STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345551	A. BUILDING _____ B. WING _____	C 08/10/2017

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

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F 000	INITIAL COMMENTS There were no deficiencies cited as a result of the complaint investigation survey for Event ID U3EH11 conducted on 08/10/17.	F 000		
F 371 SS=E	483.60(i)(1)-(3) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY (i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. (i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. (i)(3) Have a policy regarding use and storage of foods brought to residents by family and other visitors to ensure safe and sanitary storage, handling, and consumption. This REQUIREMENT is not met as evidenced by: Based on observations, staff interview and record review the facility failed to maintain the nourishment refrigerator temperature below 40 degrees, discard food and inappropriately store staff personal food in two of the three	F 371	This plan of Correction constitutes the facilities written allegation of compliance for the deficiencies cited. However, submission of this plan of correction is not an admission that deficiencies exist or	9/7/17

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

Electronically Signed | 08/31/2017

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F 371	Continued From page 1 nourishment refrigerators. Findings Included: 1 a. On 8/10/17 at 9:43 AM an observation of the nourishment refrigerator for hallways 500 -600 revealed the refrigerator temperature at 60 degrees Fahrenheit. The observation also revealed a covered cup containing resident's food dated 8/8/17 and two personal water bottles. The bottom shelf of the refrigerator had yellowish colored fluid. An observation of the freezer revealed an open soda can with "Mountain Dew" printed on it, two personal water bottles. The observations also revealed yellowish fluid spilled in the freezer. During an interview with Nurse #1 on 08/10/2017 at 9:52 AM, Nurse indicated that the refrigerator was used to store resident's food and nutritional supplements. She further stated that the refrigerator temperatures were checked by the 7pm to 7 am nursing and noted in the temperature log. Review of the temperature log placed outside on the refrigerator door indicated 38 degrees Fahrenheit marked for 8/10/17. During an interview with Nurse #2 on 08/10/2017 at 9:57 AM, Nurse indicated that she had checked the temperatures in the morning and the temperatures were within range at that time. Nurse stated that the door must have been left open for a long time when applesauce was removed by nurse aides for morning snack. 1 b, On 08/10/2017 at 10:59 AM an observation of the nourishment refrigerator on hallway 300	F 371	that one was cited correctly. This plan of correction is submitted to meet requirements established by federal and state law. 1.No resident were affected by the stated deficient practice. 2.All residents refrigerator and freezer temperatures will be monitored and logged daily by the first shift staff nurses beginning 8-11-17. Food will be labeled with residents name and date, and will be discarded after 72 hours per policy. A separate refrigerator has been designated for staff use only, no staff food items will be stored in nourishment room refrigerator. The Dietary Manager (DM) and Clinical Care Coordinator (CCC) has re-educated staff on resident food storage, staff food storage, appropriate temperature of the refrigerators and when to discard food. This re-education began 8-11-17 and will be completed by 9-7-17. Staff not attending this training will have it prior to the next shift worked. New hires will have this training during orientation. 3.A monitoring/audit tool was developed to check refrigerator and freezer temperatures, cleanliness of refrigerators and freezers, resident foods labeled and dated, resident foods discarded by policy and no staff foods in nourishment units. Monitoring/ audit tool will be completed twice a day by DHS, ADHS, CCC, DM, and unit supervisors for 2 weeks, then	

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F 371	Continued From page 2 -400 revealed a sealed container of store brought salad with a use by date of 8/8/17 printed on it and a personal lunch bag with no name or label. The refrigerator also contained resident's food and snacks which were labeled. An observation of the freezer revealed a grocery bag with date "8/1/17" and no label, three packets with label "Lemon Glycerin Swab sticks Triples" and half emptied opened ice cream box containing individually wrapped ice cream. The box cover read "Individually wrapped ice cream sandwiches". No resident name or date was indicated on the box. During an interview with the Nurse #3 on 8/10/17 at 11:01 AM, Nurse indicated that the ice cream belonged to a resident on 200 hallway and was unsure why it was not labelled and when it was placed in the refrigerator. Nurse also stated that she was unsure to whom the grocery bag belonged and what it contained. Nurse further stated that the swabs were used for residents with dry mouth and that some residents like it cold. She further stated she was unsure why it was placed in the freezer and who placed them there. Review of the "Patient /Resident Personal Food" policy revealed, food requiring refrigeration must be labeled and dated and discarded after 48 hours. Frozen foods must be labeled and dated and discarded after 14 days. During an interview with the Dietary Manager (DM) on 8/10/17 at 11:11 AM, DM indicated that the staff were educated on multiple occasions about not storing their personal food in the nourishment refrigerators. DM further stated that the temperatures were checked by the nursing	F 371	each day for one week, then 3 times a week for 4 weeks. The results of this tool will be taken to QA by the DM for 3 months and any concerns will be discussed and interventions will be added until compliance is achieved.	

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F 371	Continued From page 3 staff and any out of range temperatures were immediately notified to Dietary for appropriate action. DM also stated the nursing staff usually labels the food brought in by family members with resident's name and date before it was placed in the refrigerator or freezer. During an interview with the Administrator on 8/10/17 at 11:40 AM, Administrator stated that the unit managers check the nourishment refrigerators every day for staff food, proper labeling of resident's food and discards any food that has expired or belongs to the staff. She also stated that it was her expectation that the staff not store their personal food in the nourishment refrigerator. She further stated that all foods must be labeled with resident's name and a date when the food was placed in the nourishment refrigerator.	F 371		
F 431 SS=D	483.45(b)(2)(3)(g)(h) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. (a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. (b) Service Consultation. The facility must	F 431		9/7/17

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F 431	Continued From page 4 employ or obtain the services of a licensed pharmacist who-- (2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and (3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. (g) Labeling of Drugs and Biologicals. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. (h) Storage of Drugs and Biologicals. (1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. (2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on an observation, the facility failed to secure of 1 of 6 mobile medication carts located	F 431	1. No residents were found to be affected by the deficient practice	

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F 431	Continued From page 5 on the 200 hall. Findings included: On 8/8/17 at 11:43 until 11:52 am a mobile medication cart was observed to be unlocked and unsupervised on the 200 hall. An alert, but not oriented, resident was sitting in a wheelchair beside the cart during this observation. Nurse #4 was observed going into a resident ' s room and closing the door at 11:43 am. The mobile medication cart was located several feet away from the room. On 8/8/17 at 11:52 am, an interview was conducted with Nurse #4. Nurse #4 stated "Oh, I don ' t know how that happened. I never leave my cart unlocked!" Nurse #4 stated she always locked her cart. An interview with the Administrator on 8/10/17 at 12:08 pm, revealed her expectation of the nursing staff was to ensure the medications carts were secured at all times when not supervised.	F 431	The licensed staff member responsible for leaving the medication cart unlocked was counseled by the DHS (Director of Health Services) on 8/9/17. 2. All residents have the potential to be affected by the deficient practice. 3. The DHS and/or the ADHS will audit all six medication carts daily for two weeks, then all six medication carts will be observed/and documented 3 times a week for two weeks. Each med cart will be randomly observed once a week for one month and documented to validate security of carts when not in view of a licensed nurse. The pharmacist will observe for locked carts during med pass and while the cart is unattended during the monthly visit for 3 months. All licensed nurses responsible for medication pass will be educated regarding policy for locking medication carts when away from the cart by the Clinical Competency Coordinator starting 8/11/17 and completing training on 9/7/17. Any nurse not attending this re-education will be re-educated prior to starting their next shift. The in-service on locking and securing medications carts when not in view of a licensed nurse will be added in the education for new hires. 4. The Director of Health Services will take the findings of the audits to QAPI each month for 3 months, for continued	

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F 431	Continued From page 6	F 431	evaluation of compliance. Results of the medication passes and observations will be reported to the monthly performance improvement committee for tracking and trending purposes for 3 months with follow up action taken as needed.	
F 520 SS=E	483.75(g)(1)(i)-(iii)(2)(i)(ii)(h)(i) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS (g) Quality assessment and assurance. (1) A facility must maintain a quality assessment and assurance committee consisting at a minimum of: (i) The director of nursing services; (ii) The Medical Director or his/her designee; (iii) At least three other members of the facility's staff, at least one of who must be the administrator, owner, a board member or other individual in a leadership role; and (g)(2) The quality assessment and assurance committee must : (i) Meet at least quarterly and as needed to coordinate and evaluate activities such as identifying issues with respect to which quality assessment and assurance activities are necessary; and (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (h) Disclosure of information. A State or the	F 520		9/7/17

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F 520	Continued From page 7 Secretary may not require disclosure of the records of such committee except in so far as such disclosure is related to the compliance of such committee with the requirements of this section. (i) Sanctions. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility ' s Quality Assessment and Assurance Committee failed to maintain implemented procedures and monitor the interventions that the committee put in place in September of 2016. This was for a recited deficiency which was originally cited on 9/16/16, during the recertification survey and on the current recertification survey. The deficiency was in the area of food procurement. The continued failure of the facility during two federal survey of record show a pattern of the facility ' s inability to sustain an effective Quality Assessment and Assurance Program. Findings included: This tag is cross-referenced to: F371 Food Procurement: Based on observations, staff interview and record review the facility failed to maintain the nourishment refrigerator temperature below 40 degrees, discard food and inappropriately stored staff personal food in two of the three nourishment refrigerators. The facility was originally sited for F371 for failing	F 520	No resident was negatively impacted by this concern. a. All residents in the facility have the ability to be impacted by this stated practice. There were no adverse outcome related to this concern. On 8/11/17, the Administrator was re-educated by the Vice President of Quality Assurance and Performance Improvement on the quality assurance process. Re-education began 8/11/17 provided via Pruitt U class to all members of the Quality Assurance and Performance Improvement (QAPI) Committee, Which is comprised of the Administer, Director of Health Services, Dietary Manager, Social Services Director. Assigned classes on Pruitt U include PruittHealth QAPI Developing and Sustaining a Quality Culture, and QAPI Root Cause Analysis and PIP (Performance Improvement Plan) Development for SNF (Skilled Nursing Facility). All employees that are on the	

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F 520	Continued From page 8 to label food items in the walk in cooler and walk in freezer, failing to wash floors, refrigerator and food preparation equipment, and failing to discard dented cans in September of 2016. An interview was conducted with the Administrator on 8/10/17 at 12:10 pm. The Administrator indicated the Quality Assessment and Assurance Committee meetings occurred monthly. The Administrator confirmed the facility worked towards quality improvement.	F 520	QAPI committee are full time. There are no PRN or weekend staff on this committee, this will be 100% complete by 9/7/17. The Area Vice President of Operations or a member of the Regional Leadership team (Minimum Data Set Consultant, Senior Nurse Consultant and Certified Registered Dietician), will participate in the Quality Assurance/Performance Improvement meetings for the facility monthly X 6 months. The Regional Leadership team will review performance improvement plans for the facility monthly X 6 months to ensure effectiveness. Any negative findings will be reviewed at the Regional Leadership team at the quarterly Quality Assurance/Performance Improvement meeting for opportunities for re-education or correction. The Administrator will bring results of all open PI Plans to the Monthly Quality Assurance Performance Improvement Committee meetings X 3 months or until substantial compliance is achieved to ensure we have appropriate corrective action. Changes will be made to plan by the committee as indicated to include re-education and/or immediate corrective action. The Regional Leadership team will review performance improvement plans for the facility monthly X 6 months to ensure effectiveness. Any negative findings will	

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F 520	Continued From page 9	F 520	be reviewed at the Regional Leadership team at the quarterly Quality Assurance/Performance Improvement meeting for opportunities for re-education or correction.	