DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/19/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345061	A. BUILDING ______ B. WING ______	C 04/01/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS IDR 5/2/16 resulted in F 323 G being changed to F 323 G PNC. 5/13/16 CMS over rode the IDR panel decision. The tag remains current deficient practice.	F 000		
F 242 SS=D	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. This REQUIREMENT is not met as evidenced by: Based on observation, record review, resident and staff interviews, the facility failed to honor beverage choices for 2 of 2 residents (Residents # 144 and # 3). Findings include: 1. Resident # 144 was admitted to the facility on 2/3/05. The Quarterly Minimum Data Set assessment on 2/10/16 indicated Resident # 144 was cognitively intact and able to communicate needs and preferences effectively. During an interview on 3/30/16 at 9:26 AM, Resident # 144 stated she had repeatedly asked the nurses aids for apple juice on her meal trays but always received orange juice. Resident # 144 stated she was not supposed to have orange juice because she was on dialysis and a low potassium diet. Resident # 144 stated she left the orange juice on her tray every time. During the interview, Resident # 144's pointed out an unopened container of orange juice on her breakfast tray.	F 242	DIET PREFERENCE This plan of correction constitutes a written allegation of compliance, preparation, and submission of this plan of correction does not constitute an admission or agreement by the provider of truth of the facts alleged or the corrections of the conclusions set forth on the statement of deficiencies. The plan of correction is prepared and submitted solely because of requirements under state and federal Law. Corrective Action for those residents that have been affected. On 4/1/16 Resident #2 & #4 diet slips were checked for accuracy.	4/22/16

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed | TITLE | (X6) DATE: 04/22/2016

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
	345061	A. BUILDING ______ B. WING ______	C 04/01/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 242	Continued From page 1 Observation of the meal ticket revealed no dislikes or allergies were indicated on the meal ticket. The meal ticket had "cranberry juice" written on it. Resident # 144 stated she never got cranberry juice either. A review of Resident # 144's medical record revealed physician's orders written 12/1/15 for a no added salt, low potassium diet with double eggs with breakfast. A review of the Dietary Progress Notes for 11/18/15 revealed Resident # 144's diet was documented as regular with thin liquids, no added salt, low potassium, with no tomatoes, potatoes, bananas, orange juice, oranges, prunes, or dry beans. A review of the Nutritional Screening and Assessment Form dated 3/23/15 revealed documentation of "Patient will have diet restrictions - no tomato, potato, orange juice, oranges, bananas, prunes, dry beans, peas." During an interview on 4/1/16, the Administrator stated the facility had three Dietary Managers in a short period of time and he himself recently took on the residents' food preferences. The Administrator stated quite often someone would share a preference with him as he went down the hall, so he had been addressing preferences and putting them in the computer himself because they changed frequently. He stated Resident # 144 was very good about communicating and was not one to not make her preferences known. The Administrator stated he was not aware of Resident # 144's preference regarding no orange juice and stated his expectation was that her preference would be honored as long as they had an alternative to provide.	F 242	Corrective action will be accomplished for those residents to be affected by same deficient practice. On 4/5/16 Dietary Manager initiated 100% Diet preference audit on all 111 residents in facility. This was completed on 4/17/16. On 4/5/16 Clinical Competency Coordinator initiated an in-service to all 102 clinical staff for following drink preferences on meal tickets. This in-service was completed on 4/15/16. All new admission will have dietary preferences done timely. Measures put into place or systemic changes made to ensure that the deficient practice will not occur. The Director of Health Services, Assistant Director of Health Services, Unit Manager, Supervisors, & Dept. Heads. will be responsible for auditing 350 tickets per week for four weeks, then 200 tickets per week for four weeks, and then 100 tickets per week for four weeks. The facility plans to monitor its performance to make sure solutions are sustained. The DHS will present the findings of the Dietary Preference Audit Tool to the Quality Assurance Performance Improvement Committee monthly for three months or until a pattern of compliance is obtained.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345061	A. BUILDING ______ B. WING ______	C 04/01/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 2	F 323		
F 323 SS=G	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on record review, observation and staff, family and eyewitness interviews the facility failed to lock the wheelchair and failed to place a resident on a level surface during a scheduled appointment to an outlying medical clinic in which a resident fell from the wheelchair and sustained a left orbital (bone of the eye socket) fracture and laceration of the scalp for 1 of 1 sampled residents (Res # 205) that required staff supervision for outside appointments. Findings included: Review of the medical record revealed resident #1 was initially admitted to the facility on 12/21/2015 with diagnoses which included seizure disorder and weakness. The most recent Minimum Data Set (MDS) assessment dated 3/13/2016 indicated the resident was moderately cognitively impaired, needed a wheelchair for mobility and was only able to stabilize from sitting to standing with human assistance. Resident #1 's care plan initiated on 2/5/2016 and updated on 2/14/16 and 3/12/2016 indicated the potential for injury from falls related to recent history of fall, impaired mobility, general	F 323	Free of Accident Hazards/Supervision/Devices This plan of correction constitutes a written allegation of compliance, preparation, and submission of this plan of correction does not constitute an admission or agreement by the provider of truth of the facts alleged or the corrections of the conclusions set forth on the statement of deficiencies. The plan of correction is prepared and submitted solely because of requirements under state and federal Law. Corrective Action for those residents that have been affected. Resident was sent to the Emergency Department directly from the event. Aide present during the event accompanied the resident to the ER. Corrective action will be accomplished for	5/18/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345061	A. BUILDING ______ B. WING ______	C 04/01/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 3 weakness, and seizure disorder. The goal was resident would have no fall related injuries through the next review. Interventions included to keep pathways clear and free of obstacles and to maintain safety with transfers. Review of the clinical medical record revealed the resident was transported to a local clinic appointment via wheelchair by a transport company on 3/22/2016. The resident was accompanied by a facility nursing assistant (NA) #1. In an interview with NA#1 on 3/30/16 at 3:10 PM, NA#1 indicated she accompanied the resident to the appointment on 3/22/2016. NA#1 reported the appointment was completed at approximately 11:30 AM and she notified the transport company via telephone they were ready to go back to the facility. NA#1 reported within 15 minutes of the call, the van arrived and NA#1 propelled the resident in his wheelchair to meet the van outside the clinic. NA#1 reported she propelled the resident in his wheelchair to the sidewalk to wait for the van to back up. NA#1 reported she looked over her left shoulder and noticed a clinic employee walking toward the sidewalk. NA#1 reported she recalled her hands were not on the resident 's wheelchair at that time. NA#1 indicated when she looked back toward the resident, his wheelchair had rolled down the sidewalk. NA#1 indicated she did not lock the wheelchair. The NA#1 stated " I don't know why I didn't lock the wheels, I knew I was supposed to. " NA#1 reported she saw the resident going forward out of the wheelchair and could not stop him and the resident fell from the wheelchair and onto the pavement with the left side of his face on the pavement. NA#1 revealed resident's eyes were open and he was bleeding from a cut over his left eye. NA#1 further revealed an employee	F 323	those residents to be affected by same deficient practice. on 3/23/16 all residents in the facility were assessed for wheelchair mobility status related to stopping and locking their wheelchair safely. Residents identified with inability to stop/lock wheelchair have the potential to be affected. On 3/23/16 a 100% in-service was conducted on Wheelchair Safety. All 103 staff including the transport driver had completed this in-service by 3/27/16. This education is now a part of the initial orientating process. Measures put into place or systemic changes made to ensure that the deficient practice will not occur. The facility transport driver will observe (residents at risk) that wheelchair is locked by the accompanying aide and that the aide is within reach of the resident when the driver arrives to pickup the resident. This will be observed/documented in the Audit Log Tool (see exhibit). The Director of Health Services and Administrator will review the trend daily for seven days, then weekly for eight weeks, or until a pattern of compliance is determined. The facility plans to monitor its performance to make sure solutionsare sustained. The Director of Health Services will present the findings of	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345061	A. BUILDING ______ B. WING ______	C 04/01/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 4 from the clinic immediately assessed the resident and ran back in the clinic to call for assist. NA#1 indicated the clinic employee returned within just a few seconds and stayed with the resident until the ambulance arrived. NA#1 reported she made a call to the facility and spoke with the Director of Nursing (DON) to inform her of the incident. NA#1 was unsure what time the call was made but recalled the DON instructed NA#1 to take a picture of the resident (with her cell phone), to stay with the resident and to keep the DON updated on the resident's condition. NA#1 stated the DON notified her around 5:00PM to return to the facility. NA#1 indicated she returned to the facility, wrote a statement on the incident and went home. NA#1 reported the DON called her at home later that evening and told her she was suspended for 3 days. NA#1 indicated she returned to work on 3/28/2016. An interview was conducted on 3/31/16 at 11:40 AM with the clinic employee who witnessed the incident on 3/22/2016. The employee stated she witnessed the entire incident. The employee reported she walked out of the building around noon and noticed the resident in the wheelchair close to the curb. The employee reported the NA was standing beside the resident's wheelchair. The employee stated NA#1 left the resident unassisted and walked toward the employee. The employee looked over the NA#1 ' s shoulder and saw the resident's wheelchair as it rolled down and over the curb. The employee reported she ran to the resident and he had fallen down the curb in his wheelchair and the wheelchair was on top of him. The employee reported the resident's right foot was caught in the wheel of the chair and she had to get his foot out before the chair could be removed. The employee reported the resident was lying on the pavement with the left side of his	F 323	wheelchairstop/lock safety program to the Improvement Committee monthly for three months or until a pattern of compliances obtained.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345061	A. BUILDING ______ B. WING ______	C 04/01/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 5 face on the pavement. He was bleeding from the left side of his face. The employee indicated she assessed him briefly to make sure he was breathing and the resident took a deep breath and coughed a little. The employee noted the resident had a pulse and was attempting to verbally respond. The employee reported the resident didn't respond to her commands initially although his eyes were opened, but when she talked louder it was evident he was hard of hearing. The employee indicated when she talked louder the resident responded and moved his eyes on command. The employee reported she instructed NA#1 to stay with the resident and she ran to the clinic to call Emergency Medical Services (EMS). The employee indicated being gone for only a couple of minutes and returned to stay with the resident until EMS arrived. The resident was transported to the emergency room. On 4/1/2016 at 9:00 AM the area where the incident occurred was observed. NA#1 and the facility DON were present. The area was observed to be the designated pick up area for patients from the clinic and was located directly in front of the clinic/office building. The area was covered by a stationary canopy. There was ample room for transport vehicles to drive through. There was a curb along the flat concrete surface and a sloped area leading to a wheelchair access. There was approximately a 20-25 degree incline which was the wheelchair access from the flat concrete surface to the drive through area. NA#1 stood in the area where she placed the resident in his wheelchair on the day of the incident. The placement was approximately 12 to 18 inches from the curb and at the beginning of the incline. NA#1 reported the right side of the resident's wheelchair rolled on the incline and the	F 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345061	A. BUILDING ______ B. WING ______	C 04/01/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 6 left side went over the curb which caused the resident to fall from the wheelchair to the drive through area. NA#1 indicated the resident landed on his left side with the left side of his face on the drive through area. NA#1 stated she did not lock the wheelchair and did not know why. Review of the emergency room hospital records dated 3/22/2016 revealed the resident sustained a large abrasion to his left cheek, a laceration over his left eyebrow and a minimally displaced fracture of the left lateral orbital from blunt trauma. A physician note dated 3/23/2016 at 1:40 AM revealed the resident was admitted to the hospital after completion of initial emergency department evaluation and it was determined that resident required further evaluation and treatment in a hospital setting. The resident's hospital admitting diagnoses on 3/23/2106 were: -Urinary Tract Infection -Laceration of scalp -Fracture of lateral wall of orbit -Dementia An interview was conducted with the DON and Administrator (ADM) on 4/1/2016 at 2:00 PM. The DON reported NA#1 had called the facility and reported the incident at approximately noon on 3/22/2016. The DON stated she instructed NA#1 to take a picture of the accident scene and to stay with the resident. The DON reported she also instructed NA#1 to call with the resident's condition when updated. The DON reported she called the resident's responsible party to inform him of the incident and transfer to the emergency room. The DON indicated later in the evening on 3/22/2016 she notified NA#1 and instructed her to return to the facility. The DON also reported she	F 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345061	A. BUILDING ______ B. WING ______	C 04/01/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 7 sent another NA to sit with the resident but at that time the family was present and requested for the NA to leave. The DON revealed NA#1 returned to the facility and was require to recall the incident before any more time had passed to ensure the recollection was correct. NA#1 indicated to the DON the wheelchair was not locked and NA #1 had " let go of the wheelchair for just a few seconds " and the incident occurred. The DON stated NA#1 was suspended on the evening of 3/22/2016 pending the investigation results. In the interview with the DON, the DON stated it was her expectation for facility staff to ensure the safety of all residents. The DON also stated her expectation when a resident required facility staff to accompany for outside appointments, was for the staff member to provide the necessary supervision to prevent accidents. During the interview, the ADM revealed his expectation was the same as the DON.	F 323		
F 371 SS=D	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation and staff interviews, the	F 371	THERAPY FRIDGE TEMP	4/22/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345061	A. BUILDING ______ B. WING ______	C 04/01/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 371	Continued From page 8 facility failed to label and date open nourishment items in the refrigerator in one of one nourishment rooms and failed to remove expired nourishment items in the refrigerator in one of one nourishment room refrigerators. Findings included: During an interview with Dietary Aide #1 on 03/29/16 at 9:35 a.m., Dietary Aide #1 stated the Dietary staff were not responsible for ensuring nourishment items are labeled and dated. During an interview with the Administrator on 03/29/16 at 9:45 a.m., the Administrator stated the Housekeeping Supervisor was responsible for ensuring the 100 hall resident nourishment room refrigerator and freezer were cleaned of expired items. An observation of items in the 100 Hall resident nourishment room refrigerator and freezer on 03/29/16 at 9:52 a.m. revealed the following sample of items checked which were not labeled or dated: 1. a clear bag containing four slices of bread 2. a plastic bowl containing peanut butter 3. a plastic bowl containing jelly 4. an opened can of evaporated milk 5. a fast-food bag containing a cup of prepared oatmeal and fruit 6. a Styrofoam take-out food container containing brown lettuce 7. a bag containing hamburger buns 8. a plastic container containing a half-eaten hamburger The observation also revealed the following sample of items checked to be out-of-date: 1. an 8-ounce carton of milk dated 03-25-16 2. an opened bottle of ranch dressing dated 12/2015. During an interview with the Administrator on 03/29/16 at 10:15 a.m., the Administrator stated it	F 371	This plan of correction constitutes a written allegation of compliance, preparation, and submission of this plan of correction does not constitute an admission or agreement by the provider of truth of the facts alleged or the corrections of the conclusions set forth on the statement of deficiencies. The plan of correction is prepared and submitted solely because of requirements under state and federal Law. Corrective Action for those residents that have been affected. On 3/28/16 Therapy refrigerator was cleaned of items that were not in the accepted date ranges/labeled. A sign was posted on the refrigerator alerting families that unlabeled items will be discarded after 3 days of being opened when applicable, as well as expired items. Log book was placed next to appliance to record temperatures and label/date items. (See Exhibit) Corrective action will be accomplished for those residents to be affected by same deficient practice. On 3/28/16 the therapy refrigerator was cleaned of items that were not in the accepted date ranges/labeled. Sign was posted on the door alerting families and staff that items will be discarded after 3 days of being opened when applicable, as well as expired item. Temperature log and labels have been placed next to appliance	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345061	A. BUILDING ______ B. WING ______	C 04/01/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 371	Continued From page 9 was his expectation that nourishment items in the 100 Hall resident nourishment room refrigerator and freezer be labeled and dated. The Administrator stated it was his expectation the refrigerator and freezer be consistently cleaned and out-of-date items removed.	F 371	to recorded temperatures and label/date items. Measures put into place or systemic changes made to ensure that the deficient practice will not occur. The Housekeeping Supervisor or his designee will be responsible for inspecting the appliance five times weekly for outdated items and unlabeled items. He will discarded items not dated/labeled. This will continue for four weeks and then three times weekly for the next eight weeks. The Maintenance Director, his designee or MOD are responsible for documenting the temperature of the Therapy refrigerator. The facility plans to monitor its performance to make sure solutions are sustained. The Administrator will observe the audit tool weekly and will present the findings to the Quality Assurance Performance Improvement Committee monthly for three months or until a patter of compliance is obtained.	