STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345538	A. BUILDING ______ B. WING ______	C 09/29/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEALTH-RALEIGH	2420 LAKE WHEELER ROAD RALEIGH, NC 27603

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced recertification and complaint investigation survey was conducted on 9/25/23 through 9/29/23. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #PML811.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 9/25/29 through 9/29/23. Event ID# PML811. The following intakes were investigated NC00193249, NC00193418, NC00195846, NC00198022, NC00198812, NC00198911, NC00199393, NC00199660, NC00199833, NC00199872, NC00200158, NC00200573, NC00200644, NC00201488, NC00201514, NC00202292, NC00204716, NC00204759, NC00205936, NC00205939, NC00205981, NC00206005, NC00206188, NC00206493, NC00207210, and NC00207614. 28 of the 72 complaint allegations resulted in deficiency. The Statement of Deficiencies was amended on 10/16/23 at tag F554.	F 000		
F 554 SS=D	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and resident and staff interviews the facility failed to	F 554	This plan of correction constitutes a written Allegation of Compliance with	10/27/23

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed | TITLE | (X6) DATE 10/23/2023

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 554

Continued From page 1

complete a self-administration of medication assessment, obtain a physician's order, and care plan self- administration of medication before leaving medication at the resident's bedside. This was for 1 of 1 residents (Resident #17) reviewed for self-administration of medication.

Findings included:

Resident #17 was admitted to the facility on 12/6/21 with diagnoses including chronic obstructive pulmonary disease (COPD) and chronic pain.

A review of Resident #17's annual Minimum Data Set (MDS) assessment dated 6/22/23 revealed her vision was adequate. She was cognitively intact.

A review of Resident #17's current comprehensive care plan last revised 8/17/23 revealed she was not care planned to self-administer medication.

A review of Resident #17's medical record on 9/25/23 revealed no self-administration of medication assessment indicating Resident #17 would self-administer medication.

A review of Resident #17's medical record on 9/25/23 did not reveal any physician's order for Resident #17 to self-administer medication.

On 9/25/23 at 11:18 AM an observation of Resident #17 revealed an albuterol (medication to treat wheezing and shortness of breath) inhaler on her bedside table. An interview with Resident #17 at that time indicated she kept this inhaler at her bedside to use when she needed it. She

F 554

federal and state requirements. Preparation and submission of this Allegation of Compliance 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 #17 was assessed for self-administration of her albuterol inhaler on 10/18/23. Based upon this assessment the resident will not self-administer her inhaler. The inhaler was removed from the bedside on 9/27/23.

2. All residents potentially could be affected by the deficient practice. The facility completed an audit of all alert and oriented residents, on 10/19/23. No additional residents were identified who expressed a desire to self-administer medications.

3. All licensed staff were re-educated regarding the policy and procedure for self-administration of medication, by the Clinical Competency Coord., or designee on 10/20/23 & 10/24/23. This education has been added to the General Orientation of any newly hired licensed nurses. Licensed nurses who do not attend the training on 10/20/23 or 10/24/23 will be required to attend the training prior to working their next

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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PRUITTHEALTH-RALEIGH	2420 LAKE WHEELER ROAD RALEIGH, NC 27603

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F 554 Continued From page 2

stated she used it earlier today because the flowers in the room caused her some respiratory discomfort.

On 9/27/23 at 1:42 PM an observation of Resident #17 revealed her albuterol inhaler and a medication cup with 3 pills on her bedside table. An interview with Resident #17 at that time indicated the pills were her 2 acetaminophen (an anti-inflammatory pain medication) and her gabapentin (a medication that can treat pain). She stated the nurse left them with her earlier. She went on to say she had not taken them yet because she was cleaning out her nose.

On 9/27/23 at 1:49 PM Nurse #4 was interviewed. She indicated she was caring for Resident #17 that day and was familiar with her. She stated Resident #17 either kept her albuterol inhaler on the medication cart or at her bedside because she used it herself. She went on to say she left Resident #17's 2 acetaminophen tablets and gabapentin at her bedside earlier because Resident #17 had food in her mouth when she brought the pills to her. Nurse #4 stated she had not stayed to observe Resident #17 take this medication. She went on to say the process for resident's to self-administer medication was that a self-administration of medication assessment needed to be completed. Nurse #4 stated if the resident was appropriate to self-administer a physician's order needed to be obtained and then it would be placed on their care plan. She further indicated Resident #17 did not have any of this and she should not have left any medication at Resident #17's bedside.

On 9/27/23 at 2:04 PM an interview with the Director of Nursing (DON) indicated there needed

F 554

scheduled shift, by the Clinical Competency Coordinator, or designee.

The DHS, or designee, will audit 10 medication passes per day, for 2 weeks. Following 2 weeks of daily monitoring, the DHS or designee will audit 10 medication passes twice per week, for 2 weeks, and then monitor 10 medication passes once per month, for 2 months. Monthly med pass audits will continue after 3 months, to ensure ongoing compliance.

4. The Director of Health Services will present the analysis of the medication pass compliance percentage to the Nursing Home Administrator at the Quality Assurance and Performance Improvement Committee meeting monthly until three consecutive months of compliance is maintained and then quarterly thereafter. The DHS is responsible for implementing and maintaining the acceptable plan of correction related to self-administration of medication.

5. Completion Date: 10/27/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345538	A. BUILDING ______ B. WING ______	C 09/29/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEALTH-RALEIGH	**2420 LAKE WHEELER ROAD RALEIGH, NC 27603**

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F 554	Continued From page 3 to be a self-administration of medication assessment completed to determine if a resident was appropriate to self-administer medication, a physician's order for the self-administration of medication, and then this needed to be included in the resident's care plan. She stated if these things were not completed, medication should not be left at the bedside. On 9/29/23 at 10:22 AM an interview with the Administrator indicated if a resident requested to self-administer medication, an assessment needed to be done, a physician's order obtained, and then this needed to be placed on the resident's care plan.	F 554		
F 558 SS=D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on observations, record review and resident and staff interviews the facility failed to accommodate a resident's request to try the new type of television (TV) the facility had when he was no longer able to use the control buttons on his old TV to change the channels. This was for 1 of 1 resident (Resident #52) reviewed for the accommodation of needs. Findings included: Resident #52 was admitted to the facility on	F 558	1. Resident 52 received a new TV on 9/29/23. The facility staff have confirmed that Resident #52 can successfully operate this TV independently. 2. The facility interviewed alert and oriented residents on 10/26/23. 3% of residents interviewed stated that if staff cannot accommodate their request, they do not receive a responsible explanation why their request cannot be accommodated.	10/27/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345538	A. BUILDING ______ B. WING ______	C 09/29/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEALTH-RALEIGH	2420 LAKE WHEELER ROAD RALEIGH, NC 27603

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F 558

Continued From page 4

5/26/20 with a diagnosis paralysis of all four limbs.

A review of his quarterly Minimum Data Set (MDS) assessment dated 8/2/23 revealed he was cognitively intact. He was dependent on 1 person for personal hygiene including combing hair, brushing teeth, and shaving. He had functional limitation in range of motion of both upper and lower extremities. He had no behaviors, delusions, or rejection of care.

A review of Resident #52's current comprehensive care plan last revised on 8/12/23 revealed a focus area for activities of daily living (ADL) decline related to paralysis of bilateral lower and right upper extremity. The goal was for Resident #52 to be assisted with all his ADL needs through the next review. An intervention was to provide assistive devices as needed.

On 9/25/23 at 3:31 PM an interview with Resident #52 indicated about 2 months ago he told the Director of Nursing (DON) and the Maintenance Director that he was no longer able to use the buttons on his TV set to change the channels. He stated his hands had gotten weaker since he was first admitted to the facility and while he had previously been able to change the channels on his television set, he no longer was. He stated the DON had told him she would look into this, but no one had gotten back to him. He stated he could use his laptop to keep himself occupied but it was frustrating that he had to watch the same channel on his TV. Resident #52's TV was observed to be fixed to a swinging arm attached to his bed. The control buttons on the lower aspect of the screen were observed to be small slightly raised pillow type. Resident #52 was observed to

F 558

3. All facility staff were re-educated regarding the policy and procedure for reasonable accommodation of needs by the Clinical Competency Coord., or designee on 10/20/23 & 10/24/23. This education has been added to the General Orientation of any newly hired facility staff. Facility staff who do not attend the training on 10/20/23 or 10/24/23 will be required to attend the training prior to working their next scheduled shift, by the Clinical Competency Coordinator, or designee.

Social Services, or designee, will interview 10 residents per week, times 4 weeks, related to reasonable accommodation of needs. Following 4 weeks, the SS, or designee, will interview 10 residents per month, times 2 months, related to reasonable accommodation of needs. Following 3 months of monitoring, SS, or designee, will be interview 10 residents quarterly, related to reasonable accommodation of needs, to ensure ongoing compliance.

4. Social Services will present the analysis of the reasonable accommodation of needs interview data to the Nursing Home Administrator at the Quality Assurance and Performance Improvement Committee meeting monthly until three consecutive months of compliance is maintained and then quarterly thereafter.

5. Completion Date: 10/27/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345538	A. BUILDING ______ B. WING ______	C 09/29/2023

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PRUITTHEALTH-RALEIGH	2420 LAKE WHEELER ROAD RALEIGH, NC 27603

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F 558		F 558		

Continued From page 5
attempt to push these buttons to change the channel but was not able to successfully.

During an interview on 9/26/23 at 12:56 PM the Maintenance Director stated Resident #52 had complained about wanting a bigger newer TV because the buttons on his TV were hard to push. He stated he had gone in and tested the buttons on Resident #52's TV and they worked with barely even pushing them. He went on to say he had told Resident #52 that his TV was working as well as it should. The Maintenance Director stated Resident #52 had not been in his room when he tested the buttons on his television, and he had not heard anything about Resident #52's TV since then. He went on to say the facility had recently gotten newer bigger TV's that were touch screen rather than the push buttons like Resident #52 had.

In an interview on 9/26/23 at 1:28 PM the DON stated she recalled Resident #52 being in the front lobby and telling her he needed another TV. She stated she did not recall Resident #52 telling her why he needed a new TV and she had not asked him. She went on to say she reported to the Maintenance Director that Resident #52 needed a new TV after this discussion. She further indicated she had not followed up with Resident #52 to see if his TV issue had been resolved. The DON stated if Resident #52 had told her he couldn't use the old TV because the buttons were too hard to push, she would have immediately made sure he got a new TV. She stated the facility had recently gotten newer TVs that were a bit larger, and she had thought maybe Resident #52 had seen other residents getting new TVs and had wanted one too.

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	345538	A. BUILDING ______ B. WING ______	C 09/29/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 558	Continued From page 6 On 9/29/23 at 10:22 AM an interview with the Administrator indicated if the facility's new TVs enabled Resident #52 to change the channels, then he needed to be given a new TV.	F 558		
F 567 SS=E	Protection/Management of Personal Funds CFR(s): 483.10(f)(10(i)(ii) §483.10(f)(10) The resident has a right to manage his or her financial affairs. This includes the right to know, in advance, what charges a facility may impose against a resident's personal funds. (i) The facility must not require residents to deposit their personal funds with the facility. If a resident chooses to deposit personal funds with the facility, upon written authorization of a resident, the facility must act as a fiduciary of the resident's funds and hold, safeguard, manage, and account for the personal funds of the resident deposited with the facility, as specified in this section. (ii) Deposit of Funds. (A) In general: Except as set out in paragraph (f)(l0)(ii)(B) of this section, the facility must deposit any residents' personal funds in excess of $100 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.) The facility must maintain a resident's personal funds that do not exceed $100 in a non-interest bearing account, interest-bearing account, or petty cash fund. (B) Residents whose care is funded by Medicaid: The facility must deposit the residents' personal funds in excess of $50 in an interest bearing account (or accounts) that is separate from any of	F 567		10/27/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345538	A. BUILDING ______ B. WING ______	C 09/29/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 567	Continued From page 7 the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.) The facility must maintain personal funds that do not exceed $50 in a noninterest bearing account, interest-bearing account, or petty cash fund. This REQUIREMENT is not met as evidenced by: Based on record review and resident, staff, and Responsible Party (RP) interviews the facility failed to obtain the resident's consent before depositing and withdrawing the resident's personal funds into and from his non-transferring personal funds account. This was for 1 of 1 resident (Resident #52) reviewed for personal funds. Findings included: Resident #52 was admitted to the facility on 5/26/20 with a diagnosis of quadriplegia (paralysis of all four limbs). A review of Resident #52's quarterly Minimum Data Set (MDS) assessment dated 8/2/23 revealed he was cognitively intact. A review of Resident #52's current "Resident Fund Management Service" authorization and agreement to handle resident funds dated 6/29/21 revealed Resident #52 provided his written consent for a non-transferring account (no-automatic transfer of deposits to pay for care costs). This consent was witnessed by the facility Regional Financial Counselor. A review of Resident #52's personal check #480 dated 10/10/22 revealed it was made out to the	F 567	1. Resident 52 will receive all his mail, unopened, when it arrives at the facility. On 10/4/23 the BOM interviewed resident #52 regarding the funds in his personal trust account. The resident requested a check for a portion of the funds in his account, and stated he wanted to leave the remaining funds in his account. The resident signed a withdrawal slip and the check was issued to the resident per his request on 10/4/23. 2. The facility interviewed alert and oriented residents on 10/26/23. 43% of residents interviewed stated they are not asked to provide authorization to withdraw funds from their personal funds account when they make purchases at the snack bar. 3. The Financial Counselor (BOM #1), Social Workers, Activity Staff and Receptionists will receive re-education related to Protection/Management of Personal Funds and Resident Mail, provided on 10/19/23, by the NHA. BOM #2 no longer works at this facility. This education has been added to the General Orientation of any newly hired facility staff in the business office, activity dept and	

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	345538	A. BUILDING ______ B. WING ______	C 09/29/2023

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PRUITTHEALTH-RALEIGH	2420 LAKE WHEELER ROAD RALEIGH, NC 27603

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F 567

Continued From page 8

facility in the amount of $1502.00.

A review of Resident #52's personal check #482 dated 11/12/22 revealed it was made out to the facility in the amount of $1502.00.

A review of Resident #52's "Resident Landscape Statement" from 10/3/22 to 9/25/23 for his facility personal funds account revealed in part the deposit of a personal check dated 10/14/23 in the amount of $1502.00 and a withdrawal on 10/18/22 of a care cost payment of $1498.00. It further revealed a deposit on 11/16/22 of a personal check in the amount of $1502.00 and a withdrawal on 1/24/23 of a care cost payment of $1470.90.

A review of Resident #52's "Resident Landscape Statement" from 10/3/22 to 9/25/23 for his facility personal funds account revealed in part the deposit on 5/30/23 of a "Social Security Administration (SSA) insurance check" in the amount of $709.20 and a deposit on 7/11/23 of a "SSA insurance refund" in the amount of $664.97. These were tax refund checks issued to the resident.

On 9/25/23 at 3:09 PM in interview Resident #52 stated he was still able to take care of his finances including his tax refunds himself and it was important for him to continue doing this. He went on to say he used the facility address as his mailing address because he was residing in the facility when he completed his tax refund forms. Resident #52 stated he was expecting 2 tax refund checks for the tax forms he completed, and he never received them. He went on to say this had worried him. He stated he had contacted the Internal Revenue Service (IRS) to report the

F 567

social services. Facility staff who do not attend the training on 10/19/23 will be required to attend the training prior to working their next scheduled shift, by the NHA, or designee

The Financial Counselor, or designee, will interview 5 residents per week, times 4 weeks, related to Protection/Management of Personal Funds and Resident Mail. Following 4 weeks, the FC, or designee, will interview 5 residents per month, times 2 months, related to Protection/Management of Personal Funds and Resident Mail. Following 3 months of monitoring, FC, or designee, will interview 5 residents quarterly, related to Protection/Management of Personal Funds and Resident Mail.

4. The Financial Counselor will present the analysis of the Protection/Management of Personal Funds and Resident Mail interview data to the Nursing Home Administrator at the Quality Assurance and Performance Improvement Committee meeting monthly until three consecutive months of compliance is maintained and then quarterly thereafter.

5. Completion Date: 10/27/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345538	A. BUILDING ___ B. WING ___	C 09/29/2023

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F 567 Continued From page 9
missing checks and they put a trace on them. He went on to say he found out that the facility had opened his mail and cashed these checks without ever telling him and he filed a police report. He further indicated he had not given the facility permission to deposit these checks into his account.

On 9/26/23 at 8:21 AM a telephone interview with Resident #52's RP indicated Resident #52 did his own tax returns. She stated about a month ago the facility received Resident #52's tax refund checks, opened them, and never told him. She went on to say Resident #52 contacted the IRS and was told the checks had been sent to the facility and cashed. She further indicated she contacted Business Office Manager #1 and was told that the facility could re-issue Resident #52 a check from his facility account where these had been deposited. Resident #52's RP stated neither she nor Resident #52 had ever given the facility permission to deposit these checks or his care cost payment checks into his facility account or make any withdrawals from his facility account to pay for his care costs. She went on to say she had been aware of an account where she deposited small amounts of funds that Resident #52 used to pay for snacks and incidentals, but she paid Resident #52's care costs from Resident #52's outside personal checking account directly to the facility.

On 9/27/23 at 10:12 AM an interview with Business Office Manager #1 indicated she was aware of a recent incident where Resident #52 mentioned to her that he had been expecting some checks. She went on to say she received the mail that came to the facility from the postal carrier. She stated she told Resident #52 she

F 567

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F 567	Continued From page 10 possibly had opened these checks and deposited them into his facility account. She went on to say he told her she should not have done this. Business Office Manager #1 stated for residents who have accounts with the facility she would be on the look-out for federal checks which come in a very noticeable envelope. She went on to say even if these had a resident's name on them, she would open them and deposit them into their facility account. Business Office Manager #1 stated she had stopped doing this after Resident #52 complained to her. She further indicated this was just how she had always done things at facility's where she worked. She stated a "non-transferring" account like Resident #52 had meant that his facility account was not used to pay for his care costs. She went on to say Resident #52's RP had been bringing in his personal checks made out to the facility for this, and these would be deposited into a separate facility Operational Account that had nothing to do with the Resident #52's personal funds account. She further indicated the previous Business Office Manager #2 had deposited the checks made out to the facility for his care costs into his personal funds account and them withdrew the funds from there to pay for Resident #52's care costs. On 9/27/23 at 3:21 PM a telephone interview with BOM #2 indicated a "non-transferring account" like Resident #52 had meant that the resident did not agree to have their SS or other things like retirement pensions direct deposited into their account and then automatically debited to pay for care costs. She stated when Resident #52's RP brought in the checks made out to the facility these were slightly over the amount needed to pay for his care costs, so she manually deposited	F 567		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345538	A. BUILDING ______ B. WING ______	C 09/29/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEALTH-RALEIGH	2420 LAKE WHEELER ROAD RALEIGH, NC 27603

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F 567	Continued From page 11 them into his personal funds account and then manually debited the amount needed to pay his care costs leaving the extra in his personal funds account to pay for incidentals or snacks. She stated she had not wanted the facility to receive the extra or send the checks back to the RP to be redone. In a follow-up telephone interview on 9/27/23 at 4:21 PM BOM #2 stated she had not obtained a deposit or withdrawal slip for these transactions from Resident #52 or his RP or notified Resident #52 or his RP of these transactions other than what they would have seen on the quarterly statements. On 9/27/23 at 4:05 PM a telephone interview with the Regional Financial Counselor indicated a "non-transferring" resident funds account like Resident #52 had agreed to meant that this account was basically a personal savings account for Resident #52. She stated this type of account would require a deposit or withdrawal slip signed by Resident #52 or his RP in order for the facility to make deposits or withdrawals. On 9/28/23 at 9:53 AM in an interview the Administrator stated she did not really know the details of the types of accounts for resident fund management services the facility provided. She stated she would have to reach out to the Regional Financial Counselor and see what the facility policies were. In a follow-up interview on 9/28/23 at 3:19 PM the Administrator stated the facility did not have any specific policy for resident funds accounts.	F 567		
F 576 SS=E	Right to Forms of Communication w/ Privacy CFR(s): 483.10(g)(6)-(9)	F 576		10/27/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345538	A. BUILDING ______ B. WING ______	C 09/29/2023

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F 576		F 576		

Continued From page 12

§483.10(g)(6) The resident has the right to have reasonable access to the use of a telephone, including TTY and TDD services, and a place in the facility where calls can be made without being overheard. This includes the right to retain and use a cellular phone at the resident's own expense.

§483.10(g)(7) The facility must protect and facilitate that resident's right to communicate with individuals and entities within and external to the facility, including reasonable access to:
(i) A telephone, including TTY and TDD services;
(ii) The internet, to the extent available to the facility; and
(iii) Stationery, postage, writing implements and the ability to send mail.

§483.10(g)(8) The resident has the right to send and receive mail, and to receive letters, packages and other materials delivered to the facility for the resident through a means other than a postal service, including the right to:
(i) Privacy of such communications consistent with this section; and
(ii) Access to stationery, postage, and writing implements at the resident's own expense.

§483.10(g)(9) The resident has the right to have reasonable access to and privacy in their use of electronic communications such as email and video communications and for internet research.
(i) If the access is available to the facility
(ii) At the resident's expense, if any additional expense is incurred by the facility to provide such access to the resident.
(iii) Such use must comply with State and Federal law.

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	345538	A. BUILDING ______ B. WING ______	C 09/29/2023

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F 576	Continued From page 13 This REQUIREMENT is not met as evidenced by: Based on record review and resident, staff, and Responsible Party (RP) interviews the facility failed to deliver a residents personal mail unopened. This was for 1 of 1 residents (Resident #52) reviewed for privacy of communication. Findings included: Resident #52 was admitted to the facility on 5/26/20 with a diagnosis of quadriplegia (paralysis of all four limbs). A review of Resident #52's quarterly Minimum Data Set (MDS) assessment dated 8/2/23 revealed he was cognitively intact. On 9/25/23 at 3:09 PM in interview Resident #52 stated he was still able to take care of his finances including his tax refunds himself and it was important for him to continue doing this. He went on to say he used the facility address as his mailing address because he was residing in the facility when he completed his tax refund forms. Resident #52 stated he was expecting 2 tax refund checks for the tax forms he completed, and he never received them. He went on to say this worried him. He stated he had contacted the Internal Revenue Service (IRS) to report the missing checks and they put a trace on them. He went on to say he found out that the facility had opened his mail and cashed these checks without ever telling him and he filed a police report. On 9/26/23 at 8:21 AM a telephone interview with Resident #52's RP indicated Resident #52 did his own tax returns. She stated about a month ago	F 576	1. Resident 52 has received all his mail, unopened, when it arrives at the facility, since 9/29/23. 2. The facility interviewed alert and oriented residents on 10/26/23. 27% of those residents interviewed expressed that they receive their mail opened, by the activity staff, who do this to assist them with reading their mail. 3. The Financial Counselor (BOM #1), Social Workers, Activity Staff and Receptionists has receive re-education related to Resident Mail, provided on 10/19/23, by the Nursing Home Administrator (NHA). This education has been added to the General Orientation of any newly hired facility staff in the business office, activity dept and social services. Facility staff who do not attend the training on 10/19/23 will be required to attend the training prior to working their next scheduled shift, by the NHA, or designee The Financial Counselor, or designee, will interview 5 residents per week, times 4 weeks, related to Resident Mail. Following 4 weeks, the FC, or designee, will interview 5 residents per month, times 2 months, related to Resident Mail. Following 3 months of monitoring, FC, or designee, will interview 5 residents quarterly, related to Resident Mail. 4. The Financial Counselor will present	

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	345538	A. BUILDING ______ B. WING ______	C 09/29/2023

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F 576	Continued From page 14 the facility received Resident #52's tax refund checks, opened them, and never told him. She went on to say Resident #52 contacted the IRS and was told the checks had been sent to the facility and cashed. Resident #52's RP stated neither she nor Resident #52 had ever given the facility permission to open his mail. On 9/27/23 at 10:12 AM an interview with Business Office Manager #1 indicated she was aware of a recent incident where Resident #52 mentioned to her that he had been expecting some checks. She went on to say she received the mail that came to the facility from the postal carrier. She stated she told Resident #52 she possibly had opened these checks and deposited them into his facility account. She went on to say he told her she should not have done this. Business Office Manager #1 stated for residents who have accounts with the facility she would be on the look-out for federal checks which come in a very noticeable envelope. She went on to say even if these had a resident's name on them, she would open them and deposit them into their facility account. Business Office Manager #1 stated she had stopped doing this after Resident #52 complained to her. She further indicated this was just how she had always done things at facility's where she worked. On 9/28/23 at 9:53 AM in an interview the Administrator stated resident's mail should be delivered to them or their RP unopened.	F 576	the analysis of the Resident Mail interview data to the Nursing Home Administrator at the Quality Assurance and Performance Improvement Committee meeting monthly until three consecutive months of compliance is maintained and then quarterly thereafter, to ensure ongoing compliance. 5. Completion Date: 10/27/23	
F 641 SS=B	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the	F 641		10/27/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345538	A. BUILDING ______ B. WING ______	C 09/29/2023

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F 641	Continued From page 15 resident's status. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to accurately code the Minimum Data Set (MDS) assessment in the areas of Pre-Admission Screening Resident Review (PASRR), contraindication of a gradual dose reduction of antipsychotic medication, antibiotic use, anticoagulant use, and sedative/hypnotic use for 3 of 51 resident MDS assessments reviewed (Residents #11, #70, and #44). Findings included: 1. Resident #11 was admitted to the facility on 1/23/20 with diagnoses that included schizophrenia. a. Review of Resident #11's medical record revealed his PASSR Level II Determination dated 6/13/20 (no expiration date). Review of Resident #11's annual MDS assessment dated 2/6/23 indicated he did not have a level II PASSR. b. A pharmacy review dated 7/5/23 revealed a signed contraindication for a gradual dose reduction of Risperdal, an antipsychotic medication for Resident #11. Review of Resident #11's August Medication Administration Record revealed he received an antipsychotic medication every day of the 7-day lookback period of the assessment. His most recent MDS assessment, a quarterly assessment dated 8/8/23 revealed no contraindication of a gradual dosage reduction of	F 641	1. Resident #11 Will have his MDS modified to correct coding for a Level II PASRR, and a contraindication of a GDR of an antipsychotic medication on 10/20/23. Resident #70 will have her MDS modified to correct coding to indicate no antibiotic use during the 7 day lookback period on 10/20/23. Resident #44 will have her MDS modified to correct coding related to the anti-coagulant medication and the hypnotic medication on 10/20/23. All corrections will be made by the facility Case Mix Director. 2. The facility Case Mix Director, or designee, will audit 100% of all MDSs for residents with a Level II PASRR for contraindication of GDR of an antipsychotic medication, all residents with antibiotic use, and all residents with anti-coagulant meds, blood thinner medications and hypnotic medications, by 10/20/23. Six of 144 MDS did not have the Level II PASRR correct, 8 of 144 did not have the contraindication for a GDR correct, 1 of 144 did not have the antibiotic use correctly coded, 4 of 144 did not have the anti-coagulant correctly coded, 1 of 144 did not have a blood thinner correctly coded. All 144 MDSs had hypnotics correctly coded on the MDS. All errors were corrected on the MDS. 3. All MDS licensed nurses will receive re-education related to the accuracy of	

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F 641

Continued From page 16
an antipsychotic medication.

During an interview with the Director of MDS on 9/28/23 at 3:51 PM she stated a temporary staff member assisted with MDS assessments and miscoded Resident #11's PASSR level on his annual MDS dated 2/6/23. She further stated the failure to code the contraindication of a gradual dosage reduction of Resident #11's antipsychotic medication was an error.

An interview was conducted with the Administrator on 9/29/23 at 2:30 PM and she stated MDS assessments for Resident #11 should have been coded accurately.

2. Resident #70 was admitted to the facility on 7/7/22 with diagnoses that included hypertension and diabetes mellitus.

Resident #70's most recent MDS assessment dated 7/21/23, a quarterly indicated she received antibiotic medication 7 days of the 7-day lookback period.

Review of Resident #70's Medication Administration Record revealed no antibiotic medication administered during the 7-day lookback period.

An interview with the Director of MDS was conducted on 9/28/23 at 3:51 PM. She stated Resident #70's MDS assessment was coded in error. She reported the staff member who completed the assessment was on medical leave and she would complete education with the staff member upon her return.

An interview was conducted with the

F 641

assessments per the RAI manual, on 10/24/23, by the Regional Case Mix Director. This education has been added to the General Orientation of any newly hired Case Mix Coordinators . Case Mix Coordinators who do not attend the training on 10/24/23 will be required to attend the training prior to working their next scheduled shift, by the Case Mix Director, or designee

The Case Mix Director will complete a weekly audit of five MDSs completed by the Case Mix Coordinators. The Case Mix Coordinators will complete a weekly audit of five MDSs completed by the Case Mix Director. All inaccuracies will be corrected at the time of review. These audits will continue weekly for twelve weeks, then monthly thereafter. The Case Mix Director will maintain a log of all identified miscoding and corrections made and track and trend the data.

4. The Case Mix Director will present the analysis of the MDS Accuracy of Assessments data to the Nursing Home Administrator at the Quality Assurance and Performance Improvement Committee meeting monthly until three consecutive months of compliance is maintained and then quarterly thereafter, to ensure ongoing compliance.

5. Completion Date: 10/27/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345538	A. BUILDING ______ B. WING ______	C 09/29/2023

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F 641	Continued From page 17	F 641		

Administrator on 9/29/23 at 2:30 PM and she stated MDS assessment for Resident #70 should have been coded accurately to reflect her use of antibiotic medications.
2. Resident #44 was admitted to the facility on 7/7/22. Diagnoses included, in part, congestive heart failure and depression.

The physician orders were reviewed for June and July 2023 which revealed no order for an anti-coagulant (blood thinner) medication. An order dated 6/19/23 for Zolpidem (a sedative-hypnotic medication used to treat insomnia), 10 milligrams, one tablet at bedtime was noted.

The Medication Administration Record for 6/30/23-7/6/23 was reviewed and revealed Resident #44 received Zolpidem each bedtime, and no anticoagulant medication was documented as administered.

The quarterly MDS assessment dated 7/6/23 revealed Resident #44 received an anti-coagulant medication daily, and no hypnotic medication was noted as received during the look back period.

On 9/28/23 at 9:53 AM, an interview was conducted with MDS Nurse #1. She verified she completed the medication section of the 7/6/23 MDS assessment. She explained she coded medications by their drug classification. MDS Nurse #1 reviewed the physician orders that were in effect during the MDS look back period and stated Resident #44 received aspirin, which she considered a blood thinner, but added she knew it was not classified as an anti-coagulant medication. She confirmed the coding was an error. She reported Resident #44 was not on any

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	345538	A. BUILDING ______ B. WING ______	C 09/29/2023

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F 641	Continued From page 18 other medication that was classified as an anti-coagulant. MDS Nurse #1 said the Zolpidem was classified as a sedative/hypnotic medication and acknowledged it was not coded correctly on the MDS, and stated, "I missed it." During an interview with the Corporate Consultant on 9/28/23 at 1:25 PM, she shared the facility had provided a significant amount of training over the past couple of months due to upcoming coding instructions with the MDS process. She acknowledged that MDS Nurse #1 was new to the position and said she had mistakenly coded aspirin as an anti-coagulant and missed the coding of the Zolpidem as a hypnotic/sedative on the MDS assessment.	F 641		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews the facility failed to keep dependent residents' fingernails trimmed for 1 of 6 residents reviewed for activities of daily living care (Resident #19). Findings included: Resident #19 was admitted to the facility on 3/15/23. His active diagnoses included metabolic encephalopathy, cerebral infarction due to embolism of left middle cerebral artery, and hemiplegia and hemiparesis following cerebral	F 677	1. Resident #19 nails were trimmed on by a nursing assistant on 10/10/23. 2. The Unit Coordinators, or designee, audited 100% of residents to identify any residents who require nail care, on 10/19/23 it was identified that 96 of 135 residents required nail care. Referrals were made to podiatry for 44 residents during the podiatry visit at the facility on 10/19/23. 3. All licensed nurses and nursing	10/27/23

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	345538	A. BUILDING ______ B. WING ______	C 09/29/2023

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PRUITTHEALTH-RALEIGH	2420 LAKE WHEELER ROAD RALEIGH, NC 27603

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F 677

Continued From page 19

infarction affecting right dominant side.

Review of Resident #19's minimum data set assessment dated 7/20/23 revealed he was assessed as severely cognitively impaired. He had no rejection of care. He required extensive assistance with bed mobility, transfers, locomotion on and off unit, dressing, toilet use, and personal hygiene.

Review of Resident #19's care plan dated 7/20/23 revealed Resident #19's was care planned for activities of daily living decline related to cerebrovascular accident and weakness. The interventions included to notify the physician of changes, physical therapy and occupational therapy to evaluate and treat, encourage resident to do as much as possible, and set up resident for activities of daily living. He was not care planned for refusal of fingernail care.

During observation on 9/25/23 at 10:44 AM Resident #19's ten fingernails on both hands were observed to be long.

During an interview on 9/25/23 at 10:44 AM Resident #19 nodded when asked if his fingernails were long and if he would like them to be cut.

During observation on 9/26/23 at 10:30 AM Resident #19's ten fingernails on both hands were observed to be long following his morning shower.

During an interview on 9/26/23 at 10:34 AM the Director of Nursing stated during morning care, nails were to be trimmed if they were long. Upon observing Resident #19's fingernails, the Director

F 677

assistants will have education related to the policy and procedure for nail care, on 10/20/23 and 10/24/23, by the Clinical Competency Coordinator and/or nurse manager. This education has been added to the General Orientation of any newly hired licensed nurses and nursing assistants. Licensed nurses and nursing assistants who do not attend the training on nail care on 10/20/23 or 10/24/23 will be required to attend the training prior to working their next scheduled shift, by the Clinical Competency Coordinator, or designee

The DHS, or designee, will review 20 residents weekly to ensure nail care is completed, for four weeks. After four weeks, the DHS, or designee, will review 10 residents monthly, for clean and manicured nails. If a resident has refused nail care, documentation of the refusal will be reviewed to ensure it is in the electronic record. Monthly audits of 10 residents per month will continue, to ensure ongoing compliance.

4. The DHS will present the analysis of the nail care audit data to the Nursing Home Administrator at the Quality Assurance and Performance Improvement Committee meeting monthly until three consecutive months of compliance is maintained and then quarterly thereafter, to ensure ongoing compliance.

5. Completion Date: 10/27/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345538	A. BUILDING ______ B. WING ______	C 09/29/2023

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PRUITTHEALTH-RALEIGH	2420 LAKE WHEELER ROAD RALEIGH, NC 27603

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F 677	Continued From page 20 of Nursing stated Resident #19's fingernails should have been cut before now if he allowed. The Director of Nursing asked Resident #19 if he would like his fingernails to be cut and he nodded. During an interview on 9/26/23 at 10:35 AM Nurse Aide #3 stated he noted Resident #19's nails were long but had not gotten to them today. He stated this was his first time working with the resident in a while. He stated the fingernails were very long and he did not know how long they had been that way. He concluded Resident #19 did allow him to complete nail care previously and indicated the resident would let staff clip his nails when the resident was ready. During an interview on 9/26/23 at 10:40 AM Nurse #10 stated nurse aides were to report to nursing any refusals of nail care. She stated she was his regular nurse. The nurse concluded until today, no nurse aides had reported Resident #19's fingernails were long. During a follow up interview on 9/26/23 at 11:37 AM the Director of Nursing stated if the resident had a pattern of rejection of care, it would be on his care plan. Because rejection of nail care was not care planned, Resident #19 did not have a pattern of rejection of nail care.	F 677		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure	F 684		10/27/23

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PRUITTHEALTH-RALEIGH	2420 LAKE WHEELER ROAD RALEIGH, NC 27603

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 21 that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on record review, staff, and wound care Physician interviews the facility failed to assess and receive Physician orders for a resident who had a wound to the back of her right leg. This occurred for 1 of 1 resident (Resident #248) reviewed for wound care. Findings included: Resident #248 was admitted to the facility on 7-6-23 with multiple diagnoses that included adult failure to thrive and wound to right posterior leg. A review of Resident #248's hospital discharge record dated 7-6-23 revealed the resident was discharged with multiple decubitus ulcers on her legs and thigh. There were no treatment orders provided in the discharge summary. An admission note written by Nurse #2 on 7-6-23 at 7:17pm documented Resident #248 arrived to the facility at 6:35pm on 7-6-23 from the hospital. The documentation included diagnoses but no mention of the resident's wound. Nurse #2 was interviewed on 9-28-23 at 1:45pm. The nurse confirmed she had been assigned to Resident #248 when she was admitted on 7-6-23 and had worked from 7:00am to 7:00pm on 7-6-23. Nurse #2 explained she had not completed a full assessment of Resident #248 because the resident arrived after 6:00pm and stated the next shift would have been responsible	F 684	1. Resident #248 was discharged from the facility on 8/11/23. 2. The Unit Coordinators, or designee, will audit 100% of residents to identify any residents who have skin alterations that are not documented, including the size and a description of the area by 10/20/23. 48 of 142 resident chart audits did not have the correct documentation for a completed weekly focused skin assessment. 3. All licensed nurses will have education related to the policy and procedure for completing skin assessments, including documentation related to the size and a description of the area, and following MD orders for treatment, on 10/20/23 and 10/24/23, by the Clinical Competency Coordinator. This education has been added to the General Orientation of any newly hired licensed nurses. Licensed nurses who do not attend the training on 10/20/23 or 10/24/23 will be required to attend the training prior to working their next scheduled shift, by the Clinical Competency Coordinator, or designee. The DHS, or designee, will review 10 residents weekly to ensure documentation includes the size and a description of the area, MD orders are present for all	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345538	A. BUILDING ______ B. WING ______	C 09/29/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEALTH-RALEIGH	2420 LAKE WHEELER ROAD RALEIGH, NC 27603

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

F 684 Continued From page 22

for completing the admitting assessment. The nurse discussed when a resident was admitted to the facility with wounds, the admitting nurse would complete a skin assessment, remove any dressings over the wound, obtain measurements, and then re-dress the wound according to the facility's standing orders for wound care. She stated the admitting nurse would also notify the Wound Care Physician so the resident could be seen by the wound care team. Nurse #2 said she did not know why there had not been any orders written for four days or why there had not been any documentation of wound care being completed.

The facility's admitting "observation report" for Resident #248 was initiated on 7-6-23 at 10:09pm and was completed by the Director of Nursing (DON). The skin assessment section documented Resident #248 as having no alterations of her skin.

A nursing note dated 7-7-23 at 9:59pm written by Nurse #3 documented she changed Resident #248's dressing to her right outer thigh and placed a dry dressing "over the large area." There was no documentation as to the size or description of the area.

There was no further documentation of Resident #248's wounds or dressing changes.

Resident #248's care plan dated 7-7-23 revealed the resident was at risk for pressure injury related to decrease mobility. The goal for Resident #248 was to have no new avoidable skin breakdown and no signs or symptoms of deterioration or infection. The interventions for the goal were to provide treatment as ordered, observe, and report

F 684

treatments, and all treatments are consistent with the MD order, for four weeks. After four weeks, the DHS, or designee, will review 10 residents monthly, for wound documentation, MD orders and ensuring treatment is consistent with the MD order. Monthly audits of 10 residents per month will continue, to ensure ongoing compliance.

4. The DHS will present the analysis of the wound documentation, and the wound care treatment documentation, to the Nursing Home Administrator at the Quality Assurance and Performance Improvement Committee meeting monthly until three consecutive months of compliance is maintained and then quarterly thereafter, to ensure ongoing compliance.

5. Completion Date: 10/27/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345538	A. BUILDING ______ B. WING ______	C 09/29/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEALTH-RALEIGH	2420 LAKE WHEELER ROAD RALEIGH, NC 27603

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

Continued From page 23
any new skin breakdown, and assist with turning and repositioning.

A review of the Physician orders revealed on 7-10-23 there was an order received to clean the back of the right leg and buttocks with wound cleanser and apply a dry dressing three times a week (Monday, Wednesday, and Friday).

The admission Minimum Data Set (MDS) dated 7-12-23 revealed Resident #248 was cognitively intact with no behaviors. The resident required extensive assistance with two people for bed mobility, toileting, and personal hygiene. Resident #248 was documented as having one stage 2 pressure ulcer and 1 stage three pressure ulcer that were both present upon admission.

A review of the Physician orders revealed on 7-15-23 Resident #248's wound treatments changed to cleaning the right posterior thigh with soap and water, apply mupirocin (topical antibiotic ointment) ointment 2% then apply calcium alginate (wound dressing) and cover with a dry protective dressing three times a week (Monday, Wednesday, and Friday).

Review of Resident #248's Medication Administration Record (MAR) from 7-6-23 through 7-30-23 revealed wound treatments began on 7-10-23 and continued until 7-29-23. Documentation also revealed there was no wound treatment missed from 7-10-23 through 7-29-23 and followed the Physician's orders.

Resident #248's medical record showed the Wound Care Physician first saw the resident on 7-20-23. The Physician documented at that time Resident #248's right posterior thigh wound

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345538	A. BUILDING ______ B. WING ______	C 09/29/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEALTH-RALEIGH	2420 LAKE WHEELER ROAD RALEIGH, NC 27603

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

measured 1.2 centimeters (CM) long, 8.5 CM wide, and 0.1 CM deep with moderate drainage. The note documented no signs or symptoms of infection.

The Wound Care Physician saw Resident #248 on 7-27-23 and documented the wound measurements as 1.5CM long, 6.5CM wide, and 0.1CM deep. The Physician described the wound as having moderate drainage with no odor.

On 8-3-23 Resident #248 was seen by the Wound Care Physician. The Physician measured the resident's wound as 0.5CM long, 4.0CM wide, and 0.1CM deep. The Physician documented the wound continued to have moderate drainage with no odor.

The Director of Nursing (DON) was interviewed on 9-28-23 at 3:49pm. The DON explained the process when a resident was admitted to the facility from the hospital. She stated the nurse should complete an admission assessment using the "observation form" which included a full skin assessment and body audit. The DON confirmed she had completed the admission assessment on Resident #248 on 7-6-23. She stated she had completed a full skin assessment on Resident #248 and said she did not remember seeing any skin impairments. The DON also said she had read the hospital discharge summary but did not remember seeing anything in the summary related to a wound on Resident #248. She stated if the hospital had not sent treatment orders for Resident #248's wound, it was the responsibility of the admitting nurse to obtain orders.

Nurse #1 was interviewed on 9-28-23 at 3:13pm. Nurse #1 discussed the admission process and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345538	A. BUILDING ______ B. WING ______	C 09/29/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEALTH-RALEIGH	2420 LAKE WHEELER ROAD RALEIGH, NC 27603

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 25 stated if a resident was admitted with wounds or any skin impairment, that it should be documented in the admission assessment. She explained if the resident comes from the hospital with wounds, the hospital will typically send orders but if they did not, then it was the responsibility of the admitting nurse to obtain orders. The nurse confirmed she was assigned to Resident #248 on 7-8-23. She described the resident's skin as having excoriations and a wound to the posterior right thigh. Nurse #1 said there was not a dressing on Resident #248's right thigh but stated the resident told her it had fallen off during the night. The nurse said she had applied a dry dressing to Resident #248's posterior right thigh. The nurse stated she did not remember if there was an order for the dressing and said she had not documented applying the dressing because she forgot. During an interview with the Wound Care Practitioner on 9-28-23 at 2:10pm, the Wound Care Practitioner stated she remembered Resident #248. She explained that she expected to be notified by the next visit of any new residents who had been admitted with wounds. The Wound Care Nurse Practitioner stated she did not know why the facility had waited four days to obtain orders or why Resident #248 had not been seen until 7-20-23. She also said since there had not been prior measurements or documentation of the wound, she could not say if the resident's wounds had become worse. The Administrator was interviewed on 9-29-23 at 10:11am. The Administrator discussed that a skin assessment should be completed on all new admissions. She further stated if there was a discrepancy between the documentation of the	F 684		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345538	A. BUILDING ______ B. WING ______	C 09/29/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEALTH-RALEIGH	2420 LAKE WHEELER ROAD RALEIGH, NC 27603

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F 684	Continued From page 26 skin assessment and what was present on the resident, then the facility would need to investigate why there was a discrepancy. The Administrator explained as soon as there was a skin impairment noted on a resident, the nurse should be contacting the Physician for orders. She stated she was unaware there was an issue with the skin assessment for Resident #248 and that she expected staff to document any changes in the resident's skin and document any wound care treatments being provided.	F 684		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to place skin protection under the bridge (a section of a wound vac system used to connect the dressing to the vac) of a wound vac (Resident #8) and failed to complete weekly skin audits (Resident #397) for 2 of 4 residents reviewed for pressure ulcer care.	F 686	1. Resident #8 was discharged to the hospital on 10/3/23. Resident #397 expired on 1/11/2023. 2. The Unit Coordinators, or designee, will audit 100% of residents to identify any residents who have skin alterations that are not documented, including the size	10/27/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345538	A. BUILDING ______ B. WING ______	C 09/29/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEALTH-RALEIGH	2420 LAKE WHEELER ROAD RALEIGH, NC 27603

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F 686

Continued From page 27

Findings included:

1. Resident #8 was admitted to the facility on 2/24/23.

Resident #8's minimum data set assessment dated 8/8/23 revealed he was assessed as cognitively intact. He was assessed to reject care daily. He required supervision with bed mobility, dressing, eating, toilet use, and personal hygiene. He was independent with transfers. Resident #8 had an indwelling catheter and was always continent of bowel. His active diagnosis included osteomyelitis of vertebra, sacral and sacrococcygeal region, neurogenic bladder, diabetes mellitus, hyperlipidemia, paraplegia, anxiety disorder, and pressure ulcer of the sacral region stage IV. He had one stage IV pressure ulcer which was present upon admission and had a pressure reducing device for his bed and chair, nutritional or hydration interventions, and pressure injury care.

Resident #8's care plan dated 6/6/23 revealed he was care planned to be at risk for pressure injury related to paraplegia, decrease mobility, diabetes mellitus, and current stage 4 pressure injury present upon admission with osteomyelitis. The interventions included to follow up with reconstructive surgery per recommendations, educate on risk/complications for refusing wound care, lab/x-rays as ordered, notify physician of abnormalities, medication and supplements as ordered to aide in wound healing, wound care services and follow up with recommendations as ordered, monitor wound for signs and symptoms of decline and infection, dietician consult as indicated, encourage treatments as ordered, and pressure reduction mattress is in place to bed

F 686

and a description of the area by 10/20/23. 48 of 142 charts audited did not have the correct documentation for a weekly focused skin assessment.

3. All licensed nurses will have education related to the policy and procedure for completing skin assessments, including documentation related to the size and a description of the area, and following MD orders for treatment, and weekly skin focus observation monitoring, on 10/20/23 and 10/24/23, by the Clinical Competency Coordinator. This education has been added to the General Orientation of any newly hired licensed nurses. Licensed nurses who do not attend the training on 10/20/23 or 10/24/23 will be required to attend the training prior to working their next scheduled shift, by the Clinical Competency Coordinator, or designee.

The DHS, or designee, will review 10 residents weekly to ensure documentation includes the size and a description of the area, MD orders are present for all treatments, all treatments are consistent with the MD order, and weekly skin focus observation monitoring is documented, for four weeks. After four weeks, the DHS, or designee, will review 10 residents monthly, for wound documentation, MD orders and ensuring treatment is consistent with the MD order. Monthly audits of 10 residents per month will continue, to ensure ongoing compliance.

4. The DHS will present the analysis of the wound documentation, and the wound

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345538	A. BUILDING ______ B. WING ______	C 09/29/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEALTH-RALEIGH	**2420 LAKE WHEELER ROAD RALEIGH, NC 27603**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 28 and cushion to wheelchair. Review of Resident #8's order dated 2/25/23 revealed there was an order to cleanse sacral wound with normal saline, pat dry, and apply wound vac every Monday, Wednesday, and Friday. Review of a physician's assistant note dated 2/27/23 revealed Resident #8 was seen by the physician's assistant due to a fall over the weekend and reports of rib pain. Resident #8 was found packing his bags in bed without difficulty. Resident #8 was concerned with his wound vac care as he felt it was not appropriate and that his wound was worse than when he got here. He requested an emergency room eval. Upon assessment, the physician's assistant documented Resident #8 had no fever, and his wound vac was intact. He was to continue by mouth antibiotic through 5/12/23 and continue with wound care and vac. Resident #8 was adamant about an emergency room visit for eval. The resident had a picture of his wound, and the wound had no acute concerns, but the physician's assistant documented they would send the resident to the emergency room per Resident #8's request. Review of Nurse #1's note dated 2/27/23 revealed Resident #8's wound care treatment was initiated and a new wound to left hip was noted. Resident #8 requested the nursing supervisor. The Director of Nursing then went and spoke with Resident #8, and he stated his ribs hurt and needed an x-ray. The supervisor stated the facility could do that in the facility. Resident #8 then requested 911 to be called stating he wanted to go to the hospital. 911 was called.	F 686	care treatment and documentation, to the Nursing Home Administrator at the Quality Assurance and Performance Improvement Committee meeting monthly until three consecutive months of compliance is maintained and then quarterly thereafter, to ensure ongoing compliance. 5. Completion Date: 10/27/23	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345538	A. BUILDING ______ B. WING ______	C 09/29/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEALTH-RALEIGH	2420 LAKE WHEELER ROAD RALEIGH, NC 27603

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 29	F 686		

Review of the hospital discharge summary dated 2/27/23 revealed the physician documented Resident #8 had muscular tenderness to the left rib area without overlying signs of trauma and with a benign abdomen and no midline spinal tenderness. There was no worsening infection of his wound and Resident #8 was currently on antibiotics. The wound appeared to be healing well with no evidence of obvious cellulitis or malodorous purulent discharge appreciated although Resident #8 did have an area of concern to his wound. The area of concern was observed to have some redness to the lateral aspect of his wound where his wound vac was.

During an interview on 9/25/23 at 11:24 AM Resident #8 stated when he first came to the facility, a nurse changed his wound vac dressing and put it on wrong which resulted in discomfort and redness across his left thigh where the dressing connection ran across his skin from the wound to the wound vac. He concluded he did not know what was put on wrong or why it happened, just that a nurse later that week told him it had been placed incorrectly. He stated Nurse #1 who used to be the wound care nurse, would remember what happened.

During an interview on 9/27/23 at 10:27 AM Nurse #1 stated when Resident #8 came to the facility she had just stepped down as the wound care nurse and had offered to help Resident #8's hall nurse with wounds on 2/24/23. That nurse stated she was okay because Nurse #8 was helping her with wounds. She stated then on 2/27/23 she did not have an assignment yet and was with Wound Care Nurse #1 when Resident #8 complained about his wound vac. She stated

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345538	A. BUILDING ______ B. WING ______	C 09/29/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEALTH-RALEIGH	2420 LAKE WHEELER ROAD RALEIGH, NC 27603

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 30 she observed the wound vac as they changed the dressings and saw that the bridge did not have Tegaderm protecting the skin. She stated the nurse applied the wound vac the way that it was supposed to be except the bridge. Because the wound was at the buttock and hip, it needed a bridge to go from the wound to the vac. The nurse did not put Tegaderm on the skin under the bridge to protect the skin from the wound vac suction. She stated he was upset at that point, and she asked if she could put it on correctly, but he refused and requested wet to dry dressing and did not let any staff put the wound vac back on. She could not remember if the physician's assistant observed the wound with the wound vac on or if the wound vac was not on him at the time of her assessment. She stated if the physician's assistant viewed the wound before the wound vac was removed, it would have been impossible to know there was not a clear layer of Tegaderm under the bridge as there was also a layer of Tegaderm placed over the dressing and bridge. The physician's assistant did round early and most likely saw the wound before she had removed the wound vac dressing as he had been requesting to go to the hospital that morning. The order for the wound vac was canceled due to the resident refusing to have the wound vac placed correctly. She stated when she removed the wound vac there was an abrasion to his skin approximately two inches long and a quarter inch wide where the wound vac bridge was from his left buttock to his left hip. This was the new area she documented in her note. She stated the wound nurse let the Director of Nursing know about the wound vac being placed incorrectly and about the abrasion to the resident's skin. The abrasion healed in a matter of days and his wound was healing and had reduced in size.	F 686		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345538	A. BUILDING ______ B. WING ______	C 09/29/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEALTH-RALEIGH	**2420 LAKE WHEELER ROAD RALEIGH, NC 27603**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 31	F 686		

During an interview on 9/27/23 at 11:33 AM the Director of Nursing stated that the previous Wound Care Nurse #1 came to her shortly after Resident #8 was admitted and informed her that Nurse #8 had placed the wound vac on Resident #8 incorrectly. She was told the dressing was put on without skin protection under the bridge to the vac which caused an abrasion to his left buttock and hip. She stated he was very upset when she went to the room to assess him, and Resident #8 did now allow her to assess the wound or replace the wound vac. He requested to be sent to the hospital which the facility complied with. When he returned, he refused to have staff change his wound vac dressing as ordered and was changed to a wet to dry dressing. The Director of Nursing stated Nurse #8 was educated about wound vac use but none of the other staff. She concluded there had not been any other wound vacs in the facility since then. She concluded the wound vac should have had skin protection under the bridge to the wound vac when applied in order to protect the skin from the suction of the vac.

During an interview on 9/28/23 at 11:43 AM Nurse #8 stated she remembered Resident #8 and that she was helping the nurse on that hall with wound care. She further stated she was unable to recall exactly how she placed the bridge to the wound vac or if Resident #8 required a bridge for his wound vac.

During an interview on 9/28/23 at 11:54 AM Wound Care Nurse #1 stated she was being trained by Nurse #1 and did not remember the dressing change on 2/27/23.

During an interview on 9/28/23 at 12:06 PM

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345538	A. BUILDING ______ B. WING ______	C 09/29/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEALTH-RALEIGH	2420 LAKE WHEELER ROAD RALEIGH, NC 27603

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F 686	Continued From page 32	F 686		

Physician's Assistant #1 stated she vaguely remembered the visit with Resident #8 on 2/27/23. She further stated he was adamant he wanted to go to the hospital that day due to his fall and that he believed his wound had worsened. She stated he had a picture of his wound from when the dressing had been replaced and she saw no concerns with the wound in his picture. She stated the wound vac was in place when she assessed him, and she told him to wait until wound care to remove the dressing in order to disrupt the site as little as possible. She stated she was not present during his dressing change and only visualized the wound with the dressing intact on 9/27/23.

During an interview on 9/28/23 at 2:16 PM Wound Care Nurse Practitioner #1 stated Resident #8 refused to allow her to visualize his wound, so she had not done any recent assessments. She further stated she was not involved or aware of any concerns with Resident #8's wound vac as he did not have it when she began providing care to him. She concluded if a bridge to a wound vac was left against a patient's skin for a long time, and no Tegaderm was placed under the bridge to protect the patient's skin, the pressure of the wound vac suction could cause the development of a pressure injury to the patient's skin under the bridge if it was not corrected.

2. Resident #397 was admitted to the facility on 12/02/2021, and diagnoses included Alzheimer's and non-Alzheimer's dementia.

The care plan dated 12/02/2021 indicated Resident #397 was at risk for pressure injury.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345538	A. BUILDING ______ B. WING ______	C 09/29/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEALTH-RALEIGH	**2420 LAKE WHEELER ROAD RALEIGH, NC 27603**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 33	F 686		

Interventions included conducting weekly skin checks by the nurse. The care plan was updated on 9/20/2022 to record pressure injuries to both the right and left heel that were dated resolved on 11/01/2022. There was no documentation on the care plan indicating the resident developed a sacral wound.

A review of the medical record from September 2022 through January 2023 revealed there was one documented skin focused observation/weekly skin assessment dated 11/22/2022 and recorded a skin tear to the hand.

A review of nursing documentation from September 2022 to January 2023 in the electronic medical record did not record a pressure wound to the sacral area on Resident #397 nor record a right and left heel pressure wound since November 2022.

The quarterly Minimum Data Set (MDS) assessment dated 1/1/2023 indicated Resident #397 was severely cognitively impaired and required extensive assistance of one person for toileting and bed mobility. The MDS further indicated Resident #397 was a risk for developing a pressure ulcer but was not marked as having a pressure ulcer.

A wound care physician note dated 1/5/2023 reported an unavoidable unstageable pressure ulcer measuring 4 centimeters (cm) x 5.3cm x 0.4cm was present on the sacral area of the body. The wound care physician documented the sacral pressure wound had been present for less than one week. The sacral pressure wound was described as black and yellow in color with eighty-five percent of the tissue necrotic (dead

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	345538	A. BUILDING ______ B. WING ______	C 09/29/2023

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PRUITTHEALTH-RALEIGH	2420 LAKE WHEELER ROAD RALEIGH, NC 27603

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F 686		F 686		

Continued From page 34
tissue) and fifteen percent granulated (new connective tissue) with an odorless mild serous drainage from the wound. Treatment was provided and sharp debridement for the wound bed was planned after receiving consent from Resident #397's responsible party.

Physician orders for Resident #397 dated 1/6/2023 requested a consultation for sharp debridement by the wound care physician and a dietician consultation due to a non-stageable pressure area on the sacral area. Physician orders also included cleansing Resident #397's sacral area with a 0.25% diluted sodium hypochlorite solution moisten gauze, applying medical grade honey to the wound bed every day and covering with a dry dressing.
On 1/8/2023, the Physician ordered to clean the right and left heels with normal saline and apply a skin preparation every day.

Dietary notes dated 1/10/2023 reported Resident #397 was being followed by the wound care team for a sacral wound and a right and left heel deep tissue injury. The Dietician noted that due to Resident #397's decline in his oral intake and dehydration, Resident #397 had received intravenous fluids.

In an interview with Nurse #2 on 9/28/2023 at 12:43 p.m., she stated she was unable to recall Resident #397 having a sacral pressure wound. She explained residents were to receive weekly skin assessments. After reviewing Resident #397's chart, she stated she did not know why there were no weekly skin assessments or focused skin observations documented on Resident #397's electronic medical record.

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	345538	A. BUILDING ____ B. WING ____	C 09/29/2023

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PRUITTHEALTH-RALEIGH	2420 LAKE WHEELER ROAD RALEIGH, NC 27603

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F 686	Continued From page 35 In an interview with Nurse #1 on 9/28/2023 at 1:09 p.m., she stated while serving as the wound nurse from July 2022 to December 31,2022, she did not recall Resident #397 having a sacral pressure wound. She stated skin assessments were to be conducted weekly, and there were no weekly skin assessments or focused skin observations documented for Resident #397 in the electronic medical record. Nurse #1 had no explanation as to why the weekly skin assessments had not been conducted. In a phone interview with Nurse #12 on 9/29/2023 at 12:13 p.m., she recalled Resident #397 developing blisters on the right and left foot that resolved with skin prep treatments and wearing protective boots. She stated Resident #397's weekly skin assessments would have been conducted on the second shift, and she didn't have an answer to why weekly skin assessments for Resident #397 were not conducted or documented. She explained prior to Resident #397 being moved to another unit on 12/26/2022, she did not recall Resident #397 having a sacral pressure wound. In an interview with the Director of Nursing on 9/29/2023 at 10:48 a.m., she explained all residents were placed on weekly skin assessments as part of the standard of care to monitor skin changes. She stated Resident #397 had an order for skin audits written on 5/17/2022, and the nursing staff, who were responsible for performing weekly skin assessments, should have conducted and documented Resident #397's weekly skin assessments. She explained Resident #397's health declined, and a sacral pressure wound was identified on 1/5/2023. The Director of Nursing explained team members	F 686		

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	345538	A. BUILDING ______ B. WING ______	C 09/29/2023

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PRUITTHEALTH-RALEIGH	2420 LAKE WHEELER ROAD RALEIGH, NC 27603

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F 686	Continued From page 36 were assigned to monitor the performance of skin assessments weekly on the units and was unsure why Resident #397's weekly skin assessments not being completed had been missed except possibly the resignation of the team member. She stated in that case, she would have assumed responsibility of the monitoring of the skin assessments on the unit, and due to her workload, she was not able to complete the monitoring of skin assessments for Resident #397.	F 686		
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to provide restorative services for 1 of 2 residents reviewed for rehab and restorative (Resident #19).	F 688	1. Resident #19 was assessed by physical therapy on 10/23/23 to determine recommendations for his restorative nursing program. An MD order will be	10/27/23

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	345538	A. BUILDING ______ B. WING ______	C 09/29/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEALTH-RALEIGH	2420 LAKE WHEELER ROAD RALEIGH, NC 27603

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F 688

Continued From page 37

Findings included:

Resident #19 was admitted to the facility on 3/15/23. His active diagnoses included metabolic encephalopathy, cerebral infarction due to embolism of left middle cerebral artery, and hemiplegia and hemiparesis following cerebral infarction affecting right dominant side.

Review of Resident #19's minimum data set assessment dated 7/20/23 revealed he was assessed as severely cognitively impaired. He had no rejection of care. He required extensive assistance with bed mobility, transfers, locomotion on and off unit, dressing, toilet use, and personal hygiene. He did not receive any restorative services during the lookback period.

Review of Resident #19's occupational discharge summary dated 4/24/23 revealed occupational therapy was discontinued due to Resident #19's ceased progress and limited participation. He was discharged to the restorative nursing program for bilateral upper extremities range of motion while in the long-term care facility.

Review of Resident #19's care plan dated 7/20/23 revealed Resident #19 was care planned to require active and assistive range of motion to left upper left extremity up to 6 days per week. He also required passive range of motion to his right upper extremity up to 6 days per week. The interventions included to place Resident #19 in the restorative nursing program, complete gentle left upper extremity active / active assistive range of motion up to 6 days per week; with minimal visual and verbal cues, in each plane within normal range of motion up to 10 times to lift left

F 688

obtained once this assessment is completed and the resident plan of care will be revised accordingly.

2. The Unit Coordinators, or designee, will audit 100% of residents with a care plan for restorative nursing services to ensure that there is a schedule for them to have restorative services daily, consistent with their care plan, and that restorative services are provided and documented accordingly, by 10/23/23. Twenty Four residents are currently receiving restorative nursing services. Sixteen of 24 did not have a correct MD order for restorative nursing services and 23 or 24 did not have correct documentation consistent with their order for restorative nursing services.

3. All licensed nurses and nursing assistants will have education related to the policy and procedure for completing restorative nursing services, including documentation, on 10/20/23 and 10/24/23, by the Clinical Competency Coordinator. This education has been added to the General Orientation of any newly hired licensed nurses and nursing assistants. Licensed nurses and nursing assistants who do not attend the training on 10/20/23 or 10/24/23 will be required to attend the training prior to working their next scheduled shift, by the Clinical Competency Coordinator, or designee.

The DHS, or designee, will review 5 residents weekly to ensure restorative nursing services are provided and

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PRUITTHEALTH-RALEIGH	**2420 LAKE WHEELER ROAD RALEIGH, NC 27603**

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F 688	Continued From page 38 upper extremity / reach with left upper extremity. Resident #19 was to tolerate gentle right upper extremity passive range of motion for 1 - 2 sets x 10 repetitions, up to 6 days per week, within range of motion as tolerated, with up to 90 degrees right shoulder flexion and within functional limits right elbow, wrist, and hand; follow patient facial expressions for tolerance. Review of Resident #19's restorative history report revealed the last time he was offered and received restorative services was on 9/22/23. During an interview on 9/26/23 at 2:40 PM Nurse Aide #1 stated she worked as a restorative aide. She further stated Resident #19 was to get restorative therapy 6 days a week and she provided him with the range of motion exercises on days she was able. She stated he would miss restorative therapy the days that they were short, and she would be pulled from restorative to work on the floor. She stated she would document on the chart the days she was able to provide restorative therapy and the days she was unable to provide restorative therapy would be blank as she did not chart on those days. If the resident refused, she would enter that it was refused and would not be blank. The blank days would be the days she did not do anything with restorative if she was pulled to work the floor. She stated the last time he had restorative was 9/22/23. She stated today she was put on an assignment, and he would not get restorative today. She stated due to the job being split between herself and Nurse Aide #2, it was difficult for her to know if restorative was or was not done for the resident when she was not here. The lookback option on her tablet only looked back to 9/24/23 and the last time the screen said he received restorative was	F 688	documented for four weeks. After four weeks, the DHS, or designee, will review 5 residents monthly, to ensure restorative nursing services are provided and documented. Monthly audits of 5 residents per month will continue, to ensure ongoing compliance. 4. The DHS will present the analysis of the restorative nursing services audit, to the Nursing Home Administrator at the Quality Assurance and Performance Improvement Committee meeting monthly until three consecutive months of compliance is maintained and then quarterly thereafter, to ensure ongoing compliance. 5. Completion Date: 10/27/23	

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PRUITTHEALTH-RALEIGH	2420 LAKE WHEELER ROAD RALEIGH, NC 27603

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F 688	Continued From page 39	F 688		

9/22/23 but she was unable to look back that far to see who did it or if he received it other days. She stated on the days she is assigned restorative; it is done.

During an interview on 9/27/23 at 11:28 AM Nurse Aide #2 stated she had not been able to do restorative since August due to being pulled to the floor because of staffing. She further stated she had not been able to offer Resident #19 restorative this month and would not be able to offer it today to Resident #19 due to both her and the other restorative nurse aide being pulled to the floor.

During an interview on 9/27/23 at 11:29 AM Nurse Aide #1 stated she and the other restorative aide were pulled to the floor that day and would not be able to offer restorative services to Resident #19.

During an interview on 9/27/23 at 9:55 AM the Therapy Director stated she was familiar with Resident #19. She stated therapy's process when a resident was referred to restorative was to document the referral on the discharge summary and then enter the recommended restorative services on a template that went to the nurse over the restorative program. She further stated therapy's recommendation for restorative being offered to Resident #19 was 6 days a week. She concluded it was expected that restorative services would be offered at least six days out of the week to Resident #19.

During an interview on 9/27/23 at 12:10 PM the Infection Preventionist stated she was the head of restorative. She stated the restorative program was currently facing some struggles in order to be consistent. She stated patient care came first and

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PRUITTHEALTH-RALEIGH	**2420 LAKE WHEELER ROAD** **RALEIGH, NC 27603**

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F 688	Continued From page 40 restorative is to help continue what residents had learned once they came off therapy. The biggest struggle the restorative program had been facing was the ability of her two staff to complete the restorative workload each week due to staffing. She stated when her two aides got pulled to work the floor, restorative was not completed. She stated in a perfect world the goal would be that Resident #19 would be offered restorative 6 days a week according to his restorative care plan. She stated they did not enter orders for restorative but had it on the care plan and in a workload sheet at the central nursing station which she updates as resident are added or discharged from restorative. She stated on 9/25/23 and 9/26/23 Nurse Aide #2 was off, and Nurse Aide #1 was pulled to work the floor. On 9/27/23 both aides were at the facility, but both were pulled to work the floor. She concluded Resident #19 was not offered restorative according to his restorative plan of care this week due to her restorative aides being pulled to work the hall instead of completing their restorative caseload. During an interview on 9/27/23 at 12:50 PM the Director of Nursing stated residents should be offered restorative according to the recommendations from therapy and the residents' plan of care.	F 688		
F 689 SS=E	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and	F 689		10/27/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345538	A. BUILDING ______ B. WING ______	C 09/29/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEALTH-RALEIGH	2420 LAKE WHEELER ROAD RALEIGH, NC 27603

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F 689	Continued From page 41 §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on record review, resident, staff and physician interviews, the facility failed to supervise 1 of 1 resident (Resident #117) to prevent resident-resident altercations with other residents reviewed for supervision to prevent accidents and the non-smoking facility failed to complete smoking assessments for a resident that smoked, failed to provide supervision when a resident smoked and failed to ensure a resident did not possess smoking materials for 1 of 8 residents reviewed for accidents (Resident #12). The findings included: 1. Resident #117 was admitted to the facility on 7/7/22 with diagnoses that included dementia and schizophrenia. His quarterly Minimum Data Set assessment dated 10/11/22 revealed he was assessed as having a significant cognitive impairment with no behaviors. a. Resident #90 was admitted to the facility on 7/6/22 with diagnoses of Alzheimer's disease and dementia. He passed away at the facility on 5/6/23. His quarterly Minimum Data Set assessment dated 10/25/22 revealed he had a significant cognitive impairment with no behaviors. Review of a facility incident report dated 11/7/22 written by the Administrator revealed on 10/31/22 Resident #117 had a verbal and physical	F 689	1. Resident #117 has not had any incidents with other residents since Feb, 2023. Staff will continue to monitor the mood of resident #117 and intervene as appropriate to monitor him and maintain distance between this resident and other residents. The facility will continue to work with the MD and consulting psychologist related to interventions for resident #117 behaviors. Resident #12 had a smoking assessment completed on 10/18/23 by the DHS, or designee. Resident #12 was assessed as being unsafe to smoke independently. He was provided education related to his assessment, by the Director of Health Services and the Social Services Director on 10/18/23. He was offered smoking cessation options, or a transfer to a smoking facility, who might be able to meet his need for assistance to continue smoking. The resident elected to try smoking cessation. The facility will continue to monitor the resident choice and support him with relocation to a smoking facility, should he elect that option in the future. He was provided education related to the no smoking policy of this facility, and our inability to provide assistance for him to continue to smoke, per our facility policy. 2. PruittHealth Raleigh is a no-smoking	

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	345538	A. BUILDING ______ B. WING ______	C 09/29/2023

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PRUITTHEALTH-RALEIGH	2420 LAKE WHEELER ROAD RALEIGH, NC 27603

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F 689	Continued From page 42 altercation with Resident #90. Resident #117 was noted to self-propel his wheelchair up to Resident #90, point his finger in Resident #90's face resulting in a verbal argument and residents swinging arms at each other. An interview was conducted with the Administrator on 9/27/23 at 3:30 PM who stated the facility incident report was based upon the information provided by staff during the investigation. She indicated she did not witness the incident. Attempts to interview Resident #117 were not successful. An interview with Nurse #1 was conducted on 9/26/23 at 4:18 PM. She reported the incident occurred in the living area adjoining the nurse's station. Nurse #1 stated she witnessed the incident. Resident #90 was sitting in his wheelchair and Resident #117 passed by him in his wheelchair. She stated the wheelchairs locked. Nurse #1 stated she believed Resident #117 either kicked or punched Resident #90. She reported she was unsure of the details and could not remember the incident clearly. Nurse #1 stated it happened very quickly and she did not have time to react. She stated she reported the incident to Resident #117's nurse but was unable to recall the nurse's name. During an interview with Nurse #1 on 9/27/23 at 9:30 AM she stated Resident #90 had a scratch on his face after the incident. She stated he did not have it prior to the incident. Nurse #1 reported Resident #90 did not have any changes in behavior or express any concerns after the incident. An interview was conducted with Transporter #1	F 689	facility, which is communicated to all residents prior to their admission to the facility. The Director of Nursing completed smoking assessments on two additional residents, who staff reported have been smoking off the facility property. One resident reported he has not smoked for several months, and does not intend to smoke. One resident was assessed to be safe to smoke independently. This resident was provided education related to the facility no-smoking policy, including that all smoking materials must be kept secured at the nurses station. The resident agreed to be compliant with the facility smoking policy. This resident will have smoking assessments quarterly and with any change of condition, and his care plan has been revised. All residents have the potential to be impacted by the deficient practice. 3. All staff will have education related to the policy and procedure for ensuring that the resident environment remains as free from accident hazards as is possible and each resident receives adequate supervision & assistance devices to prevent accidents , on 10/20/23 and 10/24/23, by the Clinical Competency Coordinator. This education has been added to the General Orientation of any newly hired staff. Staff who do not attend the training on 10/20/23 or 10/24/23 will be required to attend the training prior to working their next scheduled shift, by the Clinical Competency Coordinator, or	

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PRUITTHEALTH-RALEIGH	**2420 LAKE WHEELER ROAD RALEIGH, NC 27603**

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F 689	Continued From page 43 on 9/29/23 at 10:29 AM. She stated she witnessed Resident #117 rolled his wheelchair over to Resident #90 and struck Resident #90. Transporter #1 stated she could not remember any additional details. Attempts to contact NA #4 who witnessed the incident were unsuccessful. b. Resident #67 was admitted to the facility on 11/5/22 with diagnoses that included dementia and sepsis. His admission Minimum Data Set assessment dated 11/9/22 revealed he was assessed as having a moderate cognitive impairment with no behaviors. Review of a nursing progress note dated 11/5/22 written by Nurse #10 revealed Resident #117 was found in his roommate's legs, Resident #67, attempting to pull him from his bed. Resident #117 also threatened to kill Resident #67. After being reassured the incident would be handled Resident #117 released Resident #67. An interview was conducted with Nurse #10 on 9/26/23 at 3:43 PM. She reported she observed Resident #117's attempt to remove Resident #67 from his bed. Nurse #10 reported Resident #117 will react to changes in his normal routine by escalating his behavior and will strike other residents. Nurse #10 stated she has learned his triggers. She stated she can redirect him by offering a snack or removing him from the area. She reported Resident #67 had no change in behaviors or emotions after the incident. Nurse #10 further stated she is very familiar with Resident #117 and is his assigned nurse. Record review revealed Resident #67 was moved from the room on 11/5/22. Resident #117 was placed on one-to one	F 689	designee. The DHS, or designee, will review 100% of resident-to-resident altercations weekly to ensure appropriate interventions are in place, on the care plan and the effectiveness of interventions is documented, for a minimum of 12 weeks. Monthly audits of 100% of resident to resident altercations will continue, to ensure ongoing compliance. The DHS, or designee, will review 100% of smoking assessments to ensure that the resident care plan is completed based on the assessment, and that the resident is compliant with the smoking safety care plan, including securing all smoking materials at the nurses station. 4. The DHS will present the analysis of the resident to resident altercation audit and the smoking assessment audit data, to the Nursing Home Administrator at the Quality Assurance and Performance Improvement Committee meeting monthly until three consecutive months of compliance is maintained and then quarterly thereafter, to ensure ongoing compliance. 5. Completion Date: 10/27/23	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEALTH-RALEIGH	**2420 LAKE WHEELER ROAD** **RALEIGH, NC 27603**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 44	F 689		

supervision from 11/5/22-11/13/22.
An interview was attempted with Resident #67 on 9/27/23 at 1:17 PM and he did not recall the incident.
Attempts to contact Nurse Aide #5 who witnessed the incident were not successful.

c. Resident #29 was admitted to the facility on 8/26/22 with diagnoses that included dementia and diabetes mellitus.
Resident #29's quarterly MDS assessment dated 11/25/22 revealed she was assessed as having severe cognitive impairment with no behaviors.
Review of a nursing progress note written by Nurse #15 dated 12/10/22 revealed Resident # 117 struck Resident #29 in the face.
An interview was conducted with Nurse #15 on 9/29/23 at 10:30 AM who stated she based her note on what she was told by staff. She was unable to recall who gave her the information. Nurse #15 stated she did not observe any psychosocial changes in Resident #29, and she did not express any concerns related to the incident.

Review of a facility interview of Nurse #12 revealed Resident #29 was calling out in the dayroom which appeared to frustrate Resident #117. She stated she attempted to separate the residents but Resident #117 struck Resident #29 before she could intervene.
Attempts to contact Nurse #12 were not successful.
d. Resident #11was admitted to the facility on 1/23/20 with diagnoses that included schizophrenia and epilepsy.

Resident #11's quarterly MDS dated 8/8/23 revealed he was assessed as having moderate

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345538	A. BUILDING ______ B. WING ______	C 09/29/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEALTH-RALEIGH	2420 LAKE WHEELER ROAD RALEIGH, NC 27603

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F 689	Continued From page 45 cognitive impairment with no behaviors. Review of a facility investigation dated 2/25/23 revealed Resident #11 reported to staff he was struck in the face by Resident #117. No staff witnessed the incident. The facility investigation revealed no changes in behavior or any expressions of concern after the incident. Attempts to interview Resident #11 were not successful. An interview was conducted with Resident #56 on 9/28/23 at 2:00 PM. He stated he witnessed the incident on 2/25/23 because it occurred outside his room door. Resident #56 stated the residents were arguing and he witnessed Resident #117 strike Resident #11 on the shoulder. He further reported he overheard Resident #117 tell Resident #11 he was going to hit him, and Resident #11 needed to go get him some coffee. Attempts to interview Nurse #8, the assigned nurse on the hall on 2/25/23 were not successful. An interview was conducted with Nurse #10 on 9/26/23 at 3:43 PM. She reported she is very familiar with Resident #117 and she is his assigned nurse. Nurse #10 reported Resident #117 will react to changes in his normal routine by escalating his behavior and will strike other residents. Nurse #10 stated she has learned his triggers such as loud noises and changes in his routine. She stated she can redirect him by offering a snack or removing him from the area. An interview was conducted with Physician #1 on 9/27/23 at 3:00 PM who stated Resident #117 is stable at this point because his current medication regimen is effective.	F 689		

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	345538	A. BUILDING ______ B. WING ______	C 09/29/2023

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PRUITTHEALTH-RALEIGH	2420 LAKE WHEELER ROAD RALEIGH, NC 27603

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F 689		F 689		

Continued From page 46

An interview was conducted with the Administrator and Corporate Consultant on 9/28/23 at 9:00 AM. The Administrator stated Resident #117 had not had any incidents since February 2023 and staff have done a good job managing his behavior. She reported he was admitted in July 2022 and they worked to develop a behavior management plan for him.

Review of an undated behavior management plan read in part, "facility staff have learned to look at his face and monitor his mood. They have determined if he is staring and glaring, they know to redirect him and move him away from other residents, as well as keep him in a public area for staff to monitor him".

2. The facility's "Smoke Free Policy" dated 2014 stated fire igniting materials and smoking materials should not be kept in a resident's possession. Resident's igniting smoking materials would be maintained at the nurse's station for safety of smokers. The policy also stated residents who were grandfathered-in would be assessed for risk and hazards prior to smoking in designated areas and shall be supervised as necessary based on the smoking observation form located in the electronic medical record. The smoking observation form was completed at least quarterly if questions indicated the resident smoked or had a history of smoking.

Resident #12 was admitted to the facility on 12/16/2021, and diagnoses included multiple sclerosis (an unpredictable disease of the central nervous system that disrupts the flow of information within the brain, and between the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345538	A. BUILDING ______ B. WING ______	C 09/29/2023

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PRUITTHEALTH-RALEIGH	2420 LAKE WHEELER ROAD RALEIGH, NC 27603

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F 689		F 689		

Continued From page 47
brain and body).

Resident #12's care plan initiated on 03/17/2022 and reviewed on 9/26/2023 indicated Resident #12 was care planned as a smoker and was noncompliant with the facility's smoking policy. Interventions included re-education on the smoking policy.

Nursing documentation in Resident #12's medical record recorded the following incidents related to Resident #12 smoking:

-On 10/17/2022, a former Director of Nursing documented a vaporized smoking device (an electronic smoking device) was observed in Resident #12's room. Resident #12 was educated on the facility's smoking policy that included vaporized smoking devices and the vapor device was placed in a locked box on the 500-hall medication cart.

-On 10/24/2022, Nurse #12 recorded Resident #12 was informed he could not receive his vapor smoking materials until he was ready to be escorted outside by family or visitors and staff were not to escort Resident #12 off the facility property to smoke.

-On 11/26/2022, Nurse #12 recorded Resident #12 was reminded of the facility's non-smoking policy when an empty pack of cigarettes was observed on Resident #12's bedside table. Nurse #12 recorded Resident #12 denied having any other packs of cigarettes or a lighter.

-On 4/19/2023, Nurse #3 documented the interdisciplinary team meet on that day, and Resident #12 remained a smoker and would continue with Resident #12's plan of care.

-On 4/24/2023, Nurse #12 recorded Resident #12 had been outside to smoke and subsequently

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345538	A. BUILDING ______ B. WING ______	C 09/29/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEALTH-RALEIGH	2420 LAKE WHEELER ROAD RALEIGH, NC 27603

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F 689	Continued From page 48	F 689		

received a burn to right hand middle digit at the first knuckle area. Resident #12 reported the burn occurred about one week ago while trying to hold a cigarette in his hand and he did not report the incident to the staff. Nurse #12 documented observing healing blisters to the area with no redness or signs of infection. She recorded Resident #12 occasionally had difficulty with fine motor skills and manual dexterity due to multiple sclerosis disease process. She also recorded Resident #12 stated he required someone to place the cigarette to his lips and light his cigarette. Nurse #12 recorded Resident #12 was unable to extinguish a cigarette and could not swiftly swat away a lit cigarette if dropped on himself. She documented Resident #12 required someone to propel him off the property to smoke. Nurse #12 recorded a smoking assessment was completed.

A smoking observation assessment dated 4/24/2023 completed by Nurse #12 indicated Resident #12 was unable to hold, light and extinguish his own cigarette and was unable to independently move to and from designated smoking areas. The smoking observation further indicated Resident #12 had a medical diagnosis that make unsupervised smoking a danger for Resident #12 and was a supervised smoker.

On 9/29/2023 at 12:20 p.m. in a phone interview with Nurse #12, she stated Resident #12 was a smoker, and facility's staff were aware Resident #12 went outside off the facility property to smoke. She explained smoking assessment were not conducted regularly because it was a non-smoking facility, and she conducted the smoke observation dated 4/24/2023 based on his disease process for multiple sclerosis and did not

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345538	A. BUILDING ______ B. WING ______	C 09/29/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEALTH-RALEIGH	2420 LAKE WHEELER ROAD RALEIGH, NC 27603

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F 689	Continued From page 49	F 689		

actually observe Resident #12 smoking for the assessment. She stated Resident #12 could safely smoke at times depending on how his multiple sclerosis was affecting him. She said nursing staff would assist Resident #12 to the front for coffee, but not the smoking area that was off the facility property. She explained visitors took him outside to smoke, and there was a plastic box in the medication room for residents who went off facility premises to smoke to lock up smoking materials. She stated she was unsure when Resident #12 obtained new smoking materials that were to be locked up when not in use.

The quarterly Minimum Data Set (MDS) assessment dated 6/30/2023 indicated Resident #12 was cognitively intact, required one person assistance with transfers off the unit and required supervision of one person assistance with eating.

Further review of nursing documentation in Resident #12's medical record regarding smoking included:

-On 8/10/2023, Nurse #12 recorded Resident #12 continued to go outside the facility on the sidewalk off the facility's property to smoke and she was unable to secure smoking materials.

-On 9/21/2023, Nursing #12 documented staff or other residents assisted Resident #12 outside to sit on sidewalk and smoke.

On 9/25/2023 at 11:41 a.m. during an interview with Resident #12, Resident #12 was observed removing a blue lighter and a pack of cigarettes from a black pouch laying in Resident #12's lap. Resident #12 stated the facility knew he smoked, and he smoked off the facility's property on the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345538	A. BUILDING ______ B. WING ______	C 09/29/2023

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PRUITTHEALTH-RALEIGH	2420 LAKE WHEELER ROAD RALEIGH, NC 27603

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F 689	Continued From page 50	F 689		

sidewalk at the highway. He explained friends or other residents helped him to the sidewalk because he was not able to wheel himself in the wheelchair to the sidewalk.

On 9/26/2023 at 2:30 p.m., a visitor was observed pushing Resident #12 up an elevated sidewalk from the facility's patio to the sidewalk alongside the highway, the visitor re-entered the facility leaving Resident #12 outside.

On 9/26/2023 at 2:33 p.m., Resident #12 was observed sitting upright in his wheelchair and removing a cigarette and lighter from the black pouch in his lap. Resident #12 used his right hand to place the cigarette between his lips and used both hands to hold the lighter to ignite the cigarette. Holding the cigarette between the second and third right hand fingers, Resident #12 was observed moving the cigarette from his lips to outside the right side of his wheelchair and discarding ashes onto the concrete sidewalk. Resident #12 stated he discarded the cigarette butt into the highway, and old cigarette butts were observed along the edge of the highway, as well as, on a grass area between the sidewalk and highway. Resident #12's clothing was observed with no burnt areas.

On 9/26/2023 at 2:40 p.m. in an interview with the Administration after requesting the smoking policy, she stated the facility was a smoke-free facility, and residents were not allowed to have smoking materials (lighters and cigarettes) in the rooms. The Administrator was informed Resident #12 was observed with a blue lighter and pack of cigarettes in a black pouch in his room.

In a follow up interview with the Administrator on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345538	A. BUILDING ______ B. WING ______	C 09/29/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEALTH-RALEIGH	**2420 LAKE WHEELER ROAD RALEIGH, NC 27603**

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F 689	Continued From page 51 9/28/2023 at 3:45 p.m., the Administrator stated there were no resident's grandfathered-in smokers at the facility. She stated residents' smoking materials should be locked up at the nurse's station, and Resident #12 was to obtain and return smoking materials to the nurse's station after going off the facility's property to smoke for safety concerns. On 9/28/2023 at 4:11p.m. in an interview with Nurse #13, Resident #12's assigned nurse on 9/28/2023, she stated she was not aware Resident #12 was a smoker and was not aware he had smoking materials in his room. She explained if smoking materials were in Resident #12's room, the smoking items needed to be obtained and given to the Director of Nursing. On 9/28/2023 at 4:22p.m. in an interview with Nurse #1, she stated she had observed Resident #12 date unknown smoking outside along the highway sidewalk when leaving the facility at the end of her shift. She explained when residents had smoking materials in their possession, she asked the resident for the smoking materials, and they were locked up in the medication cart until the resident was discharged. She stated she could not say Resident #12's smoking materials were locked in the medication cart. On 9/28/2023 at 4:26 p.m. in an interview with Nurse #14, he stated Resident #12 did not have any smoking materials locked inside the medication cart. He explained the facility was a smoke-free facility, Resident #12 was not to have smoking materials in his room, and there was no place to lock Resident #12's smoking materials. On 9/28/2023 at 6:26 p.m. in a phone interview	F 689		

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	345538	A. BUILDING ______ B. WING ______	C 09/29/2023

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PRUITTHEALTH-RALEIGH	2420 LAKE WHEELER ROAD RALEIGH, NC 27603

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F 689	Continued From page 52	F 689		

with Nurse Aide #4, she explained she only assisted Resident #12 to the front of the facility, and Resident #12 got other residents or visitors to assist him to the sidewalk off the facility's property to smoke. She stated nursing staff stored resident's smoking materials and she had not seen any smoking materials in his room.

On 9/29/2023 at 09:48 a.m. in an interview with Resident #12, he stated the Director of Nursing retrieved his smoking materials on the evening of 9/28/2023. He said the facility staff knew he went outside to smoke and how not asked him for his smoking materials.

On 9/29/2023 at 11:00 a.m. in an interview with the Director of Nursing, she stated she was aware that Resident #12 was a smoker and was informed on 9/28/2023 of Resident #12 having smoking materials in his room. She said Resident #12 was cooperative in turning in his smoking materials when approached on 9/28/2023 and the smoking materials had been locked up on the medication cart labeled with his name. She explained Resident #12 will need to request the smoking materials prior to going outside off the property to smoke. She further stated Resident #12 had increased his ability to self-propel his wheelchair to the front of the facility to exit outside and was not dependent on the nursing staff. She explained the facility was a non-smoking facility and Resident #12 independently exited the facility or with family to smoke off the property. She stated the one smoking assessment conducted on 4/24/2023 was performed after obtaining vaporized smoking materials from Resident #12 and not conducted routinely because the facility was a non-smoking facility.

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	345538	A. BUILDING ______ B. WING ______	C 09/29/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEALTH-RALEIGH	**2420 LAKE WHEELER ROAD** **RALEIGH, NC 27603**

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F 689	Continued From page 53 On 9/29/2023 at 12:57p.m. in an interview with the Administrator, she explained Resident #12 was aware of the facility's smoking policy. She stated the facility did not know how Resident #12 was receiving his smoking materials, and Resident #12 continued to have smoking materials in his room without informing the facility. She explained Resident #12 had been re-educated on the smoking policy and smoking materials had been gathered at this time.	F 689		
F 725 SS=D	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must	F 725		10/27/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345538	A. BUILDING ______ B. WING ______	C 09/29/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEALTH-RALEIGH	2420 LAKE WHEELER ROAD RALEIGH, NC 27603

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F 725	Continued From page 54 designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to provide sufficient nursing staff to provide restorative services for 1 of 2 residents reviewed for therapy and restorative (Resident #19). Findings included: This tag is cross referenced to: Tag F688 - Based on record review and staff interviews the facility failed to provide restorative services for 1 of 2 residents reviewed for rehab and restorative (Resident #19). During an interview on 9/27/23 at 1:32 PM the Director of Nursing stated that providing care was the priority of the facility nurse aides. Nurse aides are education to provide range of motion exercises while in school. The Director of Nursing felt that there was not a staffing issue as there were enough staff to provide care and they could provide restorative services during that care. Due to this, she stated nurse aides needed to be educated as to which residents needed restorative services in order to complete the care with the current staffing levels. During an interview on 9/28/23 at 9:08 AM the Administrator stated she felt there were enough staff to complete the restorative tasks for residents. She stated the nurse aides could be educated who was on the restorative case load and when restorative aides are unavailable or unable to complete the restorative task, the nurse	F 725	1. Resident #19 was assessed by physical therapy on 10/23/23 to determine recommendations for restorative nursing services. An MD order will be obtained based upon this assessment and the resident plan of care will be revised accordingly. 2. The Unit Coordinators, or designee, will audit 100% of residents with a care plan for restorative nursing services to ensure that there is a schedule for them to have restorative services daily, consistent with their care plan, and that restorative services are provided and documented accordingly by 10/23/23. Twenty three of 24 residents audited were not receiving restorative nursing services per their plan of care. 3. All licensed nurses and nursing assistants will have education related to the policy and procedure for completing restorative nursing services & attendance on 10/20/23 and 10/24/23, by the Clinical Competency Coordinator. This education has been added to the General Orientation of any newly hired licensed nurses and nursing assistants. Licensed nurses and nursing assistants who do not attend the training on 10/20/23 or 10/24/23 will be required to attend the training prior to working their next scheduled shift, by the Clinical Competency Coordinator, or designee.	

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	345538	A. BUILDING ______ B. WING ______	C 09/29/2023

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PRUITTHEALTH-RALEIGH	**2420 LAKE WHEELER ROAD RALEIGH, NC 27603**

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F 725	Continued From page 55 aides on the floor would be able to complete restorative services for the residents during their activities of daily living care.	F 725	All nursing assistants will have education related to the provision of restorative nursing services and documentation, provided by the Restorative Nurse, on 10/20 and 10/24/23. When there is a shift identified without a restorative aide scheduled, on a shift when restorative nursing services is required, it will be the responsibility of the Director of Health Services, or designee, to delegate responsibility for ensuring restorative nursing services are provided by a qualified nurse or nursing assistant, and documented correctly. This education has been added to the General orientation of any newly hired nursing assistants. Nursing assistants who do not attend the training on 10/20 or 10/24/23 will be required to attend the training prior to working their next scheduled shift, by the Restorative Nurse. The NHA reviewed with the DHS, Restorative Nurse, and Staffing Coordinator the staffing expectation for staffing based on census and acuity on 10/20/23. Options for covering the schedule include, but not limited to, incentive pay, review of open positions weekly, continued partnership with Talent Acquisition. Additional recruitment efforts are in effective to hire additional nursing assistants, to reduce the need to move the restorative aides to the schedule to cover vacant positions. In the event that the restorative aide is covering an open position, the nursing assistant assigned to the resident will be responsible for	

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	345538	A. BUILDING ______ B. WING ______	C 09/29/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEALTH-RALEIGH	2420 LAKE WHEELER ROAD RALEIGH, NC 27603

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F 725	Continued From page 56	F 725	providing restorative nursing services, and documentation these services. The DHS, or designee, will review 5 residents weekly to ensure restorative nursing services are provided and documented for four weeks. After four weeks, the DHS, or designee, will review 5 residents monthly, to ensure restorative nursing services are provided and documented. Monthly audits of 5 residents per month will continue, to ensure ongoing compliance. 4. The DHS will present the analysis of the restorative nursing services audit, to the Nursing Home Administrator at the Quality Assurance and Performance Improvement Committee meeting monthly until three consecutive months of compliance is maintained and then quarterly thereafter, to ensure ongoing compliance. 5. Completion Date: 10/27/23	
F 732 SS=C	Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift:	F 732		10/27/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345538	A. BUILDING ______ B. WING ______	C 09/29/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEALTH-RALEIGH	2420 LAKE WHEELER ROAD RALEIGH, NC 27603

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 732	Continued From page 57 (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to post the daily staffing sheet and post daily staffing census from May 2023 through September 2023 for 80 of 153 days reviewed for daily posted staffing. Findings included: A review of the daily posted staffing forms from May 2023 through September 2023 revealed no available posted staffing sheets and/or census	F 732	1. The facility posted the daily staffing information, including facility name, current date, number and actual hours for licensed and unlicensed nursing staff responsible for resident care per shift, and the resident census. 2. All residents have the potential to be impacted by the deficient practice. From Sept. 29 to 10/23/23, the daily staffing information has been posted 100% of the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345538	A. BUILDING ______ B. WING ______	C 09/29/2023

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F 732	Continued From page 58 information on the following days. - May 2023: There was no daily staff posting for 5-1-23, 5-2-23, 5-3-23, 5-4-23, 5-5-23, 5-6-23, 5-7-23, 5-8-23, 5-9-23, 5-10-23, 5-13-23, 5-15-23, 5-22-23, 5-27-23, 5-28-23, and 5-29-23. On 5-25-23 there was no census documented on the daily posted staffing sheet. - June 2023: There was no daily staff posting for 6-3-23, 6-4-23, 6-5-23, 6-10-23, 6-11-23, 6-13-23, 6-17-23, 6-18-23, 6-20-23, 6-24-23, 6-25-23, and 6-29-23. - July 2023: There was no daily staff posting for 7-1-23, 7-2-23, 7-3-23, 7-4-23, 7-5-23, 7-6-23, 7-7-23, 7-8-23, 7-9-23, 7-10-23, 7-11-23, 7-12-23, 7-13-23, 7-15-23, 7-16-23, 7-17-23, 7-18-23, 7-20-23, and 7-26-23. On the following days there was no documentation of the census. 7-22-23, 7-23-23, 7-25-23, and 7-28-23. - August 2023: There was no daily staff posting for 8-3-23, 8-5-23, 8-9-23, 8-17-23, 8-18-23, 8-19-23, 8-20-23, 8-21-23, 8-23-23, 8-24-23, and 8-28-23. On the following days there was no documentation of the census. 8-2-23, 8-4-23, 8-7-23, 8-10-23, 8-11-23, and 8-12-23. - September 2023: There was no daily staff posting for 9-2-23, 9-3-23, 9-9-23, and 9-19-23. On the following days there was no documentation of the census. 9-15-23, 9-16-23, 9-17-23, 9-18-23, and 9-20-23. The Scheduler was interviewed on 9-27-23 at 8:42am. The Scheduler discussed being new to	F 732	days. 3. The Nursing Home Administrator reviewed with the Director of Health Services , and Staffing Coordinator the staffing expectation for posting the daily staffing information on 10/20/23. 4. The NHA, or designee, will review daily staffing posting information for four weeks. After four weeks, the NHA, or designee, will review daily staffing posting once per week for 2 months. After 3 months, weekly monitoring of the daily staffing posting information will continue, to ensure compliance. 5. The NHA will present the analysis of the daily staffing posting audit, to the QA Committee members, at the Quality Assurance and Performance Improvement Committee meeting monthly until three consecutive months of compliance is maintained and then quarterly thereafter, to ensure ongoing compliance. 6. Completion Date: 10/27/23	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345538	A. BUILDING ______ B. WING ______	C 09/29/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEALTH-RALEIGH	**2420 LAKE WHEELER ROAD RALEIGH, NC 27603**

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F 732	Continued From page 59	F 732		

the role of Scheduler and said she started on 9-1-23. The scheduler explained she and the Director of Nursing (DON) were responsible for the daily posted staffing sheets. She stated she fills out the daily posted staffing sheet and then reviewed the sheet with the DON for accuracy. The Scheduler explained on Fridays she would complete the daily posted staffing sheet for the weekend and place the sheets behind the already posted Friday sheet. She confirmed she had training on how to complete the daily posted staffing sheet and was aware the sheets needed to have the facility census present. She also stated there was no one to complete the daily posted staffing if she was not working. The Scheduler was able to discuss the daily posted staffing was missing on 9-19-23 because she had come to work late that day and was unable to get the sheet completed. She also discussed the facility census missing on the September daily posted staffing sheets by stating she was confused on what the census was and had forgotten to go back and fill in the census when she confirmed the number.

The previous Scheduler was unable to be reached for an interview.

During an interview with the DON on 9-27-23 at 9:39am, the DON explained the daily posted staffing sheets were checked daily by her and the Administrator for accuracy. She stated she does not know why there are so many missing daily posted staffing sheets and was unaware the sheets were missing the census information. She also stated she or the Assistant DON would be responsible for completing the daily posted staffing sheets if the scheduler was not present. The DON discussed expecting the daily posted

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345538	A. BUILDING ______ B. WING ______	C 09/29/2023

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PRUITTHEALTH-RALEIGH	**2420 LAKE WHEELER ROAD RALEIGH, NC 27603**

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F 732	Continued From page 60 staffing sheets to be completed every day with complete and accurate information. The Administrator was interviewed on 9-29-23 at 10:18am. The Administrator discussed the staff coordinator being responsible for checking the daily posted staffing sheets each day and said if the staffing coordinator was not present then the Assistant DON or the DON would be responsible for assuring the daily posted staffing sheets were completed. The Administrator explained on 9-28-23 she had identified an issue with the daily posted staffing being completed and that she had put a new process in place. She stated she would expect the daily posted staffing to be filled in completely and posted daily.	F 732		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of	F 761		10/27/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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PRUITTHEALTH-RALEIGH	**2420 LAKE WHEELER ROAD RALEIGH, NC 27603**

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F 761	Continued From page 61 the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observations, resident and staff interviews and record review, the facility failed to secure medications for 1 of 2 residents (Resident #500) observed with medications at bedside and failed to keep unattended medications in a locked medication cart for 1 of 4 medication carts observed (600-hall medication cart). Findings Included: 1. Resident #500 was admitted to the facility on 7/7/22. Diagnosis included, in part, dementia. The quarterly Minimum Data Set assessment dated 8/23/23 revealed Resident #500 had severely impaired cognition. The Self-Administration of Medication assessment, dated 9/12/23, indicated Resident #500 was not appropriate to self-administer any medication. A review of the medical record revealed there was no order for Resident #500 to self-administer medication. An observation of Resident #500's room was completed on 9/25/23 at 11:49 AM. The resident was alert and sitting at the foot of the bed. A medication cup that contained ten pills was on the overbed table next to the resident's bed. During	F 761	1. Resident #500 medications were removed from the bedside on 9/25/23 by the nurse. Medication carts were locked on 9/27/23 upon notification. 2. The facility completed an audit of all alert and oriented residents, on 10/19/23. No additional residents were identified who expressed a desire to self-administer medications. Daily audits confirm that medications are not left at the bedside since 9/29/23. 3. All licensed staff were re-educated regarding the policy and procedure for self-administration of medication & securing medication carts when unattended, by the Clinical Competency Coord., or designee on 10/20/23 & 10/24/23. This education has been added to the General Orientation of any newly hired licensed nurses. Licensed nurses who do not attend the training on 10/20/23 or 10/24/23 will be required to attend the training prior to working their next scheduled shift, by the Clinical Competency Coordinator, or designee. The Director of Health Services, or	

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F 761

Continued From page 62

an interview with Resident #500 on 9/25/23 at 11:53 AM, he stated sometimes staff dropped off his medications and left them on the table for him to take. He did not know what the medications in the cup were for, and thought the nurse brought them in while he was asleep sometime during the morning.

Nurse #7 was interviewed on 9/25/23 at 11:55 AM. She explained when she gave medication to a resident, she watched the resident swallow the medication before she left the room. She verified she was Resident #500's nurse and shared when she brought the medications to Resident #500 earlier, the resident had not wanted to take them, and she left them in his room for him to take when he was ready. She added she had just returned from his room where she checked his vital signs, and she noticed the cup of pills was still on his overbed table and she left them there for him to take.

On 9/25/23 at 12:11 PM an interview was conducted with Nurse #6. She was orienting Nurse #7 during the day shift and explained that medications were not to be left at a resident's bed side. She said staff were supposed to watch a resident swallow the medications before they left the room.

In an interview with the Director of Nursing (DON) on 9/27/23 at 11:41 AM, she stated if a resident self-administered medications there had to be a physician order and an assessment that indicated a resident was able to self-administer medication. If a resident was not able to self-administer medication, the nurse watched a resident swallow the medications before they left the room. The DON verified Resident #500 was assessed as not

F 761

designee, will audit 10 medication passes per day, for 2 weeks. Following 2 weeks of daily monitoring, the DHS or designee will audit 10 medication passes twice per week, for 2 weeks, and then monitor 10 medication passes monthly thereafter until three months of sustained compliance is maintained and then quarterly thereafter.

4. The Director of Health Services will present the analysis of the medication pass, and medication cart security, compliance percentage to the Nursing Home Administrator at the Quality Assurance and Performance Improvement Committee meeting monthly until three consecutive months of compliance is maintained and then quarterly thereafter.

5. Completion Date: 10/27/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345538	A. BUILDING ______ B. WING ______	C 09/29/2023

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F 761	Continued From page 63 being able to safely self-administer medications. She said Nurse #7 was in orientation and was educated not to leave medications in a resident's room. She added, if Resident #500 refused medications, Nurse #7 should have removed the medications from his room and notified the provider. 2. During observation on 9/27/23 at 6:12 AM the 600-hall medication cart's lock was observed unlocked and unattended on the 600-hall, next to the nursing station. At 6:15 AM another nurse returned to the empty nursing station and was in view of the cart. At 6:15 AM Nurse #11 returned to the nursing station. During an interview on 9/27/23 at 6:16 AM Nurse #11 stated medication carts were to be locked when unattended. Upon observing her cart, she stated she must have left it unlocked after giving a pain medication to a resident and forgot to lock the cart prior to leaving the hall. During an interview on 9/27/23 at 7:59 AM the Director of Nursing stated medication carts should be locked when unattended.	F 761		
F 809 SS=E	Frequency of Meals/Snacks at Bedtime CFR(s): 483.60(f)(1)-(3) §483.60(f) Frequency of Meals §483.60(f)(1) Each resident must receive and the facility must provide at least three meals daily, at regular times comparable to normal mealtimes in the community or in accordance with resident needs, preferences, requests, and plan of care. §483.60(f)(2)There must be no more than 14 hours between a substantial evening meal and	F 809		10/27/23

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PRUITTHEALTH-RALEIGH	2420 LAKE WHEELER ROAD RALEIGH, NC 27603

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F 809	Continued From page 64 breakfast the following day, except when a nourishing snack is served at bedtime, up to 16 hours may elapse between a substantial evening meal and breakfast the following day if a resident group agrees to this meal span. §483.60(f)(3) Suitable, nourishing alternative meals and snacks must be provided to residents who want to eat at non-traditional times or outside of scheduled meal service times, consistent with the resident plan of care. This REQUIREMENT is not met as evidenced by: Based on record review, observation, resident interviews and staff interviews, the facility failed to provide breakfast meal trays at a regular scheduled mealtimes comparable to normal breakfast mealtimes in the community for 3 of 8 halls (100, 200 and 300 Halls). Findings included: A meal schedule was provided on 9/25/2023. Meal delivery times were recorded scheduled in 15-mnute intervals for the seven different halls (Memory unit, 700, 600, 500, 400, 300, 200, and 100-hall) between the following times: · Breakfast - 7:00 AM - 8:30 AM 1. On 9/27/2023 at 9:10 a.m., breakfast meal trays were observed not served to residents on the 100-hall and 200-hall On 9/27/2023 at 9:15 a.m., the Dietary Supervisor was observed working on the serving line and stated breakfast meals trays were delayed due to a call out in the dietary department that morning. She stated all halls except for the 100-hall and 200-hall had received their breakfast meal trays,	F 809	1. Resident #56 received his breakfast meal on 9/27/23. Resident #110 received her breakfast meal on 9/28/23. Resident #70 received her breakfast meal on 9/28/23. Resident #5 received her breakfast meal on 9/28/23. Resident #306 received her breakfast meal on 9/28/23. 2. The facility interviewed alert and oriented residents related to timeliness of meal trays on 10/26/23. 30% of residents interviewed reported that they do receive meal trays late during some days. 3. All dietary staff, and the Dietary Manager, received education regarding the policy and procedure for timely delivery of meal trays, by the RD., or designee, on 10/20/23 & 10/24/23. This education has been added to the General Orientation of any newly hired dietary staff. Dietary staff who do not attend the training on 10/20/23 or 10/24/23 will be	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 809	Continued From page 65	F 809		

and the dietary staff were currently working on preparing the 200-hall breakfast meal trays.

On 9/27/2023 at 9:40 a.m., the 100-hall residents, the last hall scheduled to receive breakfast meal trays from the kitchen, received and were served their breakfast meal trays.

a.Resident #56 was admitted to the facility 7/8/2022, and diagnoses included diabetes mellitus and end stage renal disease.

The quarterly Minimum Data Set (MDS) assessment dated 8/14/2023 indicated Resident #56 was cognitively intact.

On 9/28/2023 at 9:24 a.m. in an interview, Resident #56 explained he was a dialysis patient, and on 9/27/2023, he almost missed his breakfast meal tray because the breakfast meal trays were late to the 100-hall. He stated he was able to eat before going to dialysis, but he got his breakfast meal tray after 9:30 a.m. and left the facility for dialysis at 10:00 a.m.

On 9/27/2023 at 1:40 p.m., the 100-hall residents, the last hall scheduled to receive lunch meal trays from the kitchen, received and were served their lunch meal trays.

2. On 9/28/2023 at 8:49 a.m., breakfast meal trays were observed delivered to the 300-hall.

a. Resident #100 was admitted to the facility on 7/7/2022, and diagnoses included diabetes mellitus.

The quarterly MDS assessment dated 7/14/2023

required to attend the training prior to working their next scheduled shift, by the RD, or designee.

The RD, or designee, will audit one meal tray pass, per day, for 4 weeks. Following 4 weeks of daily monitoring, the RD, or designee, will audit 1 meal tray passes twice per week, for 4 weeks, and then monitor 1 meal tray pass once per month, for 1 months. Following 3 months of monitoring, monthly meal tray pass monitoring will continue to ensure ongoing compliance.

4. The Registered Dietician will present the analysis of the meal tray pass compliance percentage to the Nursing Home Administrator at the Quality Assurance and Performance Improvement Committee meeting monthly until three consecutive months of compliance is maintained and then quarterly thereafter.

5. Completion Date: 10/27/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345538	A. BUILDING ______ B. WING ______	C 09/29/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 809	Continued From page 66	F 809		

indicated Resident #110 was cognitively intact.

On 9/28/2023 at 8:44 a.m. in an interview, Resident #100 stated she was hungry and was waiting to receive her breakfast meal tray. She explained sometimes it was 10:30 a.m. before they received the breakfast meal trays. She stated she had not eaten anything since dinner meal trays on 9/27/2023 but had received an energy drank that she drank as much as she could, but not all of it.

The 300-hall was scheduled to receive breakfast meal trays at 8:00 a.m., and the facility had evening snacks available for residents if requested.

b. Resident # 70 was admitted to the facility on 7/7/2022, and diagnoses included diabetes mellitus and end stage renal disease.

The quarterly MDS assessment dated 7/21/2023 indicated Resident #70 was cognitively intact.

On 9/28/2023 at 8:50 a.m. in an interview, Resident #70 stated she had not eaten anything between supper last night and breakfast this morning, and she was hungry.

On 9/28/2023 at 8:52 a.m., nursing staff were observed serving breakfast meal trays to the residents on 300-hall.

c. Resident #5 was admitted to the facility on 9/1/2023, and diagnoses included diabetes mellitus.

The admission MDS dated 9/6/2023 indicated Resident #5 was severely cognitively impaired.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345538	A. BUILDING ______ B. WING ______	C 09/29/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 809		F 809		

Continued From page 67

On 9/28/2023 at 8:42 a.m., Resident #5 was observed sitting outside her room on the 200-hall. She stated she had not been served a breakfast meal tray, and she was hungry. She stated she didn't like to eat breakfast after 9:00 a.m. and preferred eating breakfast after getting up around 7:30 a.m. She said she had eaten a small Baby Ruth candy bar this morning. Resident #5 was observed receiving her breakfast tray at 9:13 a.m.

On 9/28/2023 at 9:02 a.m., breakfast meal trays were observed delivered to the 200-hall.

On 9/28/2023 at 9:04 a.m., nursing staff were observed serving residents breakfast meal trays to the residents on
200-hall.

d. Resident #306 was admitted to the facility on 9/4/2023.

The MDS assessment was not complete.

On 9/28/2023 at 9:19 a.m., Resident #306's breakfast meal tray was observed left on the meal cart due to Resident #306 was in the physical therapy department.

On 9/28/2023 at 10:00 a.m. Resident #306 was observed sitting in wheelchair in her room eating her breakfast. She stated she received her breakfast meal tray after returning from physical therapy about fifteen minutes ago, and the food was still warm. She stated she usually ate breakfast before physical therapy and breakfast meal trays usually were served after 9:00 a.m. She stated dinner meal trays were delivered at 6:30 p.m. on 9/27/2023, and she ate a small

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345538	A. BUILDING ______ B. WING ______	C 09/29/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEALTH-RALEIGH	2420 LAKE WHEELER ROAD RALEIGH, NC 27603

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 809		F 809		

Continued From page 68
snack she had in her room prior to going to bed.

On 9/28/2023 at 9:17 a.m., breakfast meal trays were observed delivered to 100-hall residents.

e. Resident #56 was admitted to the facility 7/8/2022, and diagnoses included diabetes mellitus and end stage renal disease.

The quarterly Minimum Data Set (MDS) assessment dated 8/14/2023 indicated Resident #56 was cognitively intact.

On 9/28/2023 at 9:24 a.m. Resident #56 stated breakfast meal trays were always late. Sometimes it may be 9:45 a.m. before breakfast meal trays arrive.

In an interview with the Registered Dietician on 9/28/2023 at 9:23 a.m., she stated she did not know why the breakfast meal trays were not out on the halls as scheduled because the serving line was fully staffed to prepare the breakfast meal trays.

In an interview on 9/28/2023 at 9:30 a.m. with the Dietary Supervisor, she explained the preparation of the English muffins served for breakfast caused the delay beyond the scheduled mealtime for the delivery of breakfast meal trays for the 300-hall, 200-hall and 100-hall residents. She explained English muffins, waffles and pancakes were prepared as needed instead of batching, so the food items were served soft and warm. Therefore, slowing down the serving line.

In an interview with the Dietary Manager on 9/28/2023 at 3:05 p.m., she explained she tried to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345538	A. BUILDING ______ B. WING ______	C 09/29/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEALTH-RALEIGH	2420 LAKE WHEELER ROAD RALEIGH, NC 27603

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 809	Continued From page 69 have five dietary staff scheduled daily for each shift (6a.m.-2p.m. and 12p.m. to 8p.m.) to prepare and serve meals to the residents and stated currently she had one dietary staff position opening for the evening shift that she had not been able to fill. She stated residents receiving late meal trays was not an ongoing problem. She explained to keep meals delivered on a regular scheduled time each day, she helped in the kitchen to cover call outs as needed, and the maintenance staff helped deliver prepared meal tray carts to the different halls each mealtime so dietary staff stayed in the kitchen preparing meal trays. She stated although the dietary supervisor and herself were helping to prepare and served breakfast meal trays on 9/27/2023, they were not able to catch up the hour of time the kitchen was behind in preparing and delivering breakfast meal trays at 7:00 a.m. when she arrived at the facility. She stated the kitchen did not maintain a log of the time when meal trays left the kitchen for delivery to the different halls. She also said she would need change the preparation of English muffins, waffles and pancakes, so all residents received breakfast meal trays at a regular scheduled mealtime. In an interview with the Administrator on 9/29/2023 at 12:49 p.m., she stated she was not aware of any concerns related to late meal trays for the residents. She explained the facility had enough dietary staff to prepare and deliver meal trays as scheduled, and the dietary manager was to follow the attendance policy and hold dietary staff accountable. She stated the residents' meals should be served based on the dietary schedule.	F 809		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5)	F 842		10/27/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345538	A. BUILDING ______ B. WING ______	C 09/29/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEALTH-RALEIGH	2420 LAKE WHEELER ROAD RALEIGH, NC 27603

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F 842	Continued From page 70	F 842		

§483.20(f)(5) Resident-identifiable information.
(i) A facility may not release information that is resident-identifiable to the public.
(ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so.

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345538	A. BUILDING ______ B. WING ______	C 09/29/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEALTH-RALEIGH	2420 LAKE WHEELER ROAD RALEIGH, NC 27603

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 842	Continued From page 71 by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to have a complete and accurate medical record related to documentation of a resident's wound. This occurred for 1 of 1 resident (Resident #248) reviewed for wound care. Findings included: Resident #248 was admitted to the facility on 7-6-23 with multiple diagnoses that included adult	F 842	1. Resident 248 was discharged from the facility on 8/11/23. 2. The Unit Coordinators, or designee, will audit 100% of residents to identify any residents who have skin alterations that are not documented, including the size and a description of the area. 48 of 142 residents chart audits did not have the correct documentation for a completed weekly focused skin assessment.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345538	A. BUILDING ______ B. WING ______	C 09/29/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEALTH-RALEIGH	2420 LAKE WHEELER ROAD RALEIGH, NC 27603

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

F 842 Continued From page 72
failure to thrive, wound to posterior right thigh.

A review of Resident #248's hospital discharge record dated 7-6-23 revealed the resident was discharged with multiple decubitus ulcers on her legs and thigh. There were no treatment orders provided in the discharge summary.

The facility's admitting "observation report" for Resident #248 was initiated on 7-6-23 at 10:09pm and was completed by the Director of Nursing (DON). The skin assessment section documented Resident #248 as having no alterations of her skin.

The Director of Nursing (DON) was interviewed on 9-28-23 at 3:49pm. The DON explained the process when a resident was admitted to the facility from the hospital. She stated the nurse should complete an admission assessment using the "observation form" which included a full skin assessment and body audit. The DON confirmed she had completed the admission assessment on Resident #248 on 7-6-23. She stated she had completed a full skin assessment on Resident #248 and had documented no skin impairment because she did not remember seeing any skin impairments. The DON also said she had read the hospital discharge summary but did not remember seeing anything in the summary related to a wound on Resident #248. She discussed not notifying the wound care Physician because she did not see any skin impairment on Resident #248 during her assessment.

Nurse #1 was interviewed on 9-28-23 at 3:13pm. Nurse #1 discussed the admission process and stated if a resident was admitted with wounds or any skin impairment, that it should be

F 842

3. All licensed nurses will have education related to the policy and procedure for completing skin assessments, including documentation related to the size and a description of the area, and following MD orders for treatment, on 10/20/23 and 10/24/23, by the Clinical Competency Coordinator. This education has been added to the General Orientation of any newly hired licensed nurses. Licensed nurses who do not attend the training on 10/20/23 or 10/24/23 will be required to attend the training prior to working their next scheduled shift, by the Clinical Competency Coordinator, or designee.

The DHS, or designee, will review 10 residents weekly to ensure documentation includes the size and a description of the area, MD orders are present for all treatments, and all treatments are consistent with the MD order, for four weeks. After four weeks, the DHS, or designee, will review 10 residents monthly, for wound documentation, MD orders and ensuring treatment is consistent with the MD order. Monthly audits of 10 residents per month will continue, to ensure ongoing compliance.

4. The DHS will present the analysis of the wound documentation, and the wound care treatment documentation, to the Nursing Home Administrator at the Quality Assurance and Performance Improvement Committee meeting monthly until three consecutive months of compliance is maintained and then

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345538	A. BUILDING ______ B. WING ______	C 09/29/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEALTH-RALEIGH	2420 LAKE WHEELER ROAD RALEIGH, NC 27603

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 842	Continued From page 73 documented in the admission assessment. The nurse confirmed she was assigned to Resident #248 on 7-8-23. She described the resident's skin as having excoriations and a wound to the posterior right thigh. The nurse said she had applied a dry dressing to Resident #248's posterior right thigh. The nurse stated she had not documented applying the dressing or the condition of Resident #248's skin because she forgot. The Administrator was interviewed on 9-29-23 at 10:11am. The Administrator discussed that a skin assessment should be completed on all new admissions and the finding documented in the resident's medical record. She stated she was unaware there was an issue with the skin assessment for Resident #248 and that she expected staff to document any changes in the resident's skin and document any wound care treatments being provided.	F 842	quarterly thereafter, to ensure ongoing compliance. 5. Completion Date: 10/27/23	
F 867 SS=E	QAPI/QAA Improvement Activities CFR(s): 483.75(c)(d)(e)(g)(2)(i)(ii) §483.75(c) Program feedback, data systems and monitoring. A facility must establish and implement written policies and procedures for feedback, data collections systems, and monitoring, including adverse event monitoring. The policies and procedures must include, at a minimum, the following: §483.75(c)(1) Facility maintenance of effective systems to obtain and use of feedback and input from direct care staff, other staff, residents, and resident representatives, including how such information will be used to identify problems that	F 867		10/27/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345538	A. BUILDING ______ B. WING ______	C 09/29/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEALTH-RALEIGH	**2420 LAKE WHEELER ROAD RALEIGH, NC 27603**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 867	Continued From page 74	F 867		

are high risk, high volume, or problem-prone, and opportunities for improvement.

§483.75(c)(2) Facility maintenance of effective systems to identify, collect, and use data and information from all departments, including but not limited to the facility assessment required at §483.70(e) and including how such information will be used to develop and monitor performance indicators.

§483.75(c)(3) Facility development, monitoring, and evaluation of performance indicators, including the methodology and frequency for such development, monitoring, and evaluation.

§483.75(c)(4) Facility adverse event monitoring, including the methods by which the facility will systematically identify, report, track, investigate, analyze and use data and information relating to adverse events in the facility, including how the facility will use the data to develop activities to prevent adverse events.

§483.75(d) Program systematic analysis and systemic action.

§483.75(d)(1) The facility must take actions aimed at performance improvement and, after implementing those actions, measure its success, and track performance to ensure that improvements are realized and sustained.

§483.75(d)(2) The facility will develop and implement policies addressing:
(i) How they will use a systematic approach to determine underlying causes of problems impacting larger systems;

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345538	A. BUILDING ______ B. WING ______	C 09/29/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEALTH-RALEIGH	2420 LAKE WHEELER ROAD RALEIGH, NC 27603

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 867	Continued From page 75 (ii) How they will develop corrective actions that will be designed to effect change at the systems level to prevent quality of care, quality of life, or safety problems; and (iii) How the facility will monitor the effectiveness of its performance improvement activities to ensure that improvements are sustained. §483.75(e) Program activities. §483.75(e)(1) The facility must set priorities for its performance improvement activities that focus on high-risk, high-volume, or problem-prone areas; consider the incidence, prevalence, and severity of problems in those areas; and affect health outcomes, resident safety, resident autonomy, resident choice, and quality of care. §483.75(e)(2) Performance improvement activities must track medical errors and adverse resident events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the facility. §483.75(e)(3) As part of their performance improvement activities, the facility must conduct distinct performance improvement projects. The number and frequency of improvement projects conducted by the facility must reflect the scope and complexity of the facility's services and available resources, as reflected in the facility assessment required at §483.70(e). Improvement projects must include at least annually a project that focuses on high risk or problem-prone areas identified through the data collection and analysis described in paragraphs (c) and (d) of this section.	F 867		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345538	A. BUILDING ______ B. WING ______	C 09/29/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEALTH-RALEIGH	2420 LAKE WHEELER ROAD RALEIGH, NC 27603

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F 867	Continued From page 76	F 867		

§483.75(g) Quality assessment and assurance.

§483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must:

(ii) Develop and implement appropriate plans of action to correct identified quality deficiencies;
(iii) Regularly review and analyze data, including data collected under the QAPI program and data resulting from drug regimen reviews, and act on available data to make improvements.
This REQUIREMENT is not met as evidenced by:
Based on observations, record review and staff interview the facility's Quality Assessment and Assurance Committee failed to maintain implemented procedures and monitor interventions that the committee had previously put in place following the complaint surveys of 2/10/21and 10/27/21. The deficiencies were in the areas of ADL Care Provided for Dependent Residents (677), Quality of Care (684), Free of Accident Hazards/ Supervision/Devices (689), Sufficient Nursing Staff (725), Resident Records-Identifiable Information (842), Increase/Prevent Decrease in ROM/Mobility (688) and Free from Abuse and Neglect (600). The continued failure during three federal surveys of record showed a pattern of the facility's inability to sustain an effective Quality Assurance Program.
The findings included:
The tag is cross-referenced to:

1. On 10/24/23 the Administrator had an Ad Hoc Quality Assiruance and Performance Improvement Committee (QAPI) meeting with the Interdisciplinary Team (IDT) to discuss the 7 repeat tags, F677, F684, F689, F725, F842, F688, F600. It was determined through Root Cause Analysis that the facility has gone through turnover in leadership in management positions in these identified areas.

2. All residents have the potential to be impacted by the deficient practice.

3. The Administrator and Regional Nurse Consultant educated the Interdisciplinary Team on the Quality Assurance and Performance Improvement policy and procedure for the facility, with emphasis

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345538	A. BUILDING ______ B. WING ______	C 09/29/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEALTH-RALEIGH	2420 LAKE WHEELER ROAD RALEIGH, NC 27603

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

F 867 Continued From page 77

F677: Based on observations, record review, and staff interviews the facility failed to keep dependent residents' fingernails trimmed for 1 of 6 residents reviewed for activities of daily living care (Resident #19).

During the complaint survey of 10/27/21, the facility was cited for failing to provide grooming and hygiene needs.

F684: Based on record review, staff, and wound care Physician interviews the facility failed to assess and receive Physician orders for a resident who had a wound to the back of her right leg. This occurred for 1 of 1 resident (Resident #248) reviewed for wound care.

During the complaint survey of 10/27/21, the facility was cited for failing to obtain laboratory values and intravenous/ subcutaneous fluids for a resident experiencing end of life changes; failed to obtain wound cultures and sensitivity prior to administration of antibiotics; and failed to obtain vancomycin troughs as ordered.

F689: Based on record review, resident, staff and physician interviews, the facility failed to supervise 1 of 1 resident (Resident #117) to prevent resident-resident altercations with other residents reviewed for supervision to prevent accidents and the non-smoking facility failed to complete smoking assessments for a resident that smoked, failed to provide supervision when a resident smoked and failed to ensure a resident did not possess smoking materials for 1 of 8 residents reviewed for accidents (Resident #12).

During the complaint survey of 10/27/21, the facility was cited for failing to reassess

F 867

on continuing to monitor and evaluate prior areas cited during surveys, on 10/20/23. On 10/19/23 the Administrator reviewed surveys for 2/20/2021 and 10/27/2021 to identify ongoing trends are included in the monthly QAPI meeting agenda.

The Area Vice President of Operations for Coastal North Division and/or the Regional Nurse Consultant will attend the monthly QAPI meetings to ensure that the repeat tags are monitored, monthly, for 6 months, then quarterly for 3 quarters, then annually.

4. The NHA will present the analysis of the QAPI meeting monitoring, to the QAPI committee members, at the Quality Assurance and Performance Improvement Committee meeting monthly. The Quality monitoring schedule will be modified based on the findings of the monitoring review, as needed.

5. Completion Date: 10/27/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345538	A. BUILDING ______ B. WING ______	C 09/29/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEALTH-RALEIGH	2420 LAKE WHEELER ROAD RALEIGH, NC 27603

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 867	Continued From page 78 alternative measures for siderails when the resident developed a bruise and was noted by staff to lean into the siderails and at times be combative. F725: Based on record review and staff interviews the facility failed to provide sufficient nursing staff to provide restorative services for 1 of 2 residents reviewed for therapy and restorative (Resident #19). During the recertification and complaint survey of 10/27/21, the facility was cited for failing to provide sufficient staff to provide for the hygiene needs. F842: Based on record review and staff interviews the facility failed to have a complete and accurate medical record related to documentation of a resident's wound. This occurred for 1 of 1 resident (Resident #248) reviewed for wound care. During the complaint survey of 10/27/21, the facility was cited for failing to accurately document the administration of narcotic medication and intravenous fluid administration. F688: Based on record review and staff interviews the facility failed to provide restorative services for 1 of 2 residents reviewed for rehab and restorative (Resident #19). During the complaint survey of 2/10/21, the facility was cited for failing to provide palm guards and restorative services. An interview with the Administrator was conducted on 9/29/23 at 2:34 PM. She reported	F 867		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345538	A. BUILDING ______ B. WING ______	C 09/29/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEALTH-RALEIGH	2420 LAKE WHEELER ROAD RALEIGH, NC 27603

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 867	Continued From page 79 the facility attempted to correct any on-going issues that were identified. The Administrator further stated the facility had some turnover in administrative staff which may have contributed to the repeated citations. She reported she was not sure how the Quality Assurance Committee operated prior to her arriving at the facility. The Administrator reported that the committee met monthly and they looked at trends to identify issues. She further stated employees were encouraged to discuss issues of concern.	F 867		
F 883 SS=D	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza	F 883		10/27/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345538	A. BUILDING ______ B. WING ______	C 09/29/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEALTH-RALEIGH	2420 LAKE WHEELER ROAD RALEIGH, NC 27603

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F 883	Continued From page 80 immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to administer the pneumococcal vaccine to 2 of 5 residents reviewed for immunization (Resident #144 & #70). Findings included: The facility policy for Pneumococcal Vaccinations with the revised date of 10/26/22 read in part all	F 883	1. Resident #144 was discharged from the facility on 9/29/2023. Resident #70 will be offered the pneumococcal vaccine on 10/18/23. The resident declined the vaccine. 2. The Infection Control Nurse, or designee, will offer the pneumococcal vaccine to 100% of residents on 10/20/23,	

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	345538	A. BUILDING ______ B. WING ______	C 09/29/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEALTH-RALEIGH	2420 LAKE WHEELER ROAD RALEIGH, NC 27603

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

F 883

Continued From page 81

residents who reside in this healthcare center are to receive the pneumococcal vaccine within the current CDC (Centers for Disease Control and Prevention) guidelines unless contraindicated by their physician or refused by the resident or resident's family.

1. Resident #144 was admitted to the facility on 8/29/23. The admission Minimum Data Set dated 9/02/23 indicated she was cognitively intact.

Resident #144's vaccine information consent form signed by the resident dated 8/30/23 read in part that the resident would like to be offered the pneumococcal vaccine upon admission.

Review of Resident #144's immunization records on 9/27/23 revealed no documentation of the pneumococcal vaccine being administered or refused.

An interview with the Infection Control Nurse on 9/27/23 at 10:10 AM revealed she had been in the position of the Infection Preventionist since March 2023. She stated she had not administered any pneumococcal vaccines since she had been in that position. She stated the process was to review all new admissions for pneumococcal consents, send the consent to the pharmacy and schedule the vaccine to be administered. She stated she had not been following this process but was unable to explain why not. She stated after the pharmacy received the consent that the vaccine should be delivered to the facility the same day or the next day. After that either she or the nurse on the unit could administer the vaccine.

An interview with the Director of Nursing on

F 883

with appropriate follow up based upon resident, or responsible party, consent. 145 residents were audited, 18 were current with their pneumococcal vaccine and 41 refused the vaccine. Vaccinations were ordered from the pharmacy and will be administered to those who provided consent, as soon as it is available at the facility.

3. The Director of Health Services educated the Infection Control RN related to the policy and procedure for the pneumococcal vaccine on 10/18/23. This education has been added to the General Orientation for any future Infection Control licensed staff.

The DHS, or designee, will audit 100% of new admissions to ensure the pneumococcal vaccine has been offered to the resident, and/or responsible party, at the time of admission, weekly for 4 weeks. After 4 weeks, the DHS, or designee, will audit 10 new admissions monthly, for 2 months. Monthly audits of 10 new admissions will continue, after 3 months, to ensure ongoing compliance.

4. The Director of Health Services, will present the analysis of the pneumococcal vaccine monitoring, to the Nursing Home Administrator at the Quality Assurance and Performance Improvement Committee meeting monthly. The Quality monitoring schedule will be modified based on the findings of the monitoring review, as needed.

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PRUITTHEALTH-RALEIGH	**2420 LAKE WHEELER ROAD RALEIGH, NC 27603**

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F 883	Continued From page 82 9/27/23 at 3:16 PM revealed she was unaware that new admissions had not been receiving the pneumococcal vaccines and she did not know why. An interview with the Administrator on 9/28/23 at 9:35 AM revealed she did not know why the Infection Control Nurse had not been administering the pneumococcal vaccines. 2. Resident #70 was admitted to the facility on 7/07/22. The quarterly Minimum Data Set dated 7/21/23 indicated she was cognitively intact. Review of Resident #70's immunization records revealed on 9/27/23 no documentation of the pneumococcal vaccine being offered, administered, or refused. An interview with the Infection Control Nurse on 9/27/23 at 10:10 AM revealed she had been in the position of the Infection Preventionist since March 2023. She stated she had not administered any pneumococcal vaccines since she had been in that position. She stated she could not locate any documentation that Resident #70 had been offered, administered, or refused the vaccine. She was unable to explain the lack of documentation. The Infection Control Nurse stated she had not reviewed any current residents' pneumococcal vaccine status to determine if they had been offered, administered, or refused and was unable to explain how come she had not. An interview with the Director of Nursing on 9/27/23 at 3:16 PM revealed she was unaware	F 883	5. Completion Date: 10/27/23	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 883	Continued From page 83	F 883		

that Resident #70 had no documentation to indicate whether she had been offered, administered, or refused the pneumococcal vaccine.

An interview with the Administrator on 9/28/23 at 9:35 AM revealed she did not know why the Infection Control Nurse had not been administering the pneumococcal vaccines.