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 07/14/2020

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

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F 000	INITIAL COMMENTS An on-site complaint investigation survey was conducted on 7/13/20 - 7/14/20. Event ID# 2FFY11. Six (6) of the 6 complaint allegations were not substantiated.	F 000		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, and	F 657	This plan of correction constitutes a	8/10/20

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 07/30/2020

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.

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medical record reviews, the facility failed to review and revise a resident ' s care plan to accurately reflect the fall safety interventions required to be consistently implemented for 1 of 3 residents reviewed for Accidents/Falls (Resident #2).

The findings included:

Resident #2 was admitted to the facility on 8/30/14. She was discharged to the hospital on 1/12/20 and re-entered the facility on 1/17/20. The resident ' s cumulative diagnoses included dementia, epilepsy, and a history of falls.

A review of Resident #2's plan of care revealed it included an area of focus related to falls (dated 1/18/20), noting the resident was at risk for falls related to decreased mobility, side effects from meds and overall disease process. The interventions included the following: assist for toileting and transfers as needed (start date 1/18/20); continue to cue for safety awareness (start date 1/18/20); keep environment safe (start date 1/18/20); place call light within reach (start date 1/18/20); and "safety devices" (no devices were specified) with a start date of 1/18/20. Use of a fall mat, bed in the low position, and scoop mattress were not included as interventions in the care plan.

The resident's medical record included Nursing Notes which indicated fall safety interventions not included in the care plan were being implemented:
--A Nursing Note dated 1/18/20 at 4:49 PM read, in part: " ...Bed remained in low position for safety precautions ..."
--A Nursing Note dated 1/21/20 at 10:21 AM and

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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 the resident found to have been affected by the deficient practice:

On 7/14/2020, the bed for resident#2 was put on a low position and a fall mat was placed by the bed. On 7/23/2020, the Interdisciplinary Team (IDT) reviewed and revised the care plan for resident #2 to accurately reflect the fall safety interventions and to ensure the interventions reflect on the resident□s care guide/profile. Interventions are implemented consistently for the resident. The IDT included the Director of Health Services, Clinical Competency Coordinator, MDS Coordinators, Unit Manager, charge nurse, Director of Social Services, Dietary Manager and, the Activities Director.

Corrective action for other residents having the potential to be affected by the same deficient practice:

On 7/23/2020, the IDT led by the Director of Health Services and MDS Coordinators initiated the review and revision of all care

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F 657	Continued From page 2 on 1/24/20 at 3:01 PM included notations which read, " ...lying on her back in bed with seizure mat on floor." A Fall/Incident Report dated 3/27/20 at 1:48 PM described an unwitnessed incident when Resident #2 was found lying on the floor mat beside her bed. The resident stated she was trying to stand up and walk. There were no signs/symptoms of injuries at the time of the incident and Resident #2 denied having any pain or injury. The report indicated the care plan was updated and interventions were in place. However, a review of the resident's care plan revealed the use of a fall mat, bed in the low position, and scoop mattress were not included as interventions in her care plan. Resident #2 ' s medical record included additional Nursing Notes which indicated fall safety interventions not included in the care plan were being implemented: --A Nursing Note dated 3/29/20 at 8:11 AM reported, "...Resident trying continuously to get out of bed tonight. Resident stated she was trying to get to the bathroom. Reminded resident that she doesn't walk. Resident cursed profusely at the staff. Resident's leg placed back in bed. Bed placed in lowest position with fall mats down..." --A Nursing Note written on 3/30/20 at 4:14 AM read, in part: " ...No attempts to get out of bed this shift. Bed low with fall mat in place..." --A Nursing Note dated 3/31/20 at 8:22 AM read, in part: "...Continuously trying to get up. Bed in lowest position. Fall mat beside bed Resident #2 ' s most recent quarterly Minimum Data Set (MDS) assessment dated 4/28/20 revealed the resident had severely impaired cognitive skills for daily decision making.	F 657	plans as needed for all residents at risk for falls to ensure they accurately reflect the fall safety interventions and implemented consistently as required. The review and revision of care plans will be completed by 8/5/2020. The interventions will be reviewed daily by the Director of Health Services, Unit Managers and charge nurses to ensure consistent implementation. Systemic changes made to ensure that the deficient practice will not recur: On 7/23/2020, the Administrator, the Director of Health Services and, the Clinical Competency Coordinator initiated education for the IDT members (including MDS nurses, the Social Worker, the Activities Director and, the Dietary Manager) and all licensed nurses on reviewing and revising care plans as needed to accurately reflect interventions put in place and to ensure the interventions are consistently implemented. Education was also initiated on 7/23/2020 for all nursing aides on reviewing the care guide and implement the interventions as required. Education will be completed by 8/7/2020. Any new hires to join the IDT and the nursing department will be educated as indicated above by the Clinical Competency Coordinator and/or the Director of Health Services during new hire orientation. IDT members and nursing staff not educated as indicated, will not be allowed to work until they are educated.	

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Resident #2 required extensive assistance for bed mobility and dressing. She was totally dependent on staff for toileting and personal hygiene. Section J of the MDS assessment revealed the resident had one fall with no injury reported since the last assessment (dated 1/28/20).

A Fall/Incident Report dated 5/28/20 at 3:45 PM described an unwitnessed incident when Resident #2 was observed sitting on the floor by the bedside. No injuries were reported. The report did not indicate if fall safety interventions were in place at the time of this fall. A notation made in the report indicated the Interdisciplinary Team met, discussed the resident and interventions, and updated the care plan.

The resident's plan of care revealed the area of focus related to falls was revised to include an interdisciplinary referral to rehabilitation services with a start date of 5/29/20. Use of a fall mat, bed in the low position, and scoop mattress were not included as interventions in her care plan.

Resident #2 ' s medical record indicated she was referred to Physical Therapy (PT) for the fall and was evaluated on 6/4/20. The PT evaluation notes reported fall interventions currently implemented included the following: " ...Patient with scoop mattress with raised side bolsters for falls deterrence; bed approximating wall on patient ' s right side, soft fall bedside mat on patient ' s left side, and bed kept at lowest setting when patient not provided with direct supervision, due to patient presenting with increased risk for displacement from bed 2/2 (secondary to) seizure disorder. Pt (patient) with recent fall and continued use of fall mats. Pt occasionally

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For new admissions and readmissions, the Director of Health Services, MDS Coordinators, Unit Managers and other members of the IDT will initiate and/or revise care plans as needed to accurately reflect interventions pace and ensure the interventions are consistently implemented. The interventions will be reviewed daily by the Director of Health Services, Unit Managers and charge nurses to ensure consistent implementation. The Administrator and the Director of Health Services introduced an observation tool for safety interventions and implementation to be utilized weekly by Unit Managers and/or designated personnel.

Plans to monitor its performance to make sure that solutions are sustained:

The Administrator and the Director of Health Services introduced an observation tool for safety interventions and implementation to be utilized weekly by Unit Managers and/or designated personnel. The tool will be used to observe interventions and implementation for 30 residents for 1 week, then 20 residents weekly for 3 weeks, then 20 residents monthly for 3 months and then quarterly until compliance is maintained for 2 consecutive quarters. The Administrator and the Director of Health Services will review the observation tool weekly for 4 weeks and then monthly until compliance is maintained.

Any areas of non-compliance will be

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disoriented and attempts to get out of bed. Pt recently attempting to get herself out of bed and falling ..."

An observation was conducted on 7/13/20 at 11:40 AM of the resident as she was lying awake in her bed. The resident's bed was not placed in the low position; no fall mat was in place.

An observation was conducted on 7/13/20 at 2:20 PM of Resident #2 as she was lying in bed watching television. During the observation, the resident's bed was not placed in a low position; no fall mat was in place next to her bed.

An interview was conducted on 7/13/20 at 2:30 PM with Nursing Assistant (NA) #1. NA #1 reported she was assigned to care for Resident #2. When asked about the fall safety interventions put into place for Resident #2, the NA reported the resident typically had a fall mat placed by the side of her bed and her bed was lowered at night (or when she was asleep).

Accompanied by the Corporate Senior Nurse Consultant, an observation was made on 7/14/20 at 11:42 AM of Resident #2 while she was lying in her bed awake. The resident was observed to have a low profile scoop mattress on her bed, the bed was in a low position, and a fall mat was in placed by the side of the bed.

An interview was conducted on 7/14/20 at 11:45 AM with the Corporate Senior Nurse Consultant. During the interview, the Consultant reported any intervention put into place to address a fall should be on the resident's care plan. Upon review of the resident's current care plan and Resident Profile (which served as a current care guide for

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reported by the Administrator and/or the Director of Health Services to the QAA Committee quarterly for further action as needed.

Date of Compliance: 8/10/2020

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F 657	Continued From page 5 the nursing assistants), the Consultant confirmed use of a scoop mattress, bed in the low position, and fall mat placed next to the bed were not included on either the care plan or Resident Profile as planned interventions for a problem area related to falls. An interview was conducted on 7/14/20 at 11:55 AM with the facility's Administrator. During the interview, the Administrator reported the Interdisciplinary Team (IDT) had previously reviewed Resident #2 and her falls. The Administrator reported he thought fall interventions were put into place for her, but stated the interventions may not have been saved and subsequently transferred over to the Resident Profile. When asked, the Administrator reported the care plan was a team responsibility. He reported the Director of Nursing (DON), Unit Manager, or MDS Nurse typically shared responsibility to update a resident's care plan on an as needed basis. A follow-up telephone interview was conducted on 7/14/20 at 3:45 PM with the facility's Administrator. During the interview, the Administrator reported the facility converted to electronic medication records (EMRs) approximately one year ago. The EMRs included resident care plans. Prior to the conversion, the facility was using paper records and a different system for documenting the resident care plans and care guides. The Administrator reported he discovered the facility staff were actually using all of these tools, including the old versions of Resident #2's care plans and care guides. He noted the old version of Resident #2's Care Guide did include keeping her bed in the low position, use of a fall mat, and scoop mattress (dated	F 657		

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F 657	Continued From page 6 5/16/18). When asked if he would have expected these fall interventions to be included on Resident #2's current care plan, the Administrator stated, "Absolutely."	F 657		