STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345551	A. BUILDING _____ B. WING _____	C 08/27/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEALTH-CAROLINA POINT	5935 MOUNT SINAI 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 000	INITIAL COMMENTS The complaint investigation was completed from 8/25/2020-8/27/2020. Event ID # BFKF11 1 of the 3 complaint allegations were substaintiated resulting in deficiencies.	F 000		
F 760 SS=D	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, Pharmacy Manger interview, and Nurse Practitioner interview the facility failed to provide all prescribed medications to 1 of 5 sampled residents (Resident #1) for up to four doses by not securing and administering ordered medications following resident's admission into the facility. The findings included: Resident #1 was admitted on 7/31/2020 with a diagnosis of major depressive disorder, dementia, Parkinson's disease, acute respiratory disease (Covid), and pneumonia. Record review of Resident #1's most recent minimum data sheet (MDS) assessment, dated 8/4/2020, revealed Resident #1 is assessed as severely cognitively impaired. She requires assistance from staff to provide total care with dressing, bathing, transfers, and personal hygiene. Resident #1 is unable to verbalize her needs to staff.	F 760	This plan of correction constitutes a written allegation of compliance. Preparation and submission of this plan of correction does not constitute an admission or agreement by the provider of truth of the facts alleged or the corrections of the conclusions set forth on the statement of deficiencies. The plan of correction is prepared and submitted solely because of requirements under state and federal law. 1-Resident #1 no longer in facility. 2-On August 28th, 2020 the Director of Health Services and Nurse Managers conducted a review of all new admission and readmission charts, from 7/31/2020 to present, for medication accuracy and medication availability. Medication error reports have been written for any discrepancies. 3-The Director of Nursing and/or Nurse	9/21/20

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

Electronically Signed | 09/15/2020

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F 760	Continued From page 1 Review of Medication Administration Record (MAR), dated 7/31/20-8/5/2020, revealed Resident #1 did not receive the following doses of medication: 1. Norvasc for blood pressure was missed on 8/1/2020 at 9 AM; 2. Augmentin for pneumonia were missed on 7/31/2020 at 9 PM, 8/1/2020 at 9 AM and 9 PM; 3. Brimonidine drops 0.2% for glaucoma were missed on 7/31/2020 at 9 PM, 8/1/2020 at 9 AM, 2 PM, and 9 PM; 4. Carbidopa-levodopa-entacapone for Parkinson's were missed on 7/31/2020 at 9 PM, 8/1/2020 at 9 AM, 2PM, and 9 PM; 5. Dorzolamide drops 2% for glaucoma were missed on 7/31/2020 at 9 PM and 8/1/2020 at 9 PM; 6. Entacapone for Parkinson's were missed on 7/31/2020 at 9 PM, 8/1/2020 at 9 AM, 2 PM, and 9 PM; 7. Krill Oil for health promotion was missed on 8/1/2020 at 9 AM 8. Lantanoprost drops for glaucoma was missed on 8/1/2020 at 9 AM, 9. Levothroxine for thyroid was missed on 8/1/2020 at 6 AM, 10. Mirtazapine for depression were missed on 7/31/2020 at bedtime, and 8/1/2020 at bedtime. 11. Prilosec for acid reflux were missed on 7/31/2020 at 9 PM, and 8/1/2020 at 9 PM An interview with Nurse #1 on 8/25/2020 at 9:49 AM, revealed newly admitted residents may miss one dose of medication, but usually it is "just a little late and not missed". The facility has medications available for dispensing at the facility in the automatic medication dispensing system for staff to use when resident's medications are unavailable. There is a local pharmacy available	F 760	Managers began completing a 24hour admit/ readmit chart check on all admissions/readmissions that includes verification of medication and medications arrival from pharmacy. The Director of Nursing and/or Nurse Managers will review the Medication variance report daily for 30 days then weekly thereafter. On August 31st, the Clinical Competency Coordinator began educating the current Licensed nurses on procedure for medication verification, obtaining medications from pharmacy, back up pharmacy and cubex. This education will be incorporated in the new hire Licensed Nurse orientation process. 4-The Director of Nursing will analysis the Medication variance report and report the findings to the Quality Assurance/Performance Improvement Committee monthly until three months of substantial compliance is maintained then quarterly. Allege compliance September 21, 2020	

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F 760	Continued From page 2	F 760		

to deliver medications within hours to meet resident needs.

An interview with Nurse #2 on 8/26/2020 at 12:37 PM, revealed she worked on the evening of 7/31/2020 when Resident #1 was admitted to her unit. Staff did not remember contacting the pharmacy to discuss Resident #1's evening admission. She stated her coworkers on the unit and herself were unsure where to locate the pharmacy's contact information. Staff verbalized she was unaware there was an automated medication dispensing system stocked with the facility's commonly used medications available on a different hallway in the facility. Staff revealed she did not contact the nurse practitioner and inform her Resident #1's medications were not administered during her shift.

Nurse #3 was interviewed on 8/26/2020 at 1:03 PM, revealed there is an "emergency kit" available at the facility. In this "emergency kit" there is medication available to administer to residents in the event a medication has been ordered by a physician and the facility's contracted pharmacy has not had time to deliver the prescription to the facility. If staff is unable to administer any medication to a resident, the nurse practitioner should be notified.

Interview with Pharmacy Manager on 8/26/2020 at 3:26 PM, revealed the phone line recording for in- coming calls on 7/31/2020 was reviewed, and it was discovered no message were left from facility regarding Resident #1 coming in as a late admission on 7/31/2020; this prevent Resident #1 medications from being included in the evening delivery. Pharmacist stated there is an automatic medication dispensing system at the facility that

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F 760	Continued From page 3	F 760		

allows staff to access commonly used medications. The machine's inventory was reviewed for the dates of 7/31/2020 and 8/1/2020, the following medications where available at the facility for administration: Norvasc, Augmentin, Lantanoprost, Levothroxine, and Mirtazapine. Pharmacy Manager stated a local back-up pharmacy can is available to deliver medications to the facility within hours of notification to meet resident needs.

An interview with Nurse Practitioner (NP) #1 on 8/26/2020 at 4:31 PM, revealed if staff is unable to administer any medications to a resident, the staff is required to report this information to the NP. NP revealed there have been cases when a medication is not available due to shortages. When staff notifies NP of this obstacle, the order will be changed to a comparable medication that is available to facility. Staff did not notify the NP at any time about Resident #1 missing doses of ordered medications.
The Interim Director of Nursing was interviewed on 8/26/2020 at 4:28 PM, revealed staff has not voiced any concerns regarding medications not being accessible for administration to residents. Staff also states she has not heard of any resident's not receiving their prescribed medications at the date and time they are due.

An interview with Clinical Competency Coordinator on 8/27/2020 at 8:57 AM, revealed during new staff orientation facility policies and procedures are discussed. Staff are also given a tour of the facility, including the location of the automatic medication dispensing system and receive a code to access the unit. Clinical Competency Coordinator also stated staff members have access to an on-call personal if

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F 760	Continued From page 4 assistance is needed during nights and weekend shifts. An interview with acting Administrator on 8/27/2020 at 11:29 AM, revealed he has not heard any concerns from staff about not having prescribed medications to administer to residents. Medications commonly ordered by our physicians can be found in the automatic medication dispensing system located in our facility. If a resident needs a medication not available in the automatic medication dispensing system, the pharmacy will be contacted to meet this need.	F 760		