STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345061	A. BUILDING _____ B. WING _____	C 05/27/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 241 SS=D	483.10(a)(1) DIGNITY AND RESPECT OF INDIVIDUALITY (a)(1) A facility must treat and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life recognizing each resident's individuality. The facility must protect and promote the rights of the resident. This REQUIREMENT is not met as evidenced by: Based on record review, resident, staff and family interview a facility nurse aide failed to provide care in a respectful manner for 2 (Resident #1 and Resident #3) of 4 dependent residents reviewed for dignity during care. Findings include: 1. Resident #1 had a diagnosis of cerebral vascular accident. Resident #1 had an annual minimum data set assessment dated 4/25/17 and was coded as having modified independence in cognitive skills for daily decision making and as having memory problems. She was coded as requiring extensive assistance of two or more people with transfers. The care plan for Resident #1, dated as last updated on 5/8/17, revealed, "Resident has difficulty making self-understood r/t (relative to) unclear speech and cognitive deficits. Dx (diagnosis) aphasia." One of the interventions stated, "Calm her and be patient with communication." An interview was conducted with Resident #4, the roommate of Resident #1, on 5/27/17 at 10:10 AM. Resident #4 was assessed on 1/11/17 on a brief interview for mental status as being cognitively intact. Resident #4 revealed, "My	F 241	This plan of Correction constitutes the facilities written allegation of compliance for the deficiencies cited. However, submission of this plan of correction is not an admission that deficiencies exist or that one was cited correctly. This plan of correction is submitted to meet requirements established by federal and state law. Residents affected: Residents #1 and #3 are now receiving care with dignity and respect based on interview conducted by Administrator on 5/29/2017. Nurse Aide (NA) #1 is no longer employed by the facility as of 5/22/2017. Residents with potential to be affected: All residents will continue to be treated with dignity and respect as stated in Residents Rights. A questionnaire regarding resident rights including dignity and respect was conducted and completed on 5/30/2017 by the Social Worker with 100% of all alert	6/11/17

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

Electronically Signed | 06/07/2017

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345061	A. BUILDING _____ B. WING _____	C 05/27/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 241	Continued From page 1 roommate is very sweet but she can't talk very well. I understand her and she can answer simple yes and no questions. She can't really communicate. [Nurse Aide (NA) #1] came in to change [Resident #1] and she laid her down on the bed. The bed was saturated but [NA #1] did not notice. She changed [Resident #1] and put her back in the wheel chair. [NA #1] left the room and I noticed [Resident #1] was still wet. Her pant leg was dripping. I asked [Resident #1] if she was still wet and she nodded yes. I put on my light and [NA # 1] came back in the room and I told her [Resident #1] was wet. She said to [Resident #1], "I just changed you what is going on?" I told [NA #1] she had laid her on a wet bed. [NA #1] shut the door and I heard her say to [Resident #1], "If you just wouldn't pee so much I wouldn't have to keep changing you." [NA #1] was trying to transfer [Resident #1] on her own, but [Resident #1] couldn't stand up. [NA #1] couldn't do it so she hollered out in frustration, "Come on [Resident #1], you have got to help me." She then screamed, swore, went and hit the bathroom door and went into the bathroom talking and muttering in there. [NA #1] came out of the bathroom and said she would be back and left the room. She didn't come back. [Resident #1] started crying and I talked to her trying to calm her down. I told her it would be alright. It scared her and it scared me. The nursing supervisor came to talk to us and helped to calm [Resident #1] down." An interview was conducted with the responsible party for Resident #1 on 5/27/17 at 11:07 AM. The responsible party revealed, "I visit [Resident #1] twice a day. On May 7, (2017) I came to visit [Resident #1] after I got off work at 3:00 PM. [Resident #1] is nonverbal but I understand her. She looked upset. I asked her what was wrong	F 241	and oriented residents to include resident #1 and #3 to ensure residents are treated in a dignified and respected manner. The Administrator, the Director of Nursing (DON) immediately addressed all identified areas of concerns from the questionnaire. Systemic changes: An in-service on dignity and respect was initiated on 5/29/2017 by the Clinical Competency Coordinator, Administrator and, DON for 100% of all staff to include Nurse Aides, Licensed Nurses, Dietary staff, Therapy staff, and all non-licensed staff. The in-service will be completed on 6/11/2017. Staff members who have not completed the in-service will not be allowed to work until they are in serviced. The Clinical Competency Coordinator will educated/in service all newly hired staff on dignity and respect during new hire orientation. A dignity and respect questionnaire will be completed with 10% of all alert and oriented residents to include resident #1 and #3 by the Social Worker weekly for 4 weeks then monthly for 3 months to ensure compliance is maintained. A dignity and respect questionnaire will be completed with 10% of all staff (licensed and non-licensed) by the Clinical Competency Coordinator, DON, ADON, and Unit Managers weekly for 4 weeks and then monthly for 3 months.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345061	A. BUILDING _____ B. WING _____	C 05/27/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 241	Continued From page 2 and she made a gesture like somebody was yelling at her. I went to the nurse's station and they didn't want to tell me what was going on. A nurse went to get the nursing supervisor. She told me one of the nurse aides had yelled, cursed, and punched the wall. She told me it was nothing malicious and she was glad the nurse aide had removed herself from the room. I went at 7:00 AM the next day to talk to [the Director of Nursing] about the issue. She told me the nurse aide was sent home until we know her side of the story. She told me this won't happen again and she would take care of the situation. I came in the next weekend and there she (NA #1) was working on [Resident #1's] floor again. I didn't want her near [Resident #1]. She followed me into [Resident #1's] room telling me about her fingernail." An interview was conducted with Nurse #1, the weekend nursing supervisor, on 5/27/17 at 12:05 PM. Nurse #1 revealed, "I was working the first floor cart on 5/7/17. [Nurse #2] came down to get me. She told me there was an issue with a nurse aide yelling and [Resident #1] was upset and crying. I went up and spoke with [Resident #1] and [Resident #4] to find out what happened. I then went to talk to [NA #1]. She had removed herself from the room and was working in the dining room. [Resident #4] explained to me [NA #1] was trying to transfer [Resident #1] and [NA #1] hollered at [Resident #1]. I don't know what happened to cause the verbal outburst from [NA #1]. [Resident #4] explained [NA#1] hollered out in frustration. [Resident #4] told me [NA #1] hit the door with her hand and was talking to herself in the bathroom. I asked them if [NA #1] touched either one of them inappropriately and they both denied this. [Resident #4] was more upset [NA	F 241	Monitoring: The Social Worker will report the findings to the Administrator and the DON. The Administrator and the DON will immediately address any identified areas of concern from the questionnaire. The Administrator will present the results of the dignity and respect questionnaire to the Quality Assurance and Performance Improvement committee monthly for 4 months for further recommendations as indicated. Subsequent plans of actions will be developed by the committee as needed to ensure compliance is maintained.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345061	A. BUILDING _____ B. WING _____	C 05/27/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 241	Continued From page 3	F 241		

#1] did not apologize. The whole scene frightened [Resident #1] more than [Resident #4]. [Resident #1] has difficulty speaking but can answer yes or no questions. [Resident #1] did not seem too upset. She was not crying or trembling when I got there. There were sheets on the bed of [Resident #1] but no blankets. [NA #1] was a new nurse aide to the building and was new to [Resident #1]. After I spoke with the residents I went and called [the Director of Nursing]. I told [NA #1] to clock out and go home. I told her she would need to speak to [the Director of Nursing] the next day, Monday. I asked all of the nursing staff to write statements and I collected them all and put them under [the Director of Nursing's] door. I don't know who wrote statements or what they wrote. I did speak with the [responsible party of Resident #1] and she seemed fine."

The Director of Nursing (DON), was interviewed on 5/27/17 at 1:50 PM. The DON revealed, "The weekend nursing supervisor called me about the incident on 5/7/17. The weekend supervisor handled it and looked into what happened. [NA #1] is a new nurse aide in the building. The patient (Resident #1) was a stand and pivot for transfers. The report given to [Nurse #1] was the patient was not able to bear weight at the time of the transfer and [NA #1] got frustrated. I spoke with [NA #1] and she told me she bent her nail back, went in the bathroom and said, "Ow, Ow, Ow." [NA #1] showed me her finger and there was a white line where she had bent her fingernail back. [Nurse #1] thought [NA #1] was frustrated and overwhelmed. [NA #1] went into the bathroom and removed herself from the situation. She was pounding on the counter because her nail hurt so much. I told [NA #1] that we would not have her work in that room

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345061	A. BUILDING _____ B. WING _____	C 05/27/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 241	Continued From page 4	F 241		

anymore. I spoke with the daughter and told her that [NA #1] would not work with her mother anymore and she was okay with that. I think I remember the statements being slipped under my door."

Nurse Aide (NA)#2, a nurse aide that worked on 5/7/17, was interviewed on 5/27/17 at 2:30 PM. NA #2 stated, " [Resident #2] is transferred with a Hoyer lift on the night shift but is a 1 man pivot on the day shift. [Resident #2] is in her right state of mind but little things make her cry. I didn't hear anything on 5/7/17 but [Resident #4] called me into her room. [Resident #4] told me [NA #1] hollered at [Resident #1]. [Resident #4] told me [NA #1] swore, hit the bathroom door, and then went into the bathroom talking to herself. I asked [Resident #1] if this was right and she shook her head yes. I was asked to write a statement. I was telling everybody what happened."

Nurse #2, the nurse assigned to Resident #1 on 5/7/17, was interviewed on 5/27/17 at 3:00 PM. She revealed, "I did not see or hear anything. [NA #2] came to me and said [NA #1] was being rude to the residents. I called the DON and I called the weekend supervisor (Nurse #1). [Nurse #1], the nursing supervisor, came up and I told her [Resident #1] was upset because [NA #1] was frustrated and upset. I then got all the nursing staff on the floor together in the break room and told them not to talk about the incident because it was still being investigated. [Resident #1] seemed a little upset. [Resident #1] is not really verbal but she can gesture. Verbally she is not able to put sentences together."

An interview was conducted with the DON (Director of Nursing) and the facility Administrator

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345061	A. BUILDING _____ B. WING _____	C 05/27/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 241	Continued From page 5	F 241		

on 5/27/17 at 3:20 PM. They stated they could not find the statements that were taken from the staff on 5/7/17. The DON stated NA #1 was no longer employed at the facility but it had nothing to do with the circumstances that occurred on 5/7/17.

NA #1 was interviewed via telephone on 5/27/17 at 8:00 PM. She revealed, "The bed of [Resident #1] was wet but I did not know this because she had a dark cover over the bed. I used a sit to stand lift to transfer [Resident #1] to the bed the first time I changed her. I got her all cleaned up and back in the wheel chair using the sit to stand lift again. I went out of the room and went assist [another resident]. [NA #2] came to tell me [Resident #1] was wet. I told her I had just changed her and she said well she is wet again. [NA #2] took over for me with [another resident]. I came in and the roommate [Resident #4] told me fluid was running down the leg of [Resident #1]. I said to her how did this happen. [Resident #4] told me her bed was wet. I pulled back the sheet and everything was wet. I stripped the bed and put the wet linens in the bathroom. I put a fresh sheet on the bed. [Resident #1] had went to get out fresh clothes and pants. The stand lift was not working. The battery was dead. I didn't look at the care card. I didn't even know where they were. Nobody had told me. I was new there. I was just told to document in the computer. I asked her roommate if I could pick her [Resident #1] up and she told me yes. The roommate explained to me what to do. I transferred [Resident #1] to the bed and then changed her again. I got her dressed and I was going to put her back in the chair. It was my first time working with her. I have really long fingernails and when I tried to transfer her she couldn't stand up and I bent my nail all the way back. It hurt but I never cursed. I went in the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345061	A. BUILDING _____ B. WING _____	C 05/27/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 241	Continued From page 6	F 241		

bathroom because it hurt so bad. I left the bathroom and went to go work in the dining room. The next thing I know [Nurse #1], the supervisor, was telling me to clock out and go home. She told me the DON, who I didn't even know, had to talk to me tomorrow. I have since then cut my nails and they are not as long. I told the DON I didn't know anything about the care cards. I didn't even know where they were at."

2. Resident #3 had a diagnosis of cerebral vascular accident. She had a quarterly minimum data set assessment dated 4/10/17 that coded her as cognitively intact with no moods or behaviors. She was coded as having range of motion impairment on both sides of her upper and lower extremities.

Her care plan dated as last reviewed on 4/24/17 stated, "[Resident #3] has difficulty communicating r/t (relative to) unclear speech d/t (due to) locked in syndrome and hx (history) of CVA (cerebral vascular accident)." Interventions included the allowance of plenty of time for her to respond and the provision of a quiet environment for resident when discussing important issues."

Resident #3 was interviewed on 5/27/17 at 4:20 PM. The resident revealed, "I want things done a certain way. I know the nurse aides think I am mean but I can't use but two of my fingers. I told the nurse, [NA #1] had a bad attitude and I don't want her in here anymore. I have a certain soap I want to use. I don't want to use the facility soap because I am allergic to it. I was telling [NA #1] she had to use my soap but she couldn't hear me. I told her again and she still couldn't hear me. I said to her, "I can't stand this." She said to me, "I can't stand you either" and she slammed the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345061	A. BUILDING _____ B. WING _____	C 05/27/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 241	Continued From page 7	F 241		

soap bottle down on the table. I told her I wanted her to leave. She said she thought I misunderstood her. I told her I may have misunderstood what she said but I understood what she meant when she slammed the soap bottle down. She was rude and disrespectful." Resident #3 stated she did tell a nurse she did not want NA #1 to work with her again. She did not remember which nurse she told but NA #1 did not come into her room again. The resident stated this event occurred at the end of April or beginning of May of the current year.

NA #1 was interviewed on 5/27/17 at 8:00 PM. NA #1 revealed, "[Resident #3] doesn't like new people to help her. [Resident #3] is very thorough. I washed her up the way I was taught but she wanted to be washed up her way." NA #1 stated that the assignments were rearranged by Nurse #2 so that NA #1 would no longer care for Resident #3.

The Director of Nursing and facility Administrator were interviewed on 5/27/17 at 4:40 PM. The Director of Nursing stated, "[Resident #3] is very particular with how her care needs are met." The facility Administrator revealed Resident #3 was soft spoken and could become very agitated if you don't understand her.