	-	ID HUMAN SERVICES MEDICAID SERVICES			F	ORM APPROVED 3 NO. 0938-0391
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	PLE CONSTRUCTION	(X3) I	DATE SURVEY COMPLETED
		345061	B. WING			C 06/13/2025
NAME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
PRUITTHE	EALTH-DURHAM			3100 ERWIN ROAD DURHAM, NC 27705		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS		F 0	00		
F 580 SS=G	from 6/10/2025 to 6/1 information was obtai Therefore, the exit da ID # YJ1711. The follo investigated: NC0023 NC00230369, and NC allegations resulted in Notify of Changes (Inj CFR(s): 483.10(g)(14) §483.10(g)(14) Notific (i) A facility must imm consult with the reside consistent with his or representative(s) whe (A) An accident involv results in injury and h physician intervention (B) A significant chan mental, or psychosoc deterioration in health status in either life-thr clinical complications) (C) A need to alter tre a need to discontinue treatment due to adve commence a new forr (D) A decision to trans resident from the facil §483.15(c)(1)(ii). (ii) When making notif (14)(i) of this section, all pertinent informatic	ned offsite on 6/13/2025. te was to 6/13/2025. Event owing intakes were 0836, NC00230736, 200230229. Four (4) of the 6 a deficiency. jury/Decline/Room, etc.) )(i)-(iv)(15) cation of Changes. ediately inform the resident; ent's physician; and notify, her authority, the resident enthere is- ring the resident which as the potential for requiring u; ge in the resident's physical, ial status (that is, a a, mental, or psychosocial reatening conditions or ); eatment significantly (that is, an existing form of erse consequences, or to m of treatment); or sfer or discharge the	F 54	80		7/4/25
	(iii) The facility must a	Ilso promptly notify the		TITLE		(X6) DATE

**Electronically Signed** 

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

06/27/2025

PRINTED: 06/30/2025

						IO. 0938-03
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION	· · /	TE SURVEY MPLETED
			A. BUILDING	i		С
		345061	B. WING	NG		6/13/2025
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	•	0/10/2020
				3100 ERWIN ROAD		
PRUITTHE	EALTH-DURHAM			DURHAM, NC 27705		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE
F 580	Continued From page	- 1	Γ.69	0		
1 300			F 58	0		
	when there is-	dent representative, if any,				
		or roommate assignment				
	as specified in §483.					
		ent rights under Federal or				
		ns as specified in paragraph				
	(e)(10) of this section					
		record and periodically				
	phone number of the	mailing and email) and				
	representative(s).	resident				
	§483.10(g)(15)					
		osite distinct part. A facility				
	-	istinct part (as defined in				
		e in its admission agreement				
		tion, including the various se the composite distinct				
		y the policies that apply to				
		en its different locations				
	under §483.15(c)(9).					
		⊺ is not met as evidenced				
	by:					
		iew, and staff, responsible		Corrective action for the reside		
	party (RP), Hospice N			to be affected by the deficient p		
		r failed to notify the provider ion and x-ray results after a		The facility failed to notify the F and Responsible Party (RP) of	• • •	
		#1) of three residents		change in condition and x-ray		
		ion of falls. Resident #1 fell		Resident #1 in a timely manner		
		a facility failed to notify the		to effectively communicate per		
		a new inability to bear		results between shifts for follow	v up. The	
	weight. X-ray results			MD Provider was notified of fal		
		elayed to the on-call provider		05/19/2025 and Hospice provid		
		/19/2025. Resident #1		notified of fall on 05/20/2025, o	-	
		npacted left femoral neck pacted left femoral neck		condition on 05/20/2025 and x- on 5/20/2025. The facility notifi	-	
		the upper part of the thigh		Responsible Party (RP) of fall		
		cally at the neck, where it		05/20/2025, change of condition		
	connects to the ball o	•		05/20/2025 and x-ray results o		

Facility ID: 923197

If continuation sheet Page 2 of 44

		MEDICAID SERVICES				NO. 0938-03
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · /			ATE SURVEY
			A. BUILDING	<u> </u>		С
		345061	B. WING			06/13/2025
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP		00/13/2025
				3100 ERWIN ROAD		
PRUITTHE	EALTH-DURHAM			DURHAM, NC 27705		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN O		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	THE APPROPRIATE	COMPLETIO DATE
F 580	Continued From page	e 2	F 58	0		
	included:			5/20/2025. Resident #1 w	as sent to Duke	
				University Medical Center		
	Resident #1 was adm	nitted to the facility on		following fall on 05/20/202		
		oses of history of cerebral		readmitted to facility on 06		
		miplegia, hemiparesis, and		discharged to another Ski	•	
		gia is paralysis on one side		Facility on 06/06/2025. Nu		
		eakness on one side of the arted receiving Hospice		reported to the North Card Nursing for substantiated		
	services on 3/31/202	<b>S</b> 1		neglect on 05/23/2025 an		
				terminated on 05/25/2025		
	Documentation on a	timesheet for Nurse Aide				
	(NA) #1 revealed she	e worked at the facility from		Corrective action for other	r residents	
	7:18 AM to 10:53 PM			having the potential to be	affected by the	
		e corresponding nursing		same deficient practice.	the netential to	
	for Resident #1 durin	A #1 was assigned to care		All current residents have be affected by these defic		
		g that time period.		Falls, associated change-		
	NA #1 was interviewe	ed on 6/10/2025 at 11:54 AM.		x-ray orders will be audite		
	NA #1 revealed the for	ollowing information.		ten (10) days for timely no	tification to	
		ll on 5/17/2025. NA #1 heard		Provider(s), RP and Onco	•	
	Resident #1 fall, and	she told Nurse #4.		Nurse by the Director of H		
	N 114 · · · ·			(DHS), Clinical Competen	-	
		ewed on 6/10/2025 at 6:41 following information. Nurse		(CCC), Unit Manager (UN Coordinator (UC), Infectio		
		M to 7:00 PM shift on		(IP), Nurse Navigator/Sen		
		#1 fell on 5/17/2025 while		(NN/SCP), Case Mix Dire		
		throom. Nurse #4 did full		Case Mix Coordinator (CM		
	range of motion asse	essments of all her limbs and		Nurse Consultant (SNC)	or Administrator,	
		Resident #1. Nurse #4, with		by 07/03/2025.		
		#1, helped Resident #1 up				
		her wheelchair. Nurse #4		Systemic changes made t		
	-	ew admission, helping ng incontinence briefs, and		the deficient practice will r Licensed nursing staff edu		
		ations that she was not able		regarding notifying the pro		
	-	g in the electronic medical		change in condition requir		
		o stated that she forgot to		evaluation and treatment;	-	
		the fall but, Resident #1 was		to effectively provide treat		
	without injury or pain	after the fall on 5/17/2025.		provided by the Director of		
				Services (DHS), Clinical C	Competency	

Facility ID: 923197

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIF	PLE CONSTRUCTION		TE SURVEY
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	3	CO	MPLETED
						С
		345061	B. WING		c	6/13/2025
NAME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP	CODE	
	ALTH-DURHAM			3100 ERWIN ROAD		
RUITINE				DURHAM, NC 27705		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETIC DATE
F 580	Continued From page	e 3	F 58	30		
		entation in Resident #1's		Coordinator (CCC), Unit N	lanager (LIM)	
	electronic medical re			Unit Coordinator (UC), Inf		
		fication of physician or family		Preventionist (IP), Nurse I		
		7:00 AM to 7:00 PM shift.		Care Partner (NN/SCP), C	0	
				Director (CMD), Case Mix		
		nducted with the Responsible		(CMC), Senior Nurse Con	· · ·	
		sident #1 on 6/10/2025 at		Administrator by 07/04/20	•	
	2:06 PM. RP #1 prov	0		that have not completed th		
	information. RP #1, h			be removed from the sche		
		Resident #1 on the morning barely got down the hallway		educated prior to returning staff will be educated on the	-	
	when she was stoppe			notification process during		
		ad not yet assisted Resident		orientation.	Jiewille	
		get dressed. NA #1 said she		All residents will falls will t	be audited three	
		uld like to take Resident #1		(3) x weekly for 4 weeks, t		
	outside. NA #1 then t	old RP #1 that Resident #1		times weekly x 4 weeks, th	· · ·	
	fell yesterday (5/17/2	025) but she was fine. RP #1		weekly for 4 weeks) by th	. ,	
	remarked to NA #1 th	nat nobody had called to tell		Health Services (DHS), C	linical	
		9 #1 went to see Resident #1		Competency Coordinator		
		the fall. RP #1 stated that		Manager (UM), Unit Coord		
		I were trying to help Resident		Infection Preventionist (IP		
	÷ .	emed like she was in pain,		Navigator/Senior Care Pa		
		ar any weight. This was a		Case Mix Director (CMD),		
	•	#1 because although she side she had always been		Coordinator (CMC), Senic Consultant (SNC) or Admi		
		revealed she assisted		compliance maintained.	niisuator, or unul	
		ing and then asked her about				
		e previous day. Resident #1		Plans to monitor its perfor	mance to make	
		vas trying to get to the		sure that the solutions are		
		visted her left foot and fell.		An AdHoc Quality Assurar	nce	
		#1 she did not hit her head.		Performance Improvement		
		#1 that a nurse and a nurse		will be held by 07/04/2025		
	-	bed. RP #1 indicated		Plan of Correction (POC).		
	Resident #1 seemed			The Director of Health Sei	, ,	
		e. RP #1 stated she and her		present the analysis of the		
		ent #1 to the bathroom, but		assessment audit complia		
		able to stand or bear any		to the Nursing Home Adm		
1	woight DD #4 :	ted Resident #1 required her		Quality Assurance and Pe	rformorco	

Facility ID: 923197

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	: 06/30/2025 APPROVED . 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			(X3) DATE COMP	SURVEY LETED
		345061	B. WING		_	06/ <sup>,</sup>	C 13/2025
NAME OF PI	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, ST	ATE, ZIP CODE		
			3	100 ERWIN ROAD			
PRUITTHE	EALTH-DURHAM		C	OURHAM, NC 27705			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
TAG F 580	Continued From page off the toilet and back then went to the nurse #4. RP #1 told Nurse she fell last night and said Nurse #4 acted li #1 was talking about. Resident #1 had not r fall or pain to her. Nur check and see if Resi confirmed she did not the electronic medica down to Resident #1's medication but did no anything else for Resi she told Nurse #4 tha bear weight on her lef acting like she didn't H about or with any con #1 that Nurse #4 was room last night after th Resident #1 outside to #1 seemed very sore and she required mor Nurse #4 was intervie PM. Nurse #4 confirm to 7:00 PM shift on 5/ that RP #1 came to th 5/18/2025 and told he back pain. Nurse #4 se that occurred on 5/17, all with RP #1. Nurse was not injured so the #1 about the fall. Nurse #1 about the fall. Nurse	e 4 into the wheelchair. RP #1 e's desk and spoke to Nurse #4 that Resident #1 told her she was now in pain. RP #1 ke she didn't know what RP Nurse #4 told RP #1 that nentioned anything about a se #4 stated she would dent #1 fell last night and see anything about a fall in record. Nurse #4 went s room and gave her pain t do any assessment or do dent #1. RP #1 revealed t Resident #1 was unable to t side and Nurse #4 kept snow what she was talking cern. Resident #1 told RP the nurse who was in the ne fall. RP #1 did take o get some air but Resident anytime they moved her, e assistance than usual. wed on 6/10/2025 at 6:41 led she worked the 7:00 AM 18/2025. Nurse #4 stated that Resident #1's fall /2025 was not discussed at #4 stated that Resident #1's fall. re was no reason to tell RP se #4 confirmed she red dose of Oxycodone to orning of 5/18/2025. Nurse	F 580	until three consecu compliance is main	tive months of tained and then beginning July 202		DATE
	#4 confirmed she did or notification of a phy	not do any documentation					

Facility ID: 923197

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	-	D HUMAN SERVICES MEDICAID SERVICES					FORM	0: 06/30/2025 APPROVED 0. 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345061	B. WING			_		C 13/2025
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, ST	ATE, ZIP CODE		
PRUITTHE	EALTH-DURHAM				100 ERWIN ROAD URHAM, NC 27705			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 580	Continued From page	• 5	F	580				
	and revealed the follo morning of 5/19/2025 Resident #1, so she s Hospice Nurse #1 firs #1 told Hospice Nurse fall on 5/17/2025 and Nurse #1 told RP #1 tf first person she would see on 5/19/2025 in a that she was in a lot of left side. Documentation in a H visit note dated 5/19/2 "Received message ff #1] had a fall over the [Resident #1's] room, Called out her name a without difficulty. Aske fall, [Resident #1] nam someone to help me to came, I did not want to using my cane, but m tripped over and fell of until an aide came to had an unwitnessed ff consulted facility nurs stated that he had no previous shift. Since to pain of 5 to 8 on nume able to assist in turnin to left side of body. [R had no bruising, swell #1] left side is the weat [Cerebral Vascular Aco provider [MD #1 (Phy.	t thing in the morning. RP e #1 that Resident #1 had a she was in pain. Hospice hat Resident #1 was the d visit that day. RP #1 could e video call to Resident #1 of pain and was guarding her lospice Nurse as needed 2025 at 1:46 PM revealed, rom [RP #1] that [Resident e weekend. Arrived [Resident #1] was sleeping. and [Resident #1] woke up ed [Resident #1] about the rated saying, "I called for to bathroom, but no one to pee on myself, so I got up y left foot got caught and I on my left side. I lay there help me up." [Resident #1] all on Saturday 5/17/2025, e for details but [Nurse #3] report of the fall from hen, she has complained of erical scale. [Resident #1] ag, but pain prohibits turning tesident #1] left leg and foot ling, or hotness. [Resident ak side from history of tocident]. Asked the facility						

Facility ID: 923197

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				PLE CONSTRUCTION		O. 0938-039
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	· · ·	E SURVEY IPLETED
			A. BOILDIN			С
		345061	B. WING		06	6/13/2025
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO		
PRUITTHE	EALTH-DURHAM			3100 ERWIN ROAD		
				DURHAM, NC 27705		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE E APPROPRIATE	(X5) COMPLETIOI DATE
F 580	Continued From page	e 6	F 5	80		
	_	diate) X-ray of left leg and				
		rvice for STAT x-ray and				
	collaborated with faci					
	medication, to start w	/ith [as needed] sident #1] was slightly				
	tachycardic in 111-11					
		uration initially was 88 % on				
		positioning it came up to 93				
	%. (Tachycardia is a					
		pid heart rate, typically neart rate of over 100 beats				
		amily for update, to call				
		ait next time there was a				
	concern."					
	Hospice Nurse #1 wa	as interviewed on 6/10/2025				
		Nurse #1 revealed she was				
		Resident #1. Hospice				
		on 5/19/2025 RP #1 sent her at Resident #1 had a fall				
		5/17/2025. Hospice Nurse				
		t to the facility, assessed				
		nediately contacted MD #1				
		in the building. MD #1				
		1 and ordered a STAT x-ray. lled mobile x-ray. Hospice				
	-	she asked Nurse #3 about				
		5/17/2025 but he was				
	unaware of the fall ar	-				
	about the fall.	electronic medical record				
	MD #1 (Physician) w	as interviewed on 6/11/2025				
	at 8:06 AM and revea	aled the following				
		as doing his rounds at the				
		when a nurse approached look at Resident #1. MD #1				
		f Resident #1 and noted her				
	left leg was shorter a					

Facility ID: 923197

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	-	D HUMAN SERVICES MEDICAID SERVICES					FORM	0: 06/30/2025 APPROVED 0. 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		E CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345061	B. WING			_		C 13/2025
NAME OF P	ROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, ST	ATE, ZIP CODE		
PRUITTHE	EALTH-DURHAM				3100 ERWIN ROAD DURHAM, NC 27705			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORRE) CROSS-REFERE	B PLAN OF CORRECTION CTIVE ACTION SHOULD B NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 580	MD #1 was certain the fracture, so he ordered hip and made sure the medication ordered at requested to be conta x-ray came back for file expected a provider to findings at the time th explained that Reside patients but for any ch x-ray results of a fract notified to obtain addi confirmed notification provision of care. Nurse #3 was intervie PM and provided the #3 worked from 7:00 a 5/19/2025. Nurse #3 #1 that Resident #1 h that MD #1 had order hip. Documentation on the 5/19/2025 revealed R acute impacted left fe x-ray results were fax on 5/19/2025. Nurse #2 was intervie PM and revealed the #2 worked from 3:00 5/19/2025. Nurse #2 the start of her shift th over the weekend. Nu was also the facility w some point in her shift machine to fax wound	at Resident #1 had a d a STAT x-ray of her left at Resident #1 had pain and available. MD #1 betted when the results of the urther orders. MD #1 be notified of any acute ey were available. MD #1 ant #1 was not one of his hange in condition; including ture, a provider should be tional orders. MD #1 was a key piece in the wed on 6/10/2025 at 2:53 following information. Nurse AM to 3:00 PM on was told by Hospice Nurse ad a fall on 5/17/2025 and ed a STAT x-ray of her left e x-ray results dated esident #1 had sustained an moral neck fracture. The ed to the facility at 2:50 PM wed on 6/10/2025 at 2:38 following information. Nurse PM to 11:00 PM on stated she was not aware at hat Resident #1 had a fall urse #2 explained that she round care nurse and that at	F	580				

Facility ID: 923197

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	-	D HUMAN SERVICES				FORM	: 06/30/2025
STATEMENT (	S FOR MEDICARE & I	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	CONSTRUCTION		(X3) DATE : COMPI	LETED
		345061	B. WING		_	06/1	) 13/2025
NAME OF P	ROVIDER OR SUPPLIER		ST	REET ADDRESS, CITY, STA	ATE, ZIP CODE		
			31	00 ERWIN ROAD			
PRUITTHE	EALTH-DURHAM		DI	JRHAM, NC 27705			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD BE ICED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 580	machine, and she not Resident #1. Nurse # happened to Residen point in the shift, went why she had an x-ray oriented. Resident #1 days ago. The on-call follow up with the regu Nurse #2 took her vita assessment. Nurse # aides that Resident # they turned her for inc stated she gave pain Nurse #2 explained th arrived at the facility s get up to go to the bath continent of bowel an keep reminding her th help to go to the bath Nurse #2 noted it was to be incontinent and incontinent care by th called the on-call physi because it was after h on-call provider askee Nurse #2 told the on-c #1 was stable and wa moved or turned for in Documentation in a n 5/20/2025 at 12:09 AI revealed the following fell a few days ago an turned from side to sig medication for breakt	ed the x-ray results for 2 did not know anything had t #1. Nurse #2, at some t to Resident #1 to ask her because she was alert and told Nurse #2 she fell a few provider told Nurse #2 to ular provider in the morning. al signs and did a pain 2 was alerted by the nurse 1 was in extreme pain when continence care. Nurse #2 medication to Resident #1. the was weak and could not throom. Gradually Resident d confidence and used her room. Resident #1 was d bladder, but staff had to at she needed to ask for room so she would not fall. a change for Resident #1 to be provided with e nurse aides. Nurse #2 sician with the x-ray results iours on 5/19/2025. The d if Resident #1 was stable. call provider that Resident s only in pain when she was neontinent care.	F 580				

Facility ID: 923197

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	-	D HUMAN SERVICES					FORM	06/30/2025
STATEMENT C	DF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		CONSTRUCTION		(X3) DATE COMP	LETED
		345061	B. WING			_		C 13/2025
NAME OF PF	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, ST	ATE, ZIP CODE		
				3'	100 ERWIN ROAD			
PRUITTHE	ALTH-DURHAM			D	URHAM, NC 27705			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	х	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
	Continued From page impacted left femoral after-hours provider w after-hours provider s stable, to follow up in practitioner. Nurse #2 was intervie 1:31 PM. Nurse #2 co have told her Resider out for the x-ray result 5/19/2025. Nurse #2 r aware of the x-ray result 5/19/2025. Nurse #2 r aware of the x-ray result 6/11/2025 at 8:57 AM information was provid care for Resident #1 co until 7:00 AM on 5/20, #6 that she fell on Saft what happened becau oriented. Resident #1 go to the bathroom ar fell. Resident #1 told I nurse aide picked her	ASC IDENTIFYING INFORMATION) a 9 hip neck fracture. The vas contacted. The tated that if the resident was the morning with the nurse wed again on 6/11/2025 at onceded that Nurse #3 may of #1 had a fall and to watch ts at the change of shift on reiterated that she became sults at an unknown time sponsibilities that day as the the facility. ducted with NA #6 on and the following ded. NA #6 was assigned to on 5/19/2025 from 3:00 PM /2025. Resident #1 told NA turday. NA #6 asked her use she was alert and told him she was trying to ond her foot twisted, and she NA #6 that a nurse and a rup and put her in bed. NA	TAG	580	CROSS-REFEREN	NCED TO THE APPROPRIA		
	said no. NA #6 called to provide incontinent was in pain when she	s called and Resident #1 another nurse aide for help care for her because she was moved. NA #6 stated						
	Resident #1 had a fall was in pain. Nurse #2 no documentation in t sustained by Residen #6 returned to Reside that if she needed a b he could not help her	mediately tell Nurse #2 that l over the weekend and she t told NA #6 that there was he electronic record of a fall t #1 over the weekend. NA ent #1's room and told her red pan to call him because out of bed to the bathroom A #6 said Resident #1 was						

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	0: 06/30/2025 APPROVED 0: 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345061	B. WING		_		C 13/2025
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, ST	ATE, ZIP CODE		10/2020
			:	3100 ERWIN ROAD			
PRUITTHE	ALTH-DURHAM			DURHAM, NC 27705			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE) CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD B NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 580		had to roll her little by little to	F 580				
	· ·	are for her. NA #6 revealed Resident #1 had a fall and ved.					
	AM and revealed the #5 worked the 11:00 l	ewed on 6/11/2025 at 7:27 following information. Nurse PM to 7:00 AM shift that					
	notified the nurse pra- 5/20/2025 that the x-r	Nurse #5 revealed she ctitioner in the morning on ay results were received by					
	the facility and Reside impacted left femoral						
	dated 5/20/2025 at 7:	nursing progress notes 25 AM written by Nurse #5 actitioner gave a verbal					
	order to send Resider for a left femoral neck	nt #1 to the emergency room a fracture.					
	discharge summary d	n Resident #1's hospital lated 5/28/2025 revealed nt surgery to repair her					
	femur fracture.						
	PM with the current ir (DON), who initiated a on 5/27/2025. The DC aware of the facility in	ducted on 6/13/2025 at 1:11 Interim Director of Nursing Employment with the facility DN explained she was made Investigation for Resident #1 Inistrator at the start of her					
	elaborated that each directions at the desk taken when a residen	nursing station had for what steps needed to be					

Facility ID: 923197

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA		PLE CONSTRUCTION		E SURVEY
	CORRECTION	IDENTIFICATION NUMBER:			· · ·	PLETED
						С
		345061	B. WING		06	/13/2025
NAME OF PI	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CODE		
PRIJITTHE	EALTH-DURHAM			3100 ERWIN ROAD		
				DURHAM, NC 27705		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETIO DATE
F 580	Continued From page	e 11	F 58	30		
	past non-compliance	a draft plan of correction for that was not acceptable to to a lack of measures put and monitoring of				
F 600 SS=G	Free from Abuse and CFR(s): 483.12(a)(1)		F 60	00		7/4/25
	Exploitation The resident has the neglect, misappropria and exploitation as de includes but is not lim corporal punishment,	involuntary seclusion and ical restraint not required to edical symptoms.				
	physical abuse, corpo involuntary seclusion This REQUIREMENT by:	; is not met as evidenced				
	responsible party (RF Physician, and Medic facility failed to provio after a fall; failed to ic that required medical failed to notify a provi failed to identify one I and external leg rotat evaluation and treatm effectively to provide	al Director interviews, the le ongoing assessments lentify a change in condition evaluation and treatment; ider of a change in condition; eg shorter than the other		Corrective action for the residents to be affected by the deficient pra The facility failed to ensure that st provided ongoing assessment after identify change in condition requir medical evaluation and treatments to communicate effectively to prov treatment for Resident #1. The provider was notified of fall of 05/20/2025, change of condition of 05/20/2025 and x-ray results on 5/20/2025. The facility notified the	ctice. aff er fall; ing failed vide	

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Event ID: YJ1711

Facility ID: 923197

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		MEDICAID SERVICES				8 NO. 0938-03
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION		DATE SURVEY
						С
		345061	B. WING			06/13/2025
NAME OF PI	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP C	ODE	
ייידדוווסס				3100 ERWIN ROAD		
	EALTH-DURHAM			DURHAM, NC 27705		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETIO DATE
F 600	Continued From page	a 12	F 60	0		
1 000			F 00		fall on	
		dent #1) of three residents nd/or neglect. Resident #1		Responsible Party (RP) of 05/20/2025, change of con		
		npacted left femoral neck		05/20/2025, change of cont 05/20/2025 and x-ray resul		
		ipacted left femoral neck		5/20/2025. Resident #1 wa		
		the upper part of the thigh		University Medical Center f		
		cally at the neck, where it		following fall on 05/20/2025		
	connects to the ball c	of the hip joint). Findings		readmitted to facility on 06/	04/2025.	
	included:			Resident #1 discharged to	another Skilled	
				Nursing Facility on 06/06/2		
	This tag is cross refe	rred to:		was reported to the North C		
				of Nursing for substantiated		
	F580: Based on reco			neglect on 05/23/2025 and	employment	
		P), Hospice Nurse, and the facility failed to notify the		terminated on 05/25/2025.		
	-	in condition and x-ray		Corrective action for other	residents	
	results after a fall for	one (Resident #1) of three		having the potential to be a	iffected by the	
	residents reviewed for			same deficient practice.		
		17/2025 and the facility		All current residents have t		
		ovider of pain and a new		be affected by these deficie		
		nt. X-ray results obtained		Fall assessment, change-ir		
	•	were not relayed to the		communication will be audi		
		after hours on 5/19/2025.		ten (10) days for timely not		
		d an acute impacted left . (An acute impacted left		treatment, to Provider(s), R Oncoming-Shift Nurse by th		
		is a break in the upper part		Health Services (DHS), Cli		
		nur), specifically at the neck,		Competency Coordinator (		
		the ball of the hip joint.)		Manager (UM), Unit Coordi	,	
		1- 3/		Infection Preventionist (IP),		
	F684: Based on reco	rd review, and staff,		Navigator/Senior Care Part		
		P), resident, Hospice Nurse,		Case Mix Director (CMD), 0	Case Mix	
		al Director interviews the		Coordinator (CMC), Senior		
		le ongoing assessments		Consultant (SNC) or Admir	nistrator, by	
	after a fall; failed to ic			07/03/2025.		
	condition required me			Oustamia skara sa la f		
		entify one leg shorter than		Systemic changes made to		
		al leg rotation required		the deficient practice will no		
		nd treatment; and failed to rely to provide treatment for		Licensed Nursing education ongoing assessment; ident		
	one (Resident #1) of			in condition requiring medic		

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		ID HUMAN SERVICES MEDICAID SERVICES			FOF	ED: 06/30/2025 RM APPROVED IO. 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION G	(X3) DAT	E SURVEY IPLETED
		345061	B. WING		0	C 6/13/2025
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, Z		0/10/2020
PRUITTHE	ALTH-DURHAM					
				DURHAM, NC 27705		0.0
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE / CROSS-REFERENCED T DEFICI	ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETION DATE
F 600	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 60	and treatment; commun effectively provide treatr provided by the Director Services (DHS), Clinical Coordinator (CCC), Unit Unit Coordinator (UC), Iu Preventionist (IP), Nurse Care Partner (NN/SCP), Director (CMD), Case M (CMC), Senior Nurse Co Administrator and comp 07/03/2025. Any staff th completed the education from the schedule and w prior to returning to work educated on the fall noti during new hire orientati All residents will falls wil ongoing assessment; id in condition requiring me and treatment, and com provide treatment, week weeks by the Director of	ment will be of Health I Competency t Manager (UM), nfection e Navigator/Senior , Case Mix lix Coordinator onsultant (SNC) or obleted by at have not n will be removed will be educated k. New staff will be ification process ion. I be audited for entifying change edical evaluation munication to cly x twelve (12) f Health Services	
				<ul> <li>(DHS), Clinical Competer</li> <li>(CCC), Unit Manager (U)</li> <li>Coordinator (UC), Infect</li> <li>(IP), Nurse Navigator/Se</li> <li>(NN/SCP), Case Mix Dir</li> <li>Case Mix Coordinator (C)</li> <li>Nurse Consultant (SNC)</li> <li>or until compliance main</li> <li>Plans to monitor its performance functions a</li> <li>An AdHoc Quality Assur</li> <li>Performance Improvement</li> </ul>	JM), Unit tion Preventionist enior Care Partner rector (CMD), CMC), Senior ) or Administrator ntained. formance to make are sustained. rance	
				will be held by 7/3/2025 of Correction (POC). The DHS will present th		

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	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPI	E CONSTRUCTION		NO. 0938-039 TE SURVEY
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		со	MPLETED
		345061	B. WING		C 06/13/20	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
PRUITTH	EALTH-DURHAM		3100 ERWIN ROAD DURHAM, NC 27705			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE
F 600	Continued From pag	e 14	F 60	fall assessment audit complian percentage to the Nursing Hom Administrator at the Quality Ass and Performance Improvement Committee meeting monthly ur consecutive months of complia maintained and then quarterly beginning July 2025.	ne surance t til three ince is thereafter	
F 607 SS=D	CFR(s): 483.12(b)(1) §483.12(b) The facili	ty must develop and	F 60	Date of compliance: 07/04/202	5	7/4/25
	§483.12(b)(1) Prohib neglect, and exploita misappropriation of r	esident property, ish policies and procedures				
	paragraph §483.95,	e training as required at ish coordination with the red under \$483.75				
	§483.12(b)(5) Ensure occurring in federally facilities in accordance Act. The policies and	C C				
		sting a conspicuous notice of defined at section 1150B(d)				

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PRINTED: 06/30/2025

		MEDICAID SERVICES				<u>VO. 0938-039</u>	
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION		TE SURVEY MPLETED	
						С	
		345061	B. WING		06/13/2025		
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
PRUITTHI	EALTH-DURHAM			3100 ERWIN ROAD DURHAM, NC 27705			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETIO DATE	
F 607	Continued From page	ə 15	F 60	7			
	retaliation, as defined (2) of the Act. This REQUIREMENT by: Based on record rev interview, the facility the Administrator of a a resident for one (Re residents reviewed for Findings included: Documentation on the Reporting Patient Abb Mistreatment, and Mi dated as last reviewed the following statemes suspicion, or identified involving patient abbus mistreatment, and mi including injuries of a	or abuse investigations. e facility procedures for use, Neglect, Exploitation, sappropriation of Property ed on 11/15/2024 revealed		Corrective action for the residen to be affected by the deficient pro- The facility failed to ensure staff implemented the abuse policy ar procedure for Resident #2 in a ti manner. Resident #2 Allegation reported to NCDHHS by Adminis 05/01/2025. Physician notified of 05/01/2025. Responsible Party r allegation on 05/01/2025. Durha Department notified and visited F #2 on 05/01/2025. Adult Protecti Services notified and visited Res on 05/02/2025. Skin check perfo 05/06/2025 without any unexpect findings.	actice . nd mely of Abuse strator on n otified of m Police Resident ve ident #2 rmed on		
	the provider entity. Resident #2 was adm 4/3/2025 with diagno depression, dementia Documentation on a assessment dated 5/ #2 was cognitively int bowel and bladder, a assistance with toileti Resident #2 was inte 10:28 AM. Resident #	nitted to the facility on ses of schizophrenia, a, and bipolar disorder. quarterly Minimum Data Set 16/2025 revealed Resident tact, always incontinent of nd required substantial		Corrective action for other reside having the potential to be affected same deficient practice. All residents are at risk for this di- practice. Abuse questionnaire in were conducted for all residents facility with a Brief Interview for N Status score of 10 or higher by th Services Director, Licensed nurse Administrator on 05/01/2025. Sk were completed for all residents licensed nursing personnel on 05 without any adverse response to questions or without any unknow issues identified.	d by the eficient terviews at the Mental ne Social es, and in audits by 5/01/2025		

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	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA		E CONSTRUCTION		<u>NO. 0938-03</u> TE SURVEY	
	CORRECTION	IDENTIFICATION NUMBER:			· · · ·	MPLETED	
			A. BOILDING			С	
		345061	B. WING			06/13/2025	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
				3100 ERWIN ROAD			
PRUITTHE	EALTH-DURHAM			DURHAM, NC 27705			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TON SHOULD BE THE APPROPRIATE	(X5) COMPLETIC DATE	
F 607	Continued From pag	o 16	E 60	7			
1 007			F 607		iotrotor		
		actions of a sexual nature opriate comment. Resident		Services (DHS) and Admin educated by Senior Nurse			
		urse #7 and Nurse Aide (NA)		(SNC) regarding facility po			
		ed to her. Resident #2 did		abuse reporting; investigat			
		she told Nurse #7 or NA #8.		abuse, neglect, exploitation			
	, ,			and misappropriation of pro			
	Nurse #7 was intervi	ewed on 6/11/2025 at 10:51		with emphasis on timely re			
	AM. Nurse #7 denied	Resident #2 told her of the		agencies on 05/01/2025 ar			
	abuse allegation invo	olving NA #2. Nurse #7 said					
	she heard rumors of	the abuse allegation made		Systemic changes made to	ensure that		
		ding NA #2 but when she		the deficient practice will ne			
		ator it was already known to		100% staff education regar	-		
		Resident #2 was known to		reporting completed 05/06/			
		was attention seeking		Administrator. New staff wi			
		t have been documented in		on the Identifying and Rep	-		
		Nurse #7 did not recall which		will be conducted during ne			
	day this occurred.			orientation by the Director			
	NA #8 was interview	ed on 6/11/2025 at 11:15 AM.		Services (DHS), Clinical Co Coordinator (CCC), Unit M			
		ollowing information. NA #8		Unit Coordinator (UC), Infe			
		ent #2's roommate to eat		Preventionist (IP), Nurse N			
		heard the Activity Director		Care Partner (NN/SCP), C	-		
		sident #2. Resident #2 told		Director (CMD), Case Mix			
		appropriately touched her		(CMC), Human Resources			
		ng her. NA #8 did not recall		Senior Nurse Consultant (S			
		ed. AD #1 then left the room		Administrator.	-		
	telling Resident #2 sl			Three (3) residents with a l	Brief Interview		
	Administrator. NA #8	0		for Mental Status (BIMS) s			
	-	ning her nurse aide duties.		higher, will be interviewed			
		end of her shift that nothing		abuse four (4) x weekly x f			
		nobody had come to talk to		three residents (3) residen			
		e allegation she had made		weekly x four (4) weeks, th			
		o a person she recognized to		residents weekly x 4 weeks	•		
		n and told her she needed to		Services Director (SSD)/Ac			
		ut an abuse allegation she		Director (AD); Social Servi			
		e person directed NA #8 to ne Administrator and the		Unit Manager; Unit Coordir Preventionist (IP), Clinical			
		ere having at that time. NA		Coordinator (CCC); Activit	· ·		
	Lencolor or mursing w	oro naving at that tille. NA			y Director,		

Facility ID: 923197

	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	D. 0938-039 SURVEY
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	· /		COM	PLETED
					С	
		345061	B. WING		06	/13/2025
NAME OF P	ROVIDER OR SUPPLIER		:	STREET ADDRESS, CITY, STATE, ZIP CODE		
PRUITTHI	EALTH-DURHAM			3100 ERWIN ROAD DURHAM, NC 27705		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETIO DATE
F 607	Continued From page	9 17	F 607	7		
	Administrator of the a #2 told AD #1. AD #1 was interviewed AD #1 stated she ent give mail to Resident stopped AD #1 and sc her. Resident #2 relat regarding NA #2 inap #1 revealed that NA # around the privacy cu Resident #2's roomm Resident #2's roomm Resident #2 to stop to hear anymore. AD #1 room to tell the Admir abuse but it slipped h #1 indicated she remu- from work the allegati regarding NA #2. AD morning clinical meet inform the Administrator allegation made by R informed by NA #8 at The facility's senior N was interviewed on 6. Nursing Corporate Co came to her and told abuse to report. The Consultant instructed	Ilegation of abuse Resident ed on 6/11/2025 at 11:50 AM. ered Resident #2's room to #2's roommate. Resident #2 aid she had something to tell yed to AD #1 an allegation propriately touching her. AD #8 looked at them from irtain while assisting ate. AD #1 said she told alking so NA #8 would not said she left Resident #2's histrator of the allegation of er mind as she got busy. AD embered on the way home on Resident #2 made #1 decided that in the ing the next day she would tor of the allegation made by iscovered the next morning already was aware of the esident #2 as she had been the end of her shift. ursing Corporate Consultant (11/2025 at 12:27 PM. The onsultant confirmed NA #8 her she had an allegation of Nursing Corporate NA #8 to immediately go to interrupt her meeting to tell		Coordinator (CMC); Nurse Naviga Director of Health Services (DHS) Administrator to ensure that no all of abuse have been made and not reported. Plans to monitor its performance to sure that the solutions are sustained An AdHoc Quality Assurance Performance Improvement (QAPI) will be held by 07/04/2025 to revie Plan of Correction (POC). The DHS will present the analysis fall assessment audit compliance percentage to the Nursing Home Administrator at the Quality Assura and Performance Improvement Committee meeting monthly until to consecutive months of compliance maintained and then quarterly the beginning July 2025. Date of compliance 07/04/2025	or egations t o make ed. ) review w the s of the ance three is	
		trator, whose employment n 6/6/2025, did not respond				

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		MEDICAID SERVICES			OMB NO. 0938-03
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED
					С
		345061	B. WING		06/13/2025
IAME OF PI	ROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE	
RUITTHE	ALTH-DURHAM			100 ERWIN ROAD URHAM, NC 27705	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETIO
F 607	Continued From page	e 18	F 607		
		r of Nursing (DON) was			
	interviewed on 6/13/2	2025 at 1:27 PM. The			
		ned NA #8 interrupted a			
	meeting she was hav	ing with the previous rt an allegation of abuse			
	-	le in her presence. The			
		ned NA #8 brought this			
		vious Administrator at the			
	end of her shift at app	proximately 3:00 PM.			
	Decumentation on or	initial invastigation report			
	sent to the state office	i initial investigation report			
		n 5/1/2025 at 4:09 PM			
	revealed Resident #2	had made an allegation of			
	-	for an event occurring on			
	either 4/28/2025 or 4	/29/2025.			
	The current Administ	ator was interviewed on			
		I. The Administrator stated			
	that abuse was not to	lerated at the facility. The			
		ed all allegations of abuse			
		reported to her so that a full			
F 684	investigation can be o Quality of Care	completed.	F 684		7/4/25
SS=G	CFR(s): 483.25		F 004		1/4/23
	§ 483.25 Quality of ca				
	•	ndamental principle that nt and care provided to			
		ed on the comprehensive			
	-	dent, the facility must ensure			
		treatment and care in			
	accordance with prof				
	practice, the compret care plan, and the res	nensive person-centered			
		is not met as evidenced			
	by:				
	Based on record rev			Corrective action for the residents for	.

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Facility ID: 923197

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE SURVEY	
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		COMPLETED	
		345061	B. WING		C 06/13/2025	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	00/15/2025	
PRUITTHE	EALTH-DURHAM			3100 ERWIN ROAD DURHAM, NC 27705		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLÉTIO	
F 684	Continued From page	e 19	F 684	4		
	and Medical Director to provide ongoing as to identify the change medical evaluation ar identify one leg short external leg rotation r and treatment; and fa effectively to provide #1) of three residents after a fall. Resident # impacted left femoral impacted left femoral the upper part of the specifically at the neo ball of the hip joint). I Resident #1 was adm 3/28/2025 with diagnov vascular accident, he lung cancer. Hemiple while hemiplegia is w	equired medical evaluation illed to communicate treatment for one (Resident reviewed for assessment 1 sustained an acute neck fracture (an acute neck fracture is a break in thigh bone (femur), ck, where it connects to the Findings included: nitted to the facility on oses of history of cerebral miplegia, hemiparesis, and gia is paralysis on one side eakness on one side of the arted receiving Hospice		to be affected by the deficient practic The facility failed to ensure that staff provided ongoing assessment; ident change in condition requiring medica 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. Resident #1 was sent to University Medical Center for treatm following fall on 05/20/2025 and was readmitted to facility on 06/04/2025. Resident #1 discharged to another S Nursing Facility on 06/06/2025. Nursing was reported to the North Carolina E of Nursing for substantiated allegation neglect on 05/23/2025 and employm terminated on 05/25/2025.	F Lify al Duke ent S Skilled se #4 Board on of	
	Set assessment date Resident #1 had mod with a range of motion the upper and lower e also assessed as usin Resident #1 was eval of bowel and bladder #1 had a history of fa admission.	lerately impaired cognition n impairment on one side of extremities. Resident #1 was ng a cane or a wheelchair. luated as always incontinent . It was unknown if Resident Ils with no falls since her timesheet for Nurse Aide worked at the facility from		Corrective action for other residents having the potential to be affected by same deficient practice. All current residents have the potent be affected by these deficient practic Fall ongoing assessment, identifying change-in-condition and communica will be audited for the past ten (10) of for timely notification and treatment to Provider(s), RP and Oncoming-Shift Nurse by the Director of Health Serv (DHS), Clinical Competency Coordir (CCC), Unit Manager (UM), Unit Coordinator (UC), Infection Preventi	y the tial to ces. y tition days to to to tices nator	

Facility ID: 923197

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FATEMENT O	F DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIP	PLE CONSTRUCTION	(X3) DAT	E SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	, ,	G		IPLETED
						С
		345061	B. WING		0	6/13/2025
NAME OF PF	ROVIDER OR SUPPLIER	·		STREET ADDRESS, CITY, STATE, ZI	P CODE	
PRUITTHE	ALTH-DURHAM			3100 ERWIN ROAD		
				DURHAM, NC 27705		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETIC DATE
F 684	Continued From page	e 20	F 68	34		
		e corresponding nursing		(IP), Nurse Navigator/Se	nior Care Partner	
		A #1 was assigned to care		(NN/SCP), Case Mix Dir		
	for Resident #1 during	5		Case Mix Coordinator (C	· · ·	
				Nurse Consultant (SNC)	or Administrator,	
		ed on 6/10/2025 at 11:54 AM.		by 7/3/2025.		
	NA #1 revealed the fo	-				
		I on 5/17/2025. NA #1 heard		Systemic changes made		
		she told Nurse #4. Any other ve to be obtained from		the deficient practice will Licensed Nursing educa		
	Nurse #4 and NA #1			ongoing assessment; ide		
		ther Resident #1 was in		in condition requiring me		
		d she provided the facility		and treatment; communi		
	-	arding Resident #1's fall on		effectively provide treatn		
	5/17/2025.			provided by the Director		
				Services (DHS), Clinical		
		a statement handwritten by		Coordinator (CCC), Unit		
		egarding the events of		Unit Coordinator (UC), Ir		
		mentation on the statement e following information. NA		Preventionist (IP), Nurse Care Partner (NN/SCP),		
		ent #1's room to collect the		Director (CMD), Case M		
		A #1 noted Resident #1		(CMC), Senior Nurse Co		
	stood up with her can			Administrator and comp	. ,	
		or her to set the meal tray		07/04/2025. Any staff that	-	
		ing. NA #1 turned around		completed the education		
		ent #1 fall. NA #1 called for		from the schedule and w		
		over Resident #1. NA #1		prior to returning to work		
		to do. Nurse #4 and NA #1		educated on the fall notif		
		to rise and placed her in a chair while NA #1 made		during the new hire orier All residents will falls will		
		ble in the bed. Nurse #4		ongoing assessment; ide		
	then left the room.			in condition requiring me		
				and treatment, and com	nunication to	
		ewed on 6/10/2025 at 6:41		provide treatment, week		
		following information. Nurse		weeks by the Director of		
	#4 worked the 7:00 A			(DHS), Clinical Compete		
		#1 fell on 5/17/2025 while		(CCC), Unit Manager (U		
		hroom. Nurse #4 did full ssments of all her limbs and		Coordinator (UC), Infecti (IP), Nurse Navigator/Se		
	LADDE OF MOTION 2556					

Facility ID: 923197

If continuation sheet Page 21 of 44

D PLAN OF CORRECTION IDENTIFICATION NUMBER:				СОМ	PLETED
		A. BUILDING			С
	345061	B. WING		06	/13/2025
ROVIDER OR SUPPLIER		Ş	STREET ADDRESS, CITY, STATE, ZIP CODE		
ALTH-DURHAM					
(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL	D BE	(X5) COMPLETION DATE
Continued From page	21	F 684			
off the floor and into h wheeled Resident #1 #1 stood up, pivoted, After finishing, Reside sat in the wheelchair. Resident #1 back to the stood, pivoted, and sate adamant that Resider pain. Nurse #4 was set admission, helping re- incontinence briefs, a medications that she anything in the electro #4 also stated that she notify anybody about without injury or pain a The facility provided a Nurse #4 on 5/21/202 5/17/2025. The docur revealed the following called to Resident #1' the resident had faller Resident #1 was sittin by her bed. Resident going to the bathroom flat, and one leg off th Resident #1. NA #1 a wheelchair and took h Resident #1 stood up bathroom and NA #1	her wheelchair. NA #1 to the bathroom. Resident and sat on the commode. ent #1 stood, pivoted, and NA #1 then helped he bed, where Resident #1 at on the bed. Nurse #4 was int #1 was fine and in no bo busy with a new sidents eat, changing nd administering was not able to document onic medical record. Nurse e forgot to document or the fall but, Resident #1 was after the fall on 5/17/2025. A statement handwritten by 25 regarding the events of mentation on the statement g information. Nurse #4 was s room by NA #1 because h. When Nurse #4 arrived, ng up against the nightstand #1 stated that she fell while h. Resident #1 had one leg the floor. Nurse #4 asked her arms and legs and she bok the vital signs of ssisted Resident #1 into the her to the bathroom. holding onto the rail in the put her back into the		Nurse Consultant (SNC) or Administ or until compliance maintained. Plans to monitor its performance to sure that the solutions are sustained An AdHoc Quality Assurance Performance Improvement (QAPI) of will be held by 7/03/2025 to review Plan of Correction (POC). The Director of Health Services (DH present the analysis of the fall assessment audit compliance perce- to the Nursing Home Administrator Quality Assurance and Performance Improvement Committee meeting m until three consecutive months of compliance is maintained and then	strator, make d. review the HS) will entage at the e nonthly	
	EALTH-DURHAM SUMMARY ST/ (EACH DEFICIENCY REGULATORY OR I Continued From page the assistance of NA so off the floor and into h wheeled Resident #1 #1 stood up, pivoted, After finishing, Resider sat in the wheelchair. Resident #1 back to the stood, pivoted, and sa adamant that Resider pain. Nurse #4 was so adamant that Resider pain. Nurse #4 was so adamission, helping re- incontinence briefs, a medications that she anything in the electror #4 also stated that she notify anybody about without injury or pain The facility provided a Nurse #4 on 5/21/202 5/17/2025. The docur revealed the following called to Resident #1 <sup>1</sup> the resident had faller Resident #1 was sittir by her bed. Resident going to the bathroom flat, and one leg off th Resident #1 to move complied. Nurse #4 to Resident #1 stood up bathroom and NA #1 wheelchair. NA #1 as		EALTH-DURHAM       ID         SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)       ID         Continued From page 21       F 684         the assistance of NA #1, helped Resident #1 up off the floor and into her wheelchair. NA #1       F 684         wheeled Resident #1 to the bathroom. Resident #1 stood up, pivoted, and sat on the commode.       F 684         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 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	SALTH-DURHAM     3100 ERWIN ROAD DURHAM, NC 27705       SUMMARY STATEMENT OF DEFICIENCIES (REACH DEFICIENCY UNST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)     ID PROVIDERS FLAN OF CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY       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, 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 us 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 anything in the electronic medical record. Nurse #4 also stated that she forgot to document revealed the following information. Nurse #4 was called to Resident #1 stoad pivoted as the resident #1 stated that she fell while going to the bathroom. Resident #1 was without injury or pain after the fall on 5/17/2025. The following information. Nurse #4 wars called to 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 arrived, Resident #1 to move her arms and legs and she complianc. IN #1 assisted Resident #1 hack into wheelchair. NA #1 assisted Resident #1 hack into the bathroom and NA #1 put her back into the wheelchair. NA #1 assisted Resident #1 back into     Date of compliance: 07/04/2025	SATH-DURHAM     Stop ERWIN ROAD DURHAM, NC 27705       SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MAD THE PRECEDED BY FULL REGULATORY OR LSC DEFICIENCY REGULATORY OR LSC DEFICIENCY REGULATION OR LSC DEFICIENCY REGULATION OR LSC DEFICIENCY REGULATION OR REGULATION OR REGULATION OR REGULATION OR REGULATION OR REGULATION REGULATION OR REGULATION OR REGULATION OR REGULATION OR REGULATION OR REGULATION OR REGULATION REGULATION FOR A REGULATION OR REGULATION REGULATION OR REGULAT

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	MENT OF HEALTH AN						FORM	): 06/30/2025 MAPPROVED
STATEMENT (	S FOR MEDICARE & I	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í				(X3) DATE	0. 0938-0391 SURVEY LETED
		345061	B. WING			_		C 13/2025
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, ST	ATE, ZIP CODE		
PRUITTH	EALTH-DURHAM				100 ERWIN ROAD DURHAM, NC 27705			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORREC CROSS-REFEREN	EPLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 684	assessments, or notifi on 5/17/2025 for the 7 Resident #1 was inter 6/11/2025 at 3:31 PM remembered what hap 5/17/2025 in the even was going to the bath her foot twisted causin added that eventually her but not right away was picked up off the bed. Resident #1 indice any assessment of her vital signs. Resident # the bathroom after the to confirm the fall cau able to elaborate on the Nurse #2 was interviee PM. Nurse #2 confirm PM to 11:00 PM on 5/ she had no knowledge Resident #1 had faller Nurse #2 stated that s #1 took her nighttime complaints, and went Documentation on the Resident #1 had an o 5 milligrams (mg) of C administered as one t hours as needed for m to 6 out of 10. Oxycool pain medication used	ication of physician or family 7:00 AM to 7:00 PM shift. Inviewed over the phone on . Resident #1 confirmed she ppened when she fell on ing. Resident #1 stated she room with her cane when ing her to fall. Resident #1 someone came to assist 7. Resident #1 stated she floor and placed back into cated the nurse did not do er arms or legs nor take any 41 denied she was taken to e fall. Resident #1 was able sed her pain but was not hat. weed on 6/10/2025 at 2:38 hed she worked from 7:00 17/2025. Nurse #2 stated e on 5/17/2025 that in on the previous shift. she did recall that Resident medication, had no to sleep. e physician orders revealed rder initiated on 4/8/2025 for	F	684				

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	-	ID HUMAN SERVICES MEDICAID SERVICES					FORM	): 06/30/2025 MAPPROVED ). 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345061	B. WING			_		C 13/2025
NAME OF P	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, ST	ATE, ZIP CODE		
				31(	00 ERWIN ROAD			
PRUITTH	EALTH-DURHAM			DL	JRHAM, NC 27705			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	[	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION TIVE ACTION SHOULD B ICED TO THE APPROPRIA IEFICIENCY)		(X5) COMPLETION DATE
F 684	5/17/2025. There was documentation on the was administered to F Nurse #2 was intervie 1:31 PM. Nurse #2 re came to her to tell her #1 was in pain when t #2 confirmed she gav oxycodone pain medi Nurse #5 was intervie AM. Nurse #5 confirm PM to 7:00 AM shift b ending on 5/18/2025. not informed on 5/17// fall earlier that evenin Resident #1 slept and shift ending on the mo Documentation on a t revealed she worked to 3:10 PM on 5/18/20 corresponding nursing was assigned to care time. An interview was com Party (RP #1) for Res 2:06 PM. RP #1 provi information. RP #1, he children went to visit F of 5/18/2025. RP #1 to when she was stoppe explained that she ha #1 out of bed and to g knew that RP #1 wou outside. NA #1 then to	a no corresponding MAR to confirm the dose Resident #1. wed again on 6/11/2025 at vealed the nurse aides r on 5/17/2025 that Resident they provided care. Nurse re Resident #1 her ordered cation at her request. wed on 6/11/2025 at 7:27 hed she worked the 11:00 reginning on 5/17/2025 and Nurse #5 stated she was 2025 that Resident #1 had a g. Nurse #5 indicated thad no complaints on her prining of 5/18/2025. imesheet for NA #1 at the facility from 8:31 AM 025. Documentation on the g schedule revealed NA #1 for Resident #1 during that ducted with the Responsible ident #1 on 6/10/2025 at ded the following er husband, and her Resident #1 on the morning parely got down the hallway	F 6	84				

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	S FOR MEDICARE &	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPI F	ECONSTRUCTION		O. 0938-039 E SURVEY
	F CORRECTION	IDENTIFICATION NUMBER:			· · · ·	PLETED
			-			С
		345061	B. WING		06	6/13/2025
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD		
			3	100 ERWIN ROAD		
PRUITTH	EALTH-DURHAM			DURHAM, NC 27705		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES DY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETIOI DATE
E 004		24				
F 684	13		F 684			
		hat nobody had called to tell				
		P #1 went to see Resident #1				
		the fall. RP #1 stated that				
		d were trying to help Resident				
	- ·	eemed like she was in pain,				
		ear any weight. This was a				
		#1 because although she side she had always been				
		revealed she assisted				
		ing and then asked her about ne previous day. Resident #1				
		vas trying to get to the				
		wisted her left foot and fell.				
		#1 she did not hit her head.				
		#1 that a nurse and a nurse				
		o bed. RP #1 indicated				
	Resident #1 seemed					
		le. RP #1 stated she and her				
		ent #1 to the bathroom, but				
		able to stand or bear any				
		ted Resident #1 required her				
		up and hold her to get on and				
		k into the wheelchair. RP #1				
		se's desk and spoke to Nurse				
	#4. RP #1 told Nurse	#4 that Resident #1 told her				
		d she was now in pain. RP #1				
		like she didn't know what RP				
	#1 was talking about	. Nurse #4 told RP #1 that				
		mentioned anything about a				
		irse #4 stated she would				
	check and see if Res	ident #1 fell last night and				
	confirmed she did no	ot see anything about a fall in				
		al record. Nurse #4 went				
		's room and gave her pain				
		ot do any assessment or do				
		sident #1. RP #1 revealed				
	she told Nurse #4 that	at Resident #1 was unable to				
	-	eft side and Nurse #4 kept know what she was talking				

Facility ID: 923197

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DEPARTMENT OF HEALTH AND H CENTERS FOR MEDICARE & MEI					FORM	0: 06/30/2025 APPROVED 0. 0938-0391
	) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
	345061	B. WING		_	06/ <sup>,</sup>	C 13/2025
NAME OF PROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, ST	ATE, ZIP CODE		
PRUITTHEALTH-DURHAM			100 ERWIN ROAD DURHAM, NC 27705			
PREFIX (EACH DEFICIENCY MU	MENT OF DEFICIENCIES JST BE PRECEDED BY FULL IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 684       Continued From page 25         about or with any concert         #1 that Nurse #4 was the         room last night after the f         Resident #1 outside to ge         #1 seemed very sore any         and she required more at         Nurse #4 was interviewed         PM. Nurse #4 confirmed         to 7:00 PM shift on 5/18/2         that RP #1 came to the d         5/18/2025 and told her R         back pain. Nurse #4 state         that occurred on 5/17/202         all with RP #1. Nurse #4         was not injured so there of         #1 about the fall. Nurse #4         was not injured so there of         #1 about the fall. Nurse #4         was not injured so there of         #1 about the fall. Nurse #4         was not injured so there of         #1 about the fall. Nurse #4         was not injured so there of         #1 about the fall. Nurse #4         was not injured so there of         #1 about the fall. Nurse #4         was not injured so there of         #1 about the fall. Nurse #4         was not injured so there of         #1 about the fall. Nurse #5         Documentation on the morn         Documentation on the morn	n. Resident #1 told RP e nurse who was in the fall. RP #1 did take et some air but Resident vtime they moved her, ssistance than usual. d on 6/10/2025 at 6:41 she worked the 7:00 AM 2025. Nurse #4 stated lesk on the morning of vesident #1 was having ed that Resident #1's fall 25 was not discussed at stated that Resident #1 was no reason to tell RP f4 confirmed she dose of Oxycodone to ing of 5/18/2025. edication administration lurse #4 administered an one to Resident #1 on or a pain level of 8 out of d on 6/11/2025 at 9:07 she worked on to 11:00 PM. Nurse #6 on 5/18/2025 that 2025. Nurse #6 stated plain of any pain, nor did at all on 5/18/2025 on d on 6/11/2025 at 7:27 she worked the 11:00 nning on 5/18/2025 and	F 684				

Facility ID: 923197

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	0: 06/30/2025 APPROVED 0: 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345061	B. WING		_		C 13/2025
NAME OF P	ROVIDER OR SUPPLIER	L	ST	REET ADDRESS, CITY, ST	ATE, ZIP CODE		
			31	00 ERWIN ROAD			
PRUITTHI	EALTH-DURHAM		D	URHAM, NC 27705			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE) CROSS-REFEREI	PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 684	Continued From page	26	F 684				
	unaware on her shift t that Resident #1 had 5/17/2025. Nurse #5 sleeping during that s any pain.	that began on 5/18/2025 a fall the previous day on stated that Resident #5 was hift and did not complain of					
	and revealed the follo morning of 5/19/2025 Resident #1, so she s Hospice Nurse #1 firs #1 told Hospice Nurse fall on 5/17/2025 and Nurse #1 told RP #1 t first person she would see on 5/19/2025 in a	ed on 6/10/2025 at 2:06 PM wing information. On the RP #1 had concerns for sent a text message to it thing in the morning. RP e #1 that Resident #1 had a she was in pain. Hospice that Resident #1 was the d visit that day. RP #1 could a video call to Resident #1 of pain and was guarding her					
	visit note dated 5/19/2 "Received message f #1] had a fall over the [Resident #1's] room, Called out her name a without difficulty. Aske fall, [Resident #1] nam someone to help me f came, I did not want t using my cane, but m tripped over and fell of until an aide came to had an unwitnessed f consulted facility nurs stated that he had no previous shift. Since t pain of 5 to 8 on num able to assist in turnin	[Resident #1] was sleeping. and [Resident #1] woke up ed [Resident #1] about the rated saying, "I called for to bathroom, but no one to pee on myself, so I got up y left foot got caught and I on my left side. I lay there help me up." [Resident #1] fall on Saturday 5/17/2025, se for details but [Nurse #3]					

Facility ID: 923197

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391	
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED	
		345061	B. WING				C 13/2025	
NAME OF P	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE	·		
PRUITTHI	EALTH-DURHAM				3100 ERWIN ROAD DURHAM, NC 27705			
(X4) ID PREFIX TAG	X         (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)         PREFIX TAG         (EACH CORRECTIVE AC CROSS-REFERENCED TO				PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	CTION SHOULD BE COME D THE APPROPRIATE D		
F 684	had no bruising, swel #1] left side is the wei [Cerebral Vascular Ac provider [MD #1 (Phy management. Provide ordered STAT (immed hip. Called Mobile set collaborated with facil medication, to start wei acetaminophen. [Ress tachycardic in 111-113 oximetry, oxygen satu room air then after ref %. (Tachycardia is a ri- characterized by a raid defined as a resting hiper minute.) Called fa Hospice and not to we concern." Hospice Nurse #1 wa at 5:20 PM. Hospice I the case manager for Nurse #1 stated that of a text notifying her that over the weekend on #1 revealed she went Resident #1, and imm (Physician), who was looked at Resident #1 Hospice Nurse #1 call MD #1 (Physician) wa at 8:06 AM and reveal information. MD #1 we facility on 5/19/2025 we him and asked him to did an assessment of	ling, or hotness. [Resident ak side from history of ccident]. Asked the facility sician)] for further er did an assessment and diate) X-ray of left leg and rvice for STAT x-ray and lity nurse for pain ith [as needed] ident #1] was slightly 3 beats/minute with uration initially was 88 % on positioning it came up to 93 medical condition pid heart rate, typically heart rate of over 100 beats mily for update, to call ait next time there was a rs interviewed on 6/10/2025 Nurse #1 revealed she was r Resident #1. Hospice on 5/19/2025 RP #1 sent her at Resident #1 had a fall 5/17/2025. Hospice Nurse to the facility, assessed hediately contacted MD #1 in the building. MD #1 I and ordered a STAT x-ray. lled mobile x-ray.	F	684				

Facility ID: 923197

If continuation sheet Page 28 of 44

PRINTED: 06/30/2025

	-	D HUMAN SERVICES MEDICAID SERVICES					FORM	0: 06/30/2025 APPROVED 0. 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	i í		E CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345061	B. WING			_		C 13/2025
NAME OF PI	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, ST	ATE, ZIP CODE		
				3	3100 ERWIN ROAD			
PRUITTHE	EALTH-DURHAM			0	DURHAM, NC 27705			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORRE) CROSS-REFEREI	S PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 684	MD #1 was certain that fracture, so he ordered hip and made sure that medication ordered at requested to be contar x-ray came back for full Nurse #3 was interviee PM and provided the #3 worked from 7:00 / 5/19/2025. Nurse #3 v #1 that Resident #1 h that MD #1 had order hip. Nurse #3 stated t contacted the mobile taken on his shift on t Resident #1 was in pather pain medication. I notified Nurse #2, the Resident #1 had a fail waiting on the x-ray resident #1 revealed dose of the ordered C 5/19/2025. There was documentation on the was administered to F NA #3 was interviewe and revealed the follo was assigned to care 5/19/2025 for the 7:00 had not worked that w back to work on 5/19/ Resident #1 had a fail was in pain, and he to	at Resident #1 had a d a STAT x-ray of her left at Resident #1 had pain and available. MD #1 acted when the results of the urther orders. weed on 6/10/2025 at 2:53 following information. Nurse AM to 3:00 PM on was told by Hospice Nurse ad a fall on 5/17/2025 and ed a STAT x-ray of her left hat Hospice Nurse #1 x-ray, and the x-ray was he morning of 5/19/2025. ain on his shift, and he gave Nurse #3 stated that he next shift nurse, that I and the facility was still esults. controlled drug record for Nurse #3 removed one Dxycodone at 9:00 AM on er dose at 2:00 PM on a no corresponding MAR to confirm the dose Resident #1. d on 6/10/2025 at 1:04 PM wing information. NA #3 for Resident #1 on D AM to 3:00 PM shift. NA #3 veekend, but when he came	F	684				

Facility ID: 923197

If continuation sheet Page 29 of 44

OLIVIEI	S FOR MEDICARE &					O. 0938-039	
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		E SURVEY IPLETED	
		345061	B. WING		C 06/13/2025		
NAME OF P	ROVIDER OR SUPPLIER	I		STREET ADDRESS, CITY, STATE, ZIP CODE			
PRUITTHI	EALTH-DURHAM			3100 ERWIN ROAD DURHAM, NC 27705			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY)	OULD BE	(X5) COMPLETIOI DATE	
F 684	Resident #1 for incon and it was hard. NA # Resident #1 through turn because she was Documentation on the 5/19/2025 revealed R acute impacted left fe x-ray results were fax on 5/19/2025. Nurse #2 was intervie PM and revealed the #2 worked from 3:00 5/19/2025. Nurse #2 the start of her shift th over the weekend. No was also the facility w some point in her shift	tinent care, she was in pain, 43 stated he had to talk it. Resident #1 didn't want to s in pain. e x-ray results dated Resident #1 had sustained an emoral neck fracture. The ted to the facility at 2:50 PM ewed on 6/10/2025 at 2:38 following information. Nurse PM to 11:00 PM on stated she was not aware at nat Resident #1 had a fall urse #2 explained that she yound care nurse and that at ft she went to the fax	F 684				
	went through all the f machine, and she no Resident #1. Nurse # happened to Residen point in the shift, wen why she had an x-ray oriented. Resident #1 days ago. Nurse #2 to pain assessment. Nu nurse aides that Resi when they turned her Nurse #2 stated she Resident #1. Nurse # Resident #1 first arriv weak and could not g Gradually Resident # confidence and used bathroom. Resident #	d care orders. Nurse #2 axes that were on the fax ted the x-ray results for 2 did not know anything had it #1. Nurse #2, at some t to Resident #1 to ask her v because she was alert and told Nurse #2 she fell a few ook her vital signs and did a rse #2 was alerted by the dent #1 was in extreme pain for incontinence care. gave pain medication to 2 explained that when red at the facility she was ret up to go to the bathroom. 1 gained strength and her cane to go to the fad to keep reminding her					

Facility ID: 923197

If continuation sheet Page 30 of 44

		ID HUMAN SERVICES MEDICAID SERVICES				FORM	2: 06/30/2025 1 APPROVED 2: 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` <i>`</i>	PLE CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345061	B. WING		_	( /06/	; 13/2025
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, ST	TATE, ZIP CODE		
PRUITTHE	ALTH-DURHAM			3100 ERWIN ROAD DURHAM, NC 27705			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 684	was a change for Res and to be provided winurse aides. Nurse #2 with the x-ray results on 5/19/2025. The on Resident #1 was stab provider that Residen only in pain when she incontinent care. The #2 to follow up with the morning. Nurse #2 was intervie 1:31 PM. Nurse #2 co have told her Resider out for the x-ray resul 5/19/2025. Nurse #2 co have told her Resider out for the x-ray resul 5/19/2025. Nurse #2 co have told her Resider out for the x-ray resul 5/19/2025. Nurse #2 co have told her Resider out for the x-ray resul 5/19/2025 at 12:09 Al revealed the following fell a few days ago ar turned from side to sig medication for breaktd area. The left hip x-ra Resident #1 was note impacted left femoral after-hours provider w after-hours provider s stable, to follow up in practitioner.	kk for help to go to the ld not fall. Nurse #2 noted it sident #1 to be incontinent th incontinent care by the 2 called the on-call physician because it was after hours -call provider asked if le. Nurse #2 told the on-call t #1 was stable and was a was moved or turned for on-call provider told Nurse the regular provider in the eved again on 6/11/2025 at onceded that Nurse #3 may at #1 had a fall and to watch ts at the change of shift on reiterated that she became sults at an unknown time sponsibilities that day as the the facility. ursing progress note dated M written by Nurse #2 g information. Resident #1 ad was in pain when she was de. Resident #1 received hrough pain in the left hip y results were received, and ed to have an acute hip neck fracture. The vas contacted. The tated that if the resident was the morning with the nurse	F 68				
	stable, to follow up in practitioner. Documentation on a c	the morning with the nurse					

Facility ID: 923197

If continuation sheet Page 31 of 44

DEPARTMENT OF HEAI CENTERS FOR MEDICA							FORM	): 06/30/2025 MAPPROVED ). 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345061	B. WING			_		C 13/2025
NAME OF PROVIDER OR SUPPL	IER		•	S	TREET ADDRESS, CITY, ST	ATE, ZIP CODE		
				3.	100 ERWIN ROAD			
PRUITTHEALTH-DURHAM			DURHAM, NC 27705					
PREFIX (EACH DE	FICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD BI ICED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
5/19/2025. The documentation was administer An interview w 6/11/2025 at 8 information was care for Reside until 7:00 AM of #6 that she fell what happener oriented. Resid go to the bathr fell. Resident # nurse aide picl #6 asked if RP said no. NA #6 to provide incor was in pain wh he left the roor Resident #1 ha was in pain. Ni no documenta sustained by F #6 returned to that if she neer he could not he like he usually crying in pain a provide inconti he told Nurse # was in pain wh	lered C ere was on the red to F as con 57 AM s provi- ent #1 o on Sa d beca d b	Dxycodone at 9:15 PM on a no corresponding MAR to confirm the dose Resident #1. ducted with NA #6 on and the following ded. NA #6 was assigned to on 5/19/2025 from 3:00 PM /2025. Resident #1 told NA turday. NA #6 asked her use she was alert and told him she was trying to nd her foot twisted, and she NA #6 that a nurse and a r up and put her in bed. NA s called and Resident #1 another nurse aide for help care for her because she was moved. NA #6 stated mediately tell Nurse #2 that I over the weekend and she told NA #6 that there was the electronic record of a fall t #1 over the weekend. NA ent #1's room and told her wed pan to call him because out of bed to the bathroom A #6 said Resident #1 was had to roll her little by little to are for her. NA #6 revealed Resident #1 had a fall and	F	684		)EFICIENCY)		

Facility ID: 923197

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FOR	M APPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		345061	B. WING				C 13/2025
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
PRUITTH	EALTH-DURHAM				3100 ERWIN ROAD DURHAM, NC 27705		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 684	residents, one of the 1 #5 and told her Resid she was moved durin knew Resident #1 has because she was rec Nurse #5 revealed sh Oxycodone to Reside dose of Oxycodone w Resident #1, and it was Documentation on the administered a dose of #1 on 5/20/2025 at 5: out of 10. Documentation on the ordered Oxycodone fo 5/20/2025 revealed th by Nurse #5 was refu Documentation in the dated 5/20/2025 at 7: revealed the nurse pr order to send Residen for a left femoral neck The nurse practitione on 5/30/2025, did not interview. Documentation in the written as a late entry Nurse #3 for 5/19/202 an x-ray completed do increased pain in the Documentation on an Services record dated	nurse aides came to Nurse lent #1 was grimacing when g care. Nurse #5 stated she d an order for Oxycodone eiving Hospice services. the offered a dose of ent #1, but she refused. The vas not administered to as wasted. The MAR revealed Nurse #5 of Oxycodone to Resident 49 AM for a pain level of 10 the controlled drug record for or Resident #1 dated the Oxycodone dose offered sed. Thursing progress notes 25 AM written by Nurse #5 actitioner gave a verbal th #1 to the emergency room a fracture. The whose employment ended respond to requests for an the nursing progress notes on 5/20/2025 at 7:43 AM by 25 revealed Resident #1 had ue to complaints of left thigh.	F	684			

Facility ID: 923197

If continuation sheet Page 33 of 44

PRINTED: 06/30/2025

CENTER	S FOR MEDICARE & I	D HUMAN SERVICES MEDICAID SERVICES				FORM OMB NC	0: 06/30/2025 APPROVED 0: 0938-0391
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /				
		345061	B. WING		_		_ 13/2025
NAME OF P	ROVIDER OR SUPPLIER			TREET ADDRESS, CITY, ST	ATE, ZIP CODE		
PRUITTH	EALTH-DURHAM		-	100 ERWIN ROAD DURHAM, NC 27705			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFERE	EPLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 684	to only be in pain whe medication during tran The documentation of discharge summary d Resident #1 underwe femur fracture. It was femur fracture would lin the long term. Resif facility. An interview was condo 6/10/2025 at 11:31 AN Resident #1 was releas she returned to the fa day because she was that the hospital was to bed in another facility An interview was condo 6/10/2025 at 2:06 PM results revealing Resif not conveyed to her up the concern that Resif transfer to the hospita 5/23/2025 she contact her opinion that Nurse confirmed that Resider returning to the facility unable to find another discharge from the hospita confirmed that Resider returning to the facility unable to find another discharge from the hospita sisk for falls related to generalized weakness cerebral vascular acc	tal. Resident #1 was noted on moved and declined pain insport. In Resident #1's hospital ated 5/28/2025 revealed int surgery to repair her noted that a non-operative have led to significant pain dent #1 was to return to the ducted with RP #2 on M. RP #2 stated that when ased from the hospital and cility the resident cried every is scared. RP #2 explained not able to secure another prior to her discharge. ducted with RP #1 on . RP #1 stated that x-ray dent #1 had a fracture were intil 5/20/2025. RP #1 had dent #1 was in pain until a al. RP #1 revealed on ted the facility to express is #4 was neglectful. RP #1 ent #1 was not happy about y, but the hospital was facility at the time of her ospital. are plan for Resident #1 o revealed a focus area for a	F 684				

Facility ID: 923197

If continuation sheet Page 34 of 44

	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE (	CONSTRUCTION		O. 0938-039		
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:			· · ·	IPLETED		
						С		
		345061	B. WING			6/13/2025		
NAME OF P	ROVIDER OR SUPPLIER			REET ADDRESS, CITY, STATE, ZIP COD	DE			
PRUITTHE	EALTH-DURHAM			00 ERWIN ROAD JRHAM, NC 27705				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE APPROPRIATE	(X5) COMPLETION DATE		
F 684	Continued From page	e 34	F 684					
	-	bach added on 5/28/2025						
		to be reminded to call for						
	assistance with trans	fers.						
	Decumentation in the	electronic medical record						
		was transferred to another						
	facility on 6/6/2025.							
		strator, whose employment						
		on 6/6/2025, did not respond						
	to requests for an inte							
	The facility Medical D	Pirector, was interviewed on						
		l via telephone. The Medical						
	Director revealed that	-						
		cord he was able to see that complaints of pain and						
	received very little pa							
		25. The Medical Director						
		cumentation for the fall on						
	· ·	The Medical Director stated						
		It #1 had an underlying issue						
		er left side that delayed her required treatment. The						
		indicated that he was aware						
		erred Resident #1 to the						
		ning of 5/18/2025 and may						
		the resident. The Medical						
	Director felt the x-ray							
		ent #1 being sent to the of the fracture on 5/20/2025						
	-	me frame for a resident on						
		expressing any pain. The						
	Medical Director prais	sed the Hospice services for						
	assuring Resident #1 treatment.	received assessment and						
	An interview was con	ducted on 6/13/2025 at 1:11						
	PM with the current ir	staring Director of Nursing						

Facility ID: 923197

If continuation sheet Page 35 of 44

	MENT OF HEALTH AN S FOR MEDICARE & I					FORM	D: 06/30/2025 MAPPROVED D. 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING		(X3) DATE COMP	SURVEY PLETED	
		345061	B. WING		_		C 13/2025
NAME OF P	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, ST	ATE, ZIP CODE		
PRUITTHE	EALTH-DURHAM			100 ERWIN ROAD URHAM, NC 27705			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	B PLAN OF CORRECTION CTIVE ACTION SHOULD B NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
	(DON), who initiated e on 5/27/2025. The DC aware of the facility in by the previous Admir employment. The DO the nursing staff would had a fall and if there to contact the provide the DON had the expe- would be made to cor who had fallen. The D nursing station had di steps needed to be ta including assessment and charting. The DO expected communicat nurses to make sure of to a provider as soon The facility provided a past non-compliance the state agency due into place for communi- shifts, education of ex- audits, and monitoring Resident Records - Ic CFR(s): 483.20(f)(5), §483.20(f)(5) Resider (ii) The facility may not re- resident-identifiable to accordance with a con- agrees not to use or co-	employment with the facility DN explained she was made vestigation for Resident #1 histrator at the start of her N stated she expected that d assess a resident who has was a serious medical issue r and herself. In addition, ectation that an attempt fact the family of a resident ON elaborated that each rections at the desk for what ken when a resident falls, , notification of provider, N also stated that she tion to occur between k-ray results were conveyed as received. draft plan of correction for that was not acceptable to to a lack of measures put hication between nursing spectations for nurse aides, g of compliance. entifiable Information 483.70(h)(1)-(5) t-identifiable information. elease information that is o the public. lease information that is	F 684				7/4/25

Event ID: YJ1711

Facility ID: 923197

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	0: 06/30/2025 APPROVED 0: 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · ·	CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345061	B. WING		_	( 06/	) 13/2025
NAME OF PI	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, ST	ATE, ZIP CODE		
DDUUTTU			3	100 ERWIN ROAD			
PRUITINE	ALTH-DURHAM		C	OURHAM, NC 27705			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 842	§483.70(h) Medical re §483.70(h)(1) In acco professional standard must maintain medica that are- (i) Complete; (ii) Accurately docume (iii) Readily accessible (iv) Systematically org §483.70(h)(2) The fac all information contain regardless of the form records, except when (i) To the individual, o representative where (ii) Required by Law; (iii) For treatment, pay operations, as permitt with 45 CFR 164.506; (iv) For public health a neglect, or domestic v activities, judicial and law enforcement purp purposes, research pur medical examiners, fu a serious threat to hea by and in compliance §483.70(h)(3) The fac record information agai unauthorized use. §483.70(h)(4) Medica for- (i) The period of time	ecords. rdance with accepted s and practices, the facility al records on each resident ented; e; and janized willty must keep confidential hed in the resident's records, or storage method of the release is- r their resident permitted by applicable law; wment, or health care ed by and in compliance activities, reporting of abuse, violence, health oversight administrative proceedings, oses, organ donation urposes, or to coroners, ineral directors, and to avert alth or safety as permitted with 45 CFR 164.512.	F 842				

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	OF DEFICIENCIES	MEDICAID SERVICES	(X2) MI II TI	PLE CONSTRUCTION		D. 0938-039 SURVEY	
	CORRECTION	IDENTIFICATION NUMBER:	· · ·	G		COMPLETED	
			A. BOILDIN	5		С	
		345061	B. WING				
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C		13/2023	
				3100 ERWIN ROAD			
PRUITTHE	EALTH-DURHAM			DURHAM, NC 27705			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETIO DATE	
F 842	Continued From page	o 27		10			
1 042	Continued From page		F 84	42			
	(III) For a minor, 3 ye legal age under State	ars after a resident reaches e law.					
	\$483 70(h)(5) The m	edical record must contain-					
		ion to identify the resident;					
		sident's assessments;					
	(iii) The comprehens	ive plan of care and services					
	provided;						
	(iv) The results of an	y preadmission screening					
	and resident review e						
	determinations condu	-					
		s, and other licensed					
	professional's progre						
		logy and other diagnostic equired under §483.50.					
		Γ is not met as evidenced					
	by:						
	-	iew and staff interviews, the		Corrective action for the re	esidents found		
		ively document in the		to be affected by the deficie			
	electronic medical re	cord for conveyance of		The facility failed to ensure	that staff		
	medical information f	or two (Resident #1 and		effectively documented in t	he electronic		
		e residents reviewed for		medical record (EMR) for F	Resident⊡s #1.		
	accidental falls. Resident #1 lacked initial			The occurrence was report			
		all by Nurse #4, initial		Carolina Department of He			
	physical assessment			Human Services on 05/23/			
	administration of pair and Nurse #3. Resid	n medication by Nurse #2		allegation of neglect. Nurse reported to the North Carol			
		administration of pain		Nursing for substantiated a			
		#5. Resident #5 lacked		neglect on 05/23/2025 and	-		
		ursing physical assessment		terminated on 05/25/2025.	omploymone		
	after a fall. Findings i			The facility failed to ensure	that staff		
	_			effectively documented in t			
		on a timesheet for Nurse		medical record (EMR) for F			
	, ,	d she worked at the facility		06/11/2025; fall documenta			
	from 7:18 AM to 10:5			will be completed by 07/03			
	Documentation on th	e corresponding nursing		#5 did not have any injury of	or change from		
		A #1 was assigned to care		baseline noted. The facility failed to ensure	that staff		

Facility ID: 923197

			000			O. 0938-03	
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /			(X3) DATE SURVEY COMPLETED	
			A. BUILDING	3		С	
		345061	B. WING		06/13/2025		
NAME OF P	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE			5/15/2025	
				3100 ERWIN ROAD			
PRUITTH	EALTH-DURHAM			DURHAM, NC 27705			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETIO DATE	
F 842			F 84				
		ed on 6/10/2025 at 11:54 AM.		drugs on both the Controlled Dru	-		
	NA #1 revealed the fo	-		and the Medication Administratio	on Record		
		II on 5/17/2025. NA #1 heard		(MAR) to confirm the dose was	a that		
	Resident #1 fall, and	she told nurse #4.		administered and failed to ensur documentation on the MAR was			
	Nurse #4 was intervia	ewed on 6/10/2025 at 6:41		completed only after the control			
		following information. Nurse		substance was administered. No			
		M to 7:00 PM shift on		will be education on documenta			
		#1 fell on 5/17/2025 while		administration of controlled drug			
		throom. Nurse #4 did full		07/03/2025.	<b>J</b>		
		ssments of all her limbs and					
		Resident #1. Nurse #4, with		Corrective action for other reside	ents		
	the assistance of NA	#1, helped Resident #1 up		having the potential to be affected	ed by the		
		her wheelchair. Nurse #4		same deficient practice.			
		ew admission, helping		Fall ongoing assessment, identi			
	-	ng incontinence briefs, and		change-in-condition and commu			
	Ū	ations that she was unable to		will be audited for the past ten (			
		the electronic medical		for timely notification and treatm			
		o stated that she forgot to		Provider(s), RP and Oncoming-			
		e assessment, or notify Il but, Resident #1 was		Nurse by the Director of Health (DHS), Clinical Competency Co			
		after the fall on 5/17/2025.		(CCC), Unit Manager (UM), Unit			
				Coordinator (UC), Infection Prev			
	There was no docum	entation in Resident #1's		(IP), Nurse Navigator/Senior Ca			
	electronic medical re			(NN/SCP), Case Mix Director (C			
		fication of physician or family		Case Mix Coordinator (CMC), S	,		
		7:00 AM to 7:00 PM shift.		Nurse Consultant (SNC) or Adm by 7/3/2025.			
	Nurse #4 was intervie	ewed on 6/10/2025 at 6:41		A controlled drug documentation random			
		ned she worked the 7:00 AM		sample audit of three (3) records			
		/18/2025. Nurse #4 revealed		nursing unit, will be completed b			
		sy caring for the residents on		Director of Health Services (DH			
		t document any information		Competency Coordinator (CCC)			
	about the fall in the e	lectronic medical record.		Manager (UM), Unit Coordinator Infection Preventionist (IP), Nurs			
	b. Documentation on	the physician orders		Navigator/Senior Care Partner (			
		had an order initiated on		Case Mix Director (CMD), Case			
		ams (mg) of Oxycodone to		Coordinator (CMC), Senior Nurs			
	he administered as a	ne tablet by mouth every 4		Consultant (SNC) or Administrat	or for	1	

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		MEDICAID SERVICES				NO. 0938-03		
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			· · ·	(X3) DATE SURVEY COMPLETED		
			A. BUILDING	S		С		
		345061	B. WING			06/13/2025		
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		JO/ 13/2025		
				3100 ERWIN ROAD				
PRUITTH	EALTH-DURHAM			DURHAM, NC 27705				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF	HOULD BE	(X5) COMPLETIC DATE		
IAG	REGULATORTORT		IAG	DEFICIENCY)	THOTHAT			
F 0.40								
F 842	· · · · · · · · · · · · · · · · ·		F 84					
		moderate pain at a level of 4		administration of controlled drug				
		done is a prescription opioid		the Controlled Drug Record and				
	•	as used to relieve severe		Medication Administration Reco	ord (MAR)			
	pain.			by 07/03/2025.				
	Documentation on a (	controlled drug record for		Systemic changes made to ens	ure that			
		Nurse #2 removed one		the deficient practice will not red				
		exycodone at 9:15 PM on		Licensed Nursing education rec				
	5/17/2025. There was			ongoing assessment; identifying				
		e Medication Administration		in condition requiring medical e				
	Record (MAR) to con			and treatment; communication				
	administered to Resid			effectively provide treatment wil				
				provided by the Director of Hea				
	Nurse #2 was intervie	ewed again on 6/11/2025 at		Services (DHS), Clinical Compe				
		evealed the nurse aides		Coordinator (CCC), Unit Manag				
	came to her to tell he	r on 5/17/2025 that Resident		Unit Coordinator (UC), Infection				
		they provided care. Nurse		Preventionist (IP), Nurse Naviga				
	-	ve Resident #1 her ordered		Care Partner (NN/SCP), Case I				
		lication at her request. Nurse		Director (CMD), Case Mix Coor				
		e got busy and forgot to		(CMC), Senior Nurse Consultar				
		ument on the MAR that she		Administrator and completed b	. ,			
	administered Oxycod			07/03/2025. Any staff that have	-			
				completed the education will be				
	c. Documentation on	a controlled drug record for		from the schedule and will be e				
		Nurse #3 removed one		prior to returning to work. New				
	dose of the ordered C	Dxycodone at 9:00 AM on		educated on the fall notification				
	5/19/2025 and anothe	er dose at 2:00 PM on		during orientation.				
	5/19/2025. There was			All licensed nurses will be educ	ated on			
		MAR to confirm the dose		controlled substance administra	ation			
	was administered to F	Resident #1.		documentation by the Director of	of Health			
				Services (DHS), Clinical Compe	etency			
	Nurse #3 was intervie	ewed on 6/11/2025 at 11:05		Coordinator (CCC), Unit Manag	jer (UM),			
		ned he administered the		Unit Coordinator (UC), Infection				
	doses of Oxycodone	to Resident #1 at 9:00 AM		Preventionist (IP), Nurse Navig	ator/Senior			
	on 5/19/2025 and at 2	2:00 PM on 5/19/2025.		Care Partner (NN/SCP), Case I				
	Nurse #3 stated he ei	ither forgot to document the		Director (CMD), Case Mix Coor				
		medication or just didn't		(CMC), Senior Nurse Consultar	. ,			
	document it because	he was busy.		Administrator, by 07/03/2025.				
				that have not completed the ed	upotion will			

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TATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING				
		345061	B. WING		C 06/13/2025		
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	1 00,	10/2020	
PRUITTHI	EALTH-DURHAM			3100 ERWIN ROAD DURHAM, NC 27705			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETIOI DATE	
F 842	Continued From page	e 40	F 842	2			
1 0 12	<ul> <li>d. Documentation on Resident #1 revealed dose of the ordered C 5/19/2025. There was documentation on the was administered to F</li> <li>Nurse #2 was intervie 1:31 PM. Nurse #2 cc Oxycodone to Reside 5/19/2025. Nurse #2 document the administic MAR, but she must h follow through.</li> <li>Nurse #5 was intervie AM and revealed the #5 worked the 11:00 ended on 5/20/2025. the nurse aides provio residents, one of the #5 and told her Resid she was moved durin knew Resident #1 ha because she was rec Nurse #5 revealed sh Oxycodone to Reside dose of Oxycodone w Resident #1, and it w</li> <li>Documentation on the administered a dose of #1 on 5/20/2025 at 5: out of 10.</li> </ul>	a controlled drug record for Nurse #2 removed one Dxycodone at 9:15 PM on s no corresponding MAR to confirm the dose Resident #1. weed again on 6/11/2025 at onfirmed she did administer ent #1 at 9:15 PM on revealed she normally did stration of medication on the ave gotten busy and didn't weed on 6/11/2025 at 7:27 following information. Nurse PM to 7:00 AM shift that On the last rounds where ded incontinence care to the nurse aides came to Nurse lent #1 was grimacing when g care. Nurse #5 stated she d an order for Oxycodone eiving Hospice services. the offered a dose of ent #1, but she refused. The vas not administered to as wasted. e MAR revealed Nurse #5 of Oxycodone to Resident 49 AM for a pain level of 10 e controlled drug record for		<ul> <li>be removed from the schedule and educated prior to returning to work. staff will be educated on the fall notification process during orientation process during contract (a) residents will be audited five (5): weekly x four (4) weeks, then two (residents will be audited weekly x four (4) weeks by Director of Health Services (DHS), Competency Coordinator (CCC), U Manager (UM), Unit Coordinator (CCC), U Manager (UM), Unit Coordinator (CMD), Case Mix Director (CMD), Case Mix Coordinator (CMC), Senior Nurse Consultant (SNC) or Administrator, compliance maintained. An AdHoc Quality Assurance Performance Improvement (QAPI) will be held by 07/03/2025 to review Plan of Correction (POC). This deficiency and the POC will be reviewed at the center s monthly 0 meeting for the next three months beginning July 2025.</li> <li>Date of compliance: 07/04/2025</li> </ul>	New on. make d. colled x 2) our (4) the Clinical nit IC), /SCP), x or until review v the		

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	-	ID HUMAN SERVICES					FORM	): 06/30/2025 MAPPROVED	
STATEMENT C	DF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING				OMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED		
		345061	B. WING _			_		C 13/2025	
NAME OF PF	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, ST	ATE, ZIP CODE			
DDUUTTUE				3	100 ERWIN ROAD				
PRUITINE	ALTH-DURHAM			D	URHAM, NC 27705				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	×	(EACH CORRE) CROSS-REFERE	EPLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 842	Continued From page	÷ 41	F	342					
	Nurse #5 was intervie	ewed again on 6/11/2025 at							
		explained that the nurse							
		tell her Resident #1 was in							
	pain when they turned								
		locked box, signed out the							
		ntrolled drug record, and AR that she administered							
	the medication to Res								
	explained that Reside								
		nedication was wasted in							
		rse #5 further explained that							
	after she documented								
		lent #1 on the MAR, there							
	was no way of undoin	g it that she knew of.							
	facility Medical Direct	sident #1, who was also the or (MD #2), was interviewed							
		AM via telephone. MD #2							
	revealed that after loc	s able to see that Resident							
	#1 had no complaints								
		ed very little pain medication							
		9/2025. MD #2 conceded							
	that the documentation	on for the fall on 5/17/2025							
	was poor.								
		ng (DON), who initiated her							
		facility on 5/27/2025, was 025 at 10:33 AM. The DON							
	explained that the pro								
		cumentation was as follows:							
		cation, make sure it was the							
		ct drug, correct dose, sign							
		cation on the controlled							
		Iminister the medication,							
	and then document or further explained that	-							
	-	less of the medication and							

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	): 06/30/2025 MAPPROVED ). 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345061	B. WING		_		C 13/2025
NAME OF PI	ROVIDER OR SUPPLIER		5	STREET ADDRESS, CITY, ST	ATE, ZIP CODE		
PRUITTHE	ALTH-DURHAM			100 ERWIN ROAD DURHAM, NC 27705			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE) CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 842	explained that she ex follow the fall risk che every nursing station the required documer expected that the nur- their assessments to	MAR.	F 842				
	dated 6/11/2025 at 11 #10 revealed Resider from his wheelchair o The documentation fu denied pain, did not h assisted back to bed. responsible party and documented. There w nursing progress note assessment or any as A Review of the elector reveal any recording of for the time period for Resident #5.	Notification of the the provider was also vas no documentation in the e of any range of motion essessment of vital signs. ronic medical record did not of vital signs on 6/11/2025					
	9:01 AM on 6/13/2028 was new to the electro	ducted with Nurse #10 at 5. Nurse #10 revealed she onic medical record system nad been employed at the					

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	-	ID HUMAN SERVICES MEDICAID SERVICES					FORM	D: 06/30/2025 MAPPROVED D. 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345061	B. WING			_		C 13/2025
NAME OF P	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, ST	ATE, ZIP CODE		
PRUITTHEALTH-DURHAM					100 ERWIN ROAD URHAM, NC 27705			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	×	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD BE ICED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 842	facility for four months did take the vital signs fell on 6/11/2025 in ac range of motion asses assisting him back to she thought she docu Resident #10 on the s documented notificati unable to recall which confirmed Resident # performed her assess he fell. An interview with the 6/13/2025 at 1:11 PM expected that the nurs risk cheat sheet poste for directions and listi documentation after a that the nursing staff.	s. Nurse #10 confirmed she s of Resident #5 when he ddition to performing the ssments on his limbs before bed. Nurse #10 indicated mented her assessments of same form for which she on of the physician but was form that was. Nurse #10 5 was uninjured when she sments on 6/11/2025 after DON was conducted on . The DON explained she sing staff to follow the fall ed at every nursing station ng of the required a fall. The DON expected would document their de vital signs and range of	F	842				

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