resident #1 slept and had no complaints on her shift ending on the morning of 5/18/2025.

Documentation on a timesheet for NA #1 revealed she worked at the facility from 8:31 AM to 3:10 PM on 5/18/2025. Documentation on the corresponding nursing schedule revealed NA #1 was assigned to care for Resident #1 during that time.

An interview was conducted with the Responsible Party (RP #1) for Resident #1 on 6/10/2025 at 2:06 PM. RP #1 provided the following information. RP #1, her husband, and her children went to visit Resident #1 on the morning of 5/18/2025. RP #1 barely got down the hallway when she was stopped by NA #1. NA #1 explained that she had not yet assisted Resident #1 out of bed and to get dressed. NA #1 said she knew that RP #1 would like to take Resident #1 outside. NA #1 then told RP #1 that Resident #1 fell yesterday (5/17/2025) but she was fine. RP #1

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345061	A. BUILDING _____ B. WING _____	C 06/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEALTH-DURHAM	3100 ERWIN ROAD DURHAM, NC 27705

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 24	F 684		

remarked to NA #1 that nobody had called to tell her about the fall. RP #1 went to see Resident #1 and to ask her about the fall. RP #1 stated that she and her husband were trying to help Resident #1 to get up, but it seemed like she was in pain, and she could not bear any weight. This was a change for Resident #1 because although she was weak on her left side she had always been able to stand. RP #1 revealed she assisted Resident #1 in dressing and then asked her about the fall she had on the previous day. Resident #1 told RP #1 that she was trying to get to the bathroom, and she twisted her left foot and fell. Resident #1 told RP #1 she did not hit her head. Resident #1 told RP #1 that a nurse and a nurse aide put her back into bed. RP #1 indicated Resident #1 seemed very sore and was protecting her left side. RP #1 stated she and her husband took Resident #1 to the bathroom, but Resident #1 was not able to stand or bear any weight. RP #1 indicated Resident #1 required her husband to pick her up and hold her to get on and off the toilet and back into the wheelchair. RP #1 then went to the nurse's desk and spoke to Nurse #4. RP #1 told Nurse #4 that Resident #1 told her she fell last night and she was now in pain. RP #1 said Nurse #4 acted like she didn't know what RP #1 was talking about. Nurse #4 told RP #1 that Resident #1 had not mentioned anything about a fall or pain to her. Nurse #4 stated she would check and see if Resident #1 fell last night and confirmed she did not see anything about a fall in the electronic medical record. Nurse #4 went down to Resident #1's room and gave her pain medication but did not do any assessment or do anything else for Resident #1. RP #1 revealed she told Nurse #4 that Resident #1 was unable to bear weight on her left side and Nurse #4 kept acting like she didn't know what she was talking

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345061	A. BUILDING _____ B. WING _____	C 06/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEALTH-DURHAM	3100 ERWIN ROAD DURHAM, NC 27705

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 25	F 684		

about or with any concern. Resident #1 told RP #1 that Nurse #4 was the nurse who was in the room last night after the fall. RP #1 did take Resident #1 outside to get some air but Resident #1 seemed very sore anytime they moved her, and she required more assistance than usual.

Nurse #4 was interviewed on 6/10/2025 at 6:41 PM. Nurse #4 confirmed she worked the 7:00 AM to 7:00 PM shift on 5/18/2025. Nurse #4 stated that RP #1 came to the desk on the morning of 5/18/2025 and told her Resident #1 was having back pain. Nurse #4 stated that Resident #1's fall that occurred on 5/17/2025 was not discussed at all with RP #1. Nurse #4 stated that Resident #1 was not injured so there was no reason to tell RP #1 about the fall. Nurse #4 confirmed she administered an ordered dose of Oxycodone to Resident #1 on the morning of 5/18/2025.

Documentation on the medication administration record (MAR) revealed Nurse #4 administered an ordered dose of Oxycodone to Resident #1 on 5/18/2025 at 10:47 AM for a pain level of 8 out of 10.

Nurse #6 was interviewed on 6/11/2025 at 9:07 AM. Nurse #6 confirmed she worked on 5/18/2025 from 7:00 PM to 11:00 PM. Nurse #6 stated she did not know on 5/18/2025 that Resident #1 fell on 5/17/2025. Nurse #6 stated Resident #1 did not complain of any pain, nor did she have any complaints at all on 5/18/2025 on her shift.

Nurse #5 was interviewed on 6/11/2025 at 7:27 AM. Nurse #5 confirmed she worked the 11:00 PM to 7:00 AM shift beginning on 5/18/2025 and ending on 5/19/2025. Nurse #5 revealed she was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345061	A. BUILDING _____ B. WING _____	C 06/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEALTH-DURHAM	3100 ERWIN ROAD DURHAM, NC 27705

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 26	F 684		

unaware on her shift that began on 5/18/2025 that Resident #1 had a fall the previous day on 5/17/2025. Nurse #5 stated that Resident #5 was sleeping during that shift and did not complain of any pain.

RP #1 was interviewed on 6/10/2025 at 2:06 PM and revealed the following information. On the morning of 5/19/2025 RP #1 had concerns for Resident #1, so she sent a text message to Hospice Nurse #1 first thing in the morning. RP #1 told Hospice Nurse #1 that Resident #1 had a fall on 5/17/2025 and she was in pain. Hospice Nurse #1 told RP #1 that Resident #1 was the first person she would visit that day. RP #1 could see on 5/19/2025 in a video call to Resident #1 that she was in a lot of pain and was guarding her left side.

Documentation in a Hospice Nurse as needed visit note dated 5/19/2025 at 1:46 PM revealed, "Received message from [RP #1] that [Resident #1] had a fall over the weekend. Arrived [Resident #1's] room, [Resident #1] was sleeping. Called out her name and [Resident #1] woke up without difficulty. Asked [Resident #1] about the fall, [Resident #1] narrated saying, "I called for someone to help me to bathroom, but no one came, I did not want to pee on myself, so I got up using my cane, but my left foot got caught and I tripped over and fell on my left side. I lay there until an aide came to help me up." [Resident #1] had an unwitnessed fall on Saturday 5/17/2025, consulted facility nurse for details but [Nurse #3] stated that he had no report of the fall from previous shift. Since then, she has complained of pain of 5 to 8 on numerical scale. [Resident #1] able to assist in turning, but pain prohibits turning to left side of body. [Resident #1] left leg and foot

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345061	A. BUILDING _____ B. WING _____	C 06/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEALTH-DURHAM	3100 ERWIN ROAD DURHAM, NC 27705

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 27	F 684		

had no bruising, swelling, or hotness. [Resident #1] left side is the weak side from history of [Cerebral Vascular Accident]. Asked the facility provider [MD #1 (Physician)] for further management. Provider did an assessment and ordered STAT (immediate) X-ray of left leg and hip. Called Mobile service for STAT x-ray and collaborated with facility nurse for pain medication, to start with [as needed] acetaminophen. [Resident #1] was slightly tachycardic in 111-113 beats/minute with oximetry, oxygen saturation initially was 88 % on room air then after repositioning it came up to 93 %. (Tachycardia is a medical condition characterized by a rapid heart rate, typically defined as a resting heart rate of over 100 beats per minute.) Called family for update, to call Hospice and not to wait next time there was a concern."

Hospice Nurse #1 was interviewed on 6/10/2025 at 5:20 PM. Hospice Nurse #1 revealed she was the case manager for Resident #1. Hospice Nurse #1 stated that on 5/19/2025 RP #1 sent her a text notifying her that Resident #1 had a fall over the weekend on 5/17/2025. Hospice Nurse #1 revealed she went to the facility, assessed Resident #1, and immediately contacted MD #1 (Physician), who was in the building. MD #1 looked at Resident #1 and ordered a STAT x-ray. Hospice Nurse #1 called mobile x-ray.

MD #1 (Physician) was interviewed on 6/11/2025 at 8:06 AM and revealed the following information. MD #1 was doing his rounds at the facility on 5/19/2025 when a nurse approached him and asked him to look at Resident #1. MD #1 did an assessment of Resident #1 and noted her left leg was shorter and was externally rotated.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345061	A. BUILDING _____ B. WING _____	C 06/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEALTH-DURHAM	3100 ERWIN ROAD DURHAM, NC 27705

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 28	F 684		

MD #1 was certain that Resident #1 had a fracture, so he ordered a STAT x-ray of her left hip and made sure that Resident #1 had pain medication ordered and available. MD #1 requested to be contacted when the results of the x-ray came back for further orders.

Nurse #3 was interviewed on 6/10/2025 at 2:53 PM and provided the following information. Nurse #3 worked from 7:00 AM to 3:00 PM on 5/19/2025. Nurse #3 was told by Hospice Nurse #1 that Resident #1 had a fall on 5/17/2025 and that MD #1 had ordered a STAT x-ray of her left hip. Nurse #3 stated that Hospice Nurse #1 contacted the mobile x-ray, and the x-ray was taken on his shift on the morning of 5/19/2025. Resident #1 was in pain on his shift, and he gave her pain medication. Nurse #3 stated that he notified Nurse #2, the next shift nurse, that Resident #1 had a fall and the facility was still waiting on the x-ray results.

Documentation on a controlled drug record for Resident #1 revealed Nurse #3 removed one dose of the ordered Oxycodone at 9:00 AM on 5/19/2025 and another dose at 2:00 PM on 5/19/2025. There was no corresponding documentation on the MAR to confirm the dose was administered to Resident #1.

NA #3 was interviewed on 6/10/2025 at 1:04 PM and revealed the following information. NA #3 was assigned to care for Resident #1 on 5/19/2025 for the 7:00 AM to 3:00 PM shift. NA #3 had not worked that weekend, but when he came back to work on 5/19/2025 he had heard Resident #1 had a fall. NA #3 stated Resident #1 was in pain, and he told Nurse #3 she was in pain. NA #3 stated that every time he turned

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345061	A. BUILDING _____ B. WING _____	C 06/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEALTH-DURHAM	3100 ERWIN ROAD DURHAM, NC 27705

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 29	F 684		

Resident #1 for incontinent care, she was in pain, and it was hard. NA #3 stated he had to talk Resident #1 through it. Resident #1 didn't want to turn because she was in pain.

Documentation on the x-ray results dated 5/19/2025 revealed Resident #1 had sustained an acute impacted left femoral neck fracture. The x-ray results were faxed to the facility at 2:50 PM on 5/19/2025.

Nurse #2 was interviewed on 6/10/2025 at 2:38 PM and revealed the following information. Nurse #2 worked from 3:00 PM to 11:00 PM on 5/19/2025. Nurse #2 stated she was not aware at the start of her shift that Resident #1 had a fall over the weekend. Nurse #2 explained that she was also the facility wound care nurse and that at some point in her shift she went to the fax machine to fax wound care orders. Nurse #2 went through all the faxes that were on the fax machine, and she noted the x-ray results for Resident #1. Nurse #2 did not know anything had happened to Resident #1. Nurse #2, at some point in the shift, went to Resident #1 to ask her why she had an x-ray because she was alert and oriented. Resident #1 told Nurse #2 she fell a few days ago. Nurse #2 took her vital signs and did a pain assessment. Nurse #2 was alerted by the nurse aides that Resident #1 was in extreme pain when they turned her for incontinence care. Nurse #2 stated she gave pain medication to Resident #1. Nurse #2 explained that when Resident #1 first arrived at the facility she was weak and could not get up to go to the bathroom. Gradually Resident #1 gained strength and confidence and used her cane to go to the bathroom. Resident #1 was continent of bowel and bladder, but staff had to keep reminding her

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345061	A. BUILDING _____ B. WING _____	C 06/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEALTH-DURHAM	3100 ERWIN ROAD DURHAM, NC 27705

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 30	F 684		

that she needed to ask for help to go to the bathroom so she would not fall. Nurse #2 noted it was a change for Resident #1 to be incontinent and to be provided with incontinent care by the nurse aides. Nurse #2 called the on-call physician with the x-ray results because it was after hours on 5/19/2025. The on-call provider asked if Resident #1 was stable. Nurse #2 told the on-call provider that Resident #1 was stable and was only in pain when she was moved or turned for incontinent care. The on-call provider told Nurse #2 to follow up with the regular provider in the morning.

Nurse #2 was interviewed again on 6/11/2025 at 1:31 PM. Nurse #2 conceded that Nurse #3 may have told her Resident #1 had a fall and to watch out for the x-ray results at the change of shift on 5/19/2025. Nurse #2 reiterated that she became aware of the x-ray results at an unknown time and she had many responsibilities that day as the wound care nurse for the facility.

Documentation in a nursing progress note dated 5/20/2025 at 12:09 AM written by Nurse #2 revealed the following information. Resident #1 fell a few days ago and was in pain when she was turned from side to side. Resident #1 received medication for breakthrough pain in the left hip area. The left hip x-ray results were received, and Resident #1 was noted to have an acute impacted left femoral hip neck fracture. The after-hours provider was contacted. The after-hours provider stated that if the resident was stable, to follow up in the morning with the nurse practitioner.

Documentation on a controlled drug record for Resident #1 revealed Nurse #2 removed one

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345061	A. BUILDING _____ B. WING _____	C 06/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEALTH-DURHAM	3100 ERWIN ROAD DURHAM, NC 27705

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F 684	Continued From page 31	F 684		

dose of the ordered Oxycodone at 9:15 PM on 5/19/2025. There was no corresponding documentation on the MAR to confirm the dose was administered to Resident #1.

An interview was conducted with NA #6 on 6/11/2025 at 8:57 AM and the following information was provided. NA #6 was assigned to care for Resident #1 on 5/19/2025 from 3:00 PM until 7:00 AM on 5/20/2025. Resident #1 told NA #6 that she fell on Saturday. NA #6 asked her what happened because she was alert and oriented. Resident #1 told him she was trying to go to the bathroom and her foot twisted, and she fell. Resident #1 told NA #6 that a nurse and a nurse aide picked her up and put her in bed. NA #6 asked if RP #1 was called and Resident #1 said no. NA #6 called another nurse aide for help to provide incontinent care for her because she was in pain when she was moved. NA #6 stated he left the room to immediately tell Nurse #2 that Resident #1 had a fall over the weekend and she was in pain. Nurse #2 told NA #6 that there was no documentation in the electronic record of a fall sustained by Resident #1 over the weekend. NA #6 returned to Resident #1's room and told her that if she needed a bed pan to call him because he could not help her out of bed to the bathroom like he usually did. NA #6 said Resident #1 was crying in pain and he had to roll her little by little to provide incontinent care for her. NA #6 revealed he told Nurse #5 that Resident #1 had a fall and was in pain when moved.

Nurse #5 was interviewed on 6/11/2025 at 7:27 AM and revealed the following information. Nurse #5 worked the 11:00 PM to 7:00 AM shift that ended on 5/20/2025. On the last rounds where the nurse aides provided incontinence care to the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345061	A. BUILDING _____ B. WING _____	C 06/13/2025

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F 684	Continued From page 32	F 684		

residents, one of the nurse aides came to Nurse #5 and told her Resident #1 was grimacing when she was moved during care. Nurse #5 stated she knew Resident #1 had an order for Oxycodone because she was receiving Hospice services. Nurse #5 revealed she offered a dose of Oxycodone to Resident #1, but she refused. The dose of Oxycodone was not administered to Resident #1, and it was wasted.

Documentation on the MAR revealed Nurse #5 administered a dose of Oxycodone to Resident #1 on 5/20/2025 at 5:49 AM for a pain level of 10 out of 10.

Documentation on the controlled drug record for ordered Oxycodone for Resident #1 dated 5/20/2025 revealed the Oxycodone dose offered by Nurse #5 was refused.

Documentation in the nursing progress notes dated 5/20/2025 at 7:25 AM written by Nurse #5 revealed the nurse practitioner gave a verbal order to send Resident #1 to the emergency room for a left femoral neck fracture.

The nurse practitioner, whose employment ended on 5/30/2025, did not respond to requests for an interview.

Documentation in the nursing progress notes written as a late entry on 5/20/2025 at 7:43 AM by Nurse #3 for 5/19/2025 revealed Resident #1 had an x-ray completed due to complaints of increased pain in the left thigh.

Documentation on an Emergency Medical Services record dated 5/20/2025 at 7:54 PM revealed Resident #1 received non-emergent

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345061	A. BUILDING _____ B. WING _____	C 06/13/2025

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F 684	Continued From page 33	F 684		

transport to the hospital. Resident #1 was noted to only be in pain when moved and declined pain medication during transport.

The documentation on Resident #1's hospital discharge summary dated 5/28/2025 revealed Resident #1 underwent surgery to repair her femur fracture. It was noted that a non-operative femur fracture would have led to significant pain in the long term. Resident #1 was to return to the facility.

An interview was conducted with RP #2 on 6/10/2025 at 11:31 AM. RP #2 stated that when Resident #1 was released from the hospital and she returned to the facility the resident cried every day because she was scared. RP #2 explained that the hospital was not able to secure another bed in another facility prior to her discharge.

An interview was conducted with RP #1 on 6/10/2025 at 2:06 PM. RP #1 stated that x-ray results revealing Resident #1 had a fracture were not conveyed to her until 5/20/2025. RP #1 had the concern that Resident #1 was in pain until a transfer to the hospital. RP #1 revealed on 5/23/2025 she contacted the facility to express her opinion that Nurse #4 was neglectful. RP #1 confirmed that Resident #1 was not happy about returning to the facility, but the hospital was unable to find another facility at the time of her discharge from the hospital.

Documentation in a care plan for Resident #1 updated on 5/28/2025 revealed a focus area for a risk for falls related to disease process, generalized weakness, contractures, history of cerebral vascular accident, incontinence, and medication side effects with an actual fall on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345061	A. BUILDING _____ B. WING _____	C 06/13/2025

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F 684	Continued From page 34	F 684		

5/19/2025. The approach added on 5/28/2025 was for Resident #1 to be reminded to call for assistance with transfers.

Documentation in the electronic medical record revealed Resident #1 was transferred to another facility on 6/6/2025.

The previous Administrator, whose employment at the facility ended on 6/6/2025, did not respond to requests for an interview.

The facility Medical Director, was interviewed on 6/11/2025 at 8:06 AM via telephone. The Medical Director revealed that after looking at the electronic medical record he was able to see that Resident #1 had no complaints of pain and received very little pain medication from 5/17/2025 to 5/19/2025. The Medical Director conceded that the documentation for the fall on 5/17/2025 was poor. The Medical Director stated that perhaps Resident #1 had an underlying issue due to paralysis on her left side that delayed her expressing pain and required treatment. The Medical Director also indicated that he was aware the family had transferred Resident #1 to the bathroom on the morning of 5/18/2025 and may have caused injury to the resident. The Medical Director felt the x-ray being completed by 5/19/2025 and Resident #1 being sent to the hospital for treatment of the fracture on 5/20/2025 was an appropriate time frame for a resident on Hospice who was not expressing any pain. The Medical Director praised the Hospice services for assuring Resident #1 received assessment and treatment.

An interview was conducted on 6/13/2025 at 1:11 PM with the current interim Director of Nursing

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345061	A. BUILDING _____ B. WING _____	C 06/13/2025

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F 684	Continued From page 35 (DON), who initiated employment with the facility on 5/27/2025. The DON explained she was made aware of the facility investigation for Resident #1 by the previous Administrator at the start of her employment. The DON stated she expected that the nursing staff would assess a resident who has had a fall and if there was a serious medical issue to contact the provider and herself. In addition, the DON had the expectation that an attempt would be made to contact the family of a resident who had fallen. The DON elaborated that each nursing station had directions at the desk for what steps needed to be taken when a resident falls, including assessment, notification of provider, and charting. The DON also stated that she expected communication to occur between nurses to make sure x-ray results were conveyed to a provider as soon as received. The facility provided a draft plan of correction for past non-compliance that was not acceptable to the state agency due to a lack of measures put into place for communication between nursing shifts, education of expectations for nurse aides, audits, and monitoring of compliance.	F 684		
F 842 SS=E	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(h)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so.	F 842		7/4/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345061	A. BUILDING _____ B. WING _____	C 06/13/2025

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F 842	Continued From page 36	F 842		

§483.70(h) Medical records.
§483.70(h)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are-
(i) Complete;
(ii) Accurately documented;
(iii) Readily accessible; and
(iv) Systematically organized

§483.70(h)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is-
(i) To the individual, or their resident representative where permitted by applicable law;
(ii) Required by Law;
(iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506;
(iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512.

§483.70(h)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use.

§483.70(h)(4) Medical records must be retained for-
(i) The period of time required by State law; or
(ii) Five years from the date of discharge when there is no requirement in State law; or

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F 842	Continued From page 37 (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(h)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to effectively document in the electronic medical record for conveyance of medical information for two (Resident #1 and Resident #5) of three residents reviewed for accidental falls. Resident #1 lacked initial documentation of a fall by Nurse #4, initial physical assessments by Nurse #4, and administration of pain medication by Nurse #2 and Nurse #3. Resident #1 had incorrect documentation of the administration of pain medication by Nurse #5. Resident #5 lacked documentation of a nursing physical assessment after a fall. Findings included: 1. a. Documentation on a timesheet for Nurse Aide (NA #1) revealed she worked at the facility from 7:18 AM to 10:53 PM on 5/17/2025. Documentation on the corresponding nursing schedule revealed NA #1 was assigned to care for Resident #1 during that time period.	F 842	Corrective action for the residents found to be affected by the deficient practice. The facility failed to ensure that staff effectively documented in the electronic medical record (EMR) for Resident□s #1. The occurrence was reported to North Carolina Department of Health and Human Services on 05/23/2025 for allegation of neglect. Nurse #4 was reported to the North Carolina Board of Nursing for substantiated allegation of neglect on 05/23/2025 and employment terminated on 05/25/2025. The facility failed to ensure that staff effectively documented in the electronic medical record (EMR) for Resident #5 on 06/11/2025; fall documentation process will be completed by 07/03/2025. Resident #5 did not have any injury or change from baseline noted. The facility failed to ensure that staff documented administration of controlled	

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	345061	A. BUILDING _____ B. WING _____	C 06/13/2025

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F 842	Continued From page 38 NA #1 was interviewed on 6/10/2025 at 11:54 AM. NA #1 revealed the following information. Resident #1 had a fall on 5/17/2025. NA #1 heard Resident #1 fall, and she told Nurse #4. Nurse #4 was interviewed on 6/10/2025 at 6:41 PM and revealed the following information. Nurse #4 worked the 7:00 AM to 7:00 PM shift on 5/17/2025. Resident #1 fell on 5/17/2025 while trying to go to the bathroom. Nurse #4 did full range of motion assessments of all her limbs and took the vital signs of Resident #1. Nurse #4, with the assistance of NA #1, helped Resident #1 up off the floor and into her wheelchair. Nurse #4 was so busy with a new admission, helping residents eat, changing incontinence briefs, and administering medications that she was unable to document anything in the electronic medical record. Nurse #4 also stated that she forgot to document the fall, the assessment, or notify anybody about the fall but, Resident #1 was without injury or pain after the fall on 5/17/2025. There was no documentation in Resident #1's electronic medical record of any fall, assessments, or notification of physician or family on 5/17/2025 for the 7:00 AM to 7:00 PM shift. Nurse #4 was interviewed on 6/10/2025 at 6:41 PM. Nurse #4 confirmed she worked the 7:00 AM to 7:00 PM shift on 5/18/2025. Nurse #4 revealed that she was very busy caring for the residents on 5/18/2025 and did not document any information about the fall in the electronic medical record. b. Documentation on the physician orders revealed Resident #1 had an order initiated on 4/8/2025 for 5 milligrams (mg) of Oxycodone to be administered as one tablet by mouth every 4	F 842	drugs on both the Controlled Drug Record and the Medication Administration Record (MAR) to confirm the dose was administered and failed to ensure that documentation on the MAR was completed only after the controlled substance was administered. Nurse #5 will be education on documentation and administration of controlled drugs by 07/03/2025. Corrective action for other residents having the potential to be affected by the same deficient practice. Fall ongoing assessment, identifying change-in-condition and communication will be audited for the past ten (10) days for timely notification and treatment to Provider(s), RP and Oncoming-Shift Nurse by the Director of Health Services (DHS), Clinical Competency Coordinator (CCC), Unit Manager (UM), Unit Coordinator (UC), Infection Preventionist (IP), Nurse Navigator/Senior Care Partner (NN/SCP), Case Mix Director (CMD), Case Mix Coordinator (CMC), Senior Nurse Consultant (SNC) or Administrator, by 7/3/2025. A controlled drug documentation random sample audit of three (3) records per nursing unit, will be completed by the Director of Health Services (DHS), Clinical Competency Coordinator (CCC), Unit Manager (UM), Unit Coordinator (UC), Infection Preventionist (IP), Nurse Navigator/Senior Care Partner (NN/SCP), Case Mix Director (CMD), Case Mix Coordinator (CMC), Senior Nurse Consultant (SNC) or Administrator, for	

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F 842	Continued From page 39 hours as needed for moderate pain at a level of 4 to 6 out of 10. Oxycodone is a prescription opioid pain medication. It was used to relieve severe pain. Documentation on a controlled drug record for Resident #1 revealed Nurse #2 removed one dose of the ordered oxycodone at 9:15 PM on 5/17/2025. There was no corresponding documentation on the Medication Administration Record (MAR) to confirm the dose was administered to Resident #1. Nurse #2 was interviewed again on 6/11/2025 at 1:31 PM. Nurse #2 revealed the nurse aides came to her to tell her on 5/17/2025 that Resident #1 was in pain when they provided care. Nurse #2 confirmed she gave Resident #1 her ordered Oxycodone pain medication at her request. Nurse #2 conceded that she got busy and forgot to follow through to document on the MAR that she administered Oxycodone to Resident #1. c. Documentation on a controlled drug record for Resident #1 revealed Nurse #3 removed one dose of the ordered Oxycodone at 9:00 AM on 5/19/2025 and another dose at 2:00 PM on 5/19/2025. There was no corresponding documentation on the MAR to confirm the dose was administered to Resident #1. Nurse #3 was interviewed on 6/11/2025 at 11:05 AM. Nurse #3 confirmed he administered the doses of Oxycodone to Resident #1 at 9:00 AM on 5/19/2025 and at 2:00 PM on 5/19/2025. Nurse #3 stated he either forgot to document the administration of the medication or just didn't document it because he was busy.	F 842	administration of controlled drugs on both the Controlled Drug Record and the Medication Administration Record (MAR) by 07/03/2025. Systemic changes made to ensure that the deficient practice will not recur. Licensed Nursing education regarding ongoing assessment; identifying change in condition requiring medical evaluation and treatment; communication to effectively provide treatment will be provided by the Director of Health Services (DHS), Clinical Competency Coordinator (CCC), Unit Manager (UM), Unit Coordinator (UC), Infection Preventionist (IP), Nurse Navigator/Senior Care Partner (NN/SCP), Case Mix Director (CMD), Case Mix Coordinator (CMC), Senior Nurse Consultant (SNC) or Administrator and completed by 07/03/2025. Any staff that have not completed the education will be removed from the schedule and will be educated prior to returning to work. New staff will be educated on the fall notification process during orientation. All licensed nurses will be educated on controlled substance administration documentation by the Director of Health Services (DHS), Clinical Competency Coordinator (CCC), Unit Manager (UM), Unit Coordinator (UC), Infection Preventionist (IP), Nurse Navigator/Senior Care Partner (NN/SCP), Case Mix Director (CMD), Case Mix Coordinator (CMC), Senior Nurse Consultant (SNC) or Administrator, by 07/03/2025. Any staff that have not completed the education will	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345061	A. BUILDING _____ B. WING _____	C 06/13/2025

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PRUITTHEALTH-DURHAM	3100 ERWIN ROAD DURHAM, NC 27705

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F 842	Continued From page 40 d. Documentation on a controlled drug record for Resident #1 revealed Nurse #2 removed one dose of the ordered Oxycodone at 9:15 PM on 5/19/2025. There was no corresponding documentation on the MAR to confirm the dose was administered to Resident #1. Nurse #2 was interviewed again on 6/11/2025 at 1:31 PM. Nurse #2 confirmed she did administer Oxycodone to Resident #1 at 9:15 PM on 5/19/2025. Nurse #2 revealed she normally did document the administration of medication on the MAR, but she must have gotten busy and didn't follow through. Nurse #5 was interviewed on 6/11/2025 at 7:27 AM and revealed the following information. Nurse #5 worked the 11:00 PM to 7:00 AM shift that ended on 5/20/2025. On the last rounds where the nurse aides provided incontinence care to the residents, one of the nurse aides came to Nurse #5 and told her Resident #1 was grimacing when she was moved during care. Nurse #5 stated she knew Resident #1 had an order for Oxycodone because she was receiving Hospice services. Nurse #5 revealed she offered a dose of Oxycodone to Resident #1, but she refused. The dose of Oxycodone was not administered to Resident #1, and it was wasted. Documentation on the MAR revealed Nurse #5 administered a dose of Oxycodone to Resident #1 on 5/20/2025 at 5:49 AM for a pain level of 10 out of 10. Documentation on the controlled drug record for ordered Oxycodone for Resident #1 dated 5/20/2025 revealed the Oxycodone dose offered by Nurse #5 was refused.	F 842	be removed from the schedule and will be educated prior to returning to work. New staff will be educated on the fall notification process during orientation. Plans to monitor its performance to make sure that the solutions are sustained. Three (3) residents receiving controlled substances will be audited five (5) x weekly x four (4) weeks, then two (2) residents will be audited weekly x four (4) weeks, then one (1) resident will be audited weekly x four (4) weeks by the Director of Health Services (DHS), Clinical Competency Coordinator (CCC), Unit Manager (UM), Unit Coordinator (UC), Infection Preventionist (IP), Nurse Navigator/Senior Care Partner (NN/SCP), Case Mix Director (CMD), Case Mix Coordinator (CMC), Senior Nurse Consultant (SNC) or Administrator, or until compliance maintained. An AdHoc Quality Assurance Performance Improvement (QAPI) review will be held by 07/03/2025 to review the Plan of Correction (POC). This deficiency and the POC will be reviewed at the center□s monthly QAPI meeting for the next three months beginning July 2025. Date of compliance: 07/04/2025	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 842	Continued From page 41	F 842		

Nurse #5 was interviewed again on 6/11/2025 at 12:22 PM. Nurse #5 explained that the nurse aides came to her to tell her Resident #1 was in pain when they turned her so she removed Oxycodone out of the locked box, signed out the medication on the controlled drug record, and checked off on the MAR that she administered the medication to Resident #1. Nurse #5 explained that Resident #1 did not want Oxycodone, and the medication was wasted in view of Nurse #3. Nurse #5 further explained that after she documented the Oxycodone as administered to Resident #1 on the MAR, there was no way of undoing it that she knew of.

The Physician for Resident #1, who was also the facility Medical Director (MD #2), was interviewed on 6/11/2025 at 8:06 AM via telephone. MD #2 revealed that after looking at the electronic medical record he was able to see that Resident #1 had no complaints of pain and per the documentation received very little pain medication from 5/17/2025 to 5/19/2025. MD #2 conceded that the documentation for the fall on 5/17/2025 was poor.

The Director of Nursing (DON), who initiated her employment with the facility on 5/27/2025, was interviewed on 6/11/2025 at 10:33 AM. The DON explained that the process for medication administration and documentation was as follows: pull the narcotic medication, make sure it was the correct person, correct drug, correct dose, sign out the narcotic medication on the controlled medication record, administer the medication, and then document on the MAR. The DON further explained that the final step was to monitor the effectiveness of the medication and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345061	A. BUILDING _____ B. WING _____	C 06/13/2025

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 842	Continued From page 42	F 842		

document this on the MAR.

An additional interview with the DON was conducted on 6/13/2025 at 1:11 PM. The DON explained that she expected that the nursing staff follow the fall risk cheat sheet that was posted at every nursing station for directions and a listing of the required documentation after a fall. The DON expected that the nursing staff would document their assessments to include vital signs, range of motion assessments, pain, as well as medication administration.

2. Documentation in the nursing progress notes dated 6/11/2025 at 11:55 PM written by Nurse #10 revealed Resident #5 had a fall on the floor from his wheelchair observed by his roommate. The documentation further revealed the resident denied pain, did not hit his head, and was assisted back to bed. Notification of the responsible party and the provider was also documented. There was no documentation in the nursing progress note of any range of motion assessment or any assessment of vital signs.

A Review of the electronic medical record did not reveal any recording of vital signs on 6/11/2025 for the time period for the fall sustained by Resident #5.

There was no documentation on the situation, background, assessment, and recommendation (SBAR) form initiated on 6/11/2025 at 11:55 PM by Nurse #10.

An interview was conducted with Nurse #10 at 9:01 AM on 6/13/2025. Nurse #10 revealed she was new to the electronic medical record system the facility used and had been employed at the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345061	A. BUILDING _____ B. WING _____	C 06/13/2025

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F 842	Continued From page 43	F 842		

facility for four months. Nurse #10 confirmed she did take the vital signs of Resident #5 when he fell on 6/11/2025 in addition to performing the range of motion assessments on his limbs before assisting him back to bed. Nurse #10 indicated she thought she documented her assessments of Resident #10 on the same form for which she documented notification of the physician but was unable to recall which form that was. Nurse #10 confirmed Resident #5 was uninjured when she performed her assessments on 6/11/2025 after he fell.

An interview with the DON was conducted on 6/13/2025 at 1:11 PM. The DON explained she expected that the nursing staff to follow the fall risk cheat sheet posted at every nursing station for directions and listing of the required documentation after a fall. The DON expected that the nursing staff would document their assessments to include vital signs and range of motion assessments after a fall.