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 02/12/2021

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 000	INITIAL COMMENTS A complaint investigation survey was conducted from 02/10/21 through 02/12/21. Event ID# Y4SL11. One of the seven complaint allegations was substantiated resulting in a deficiency.	F 000		
F 585 SS=D	Grievances CFR(s): 483.10(j)(1)-(4) §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay. §483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph. §483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident. §483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include: (i) Notifying resident individually or through	F 585		3/10/21

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

Electronically Signed | 03/07/2021

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F 585	Continued From page 1	F 585		

postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system;
(ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations;
(iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated;
(iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law;

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F 585	Continued From page 2 (v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued; (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. This REQUIREMENT is not met as evidenced by: Based on record review, family and staff interviews the facility failed to document a grievance and failed to provide a written grievance summary for 1 of 5 resident reviewed for grievances. (Resident #8). Findings included: Resident #8 was admitted to the facility on 11/11/20 with diagnoses that included pneumonia due to 2019-nCoV, acute respiratory disease, and acute kidney injury. Review of the admission Minimum Data Set (MDS) assessment dated 11/16/20 revealed	F 585	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 that one was cited correctly. This plan of correction is submitted to meet requirements established by federal and state law. Description of the Deficient Practice Facility failed to document a grievance and failed to provide a written grievance summary for 1 of 5 resident reviewed for	

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F 585	Continued From page 3 Resident #8 was coded for moderate cognitive impairment, required assistance with activities of daily living and transfers. The MDS assessment also revealed Resident #8 was coded for bilateral hearing aids. Review of progress note dated 11/13/20 revealed there was a plan of care conference held that included the interdisciplinary team and the responsible party via telephone. It was confirmed that Resident #8 wore hearing aids in both ears. Review of the grievance log from 11/1/20 to 2/10/21 revealed there were no issues documented for Resident #8 about missing hearing aids. Interview conducted with the Social Worker (SW) on 2/10/21 at 1:30 PM revealed she took a grievance from Resident #8 about her missing hearing aids but did not remember the exact date. The SW stated the nursing staff attempted to locate the hearing aids but were unable to find them. She stated there was a process for missing items and reimbursement if items were not located. The SW further stated she contacted Resident #8's POA about getting a price for the hearing aids but did not receive a call back from the POA. The SW stated she did not write this up on a formal grievance form and did not follow up with the daughter after she attempted to contact her. When asked why she did not document the grievance for Resident #8, the SW replied, "I just took the grievance verbally, I don't have it written down". A phone interview was conducted on 2/10/21 at 3:05 PM with the Resident # 8's Power of Attorney (POA). The POA stated she mailed the	F 585	grievances. (Resident #8) Corrective Action for those Residents found to have been affected Resident #8 discharged from the facility on 11-16-2020. The facility has communicated with Resident #8□s responsible party on 2-15-2021 regarding the replacement of the missing hearing aids. The facility has received a quote for the cost of replacing Resident #8□s hearing aids and has been processed in the company financial department. The facility social worker has been assigned to document, resolve, and report all grievances per the facility□s policy. Corrective Action to identify potential affected residents All grievances have been resolved and follow-up has occurred with appropriate parties. A review of all grievances within the last 30 days was conducted. A copy of all grievances taken will promptly be provided to the LNHA and tracked during the daily stand-up meeting. The facility will conduct monthly reviews of all grievances confirming concerns or complaints are a) documented, b) processed in accordance with the facility□s grievance policy, c) logged into the facility□s grievance log, d) missing items logged into the facility□s missing items reflect response and resolution, e) communication of that resolution to the complainant/group. Findings will be promptly addressed and forwarded to QA committee for	

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F 585	Continued From page 4 facility the information that specified the replacement cost of the hearing aids. The POA stated she did not recall what date she mailed it, but it was shortly after being notified by the facility that they were missing. The POA stated she did not hear anything back from the facility. Review of progress note dated 2/10/21 at 4:31 PM revealed the Social Worker called Resident #8's POA regarding the cost for the missing hearing aids. The daughter informed the Social Worker that she was out of town and would send her the information upon her return home on 2/12/21. During an interview conducted with the Administrator on 2/10/21 at 2:35 PM he stated there was a policy for grievances and the procedure was to file the grievance with the social worker, the social worker would complete the intake then would delegate to the designee to investigate. He stated he expected the family would be contacted and follow up would occur by the social worker or whomever completed the investigation.	F 585	processing. Ongoing Corrective Action The facility has educated residents and staff on the Grievance and Missing Items Policy and Procedure. The facility has explained that concerns such as: missing items, staffing, cleanliness, maintenance, water temperatures, diet slips, call light response times and more are appropriate concerns to document on the grievance form. If the grievance is associated with a missing item, the grievance will be recorded on the Missing Items Log. The LNHA has re-educated department directors as to his/her responsibility to promptly address the concerns/complaints following the completed investigation. Monitoring Plan QA The LNHA is responsible for the Plan of Correction implementation. The QA Coordinator and its member will be responsible for the ongoing monitoring of this process as follows: 1) The Grievance Log will be reviewed by the LNHA weekly x4 and then monthly x3; confirming required documentation, and timely, thorough, and adequately communicated responsive action to the complainant. 2) The grievance logs will be reviewed and discussed by the QA meeting monthly. Findings will be addressed promptly by the QA team. After the conclusion of the	

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F 585	Continued From page 5	F 585	ongoing monitoring as described above, the QA team will determine the frequency of ongoing monitoring. Date of Compliance March 10, 2021	
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff and resident interviews, the facility failed to thoroughly investigate an allegation of resident to resident abuse for 1 of 3 residents reviewed for abuse (Resident #9). The findings included:	F 610	Description of the Deficient Practice Based on record reviews and staff and resident interviews, the facility failed to thoroughly investigate an allegation of resident to resident abuse for 1 of 3 residents reviewed for abuse. Corrective Action for those Residents	3/10/21

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F 610	Continued From page 6 Resident #9 was admitted to the facility on 2/11/20. A quarterly Minimum Data Set (MDS) dated 10/17/20 indicated Resident #9 was cognitively intact. During an interview on 2/10/21 at 12:00 p.m., Resident #9 revealed that a few weeks prior she complained to the Administrator that Resident #3 played her music too loud at night. Resident #9 stated that on the following Saturday, Resident #3 verbally threatened if she (Resident #9) continued to complain about her music, she (Resident #3) would sneak into her room and choke her. Resident #9 indicated she was not afraid of Resident #3 and did not feel in fear for her life or feel unsafe. She stated she reported the verbal threat to the Administrator the following Monday and felt he should have investigated it. A review of facility reported incidents revealed none found for Resident #9's allegation of abuse. There was no evidence the facility interviewed staff or other residents regarding the allegation of abuse. Review of a Progress Note dated 1/18/21 revealed the Social Worker spoke with Resident #3 regarding playing loud music disturbing the other residents. The resident refused the offer of headphones and denied playing her music loudly. Review of the Social Worker's note dated 1/18/21 indicated Resident #9 refused a room change and denied wanting to go to another facility. Headphones were provided to the resident. During an interview on 2/10/21 at 2:00 p.m., the	F 610	found to have been affected Resident #9 is at baseline. Resident #3 is at baseline. The facility has opened and completed the investigation for allegation of resident to resident abuse for Resident #9 and Resident #3 on 3/5/2021. Now included in the investigation are the following: 1) An interview summary with both residents; 2) Evidence the resident□s concerns were investigated; 3) Documentation reflecting MD/RP notification of the allegations. Corrective Action to identify potential affected residents The facility has conducted an audit of all alert and oriented resident□s ensuring that all residents had not experienced or witnessed abuse or neglect. Ongoing Corrective Action The facility has reviewed its□ policies on Reporting Patient Abuse, Neglect, Exploitation, Mistreatment, and Misappropriation of Property and Abuse Identification. All staff will be in-serviced on Reporting Patient Abuse, Neglect, Exploitation, Mistreatment, and Misappropriation of Property and Abuse Identification. The LNHA will submit allegations of abuse and/or neglect in	

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F 610	Continued From page 7 Administrator stated he recalled Resident #9 had complaints about Resident #3 playing her television and radio, loudly. He revealed he spoke with Resident #3 about being respectful of the other residents and offered her the use of headphones which she refused. The Administrator also confirmed Resident #9 reported to him Resident #3 told her that if she (Resident #9) complained to him again, she would choke her in her sleep. He stated Resident #3 was not ambulatory and unable to transfer unassisted; she was mostly bedridden. He stated he had no validation that verbal abuse occurred; there were no witnesses. He stated both residents were offered and refused room changes. The Administrator acknowledged he did not document any of his investigation.	F 610	accordance with the facility□s policy. All allegations and investigation will be reviewed by the LNHA and appropriate Department Director. The facility has implemented daily compliance rounds to attain and maintain consistency in providing quality resident care. Compliance rounds are to be completed by the IDT or designee daily Monday □ Friday. The completed Compliance Rounds Forms will be reviewed by the LNHA/DHS ensuring that all findings are promptly addressed and investigated as necessary. Monitoring Plan QA The LNHA is responsible for the Plan of Correction implementation. The QA Coordinator and its members as noted below will be responsible for the ongoing monitoring of this process as follows: 1) The facility will interview 10 residents per week x4 weeks, and then 10 residents per month x3 months ensuring that all residents had not experienced or witnessed abuse or neglect. 2)Monthly the LNHA will report a summary of all allegations a) confirming timely reporting b) thorough investigation. 3) All active investigations will be reviewed daily during stand up. Findings will be addressed promptly with the QA team. After the conclusion of the ongoing monitoring as described above, the QA team will determine the frequency of	

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F 610	Continued From page 8	F 610	ongoing monitoring. Date of Compliance March 10, 2021	
F 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the	F 655		3/10/21

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F 655	Continued From page 9 resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to develop a baseline care plan within 48 hours of admission for Resident #8 that included therapy goals, activities of daily living (ADL) assistance, transfer, diet, and oxygen for 1 of 9 residents reviewed for baseline care plans. Findings included: Resident #8 was admitted to the facility on 11/11/20 with diagnoses that included pneumonia due to 2019-nCoV, acute respiratory disease with supplemental oxygen use, acute kidney injury, dehydration, chronic obstructive pulmonary disorder, and deconditioning. Admission orders dated 11/11/20 included heart healthy diet, drink supplement for poor intake, therapy services, supplemental oxygen, and quarantine isolation for 14 days. Review of the MDS dated 11/11/20 revealed the 48-hour baseline care plan was incomplete for Resident #8 and did not have all the minimum healthcare information necessary.	F 655	Description of the Deficient Practice Based on record review and staff interviews, the facility failed to develop a baseline care plan within 48 hours of admission for Resident #8 that included therapy goals, activities of daily living (ADL) assistance, transfer, diet, and oxygen for 1 of 9 residents reviewed for baseline care plans. Corrective Action for those Residents found to have been affected Resident #8 discharged from the facility on 11-16-2020. Director of Health Services has been re-educated to the facility Baseline Care Plan Policy. Corrective Action to identify potential affected residents The facility has conducted a review of all residents admitted to the facility in the past 30 days; ensuring that a baseline care plan has been developed within 48	

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F 655	Continued From page 10 Record review revealed two care plans dated 11/11/20 were developed for fall risk and discharge planning. These care plans did not include information for diet, supplemental oxygen, therapy, transfer, goals, or ADL assist necessary. Review of the admission Minimum Data Set (MDS) assessment dated 11/16/20 revealed Resident #8 was coded for moderate cognitive impairment, required moderate assistance with ADL and transfers, incontinent of bowel and bladder, received supplemental oxygen and therapy services. An interview was conducted with the MDS Coordinator on 2/10/21 at 3:21 PM. She stated the 48-hour baseline care plan was not developed for Resident #8. She did not provide a reason for this and stated that normally a 48-hour baseline care plan was developed for new admissions. An interview was conducted with the Director of Nursing (DON) on 2/10/21 at 3:24 PM. The DON stated the policy was 48-hour baseline care plans were to be completed for new admissions.	F 655	hours of admission. Ongoing Corrective Action The facility has reviewed its Baseline Care Plan policy. Facility IDT, Unit Manager, and nursing staff have been re-educated to the policy. The facility will review all new admissions with the next business day; ensuring the development of a baseline care plan within 48 hours of admission. Monitoring Plan QA The LNHA is responsible for the Plan of Correction implementation. The QA Coordinator and its members as noted below will be responsible for the ongoing monitoring of this process as follows: 1)All new admissions to the facility will be audited by the Director of Health Services daily Monday through Friday to ensure the development of a baseline care plan within 48 hours. 2)All new admissions will be discussed by the IDT daily Monday through Friday during the daily morning stand-up meeting to ensure that a baseline care plan has been developed with 48 hours of admission. 3) LNHA will audit all new admissions for the last 30 days monthly x3. The LNHA is responsible for the Plan of Correction implementation. The QA	

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F 655	Continued From page 11	F 655	Coordinator and its members as noted below will be responsible for the ongoing monitoring of this process as follows: 4) All new admissions to the facility will be audited by the Director of Health Services daily Monday through Friday to ensure the development of a baseline care plan within 48 hours. 5) All new admissions will be discussed by the IDT daily Monday through Friday during the daily morning stand-up meeting to ensure that a baseline care plan has been developed with 48 hours of admission. 6) LNHA will audit all new admissions for the last 30 days monthly x3. Findings will be addressed and promptly reported to the QA team. After the conclusion of the ongoing monitoring as described above, the QA team will determine the frequency of ongoing monitoring. Date of Compliance March 10, 2021	