STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345551	A. BUILDING _____ B. WING _____	C 09/16/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEALTH-CAROLINA POINT	5935 MOUNT SINAI ROAD DURHAM, NC 27705

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 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. 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, staff and resident interviews, and observations, the facility failed to accurately code the Minimum Data Set (MDS) for two (2) of 2 residents (Resident #17 and Resident #144) for dental status, and one (1) of 1 resident (Resident #60) for Hospice care.	F 278	What Corrective action will be accomplished for the residents found to have been affected by the deficient practice? Resident #17, #60 and #144 MDS	10/14/16

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

Electronically Signed | 10/07/2016

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F 278	Continued From page 1 Findings included: 1. Resident #17 was re-admitted to the facility on 11/1/13 with diagnoses which included diabetes mellitus, hypertension, and non-Alzheimer ' s dementia. A review of the annual MDS dated 12/21/15 revealed Resident #17 was moderately cognitively impaired, required limited assistance to complete all activities of daily living (ADLs), and received a therapeutic, non-mechanically altered diet. Section L of the MDS, which indicated dental status, was not coded to reflect Resident #17 had no natural teeth or tooth fragments present. An observation of Resident #17 was made on 9/13/16 at 3:14 PM and revealed no natural teeth or tooth fragments present. An interview was conducted with Resident #17 on 9/13/16 at 3:14 PM. She stated, " I used to have dentures, but haven ' t in a while. I don ' t know what happened to them. But I can still eat. " She stated if she had difficulty eating she would have let the staff know, but stated she had no problems and did not want to seek dental care. An interview was conducted with the MDS Coordinator on 9/15/16 at 9:40 AM. She stated, " Section L of the MDS is information for dental status. The information is coded from the chart, a face to face assessment with the resident, physician notes, certified dietary manager (CDM) notes, nursing assessments and notes, family and resident interviews, and physician orders. If a resident is edentulous (no teeth) Section L should be coded to reflect that, whether it bothers the resident or not. " After the MDS coordinator made an observation of Resident #17 on 9/15/16, she returned to the interview at 9:48 and stated, " She ' s (Resident #17) edentulous and the MDS should reflect that, but doesn ' t. " 2. Resident #144 was admitted to the facility on	F 278	sections LO200 and O0100K were corrected to reflect proper coding All residents are at risk for being affected by this deficient practice How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? The CMD/CMC will audit sections LO200 and O0100K for coding accuracy □ completed by 10/14/16. Current residents will be assessed per RAI guidelines related to sections LO200 and O0100k to identify inaccurate coding What measures will be put in place or what systemic changes will be made to ensure that the deficient practice will not reoccur? The sample size of the audit by the CMC/CMD will be 25% of the MDS submitted monthly The CRC will continue to monitor and educate on an ongoing basis How will the corrective action be monitored to assure that the deficient practice will not reoccur, i.e., what quality assurance program will be put in place for monitoring to assure continued compliance. The results of the Audit will be reported in monthly QAPI until 100% compliance is achieved in 3 months and is ongoing as	

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F 278	Continued From page 2 1/8/16 with diagnoses which included cerebrovascular accident (CVA), aphasia (inability to speak), dysphagia (difficulty swallowing), hemiparesis of the dominant side (paralysis), and cognitive deficit. A review of the Quarterly MDS dated 5/24/16 revealed Resident #144 was severely cognitively impaired, needed extensive to total assistance for all ADLs, had 1 upper and 1 lower limb impaired, had a feeding tube, and received a mechanically altered diet. Section L of this MDS was not completed. A review of the Comprehensive Admission MDS dated 1/15/16 was reviewed to obtain dental information from Section L and revealed an entry of none of the above for dental status, which included a coding option for edentulous. An observation was made on 9/13/16 at 8:30 AM of Resident #144 while he ate his morning meal. No teeth or dentures were observed while Resident #144 consumed his meal. An interview was conducted with the MDS Coordinator on 9/15/16 at 9:40 AM. She stated, " Section L of the MDS is information for dental status. The information is coded from the chart, a face to face assessment with the resident, physician notes, certified dietary manager (CDM) notes, nursing assessments and notes, family and resident interviews, and physician orders. If a resident is edentulous (no teeth) Section L should be coded to reflect that, whether it bothers the resident or not. (Resident #144) doesn ' t have any teeth so the MDS should be coded to reflect that. " 3. Resident #60 was admitted to the facility on 4/23/14 with diagnoses which included breast cancer and atrial fibrillation (an irregular heartbeat). A review of the quarterly MDS assessment dated 7/27/16 revealed Resident #60 was cognitively	F 278	needed.	

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F 278	Continued From page 3 impaired. The resident required extensive assistance for all ADLs. Active diagnoses included coronary artery disease, anxiety, depression, muscle weakness, chronic kidney disease, and anorexia. Section O, which indicated special treatments, procedures, and programs to include Hospice Care, revealed no entries. A review of the care plans dated 8/23/16 revealed a care plan for hospice care. A review of the physician orders dated 9/1/13 through 9/30/16 revealed Resident #60 was being followed by Hospice Services. An interview was conducted with the MDS Coordinator on 9/15/16 at 4:15PM. She stated, "(Resident #60) has diagnoses of Breast cancer and atrial fibrillation. I use consult diagnoses for MDS completion. She is a hospice resident, and she should have been coded Hospice in July for the Quarterly MDS. I can't tell you an honest answer of why I missed it. I just missed it." An interview was conducted on 9/15/16 at 1:00 PM with the Director of Nursing. She stated, "I know the MDS process, but I don't complete the MDS. My expectation is the MDS assessments will be done timely and accurately."	F 278		
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:	F 312		10/14/16

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F 312	Continued From page 4 Based on record review, staff interview, and observation, the facility failed to provide perineal care in a manner to prevent urinary tract infection for one (1) of four (4) residents (Resident #70) dependent on staff to complete activities of daily living (ADLs). Findings included: Resident #70 was admitted to the facility 3/2/11 with diagnoses which included dementia. Data Set (MDS) dated 7/29/16 revealed Resident #70 was cognitively impaired, displayed verbal behaviors towards others, and frequently rejected care. Resident #70 required extensive assistance for all activities of daily living (ADLs), which included personal hygiene, and was always incontinent of bowel and bladder (urine). A care plan updated 8/23/16 addressed an alteration in elimination related to incontinence of bowel and bladder. Goals included " (Resident #70) will be kept clean and dry, and dignity maintained until next review. " Interventions included incontinent care be provided after each incontinence episode. " A continuous observation of incontinence care for Resident #70 was conducted on 9/16/16 from 8:00 AM through 8:35 AM. . Nurse Aide #5 (NA #5) was observed to enter Resident #70 ' s room from the hallway, donned gloves on both hands, removed an adult brief soiled with urine and stool, removed a washcloth from a basin which contained soap and water, wiped the soiled area from front to back, back to front, front to back, and back to front with the same washcloth and without using a clean area of the cloth for each wipe. NA #5 then took a clean washcloth which contained water without soap and rinsed the area, removed the soiled gloves, donned clean gloves, and the treatment nurse provided wound care. NA #5 placed a clean adult brief on Resident #70,	F 312	What Corrective action will be accomplished for the residents found to have been affected by the deficient practice? The DHS immediately removed the C NA from the floor and provided 1 to 1 in-service education on pericare, only wiping front to back, changing gloves, use of handwashing and using hand sanitizer. For resident # 70: the CCC immediately provided ADL care for the resident. The Physician Assistant was notified of the potential for UTI and the resident was started on daily observation for signs and symptoms of UTI for 72 hours. The resident did not develop signs or symptoms of UTI. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? The incontinent residents have the potential to be affected and are Identified by assessments. Corrective action: The DHS and CCC will in-service and perform skill checks on all Nursing Assistants on the proper procedure for providing ADL care for dependent, incontinent residents. The in-servicing and training started on 9/16/16 will be completed by 10/14/16.	

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F 312	Continued From page 5 and provided comfort care. An interview was conducted with NA #5 on 9/16/16 at 8:45AM. She stated, "I should always clean from front to back and not go back to front. This could make an infection. NA #5 added, "I'm sorry, I made a mistake. " An interview was conducted on 9/16/16 at 10:13 AM with the infection control/staff development nurse. She stated, "Our staff are in serviced annually and as needed on incontinent care techniques. The NAs get training during new hire orientation too. If a staff member deviated from the established guidelines that ' s something I need to address. "	F 312	What measures will be put in place or what systemic changes will be made to ensure that the deficient practice will not reoccur? The DHS and the CCC will observe 3 Nursing Assistants 3 times a week for one month, then 3 Nursing Assistants will be observed 3 times a week for 2 months for performing proper ADL care and maintaining appropriate infection control techniques to prevent the spread of infection. New employees will be educated by the CCC during orientation on infection control to include, hand hygiene and the correct procedure for handling linen, the nursing staff will include education on proper ADL care, entering resident rooms, staff not completing the training will be educated prior to the start of their next scheduled shift. How will the corrective action be monitored to assure that the deficient practice will not reoccur, i.e., what quality assurance program will be put in place for monitoring to assure continued compliance. The DHS and CCC will report compliance at the monthly QAPI meeting until 100% compliance is achieved for 3 months. The QAPI team will review audits to make recommendations to assure compliance to sustain ongoing appropriate ADL care and infection control techniques.	

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F 371	Continued From page 6	F 371		
F 371 SS=E	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, staff interview and record review, the facility failed to label one plastic bag of Jumbo shrimps, one plastic bag of barbeque chicken, three plastic containers with barbeque, sausage and Sauerkraut in walk in cooler, one plastic bag of vegetarian patties and one plastic bag of potato tater tots in walk in freezer, failed to keep clean walk in cooler floor, small refrigerator and puree machine blade, failed to discard three dented cans in the dry storage room. The findings included: 1 a. On 9/12/16 at 6:15 PM, during the observation of the walk-in cooler in the kitchen, there were plastic bag of Jumbo shrimps, plastic bag of barbeque chicken, plastic container with barbeque, plastic container with sausage, plastic container with Sauerkraut without label/date. On 9/12/16 at 6:15 PM, during an interview, the kitchen manager stated that all the food in walk in cooler needed to be labeled with expiration date and the date of opening. b. On 9/12/16 at 6:15 PM, during the observation of the walk-in cooler in the kitchen, the floor was	F 371	What Corrective action will be accomplished for the residents found to have been affected by the deficient practice? All residents have the potential to be affected by the stated deficient practice. All unlabeled/undated food items in refrigerator and freezer were discarded on 9-12-16. Puree machine blade was cleaned and removed from service on 9-12-16. Dented cans were removed from dry storage and placed in designated dented can storage area away from food storage on 9-12-16 for pickup by food vendor. Walk in cooler floor and small refrigerator were cleaned on 9-12-16. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?	10/14/16

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F 371	Continued From page 7 dirty, sticky with yellow/brown spots and food debris. On 9/12/16 at 6:15 PM, during an interview, the kitchen manager stated that the floor in the walk in cooler needed to be cleaned. c. On 9/12/16 at 6:25 PM, during the observation of the walk in freezer, there were plastic bag of vegetarian patties, plastic bag of potato tater tots and paper bag of small potato tots without label/date. On 9/12/16 at 6:25 PM, during an interview, the kitchen manager stated that all the food in walk in freezer needed to be labeled with expiration date and the date of opening. d. On 9/12/16 at 6:30 PM, during the dry food storage room observation, there were three dented cans of Sauerkraut found on the shelf among other cans, available to use. On 9/12/16 at 6:30 PM, during an interview, the kitchen manager stated that all the dented cans needed to be removed from the shelves. e. On 9/12/16 at 6:35 PM, during the observation, the small refrigerator in the kitchen was found dirty with food debris and dry pink/brown spots. On 9/12/16 at 6:35 PM, during an interview, the kitchen manager stated that the small refrigerator needed to be cleaned. f. On 9/12/16 at 6:45 PM, during the observation of the clean/dry area, the puree machine blade was observed dirty with dry food debris on the shelf among others, ready to use dishes. On 9/12/16 at 6:45 PM, during an interview, the kitchen manager stated that all the dishes and kitchen equipment needed to be cleaned before placed on the shelf to dry. On 9/12/16 at 6:55 PM, during an interview, the kitchen manager stated that all the staff members, who restocked the shelves in walk in cooler and refrigerator, were responsible to keep	F 371	All residents have the potential to be affected by the stated deficient practice. What measures will be put in place or what systemic changes will be made to ensure that the deficient practice will not reoccur? Dietary Manager will re-educate Dietary staff on proper labeling of leftover food items, removal of dented cans from food storage, and cleaning schedules and assignments, began 9-12-16 completed 9-14-16. Cleaning assignments will be posted by Dietary Manager/Kitchen Manager or Kitchen Supervisor for daily, weekly, and monthly cleaning tasks to ensure all areas of the kitchen are cleaned according to company policy, began 9-12-16, ongoing. How will the corrective action be monitored to assure that the deficient practice will not reoccur, i.e., what quality assurance program will be put in place for monitoring to assure continued compliance. Daily cleaning schedules will be checked each morning by Dietary Manager/Kitchen Manager/ Supervisor to ensure all daily assignments were completed. Weekly cleaning schedules will be checked each Monday by Dietary Manager/Kitchen Manager/ Supervisor to ensure all weekly assignments were	

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F 371	Continued From page 8 the areas (shelves and floor) clean and food labeled with expiration date and date of opening. He confirmed that there was daily, weekly and monthly kitchen cleaning schedule available for all the staff at any time. The staff members were assigned to clean the workstation at the end of every shift. On 9/15/16 at 9:55 AM, during an interview, director of nursing indicated that her expectation was the kitchen staff to keep the entire kitchen in clean/sanitary condition and all the food correctly labeled in storage areas. Record review of the kitchen cleaning schedule from 9/4/16 to 9/12/16 revealed the daily and weekly kitchen cleaning assignments with AM and PM schedule for cleaning per kitchen areas per shift. All of the assignments were posted and marked as done by the kitchen staff, including 9/12/16.	F 371	completed. Monthly cleaning schedules will be checked the 1st date of each consecutive month by Dietary Manager/Kitchen Manager/ Supervisor to ensure all monthly assignments were completed.	
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.	F 441		10/14/16

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F 441	Continued From page 9 (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on record review, staff interviews, and observation, the facility failed to ensure standard infection control guidelines were followed for 1 of 2 residents (Resident #70) when a staff member 1) failed to wash hands or use an alcohol based hand sanitizer/rub before donning and between changing gloves, 2) failed to change gloves between glove contamination and incontinence care, 3) failed to wash hands after disposal of soiled linens and soiled incontinence brief and before obtaining clean towels and wash cloths, and 4) entered a resident room with the clean linens, closed the privacy curtain without performing hand hygiene. Findings included: A continuous observation was made on 9/16/16	F 441	What Corrective action will be accomplished for the resident found to have been affected by the deficient practice? The DHS immediately removed the C NA from the floor and provided 1 to 1 in-service education on pericare, only wiping front to back, changing gloves, handwashing, using hand sanitizer, obtaining clean linen, entering resident□s rooms and closing privacy curtains, while maintaining proper infection control techniques. For resident # 70: the CCC immediately	

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F 441	Continued From page 10 from 8:00 AM through 8:35 AM of incontinence care for Resident #70. Nurse Aide #5 (NA #5) was observed to enter Resident #70 ' s room from the hallway, donned (placed) gloves on both hands, removed a soiled adult brief, provided urinary and bowel incontinence care, removed soiled gloves, donned clean gloves, and waited for the wound care nurse to complete wound care. She then placed a clean adult brief on Resident #70, provided comfort care (rearranged the sheets and repositioned the resident), removed the soiled gloves, picked up two (2) trash bags from the bedside floor (one contained the soiled brief and contaminated dressing from wound care and the other contained soiled linens), exited the room, entered the soiled utility room, dropped the bags from Resident #70 ' s room, exited the soiled utility room, entered the clean utility/linen room, removed 2 clean wash cloths, and 2 clean towels, walked to another resident room on the 600 Hall, entered the room, placed the clean linen on the over bed table, closed the privacy curtain, and then performed hand hygiene. A review of the facility ' s hand hygiene policy revealed, in part, " Using an alcohol-based hand rub is appropriate for decontaminating the hands before direct patient contact, before putting on gloves, before inserting an invasive device, after contact with a patient, when moving from a contaminated body site to a clean body site during patient care, after contact with bodily fluids, excretions, mucous membranes, non-intact skin, or wound dressings (if hands aren ' t visibly soiled), and after contact with inanimate objects in the patients ' environment. There are five (5) key moments during which health care workers should perform hand hygiene: 1) before touching a patient, 2) before a	F 441	provided ADL care for the resident using proper technique. The Physician Assistant was notified of the potential for UTI and the resident was started on daily observation for signs and symptoms of UTI for 72 hours. The resident did not develop signs or symptoms of a UTI. Housekeeping was alerted and disinfected the door knobs of the soiled utility door and the clean utility door. Linens in the clean utility closet were removed, the shelves were disinfected and clean linen were replaced. The privacy curtain removed and washed and the bedside table was sanitized in room 603. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? All residents have the potential to be affected by this deficient practice. 100 % of the staff will be educated on infection control and prevention of the spread of infections by 10/14/16. What measures will be put in place or what systemic changes will be made to ensure that the deficient practice will not reoccur? The DHS and the CCC will be in-servicing the nursing staff on infection control prevention, proper procedure for ADL care, education on pericare, wiping front to back, changing gloves, handwashing,	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345551	A. BUILDING _____ B. WING _____	C 09/16/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEALTH-CAROLINA POINT	5935 MOUNT SINAI ROAD DURHAM, NC 27705

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 11 clean/aseptic (not sterile) technique, 3) after body fluid exposure risk, 4) after touching a patient, and 5) after touching patient surroundings. An interview was conducted with NA #5 on 9/16/16 at 8:45AM. She stated, "I should wash my hands before I put gloves on, after I remove gloves, and between changing gloves. During incontinent care I change gloves after I remove the brief and provide the incontinent care. I should wash my hands, and then put clean gloves on to put a clean brief on. I made a mistake with (Resident #70). I'm sorry. I didn't wash my hands before I put gloves on or in between changing gloves. I'm sorry, I made a mistake. I did wash my hands after I went into (the other room on the 600 Hall)." An interview was conducted on 9/16/16 at 10:13 AM with the infection control/staff development nurse. She stated, "Our staff are in serviced annually and as needed on hand hygiene. Hand hygiene should be performed according to the CDC (Center for Disease Control) guidelines. So before and after wearing gloves, before and after incontinence care, before meals, when hands are visibly soiled or contaminated. Basically anytime you have to put on gloves you should wash your hands and anytime you take gloves off you should wash your hands. After you discard the trash and dirty linen you should perform hand hygiene before touching anything clean. If a staff member deviated from the established guidelines for hand hygiene, that ' s something I need to address. "	F 441	using hand sanitizer, obtaining clean linen, entering resident□s rooms and closing privacy curtains while maintaining proper infection control techniques. The in-servicing and training started on 9/16/16 will be completed by 10/14/16. The DHS and the CCC will observe 3 staff members 3 times a week for 3 months for performing proper ADL care and maintaining appropriate infection control techniques to prevent the spread of infection. New employees will be educated by the CCC during orientation on infection control to include, hand hygiene and the correct procedure for handling linen, the nursing staff will include education on proper ADL care, entering resident rooms, staff not completing the training will be educated prior to the start of their next scheduled shift. How will the corrective action be monitored to assure that the deficient practice will not reoccur, i.e., what quality assurance program will be put in place for monitoring to assure continued compliance. The DHS and CCC will report compliance at the monthly QAPI meeting until 100% compliance is achieved for 3 months. The QAPI team will review audits to make recommendations to assure compliance to sustain ongoing appropriate ADL care and infection control techniques.	