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 02/12/2016

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 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff, family and resident interviews the facility failed to treat a resident in a dignified manner during discharge for 1 of 3 residents (Resident #1) reviewed for admission, transfer, and discharge rights, and failed to provide a bath in a dignified manner for 1 of 2 residents observed for a bath, Resident #9. Findings included: 1. Resident #1's Admission Minimum Data Set (MDS) dated 01/17/16 revealed she was admitted to the facility on 01/10/16 with diagnoses of heart failure, arthritis and hypertension. Resident #1 was cognitively aware. Review of the Physician's Interim Orders dated 01/27/16 showed an order to discharge Resident #1 home on 01/29/16 with all current medications and for Home Health Physical Therapy, Occupational Therapy and Skilled Nursing to evaluate and treat. In an interview on 02/10/16 at 5:05 PM the Social Worker (SW) stated when she discussed discharge with the residents or family she let them know that discharge was at 11:00 AM. She indicated she told them if it would be later than that she would need to be informed. The SW stated admissions were based on discharges and rooms were usually available by 1:00-2:00 PM. She stated Resident #1 initiated the discharge	F 241	1. Resident #1 Resident affected: The resident affected has been discharged from the facility. Residents with potential to be affected: All residents with the need to be discharged have the ability to be affected. Systemic changes: a. Residents awaiting discharge will maintain access to their room until transportation has arrived and resident is placed in the vehicle. b. All staff members have been educated related to residents maintaining access to their room until transportation has arrived and resident is placed in the vehicle. c. Education related to residents maintaining access to their room until they have been placed in the vehicle has been added to new hire orientation. d. When the facility is placing a new resident in a bed that is occupied by a resident who is discharging that same day, the facility Admission Director and/or Nursing Supervisor will contact the admitting transition nurse when the bed is	3/11/16

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

Electronically Signed | 03/04/2016

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 02/12/2016

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 241	Continued From page 1 herself. The SW stated Resident #1 was alert and oriented and made her own transportation arrangements for discharge. She indicated she did not follow-up with family to check on discharge transportation because Resident #1 was alert and oriented. In an interview on 2/10/16 at 9:10 AM the Director of Nursing (DON) stated Resident #1 was alert and oriented and made her own transportation arrangements. She indicated it was her right to do that and the facility did not check to make sure someone would be picking the resident up. In a telephone interview on 02/11/16 at 9:40 AM Resident #1 stated she notified the SW and the nursing staff that her family was picking her up after work at about 5:00 PM. She stated the Assistant Administrator (AA) "barged" into her room about 3:00 PM and threw her belongings into her bag and told her she had to leave because they were getting a new admission into her room. Resident #1 indicated the AA told her she could sit in the lobby or at the nursing station to wait for her family. Resident #1 stated she picked the lobby because she knew residents that "acted up" were placed at the nursing station and she did not want anyone to think she was acting out. She indicated she did not have a cellular telephone to call her family and there was no telephone access in the lobby. She indicated the only staff around was the "coffee girl" at the desk. Resident #1 stated no one offered to help her to the bathroom and she really needed to go. She stated there was no call light available to her in the lobby. She stated she was very upset at how she was treated and did not understand why she needed to leave her room before her family came to pick her up. She indicated that staff made her feel like she had done something wrong. In a telephone interview on 02/11/16 at 11:45 AM	F 241	available; the admitting transition nurse will contact the hospital case manager for transport of new resident. e. The Social Services Department, Admission Director and/or Senior Care Partner will maintain a log of beds with residents who are discharging that includes the current resident discharge time and new resident admission time to ensure times do not overlap. f. The Social Services Department/Admissions Director/Senior Care Partner will discuss the log in morning stand-up meeting weekly for four weeks, and then monthly for five months. QAPI: The Social Services Department, Admissions Director and/or Senior Care Partner will present the analysis of the tracking and trending of the admission/discharge log to the QAPI Committee monthly for six months; after two consecutive quarters showing substantial compliance, the audit will be discontinued. 2. Resident #9 Resident affected: Resident #9 was affected. Residents with potential to be affected: All residents have the potential to be affected. Systemic changes: a. On 2/12/2016 the Clinical Competency Coordinator (CCC) and/or RN Nurse	

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 02/12/2016

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 241	Continued From page 2 Resident #1's family member stated she never received a telephone call from the facility to set up Resident #1's discharge. The family member indicated when she arrived to pick up Resident #1 her face was beet red because she needed to use the bathroom and no one would assist her. She indicated she spoke to the AA and told her how upset Resident #1 was at the way she was treated. She stated putting Resident #1 out in the lobby with her baggage made Resident #1 feel bad. In an interview on 02/11/16 at 12:10 PM the AA stated she was in the SW office at 3:00 PM on the day Resident was discharged and was told the facility was getting admissions. She indicated they needed Resident #1's room so she asked the resident if she could place her in the lobby or at the nursing desk to wait for her family. She indicated Resident #1 agreed to sit in the lobby. The AA indicated she told the receptionist to keep an eye on Resident #1. She stated she did not realize there would be a problem with Resident #1 sitting in the lobby waiting for her family. She stated it was "terrible customer service" and that she made a "terrible mistake." The AA indicated she realized this when Resident #1's family stated they planned to notify the Ombudsman of the way Resident #1 was treated. She indicated when she wheeled Resident #1 to the lobby she was provided with snacks but she did not explain to Resident #1 how she could call for assistance if she needed something. She indicated she had apologized to Resident #1's family member and explained the room had been needed for a new admission. In an interview on 02/12/16 at 2:50 PM the DON stated she expected the staff to treat all the residents with dignity and respect.	F 241	Managers started to educate all of the CNAs on bathing protocol including perineal care of male and female residents. b. On 2/23/2016 the CCC, Assistant DON and/or Nurse Managers began competency checks and sign-offs of all of the CNAs for perineal care and bathing. c. Perineal care of male and female residents has been added to the general orientation education of the CNAs. d. The CCC, DON, Assistant DON, Nurse Managers and/or Registered/Licensed Nurses will observe perineal care of 10 residents per day for seven days, then 12 residents per week for four weeks, then 15 residents monthly for five months. QAPI: The DON or her designee will track and trend the CNA perineal observations and present the analysis to the QAPI committee for review and revision monthly for six months; after two consecutive quarters showing substantial compliance, the audit will be discontinued.	

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 02/12/2016

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 241	Continued From page 3	F 241		

2. A review of the Minimum Data Set quarterly assessment for dated 11/05/15 revealed Resident #9 was mildly cognitively impaired and that she required physical assistance in part of her bathing activity. The same assessment indicated she was always incontinent of bowel and occasionally incontinent of the bladder, and that she was receiving hospice services.

Resident #9's nursing care plan which was initiated on 02/05/16 included a goal and approaches to address her self-care deficit related to her physical status and weakness. The goal listed for this problem was, "Activities of daily living needs [to be] met as indicated and dignity [to be] maintained over next review." Some of the approaches included on the nursing care plan to meet the goals were to provide a bath/shower as scheduled, to provide incontinent care after each episode, and to consult with hospice.
In an observation of a bath with incontinent care for Resident #9 on 02/10/16 at 11:55 AM, NA #1 explained the bathing procedure to the resident, then drew a basin of warm water and added no-rinse soap. NA #1 dampened a washcloth in the warm water and handed the washcloth to the resident and encouraged her to wash her face. After Resident #9 washed her face, NA #1 rinsed the washcloth and provided the resident a bath to the remainder of the upper body. As NA #1 provided the bath, she noted Resident #9 had a moderate amount of stool in her gluteal fold and perineal area. NA #1 cleaned the stool, first using disposable wipes, then using a washcloth dampened with the warm soapy water from the basin. After cleaning the stool from the resident, she rinsed the washcloth in the basin of warm, soapy water. The water in the basin became

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 02/12/2016

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 241	Continued From page 4 visibly brown with stool. NA #1 did not change the water in the basin. NA #1 placed a clean washcloth in the basin of contaminated water, then provided the remainder of Resident #9's bath to her legs and feet. In an interview with the NA #1 on 02/10/16 at 12:45 PM, she stated she forgot to change the water in the basin after cleaning the stool from Resident #9, and add she would not have wanted to be bathed with same water used to rinse a stool soiled washcloth. An attempt was made to interview Resident #9 on 02/10/2016 at 2:20 PM. Resident #9 was unable to communicate her feelings regarding the bath due to her inability to speak English clearly. The Director of Nursing stated in an interview on 02/10/16 at 4:10 PM that the nursing assistant should not have used the visibly soiled water to complete the remainder of Resident #9's bath.	F 241		
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.	F 278		3/11/16

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 02/12/2016

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 278	Continued From page 5 Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to complete an accurate Minimum Data Set (MDS) assessment for 1 of 8 sampled residents (Resident #7) whose MDS' were reviewed. Findings included: Resident #7's Quarterly MDS dated 01/10/16 revealed he was re-admitted to the facility on 01/03/16 with diagnoses of hypertension, Parkinson's disease and dementia. Resident #7 was severely cognitively impaired. The MDS did not reflect that Resident #7 was re-admitted with two pressure ulcers. In an observation/interview on 02/10/16 at 9:28 AM Resident #7 received pressure ulcer care from the Treatment Nurse. The wound was located on the left lateral foot. The wound bed was red with yellow slough. The area around the wound was pink. No odor or drainage was noted. The second wound was on the left lateral ankle and was covered with a scabbed area. The Treatment Nurse indicated that Resident #7 was	F 278	Resident affected: Assessment was completed by Case Mix nurse to accurately code for resident #7 for pressure ulcers. Residents with potential to be affected: a. All residents have the potential to be affected. b. MDS assessments for all pressure ulcers will be reviewed for coding accuracy by March 11, 2016. Systemic changes: a. The DON and/or Clinical Reimbursement Coordinator will in-service the interdisciplinary team (IDT) on MDS coding accuracy by March 11, 2016. b. By March 11, 2016, the IDT will begin to validate accuracy of new MDS assessments by utilizing quick print, real	

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 02/12/2016

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 278	Continued From page 6 readmitted with pressure ulcers to the left lateral foot and left lateral ankle on 01/03/16. In an interview on 02/12/16 at 1:30 PM MDS Nurse #1 stated she did not remember Resident #7 as she only worked as needed. She indicated she got the information to create the MDS from reviewing the chart. She stated she reviewed physician orders, the medication administration record, the treatment record and other paperwork. MDS Nurse #1 indicated she could also speak to the nursing staff if she had any questions. She indicated the Treatment Nurse had not provided her with the Section M Skin Conditions sheets dated 01/04/16. MDS Nurse #1 stated she could not provide a clear answer as to why she had not input the correct information into Resident #7's Quarterly MDS. In an interview on 02/12/16 at 1:44 PM MDS Nurse #2 stated to get the information required for the MDS she needed to read through the chart including the Hospital Discharge paperwork, physician notes, medication administration record, treatment record and the admission assessment. She indicated it was a problem that the information was available but the MDS did not reflect it accurately. In an interview on 02/12/16 at 2:00 PM the Treatment Nurse stated she filled out the Section M Skin Conditions worksheets for the MDS and placed them in the binder with the Treatment Record sheets. She indicated the binder and the sheets were available to MDS Nurse #1 at the time of the assessment. In an interview on 02/12/16 at 2:44 PM the Director of Nursing (DON) stated she expected the MDS to be accurate and match the resident. She indicated she expected the MDS Nurse to check physician orders, medication administration records, treatment records and	F 278	time data integrity analysis from Point Right and chart review daily to discuss MDS prior to submission. c. The Case Mix Director and/or Nursing Management will complete the MDS accuracy audit tool for each assessment weekly for four weeks, then monthly for five months. QAPI: The MDS Director or DON will track and trend the MDS accuracy audit tool and present the analysis to the QAPI committee for review and revision for six months; after two consecutive quarters showing substantial compliance, the audit will be discontinued.	

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 02/12/2016

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 278	Continued From page 7 any other applicable paperwork so the MDS would be accurate. She also indicated she expected the MDS Nurse to interview other staff members and the resident if possible to obtain the information.	F 278		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to revise the Care Plan for 1 of 3 sampled residents (Resident #7) reviewed for pressure ulcers. Findings included: Resident #7's Quarterly MDS dated 01/10/16 revealed he was re-admitted to the facility on	F 280	Resident affected: Resident #7 care plan was reviewed and revised on February 12, 2016. Residents with potential to be affected: a. All residents with pressure ulcers have	3/11/16

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 02/12/2016

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 280	Continued From page 8 01/03/16 with diagnoses of hypertension, Parkinson's disease and dementia. Resident #7 was severely cognitively impaired. The MDS did not reflect that Resident #7 was re-admitted with two pressure ulcers. Review of Resident #7's Care Plan last updated 01/07/16 revealed a problem for a potential risk for an alteration in skin integrity with approaches (interventions) to report any signs/symptoms of skin alteration to the charge nurse and to encourage and/or assist Resident #7 to change positions frequently. In an observation/interview on 02/10/16 at 9:28 AM Resident #7 received pressure ulcer care from the Treatment Nurse. The wound was located on the left lateral foot. The wound bed was red with yellow slough. The area around the wound was pink. No odor or drainage was noted. The second wound was on the left lateral ankle and was covered with a scabbed area. The Treatment Nurse indicated that Resident #7 was re-admitted with pressure ulcers to the left lateral foot and left lateral ankle on 01/03/16. In an interview on 02/12/16 at 1:44 PM MDS Nurse #2 stated the Care Plan should be updated with each quarterly review and when there was a change such as a fall or the resident developed a pressure ulcer. She indicated anyone could update a Care Plan and it was not just the responsibility of the MDS Nurse. She indicated it was a shared responsibility. MDS Nurse #2 stated Resident #7's Care Plan should have been updated to reflect his pressure ulcers. In an interview on 02/12/16 at 2:00 PM the Treatment Nurse stated that anyone could update a resident's Care Plan. She indicated no one was responsible for updating Care Plans and it was not done. She stated Resident #7's Care Plan had fallen through the cracks.	F 280	the potential to be affected. b. The care plans of residents with pressure ulcers will be reviewed and revised by March 1, 2016. Systemic changes: a. The DON, Nurse Manager and/or Clinical Competency Coordinator (CCC) will educate the RNs/LPNs on updating the care plans related to pressure ulcer assessments by March 11, 2016. b. The CCC will provide education on updating care plans related to pressure ulcer assessments during general orientation of RNs/LPNs. c. The Skin Integrity Nurse and or Nurse Manager will complete the Pressure Ulcer Monitoring Tool including validation of wound documentation and care plan updating for residents with pressure ulcers weekly for four weeks, then monthly for five months. QAPI: The DON or her designee will track, trend, and then present the analysis of the Pressure Ulcer Monitoring Tool to the QAPI committee for review and revision monthly for six months; after two consecutive quarters showing substantial compliance, the audit will be discontinued.	

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 02/12/2016

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 280	Continued From page 9 In an interview on 02/12/16 at 2:44 PM the Director of Nursing (DON) stated she expected Care Plans to be updated quarterly and in between if needed. She indicated the Care Plan should be updated with the onset of any new condition. The DON stated the development of pressure ulcers would be something that should be updated on the Care Plan. She stated that Care Plans were a shared responsibility.	F 280		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS 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 observation, record review, and staff interviews, a staff member used water contaminated with stool to provide a bath to the lower extremities for one of three residents reviewed for activities of daily living care, Resident #9. Findings included: A review of the Minimum Data Set quarterly assessment dated 11/05/15 revealed Resident #9 was mildly cognitively impaired, was always incontinent of bowel, and that she required assistance with part of her bathing activity. Resident #9's nursing care plan which was initiated on 02/05/16 included a goal and approaches to address her self-care deficit related to her physical status and weakness. The	F 312	Resident affected: Resident #9 was provided bathing. Resident with potential to be affected: All residents have the potential to be affected. Systemic changes: a. The Clinical Competency Coordinator (CCC) and/or Nurse Managers began educating all the CNAs on bathing protocol including perineal care of male and female residents on February 12, 2016. b. On February 23, 2016, the CCC, Assistant DON, and/or Nurse Managers began competency checking and sign-offs	3/11/16

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 02/12/2016

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 312	Continued From page 10 goal listed for this problem was, "Activities of daily living needs [to be] met as indicated and dignity [to be] maintained over next review." Some of the approaches included on the nursing care plan to meet the goals were to provide a bath/shower as scheduled, and to provide incontinent care after each episode. An observation of a bath provided by Nursing Assistant #1 (NA #1) for Resident #9 was made on 02/10/16 at 11:55 AM. NA #1 drew a basin of warm water and added no-rinse soap to provide a bath to the resident's neck and upper body. After bathing Resident #9's upper body and applying body lotion, NA #1 emptied the basin of water, washed her hands, drew a basin of fresh warm water, and added soap. NA #1 assisted Resident #9 to turn to her side to bathe her buttock and observed a moderate amount of stool present in the gluteal fold. NA #1 used disposable wipes to remove a large portion of stool and disposed of the wipes. NA #1 then dampened a washcloth using the basin of fresh warm, soapy water and removed the remaining stool from the resident's buttocks. NA #1 rinsed the stool from the washcloth in the basin of warm soapy water, then dampened a clean washcloth in the same basin of water and continued cleaning the stool from the resident's perineum. NA #1 again rinsed the soiled washcloth in the same basin of water. The water in the basin was visibly brown with stool. NA #1 changed her gloves, then placed a clean washcloth in the visibly brown water and used it to bathe the resident's legs and feet. In an interview with NA #1 following the bathon 02/10/16 at 12:45 PM, she stated she forgot to change the basin of water after she finished cleaning the stool from the resident. She stated she should have used fresh water to provide the remainder of Resident #9's bath to her legs and	F 312	of the CNAs for perineal care and bathing. c. The CCC has added education on perineal care of male and female residents and bathing to the general orientation for all CNAs. d. The CCC, DON, Assistant DON, Nurse Managers, and/or registered/licensed nurses will observe perineal care of 10 residents per day for seven days, then 12 residents per week for 4 weeks, then 15 residents per month for five months; after two consecutive quarters showing substantial compliance, this monitoring will be discontinued. QAPI: The DON or her designee will track and trend the CNA observations and present the analysis to the QAPI committee for review and revision monthly for six months; after two consecutive quarters showing substantial compliance, this will be discontinued.	

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 02/12/2016

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 312	Continued From page 11 feet. The Director of Nursing stated in an interview on 02/10/16 at 4:10 PM that she would have expected for NA #1 to draw a fresh basin of water to provide the remainder of Resident #9's bath to her legs and feet.	F 312		
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interviews the facility failed to document an initial assessment and a weekly assessment of a pressure ulcer for 1 of 3 residents (Resident #7) reviewed for pressure ulcers. Findings included: Resident #7's Quarterly Minimum Data Set (MDS) dated 10/17/15 revealed he was re-admitted to the facility on 01/21/15 with diagnoses of hypertension, Parkinson's disease and dementia. Resident #7 had long and short term memory problems and was severely impaired in cognitive skills for daily decision making. Resident #7 was at risk for and had an unhealed pressure ulcer at the time of the assessment. Review of the Physician Progress Notes dated	F 314	Resident affected: Resident #7 with pressure ulcer care and treatment was documented on January 4, 2016. Residents with potential to be affected: a. All residents with pressure ulcers have the potential to be affected related to pressure ulcer monitoring and documentation. b. Body observations were completed on all residents between February 18, 2016, and February 19, 2016, to capture all skin areas. Systemic changes:	3/11/16

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 02/12/2016

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 314	Continued From page 12 12/15/15 showed Resident #7 had a 2mm (millimeter) ulcer to the left lateral side of the foot with slough (a yellow tissue consisting of fibrin, pus, and protein materials). The note indicated the wound care nurse was to follow-up on the wound. Review of the Physician's Interim Orders dated 12/16/15 showed an order for the WOCN (wound care nurse) to follow the lesion to the left foot. Review of the Wound Observation and Assessment Form for Resident #7's left lateral foot pressure ulcer was unable to be completed as it was unavailable. In an observation/interview on 02/10/16 at 9:28 AM Resident #7 received pressure ulcer care from the Treatment nurse. The wound was located on the left lateral foot. The wound bed was red with yellow slough. The area around the wound was pink. No odor or drainage was noted. The Treatment Nurse indicated that Resident #7 did not have any skin issues when he was discharged to the hospital on 12/25/15 but was readmitted with pressure ulcers to the left lateral foot and left lateral ankle on 01/04/16. In an interview on 02/12/16 at 9:50 AM the Director of Nursing (DON) stated there were no pressure ulcer measurements or a description of Resident #7's wound in December. She indicated there was no written assessment of the left lateral foot wound. She indicated the Treatment Nurse was in the facility at that time and should have measured Resident #7's wound. She indicated it was her expectation that written measurements and documentation of the assessment of the wound be done on initial discovery and weekly. In an interview on 02/12/16 at 11:22 AM the Family Nurse Practitioner (FNP) who worked with Resident #7 stated that when she wrote an order for the wound nurse to follow a wound she	F 314	a. The DON provided education to the Skin Integrity Nurse on pressure ulcer assessment, monitoring, and documentation on February 23, 2016. b. The Skin Integrity Nurse will complete a weekly pressure ulcer monitoring form that identifies that the weekly documentation is completed for pressure ulcers. c. The DON/Assistant ADON will review the pressure ulcer monitoring form with the Skin Integrity Nurse weekly. d. The Skin Integrity Nurse and/or RN Nurse Manager will complete the Pressure Ulcer Monitoring Tool, which includes validation of wound documentation and care plan updates, weekly for four weeks, then monthly for five months; after two consecutive quarters of substantial compliance the audit will be discontinued. QAPI: The DON will track, trend, and present the analysis of the pressure ulcer monitoring tool to the QAPI committee for review monthly for six months; after two consecutive quarters showing substantial compliance, the audit will be discontinued.	

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 02/12/2016

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 314	Continued From page 13 expected the wound to be assessed to see what treatment should be used. She indicated she expected measurements to be done and a description of the wound to be noted. The FNP stated without measurements an evaluation of the interventions could not be done. She indicated she had not staged the wound but verified her written note indicated that it was 2mm in size. The FNP stated she depended on the facility staff to assess residents and carry out the orders they were given. In an interview on 02/12/16 at 11:55 AM the Treatment Nurse stated she thought she had done measurements when Resident #7's pressure ulcer was discovered in December 2015. She indicated when a pressure ulcer was found she usually did an initial assessment with measurements and then updated them weekly. In an interview on 02/12/16 12:45 PM the Treatment Nurse stated she had been unable to find any paperwork other than a worksheet dated 12/22/15 that showed Resident #7's wound had been assessed. She stated the worksheet did not contain all the information that an assessment of a pressure wound would have. In an interview on 02/12/16 at 2:46 PM the DON stated it was her expectation that pressure ulcers be reported to the physician and a plan for treatment be put in place. She indicated she expected an initial assessment be completed and documented and for the wound to be monitored weekly. She indicated the wound information should be kept in the medical record and not on a worksheet in the computer.	F 314		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive	F 315		3/11/16

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 02/12/2016

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 315	Continued From page 14 assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interviews, the facility failed to provide perineal care and indwelling catheter care to avoid contamination and to minimize the risk of urinary tract infections for 1 of 3 residents reviewed for indwelling catheter care, Resident #9. Findings included: A review of the Minimum Data Set quarterly assessment for dated 11/05/16 revealed Resident #9 was mildly cognitively impaired and that she required physical assistance in part of her bathing activity. The same assessment indicated she was always incontinent of bowel and occasionally incontinent of the bladder. Resident #9's nursing care plan which was initiated on 02/03/2016 included a goals and interventions to address her use of an indwelling catheter for comfort due to urinary retention. The specific goal related to the indwelling catheter use was that the resident would experience no infections from the catheter use. One of the interventions was to provide catheter care for Resident #9 every shift.	F 315	Resident affected: Resident #9 was provided appropriate Foley catheter care. Residents with potential to be affected: All residents with Foley catheters have the potential to be affected. Systemic changes: a. The Clinical Competency Coordinator (CCC) and/or Nurse Managers began training on Foley catheter care for all CNAs on February 12, 2016. b. The CCC will provide Foley catheter care training for all CNAs at general orientation. c. The CCC, DON, Assistant DON, Nurse Managers, and/or registered/licensed nurses will observe Foley catheter care provided to all residents with a catheter daily for seven days, then weekly for four weeks, then monthly for five months; after two consecutive quarters showing substantial compliance, monthly observations will be discontinued.	

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 02/12/2016

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 315	Continued From page 15 Further review of Resident #9's nursing care plan revealed that on 02/05/2016 a goal was added to address the risk for urinary tract infections related to her history of urinary tract infections. The goal was for the resident to remain free of urinary complications. One of the interventions related to this goal was to provide perineal care, wiping the resident from front to back. An additional goal was added on 02/05/2016 to address Resident #9's self-care deficit with an intervention to provide incontinent care after each episode. In an observation of incontinent care provided during a bath on 02/10/2016 at 11:55 AM, nursing assistant (NA) #1 washed her hands, drew a basin of warm water, and added no-rinse soap. NA #1 applied gloves and used disposable wipes to remove a moderate amount of stool from the resident's buttocks, using wiping motions from the lower gluteal fold up toward the sacrum, then disposed of the soiled wipes. NA #1 dampened a clean washcloth with the warm soapy water from the basin and removed remaining stool from the resident's buttocks. NA #1 rinsed the soiled washcloth in the warm soapy water in the basin. The water in the basin became brown in color. NA #1 then changed her gloves and assisted Resident #9 to lie on her back. NA #1 dampened another clean washcloth in the same basin of warm water which was visibly contaminated. NA #1 noted there was soft brown stool present at the posterior section of the perineal area and used the dampened washcloth to wipe from the back of the perineal area toward the meatus where the indwelling catheter was inserted. The stool that was present at the back of the perineal area was brought forward toward the meatus and was spread over the labia with each wiping stroke from the back to the front. Stool was also noted	F 315	QAPI: The DON or her designee will track and trend catheter observations and present the analysis to the QAPI committee for review monthly; after two consecutive quarters showing substantial compliance, monthly reporting will be discontinued.	

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 02/12/2016

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 315	Continued From page 16	F 315		

on the shaft of the external portion of the catheter. NA #1 continued to use wiping motions until all the stool was visibly removed, and then rinsed the soiled washcloth in the basin of water. After the perineal area was visibly clean, NA #1 dampened a clean washcloth in the same basin of stool contaminated water, and wiped the catheter from the end of the catheter (where it was connected to the tubing to the urine collection bag) toward the meatus.

In an interview with NA #1 after the incontinent and catheter care was provided on 02/10/16 at 12:45 PM, she stated she did not realize she was wiping in the wrong direction for the perineal care and that she thought the direction she was cleaning the catheter from the end to the insertion point at the meatus was correct.

The Clinical Competence Coordinator stated in an interview on 02/10/16 at 3:15 PM that he would expect the nursing assistants to provide indwelling catheter care and incontinent care per the accepted standard of care stated in the indwelling catheter care procedure. He stated that Resident #9 had a history of urinary tract infections, although she did not have one during the month of January 2016. He stated the manner in which NA #1 provided the catheter care was incorrect.

In an interview with the Director of Nursing (DON) on 02/10/16 at 4:10 PM, she stated that she would have expected NA #1 to have provided indwelling catheter care per the procedure stated in the facility's procedure which was based upon the [name of nursing procedure] manual.