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 06/27/2019

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 A complaint survey was conducted on 6/27/19. Past noncompliance was identified at: CFR 483.12 at tag F600 at a scope and severity G.	F 000		
F 600 SS=G	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based upon staff interview and medical record review it was determined that the facility failed to prevent staff to resident abuse when a staff member stretched the fingers of a resident to get her hand open while providing assistance with dressing for 1 of 1 resident's (Resident #1) reviewed for abuse. Resident #1 experienced a fractured finger and was treated at the hospital. Findings include: Resident #1 was admitted to the facility on 7/25/17. The resident had diagnosis including	F 600	Past noncompliance: no plan of correction required.	7/16/19

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

Electronically Signed | 07/16/2019

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C4-C5 arthritis and Parkinson's disease. Review of the Resident's MDS (minimum data set assessment) dated 6/7/19, revealed that the scored 12 on the brief interview of mental status indicating that the resident had a mild memory deficit. She required staff assistance to complete activities of daily living including dressing.

A nurse's note (NN) dated 6/4/19 7 AM-3 PM shift stated, Resident alert and oriented times 3 (Person, Place and Time), able to make needs known. Left, digit finger swollen and purplish in color. Outgoing nurse reported that resident was swollen from last night. Called provider to have an order to x-ray the finger. X-ray done and awaiting the results. Resident tolerated all meds and meal and will monitor per protocol.

A nurse's note dated 6/4/19 at 12:48 PM stated, Resident x-ray result shows that 4th digit finger left hand was fractured. 911 called and resident sent to emergency room at 12:30 PM. NN dated 6/4/19 3 PM-11PM shift stated, Resident returned to facility via stretcher, denies pain, observed in stable condition. Resident observed with stabilizer on first finger.

Review of a Physician Progress note dated 6/4/19 stated, Patient seen today 2 of 2 staff reported that the patients 4th finger on her left hand was purple and swollen. Staff reported that patient injured her finger while staff was trying to clean her up. Staff reported that she hit her hand on the siderail during the turning. Resident agreed to hitting her finger. She reported pain and demonstrated a decrease in movement. X-ray of left hand shows fracture of 4th finger.

Review of the Radiology Interpretation dated

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6/4/19 revealed Resident #1 had an x-ray of her left hand which showed an acute oblique intra-articular slightly displaced fracture in the head of the proximal phalanx 4th digit.

Review of the hospital note dated 6/4/19 revealed that the resident had a "left ring finger deformity, presents with a left ring finger head of the proximal phalanx fracture. While she was changing rested her hand on something and slipped, and experienced immediate pain and swelling of her left right finger."

Review of the facility's investigation report of Resident #1's fractured finger with an end date of 6/11/19, revealed the allegation of staff to resident abuse was substantiated. The investigation specified Resident #1 was abused by the NA who provided care for her on 6/3/19 by stretching her fingers to pull her sweater off during the provision of care.

Review of a statement dated 6/5/19, signed by the administrator stated, "Administrator interviewed resident with family advocate present. Resident states at around 6:00PM on 6/3/19 the Nurse Aide came into her room to change her and get her ready for bed. Resident stated she told the aide she wanted her meds (medication) first. Resident states the aide said no I must change you first, resident refused to be changed as she was in pain. Resident states she grabbed ahold the rail because she did not want to be changed and started to scream, "Stop", but aide did not listen. After some time, the resident's roommate came into the room then went to get nurse. Once nurse got into room the resident was changed. When asked by the Admin

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(Administrator) in the interview what happened to her hand resident states the aide pulled finger off rail and that is what injured her hand.

During the survey Resident #1 was unavailable for interview due to transfer to another facility.

Review of statement written dated 6/4/19 by NA #1 ho provided care for Resident #1 on 6/3/19 stated, "Resident #1 was brought from the hospital and transferred on the bed by EMS (Emergency Services) on Monday evening at around 5:00. I changed her bed because she still had the sheets and Hoyer pad under her. When I was changing her clothes, she held on to her sweater and I tried to take it out. When she let go I put on her gown. Her roommate noticed that I was having a hard time, so she offered to call the nurse to come help. When I did the next rounds, she didn't complain of pain and everything was normal for the rest of the shift."

An additional statement written by NA #1 who provided care for Resident #1 dated 6/12/19 regarding his care for Resident #1 on 6/3/19 stated "I opened up her hand by stretching her fingers on both hands to pull the sweater off." During telephone interview on 6/27/19 at 6:54 PM with NA #1 who provided care for Resident #1 on 6/3/19 during 2nd shift, the NA stated, it was a normal shift. The NA reported that he was changing Resident #1's clothing and she was holding her sweater when he took it off. He stated that he did not know anything happened and the resident did not complain of pain during his shift. The NA reported that he provided care for the resident at 5:00 PM, 9:00 PM, and 11:00 PM with no complaints of pain.

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Interview with the facility administrator at 5:11 PM on 6/27/19 revealed that Resident #1's finger was x-rayed, and she was sent out to the emergency room. The administrator stated the facility investigated the resident's fractured finger and determined Resident #1's finger was injured when the NA #1 stretched her fingers to open her hand on 6/3/19. He stated that the NA involved in the incident was suspended on 6/4/19 and the facility implemented a corrective action plan to prevent reoccurrence.

Facility Plan of Correction Date 6/4/19.

Facility alleged date of compliance 6/12/19.

Corrective Action for the resident involved, (Resident #1):
Resident physician notified and gave order for an x-ray. Resident was x-rayed and sent to the hospital for a fractured finger, the resident returned to the facility the same day with a stabilizer for her finger.

Identification of potentially affected resident and corrective actions taken:
The Nursing Assistant who provided care for Resident #1 was suspended on 6/4/19. Administrator interviewed other alert and oriented residents on 6/5/19, residents who were not alert and oriented were assessed from head to toe by a nurse on 6/11/19.

Measures put in place or systemic changes that were made to ensure that the deficient practice will not reoccur:
6/12/19, staff were in-serviced refusal of care and the facility abuse policy by the Administrator, Director of Nurses, Assistant Director of Nurses

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and Nursing Supervisor.

Monitoring/Quality Assurance Plan:
SW or designee will interview 10 alert and oriented residents as it relates to staff/resident abuse weekly for 4 weeks.
Nurse or designee will perform 10 random skin audits for residents who are not alert and oriented weekly for 4 weeks.
Nurse or designee will interview 10 random employees as it relates to the facility abuse policy weekly for 4 weeks.
Facility administrator will report the results of the audits to the QAPI committee for further review and recommendations as needed and thereafter.

Review of the facility's Plan of Correction on 6/27/19 revealed an Inservice Education Program Summary Record Form. The Program was title Refusal of Care /Abuse Policy. Program Content included, zero tolerance policy regarding abuse and stopping care immediately upon resident refusal of care. All employees are provided abuse and neglect training upon hire. Inservice attendance records were signed by staff and dated 6/12/19.
Review of facility monitoring on 6/27/19 revealed Resident interviews were conducted on 6/17/19 and 6/25/19. Body audits were documented on 6/19 and 6/25/19. Staff interviews were documented as being completed on 6/17 and 6/25/19. Review of the facility tracking sheets revealed that monitoring/audits were conducted per the plan of correction.

Interview with facility staff on 6/27/19 at 7:05 PM, 7:16 PM, and 7:34 PM revealed that they participated in abuse and neglect training and refusal of care a during the past month. Staff

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F 600	Continued From page 6 were able to appropriately state the correct response to resident refusal of care. Date of 6/12/19 was verified as the facility's date of correction.	F 600		