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 10/27/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEALTH-DURHAM	3100 ERWIN 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
E 000	Initial Comments An unannounced recertification survey was conducted on 10/10/22 through 10/27/22. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #GUO111.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint survey was conducted from 10/10/2022 through 10/27/2022. Intake NC00192549 resulted in immediate jeopardy. Immediate Jeopardy was identified at CFR 483.25 at tag F684 at a scope and severity (K). Tag F684 constituted Substandard Quality of Care. Immediate Jeopardy began on 7/27/22 and was removed on 10/22/22. An extended survey was conducted. The following intakes were investigated NC00192562, NC00192689, NC00191451, NC00192622, NC00193685, NC00190458, NC00192220,NC00192549 and NC00192664. Six of the 29 complaint allegations were substantiated resulting in deficiencies (F550, F561, F677, F684, F686 and F580).	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section.	F 550		11/21/22

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

Electronically Signed | 11/17/2022

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 10/27/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEALTH-DURHAM	3100 ERWIN 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 550	Continued From page 1 §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observations, record review, resident and staff interviews, the facility failed to exercise resident rights, failed to provide privacy for 1 of 5 residents (Resident #86) reviewed for resident rights.	F 550	Corrective action for the residents found to be affected by the deficient practice. In-servicing was conducted by the Director of Health Services (DHS) on	

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 10/27/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEALTH-DURHAM	3100 ERWIN 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 550	Continued From page 2 Findings included: Resident #86 admitted to the facility on 4/15/22 and with diagnoses that included a history of type 2 diabetes mellitus, hypertension, hypothyroidism, and asthma. A review of Resident #86's quarterly minimum data set (MDS) dated 8/26/22 revealed Resident was cognitively intact. During an observation on 10/13/22 at 10:23 am Nurse # knocked on Resident #86's room door while NA #3 was providing activities of daily living care (ADL) care. NA #3 stated patient care when heard knock on room door, however Nurse # 12 proceeded to open room door. Resident #86 was lying in bed with lower body exposed and privacy curtain was open and while room door was open. Nurse #12 indicated she was doing covid testing and gestured with hand she was going to roommates' side of the room. NA #3 again stated "patient care" and Nurse #12 then closed room door. NA #3 pulled privacy curtain at that time. An interview was conducted on 10/13/22 at 10:39 am with Resident #86 and she indicated she did not like it when Nurse walked in room while she was receiving ADL care. She stated, "I did not like it, made me feel like I don't have no privacy, me laying here naked". Resident #86 indicated staff do not usually pull the privacy curtain while giving ADL care. An interview was conducted on 10/13/22 at 11:10 am with NA #3 and she indicated she should have had the privacy curtain but forgot to pull it.	F 550	10/08/22 with NA #3 and Nurse #12 on providing privacy to residents while providing activities of daily living (ADL). The education included the closing of curtains around the resident□s bed while providing care and waiting for a response from the resident or staff member behind a closed door before entering a resident room. Corrective action for other residents having the potential to be affected by the same deficient practice. All residents have the potential to be affected by the alleged deficient practice. In-servicing was conducted by the Director of Health Services (DHS) and/or the Clinical Competency Coordinator (CCC) to all employees on resident rights and specifically their right to privacy on 11/08/22 through 11/14/22. Employees not educated by 11/21/22 will be educated prior to their next scheduled shift. All new hires will receive education on Resident Rights, specifically to include a resident□s right to privacy during their general orientation. Systemic changes made to ensure that the deficient practice will not recur. Director of Health Services (DHS) and/or Department Managers will audit for employees knocking on resident□s door and waiting for response from Resident and/or employee prior to entering resident□s room to ensure privacy is	

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 10/27/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEALTH-DURHAM	3100 ERWIN 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 550	Continued From page 3 During an interview on 10/13/22 at 11:20 am with Nurse #12 she indicated she did not hear NA #3 say patient care and she was not aware that Resident #86 was uncovered. She indicated she should have waited for Resident response before she entered room. On 10/13/22 at 1:06 pm an interview was conducted with the Director of Nursing (DON), and she indicated Nurse #12 was a new Nurse and new to the facility. She indicated Nurse # was in orientation, and believed it was a cultural difference and did not understand what was meant when NA #3 said patient care. The DON indicated Nurse #12 she should have knocked on the door and waited to be instructed to come in room before opening room door. She also indicated it was her expectation that the privacy curtain was pulled while providing ADL care. During an interview with the Administrator on 10/13/22 at 5:15 pm, she indicated she was aware of Nurse #12 and NA #3 not providing privacy for Resident #86 while she was receiving ADL care. She indicated Nurse #12 was in training and was doing a task. She further indicated it was her expectation that staff knocked on Residents room doors and waited for response before proceeding and privacy curtains to be pulled while providing ADL care.	F 550	being provided during Activities of Daily Living (ADL) care. This review will occur for 5 residents 3 times a week for 4 weeks and then 5 residents monthly times 3 months to ensure privacy is being provided during Activities of Daily Living (ADL) care. Plans to monitor its performance to make sure that the solutions are sustained. The Director of Health Services (DHS) will report findings of the employees by knocking on doors and waiting for resident and/or employee response to ensure privacy is maintained to the Quality Assurance Performance Improvement (QAPI) for review and revision monthly x 3 months or until substantial compliance is achieved. Date of compliance: 11/21/22	
F 561 SS=E	Self-Determination CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)	F 561		11/21/22

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 10/27/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEALTH-DURHAM	3100 ERWIN 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 561	Continued From page 4 (1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on record review, staff and resident interviews, the facility failed to honor a resident's preference for a shower (Resident #92) and failed to allow residents the right to choose to leave their assigned room while the facility was in a Covid-19 outbreak ((Resident #13, Resident #20, Resident #54, and Resident #26) for 5 of 7 residents reviewed for choices. Findings included: 1.Resident #92 was admitted to the facility on 9/13/22. Review of the admission Minimum Data Set (MDS) assessment dated 9/18/22 indicated	F 561	Corrective action for the residents found to be affected by the deficient practice. On 11/16/22 the facility Social Workers (SW) informed residents #92, #13, #20, #54 and #26 of their Resident Rights and the current Covid-19 guidelines. Specifically, their right to choose Activities of Daily Living (ADL) care including showers and/or bed baths, dining, activities, and leaving their rooms during a Covid-19 outbreak. Corrective action for other residents	

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 10/27/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEALTH-DURHAM	3100 ERWIN 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 561	Continued From page 5 the assessment was in process. The resident was assessed as cognitively intact. Resident's Activity of Daily Living (ADL) was assessed as requiring total dependence of one person for bathing. The resident did not exhibit rejection of care and had no behavioral symptoms. Review of the Point of Care history documentation from 9/13/22 to 10/11/22 revealed the resident received complete bed baths on 9/14/22, 9/15/22, 9/23/22, 9/28/22, 10/4/22, 10/5/22, and 10/7/22. Resident #92 received partial bed baths on 9/24/22, 9/26/22, 9/27/22, and 10/1/22. There was no documentation of the resident receiving any showers. Review of the shower schedule book revealed Resident #92's scheduled shower days were Thursday during the first shift (7:00 AM- 3:00 PM). During an observation and interview on 10/10/22 at 12:30 PM, Resident #92 was observed sitting in his motorized wheelchair. Resident was observed to be well groomed and clean. Resident indicated he was going out of the facility for a doctor's appointment. Resident #92 stated he did not receive any showers since his admission to the facility (9/13/22). Resident indicated he received bed baths three times a week. Resident #92 stated that when he requested staff for a shower, he was informed that due to COVID-19 outbreak in the facility, the residents were not offered showers. During an interview on 10/12/22 at 10:40 AM, Nurse Aide (NA) #6 stated she was frequently assigned to the resident and worked the first shift (7:00 AM - 3:00 PM). Resident #92 was	F 561	having the potential to be affected by the same deficient practice. All residents have the potential to be affected by the alleged deficient practice. The Activity Director held a resident council meeting on 11/11/22 to review Resident Rights Self-Determination and current Covid-19 guidelines related to Resident Activities of Daily Living (ADL) care including showers and/or bed baths, dining, activities, and leaving their rooms during a Covid-19 outbreak. All alert and oriented residents that did not attend was given a copy of Resident Rights Self Determination and the current Covid-19 guidelines on Resident Activities and Dining. Letters were mailed on 11/17/22 to those residents with designated Resident Representatives who are not alert and oriented. In-servicing was conducted by the Director of Health Services (DHS) and the Clinical Competency Coordinator (CCC) to all employees on 11/08/22 through 11/21/22 on the current Covid-19 guidelines and resident rights to self-determination. Employees not educated by 11/21/22 will be educated prior to their next scheduled shift. Education on the current Covid-19 guidelines and Resident Rights to Self-Determination will occur during new hire orientation for all employees. Systemic changes made to ensure that the deficient practice will not recur.	

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 10/27/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEALTH-DURHAM	3100 ERWIN 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 561	Continued From page 6 scheduled for showers every Thursday during first shift. NA #6 indicated the resident was totally dependent for bathing and needed a shower bed. NA #6 stated residents who needed a bariatric shower chair a shower bed for showers needed to be taken to the basement floor for showers in the "big" shower room that could accommodate the shower bed or the bariatric shower chair. Showers for these residents could not be offered in their rooms as the shower rooms could not accommodate a shower bed or a bariatric shower chair. NA #6 indicated due to COVID -19 outbreak in the facility, NAs were made aware by the management that the residents could not leave their rooms and hence could not be taken downstairs. NA #6 further indicated the resident required 2-person physical assistance for showers and there were not enough staff available to accommodate the resident request. NA stated the resident was offered a complete bed bath or partial bed bath instead. During an interview on 10/13/22 at 2:03 PM, NA #1 indicated she was occasionally assigned to Resident #92 during the first. NA #1 stated due to COVID-19 outbreak in the facility, residents who needed to be taken to the large shower room on the basement floor were not taken. These residents were offered a bed bath instead. During an interview on 10/12/22 at 11:00 AM, Nurse #3 stated she was the unit supervisor. Nurse #3 further stated Resident #92 was offered a complete or partial bed bath almost daily. Nurse #3 indicated to assist the resident to be transferred to shower and offer shower would require 2 NAs to leave the floor. This would mean the floor would be short staff and other residents' care would not be able to be provided. The floor	F 561	The Activity Director will review Resident Rights □ Self-Determination and current Covid-19 guidelines on Activities of Daily Living (ADL) care including showers and/or bed baths, dining, activities, and leaving their rooms during a Covid-19 outbreak during the Resident Council meetings for the next 2 months. The Administrator and/or Social Worker (SW) will interview 6 residents twice a week for 4 weeks then, 6 residents weekly for 4 weeks to review understanding of resident rights to self-determination and the current Covid-19 guidelines regarding Resident Activities of Daily Living (ADL) care including showers and/or bed baths, dining, activities, and leaving their rooms during a Covid-19 outbreak. Plans to monitor its performance to make sure that the solutions are sustained. The Administrator and/or Social Worker (SW) will report findings of the twice weekly and weekly resident and staff interviews. These findings will be brought to the monthly Quality Assurance Performance Improvement (QAPI) meeting for review and revision monthly x 3 months or until substantial compliance is achieved. Date of compliance: 11/21/22	

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 10/27/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEALTH-DURHAM	3100 ERWIN 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 561	Continued From page 7	F 561		

had 3-5 NAs assigned during 1st and 2nd shift but usually the floor had only 3 NA's. Residents who could be provided showers in their rooms were offered showers and other residents were offered bed baths.

During an interview on 10/12/22 at 11:15 AM, the Director of Nursing (DON) stated that she was unaware of any policy that indicated that residents would not be offered showers due to the COVID-19 outbreak. The DON further stated there was adequate staff available if needed to offer showers to the resident. DON stated she expected residents to be offered and given showers as scheduled and as requested.

During an interview on 10/13/22 at 3:06 PM, the Administrator indicated there was a policy that stated all residents and staff could wear the appropriate personal protective equipment (PPE) and could take the residents to showers as needed. All residents should be offered showers on shower days and as needed when requested. Staff were available to assist the residents with required care as needed.

2. Resident #26 was admitted to the facility on 8/31/2022 with diagnoses of heart failure, diabetes mellitus, and non-Alzheimer's dementia.

An interview with Resident #26 was conducted in her room on 10/11/2022 at 9:05 A.M. During the interview, Resident #26 indicated she was told by staff due to the current Covid-19 outbreak in the facility, she was unable to leave her room to sit in the dining room and look out the window. Resident #26 stated she enjoyed being in the dining room and did not like being in her room. Resident #26 further indicated staff indicated they would make her aware when the outbreak was

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 10/27/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEALTH-DURHAM	3100 ERWIN 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 561	Continued From page 8	F 561		

over, and she was able to leave her room.

During the onsite survey a Resident Council Meeting, with the surveyor and four residents, was held on 10/12/2022 at 2:30 P.M. During the meeting the residents in attendance (Resident #13, Resident #20, Resident #54, and Resident #26) each confirmed they had been told by all facility staff they were unable to leave their room until two weeks after the last positive Covid-19 test in the facility had been identified.

An interview was conducted with Resident #13 in her room on 10/13/22 at 11:30 A.M. During the interview, Resident #13 indicated two weeks ago when the facility had a positive Covid-19 test result, staff told her due to the facility being in a Covid-19 outbreak status they would not be allowed to eat in the dining room, participate in group activities, or leave their rooms.

An interview was conducted with Nurse #9 on 10/13/2022 at 11:42 P.M. During the interview, Nurse #9 indicated when the Covid-19 outbreak began two weeks prior, the Infection Preventionist (IP) spoke with staff when the positive cases of Covid-19 were identified and indicated residents were to stay in their rooms due to the outbreak in the facility. During the interview, she indicated the IP provided staff with all the latest updates and was responsible for telling staff at the conclusion of the outbreak when residents were able to leave their rooms.

An interview was conducted with the Infection Preventionist (IP) on 10/12/2022 at 4:36 P.M. During the interview, the IP indicated when the facility was in a Covid-19 outbreak status, such as now, residents had to stay in their rooms to

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 10/27/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEALTH-DURHAM	3100 ERWIN 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 561	Continued From page 9 help prevent the spread of the virus An interview was conducted with the Director of Nursing (DON) on 10/13/2022 at 1:15 P.M. The DON indicated if staff told residents to stay in their rooms, the staff had misunderstood the newest Covid-19 guidance. The DON further indicated residents who have tested negative for Covid-19 have no restrictions to their movements and are allowed outside of their rooms. An interview was conducted with the Administrator on 10/13/2022 at 12:15 P.M. During the interview, the Administrator indicated residents were allowed to leave their rooms and eat in the dining room. The Administrator stated there have been no positive cases on second floor and residents who resided on the third floor, where positive Covid-19 cases had been identified, had been asked not to enter the second floor to limit the spread of the Covid-19 outbreak. The Administrator indicated staff needed to explain the risks of exposure to residents and allow the residents to leave their rooms.	F 561		
F 580 SS=K	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a	F 580		11/21/22

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 10/27/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEALTH-DURHAM	3100 ERWIN 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 580	Continued From page 10	F 580		

deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications);
(C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or
(D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii).
(ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician.
(iii) The facility must also promptly notify the resident and the resident representative, if any, when there is-
(A) A change in room or roommate assignment as specified in §483.10(e)(6); or
(B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section.
(iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s).

§483.10(g)(15)
Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9).
This REQUIREMENT is not met as evidenced by:

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 10/27/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEALTH-DURHAM	3100 ERWIN 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 580	Continued From page 11 Based on record review, staff interviews, physician assistant and physician interview, the facility failed to notify the physician of the development of an open wound to a resident's right leg on 7/27/22 that deteriorated in condition through 8/13/22 for 1 of 3 residents (Resident #293) reviewed for notification of change. This failure resulted in no physician evaluation of the wound and no physician ordered treatments to the wound. On 8/12/22 the wound was assessed by Nurse #7 with a foul odor and on 8/13/22 Nurse #7 notified the physician of the wound, a change in the resident's condition, and the physician ordered for the resident to be transferred to the hospital. Resident #293 was treated in the hospital for septicemia (blood poisoning, especially caused by bacteria or their toxins) and osteomyelitis (inflammation of the bone caused by infection) related to right leg wound. Immediate Jeopardy began on 7/27/22 when the facility failed to notify the physician of the open wound found on Resident #293's right leg. The Immediate Jeopardy was removed on 10/22/22 when the facility provided an acceptable credible allegation of immediate jeopardy removal. The facility will remain out of compliance at a scope and severity E (no actual harm with potential for more than minimal harm that is not immediate jeopardy) to ensure monitoring systems implemented are effective and to complete staff education. Findings included: Resident #293 was admitted to the facility on 6/8/22.	F 580	Corrective action for the residents found to be affected by the deficient practice. Resident #293 no longer resides in the facility. Corrective action for other residents having the potential to be affected by the same deficient practice. All residents have the potential to suffer a serious adverse outcome because of the failure to address/communicate/report/document the identification/condition/status/size/appearance of a wound on a weekly basis. The Director of Health Services (DHS) initiated 100% body audits on all residents within the facility on 10/20/22. The audit was completed on 10/21/22. There were no new skin integrity issues identified by comparing the known (current) skin integrity (wounds) on the wound manager report in the electronic medical record to those residents currently in house to the body audits completed on 10/20/2022. The Director of Health Services (DHS) and/or Nurse Managers have reviewed the wound audits conducted on 10/20-21/2022 and reviewed the documentation to ensure residents with skin impairments had a physician□s order for treatment to affected areas, physician notification and documentation of the condition/status/size/appearance of the wound. The Director of Health Services (DHS)	

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 10/27/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEALTH-DURHAM	3100 ERWIN 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 580	Continued From page 12 A review of a nursing progress note dated 7/27/22 at 7:24 pm made by Nurse # 11 read in part Resident #293 had an open wound to his right leg. No treatment orders were found. Wound was packed with normal saline, damp to dry sterile gauze, and covered with sterile gauze secured by kerlix (white gauze dressing). Resident tolerated well. During a telephone interview on 10/11/22 at 5:48 pm with Nurse #11 she indicated, on 7/27/22 she recalled Nursing Assistant (NA) #4 asked for assistance to provide care to Resident #293. She indicated when they went to turn the Resident, she observed an open area on the Resident's right leg that was about 1/2 inch in diameter and 2 inches long. She indicated she cleaned the wound and put a dressing on it and looked at the Resident's skin and did not see any other areas on the Resident's body. She indicated she reported the wound to Nurse #1 who was in the facility at the time, and Nurse #1 informed her she would let the wound Physician know about the wound the next morning. Nurse #11 indicated she asked Nurse #1 if she wanted her to measure the wound or get orders and she stated Nurse #1 informed her she would take care of it and instructed her to put a dressing on the wound. On 10/13/22 at 3:45 pm an interview was conducted with Nurse #1. She denied being notified by Nurse #11 of Resident #293 having any wounds on 7/27/22. She indicated she had no knowledge of the Resident having any wounds in July. Record review from 7/27/22 through 8/12/22 revealed no evidence the physician was notified	F 580	and/or Nurse Managers began education to the Nurses on 10/20/22 regarding weekly skin observations, documentation, physician order and physician notification. When a new skin impairment is noted, the Nurse will complete the wound documentation in the electronic medical record that includes description and measurement of area and contact the physician/physician extender for orders, regarding newly identified skin impairments and/or worsening skin impairments for wound treatment orders. This includes the observations and measurements are necessary as a monitoring tool to determine if there are any changes in the wound that would require a change in the treatment plan. On 10/20/22 and 10/21/22 the Director of Health Services (DHS) and Nurse Managers educated the Certified Nursing Assistants (CNA) on daily skin checks during personal care. This education includes notification to the nurse of any skin impairment and/or new dressing noted on resident□s skin. The Certified Nursing Assistant will obtain a paper body diagram at the beginning of their shift from the nursing station on each unit and maintain in their possession throughout their shift. The Certified Nursing Assistant (CNA) will utilize a body diagram for each resident daily during resident care, for nurse notification of skin integrity issues. The Certified Nursing Assistant (CNA) will circle the area of the body on the body diagram noting where the skin integrity issue is with a pen / pencil and notify nurse regarding skin integrity issue. The	

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 10/27/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEALTH-DURHAM	3100 ERWIN 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 580	Continued From page 13 of Resident #293's right leg wound first identified on 7/27/22, no treatment orders were in place, and no wound assessments or physician evaluations of the wound were completed. A review of Nursing progress note dated 8/12/22 at 10:00 pm by Nurse #7 read in part, Resident # 293 was found to have an open wound on right leg (calf) with a foul-smelling odor, and some bleeding noted. Observations left in wound care and Physician book for evaluation. On 10/11/22 at 4:10 pm an interview was conducted with Nurse #7, and she indicated she was the Nurse that worked on 8/12/22. She indicated it was reported by NA #4 who was assigned to Resident #293 that he had blood on his sheets. She indicated she went to check the Resident and observed a bandage wrapped on his right leg. Nurse #7 indicated the bandage had no date on it and when she removed the bandage, she observed wound to right calf that had bloody, greenish drainage. She indicated she observed the wound to be to the bone. Nurse #7 indicated it was the end of her shift and she had to leave and left a written note in Physician book that is left at the nurse's station for further evaluation when Physician returned to facility, and she notified Physician verbally on the phone on 8/13/22. Review of electronic medical record revealed on 8/12/22 a SBAR (situation, background, assessment, resident evaluation) communication form was completed by Nurse #7. The communication form read in part a change in condition identified on 8/12/22 was a wound to right leg. Wound was evaluated to have drainage and foul smell. The responsible party (RP) was	F 580	Nurse will complete a body observation on all residents the Certified Nursing Assistant (CNA) has identified with new skin integrity issues and notify physician for treatment orders. The Clinical Competency Coordinator (CCC) was notified on 10/21/2022 by the Licensed Nursing Home Administrator (LNHA), to add the education regarding the body diagrams and utilization of a body diagram for each resident daily for nurse notification of skin integrity issues to the general orientation of the Certified Nursing Assistant. Systemic changes made to ensure that the deficient practice will not recur. On 10/21/22 The Licensed Nursing Home Administrator (LNHA) notified the Director of Health Services (DHS) and/or Nursing Leadership to review the weekly skin observations (weekly focus observation), in the electronic medical record under observation section, to validate all areas identified have physician notification, treatment orders are written, and wound is monitored for changes weekly for four weeks then monthly thereafter. The Clinical Competency Coordinator (CCC) was notified on 10/21/22 by the Licensed Nursing Home Administrator (LNHA) to add the skin observations and documentation in the electronic health record education to the general orientation for Nurses upon hire with emphasis that the nurse who identifies the skin integrity issue completes the wound documentation, physician notification, initiates treatment per physician order and	

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 10/27/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEALTH-DURHAM	3100 ERWIN 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 580	Continued From page 14 notified on 8/13/22 at 4:50 pm, and Physician notified. A review of hospital records read, in part, Resident #293 presented to hospital on 8/13/22 ill-appearing, in acute distress, had diffuse pain, and had a wound to the right lower leg that was covered. On exam it was noted Resident meet SIRS (Systemic Inflammatory Response, an exaggerated defense response of the body to a noxious stressor like infection and/or inflammation) criteria and was started on intravenous fluids and antibiotics. On 8/15/22 MRI (magnetic resonance imaging) of Resident #293's right lower leg was done, and results revealed MRI along posterolateral (situated on the side and toward the posterior aspect) upper leg with sinus tract to bone with osteomyelitis. A telephone interview was conducted on 10/12/22 at 10:15 am with the Physician Assistant (PA) and it was indicated she no longer worked in the facility and did not have access to her notes. She indicated she did not recall personally seeing any wounds on Resident #293 or being informed of any. On 10/12/22 at 10:28 am a telephone interview was conducted with the primary Physician of Resident #293, and he indicated as of 9/17/22, he no longer worked at the facility and no longer had access to Resident #293's records. He indicated he was not aware of Resident #293 having any wounds in July and was not able to access the records for the Resident. During an interview on 10/13/22 at 1:06 pm with the Director of Nursing (DON) she indicated the process to be followed when a wound was	F 580	notifies the Responsible Party (RP) of new / changes in skin integrity. On 10/21/22 The Director of Health Services (DHS) notified the Wound Nurse and the Nurse Practitioner (NP) that they are to meet weekly ongoing to discuss and review all residents with wounds and both parties will sign the weekly wound manager report. Plans to monitor its performance to make sure that the solutions are sustained. The facility wound manager report will be brought to the Monthly Quality Assurance Performance Improvement (QAPI) Committee meeting by the Director of Health Services (DHS) for review and revision monthly x 3 months or until substantial compliance is achieved. Date of compliance: 11/21/22	

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 10/27/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEALTH-DURHAM	3100 ERWIN 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 580	Continued From page 15	F 580		

identified was to notify the Physician and Responsible party (RP), get an order for treatment of the wound from the Physician and transcribe the order in the computer. She also indicated the nursing staff should put any new wounds identified in the wound communication book to notify the wound nurse. She indicated she reviewed the activity report in the computer and 24-hour report to see if any report included abnormal findings. She indicated she was not aware Resident #293 had any wounds in July.

During an interview on 10/13/22 at 5:10 pm with the Administrator it was indicated her expectation when a new wound was identified was to notify the Physician, get orders to treat the wound, and notify the family. She further indicated it was her expectation skin observations were to be done weekly and documented in the computer.

The Administrator was notified of immediate jeopardy on 10/21/22 at 11:11 am.

On 10/21/22 the facility provided the following credible allegation of Immediate Jeopardy removal:

Identify those recipients who have suffered, or are likely to suffer, a serious adverse outcome because of the noncompliance.

Resident #293 no longer resides in the facility. On 7/27/22 Nurse #11 noted wound to posterior right lower leg, applied dressing but failed to notify physician. On 8/12/22 Nurse noted open wound to posterior right lower leg with foul odor and placed in physician and wound care notification books without verbal notification to the physician. On 8/13/22 nurse spoke with physician and new

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 10/27/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEALTH-DURHAM	3100 ERWIN 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 580	Continued From page 16	F 580		

orders were obtained for antibiotics, wound care orders and an x-ray to right lower leg. X-ray dated 8/13/22 identified lytic lesion to distal femoral shaft. Upon the Nurse's notification to the Physician regarding the Right leg X-ray results the Physician transferred the resident #293 to the Emergency room. The Residents admitting diagnosis to Hospital was rule out osteomyelitis to the right lower leg. Nurse #11 is no longer employed by this facility.

The Director of Health Services initiated 100% body audits on all residents within the facility on 10/20/22 to be done by the Nurses. There were no new skin integrity issues identified by comparing the known (current) skin integrity (wounds) on the wound manager report, in the electric medical record, currently in house to the body audits completed on 10/20/2022.

Actions taken by the facility to alter to alter the process or system failure to prevent a serious adverse outcome from reoccurring and when the action will be completed.

The Director of Health Services and/or Nurse Managers have reviewed the wound body audit completed by the Nurses, conducted on 10/20-21/22, and reviewed the documentation to ensure residents with skin impairments had an order for treatment to areas and Physician notification. The Director of Health Services and Nurse Managers reviewed residents with skin integrity impairments to ensure weekly documentation including notification to the physician of any changes in their skin integrity impairment status.

The Director of Health Services and/or Nurse

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 10/27/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEALTH-DURHAM	3100 ERWIN 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 580	Continued From page 17	F 580		

Managers began education to the Nurses, on 10/20/22 regarding weekly skin observations and documentation in the electronic health record of same. When a new skin impairment is noted, the nurse will complete the wound documentation in the electronic medical record that includes description and measurement of area and contact the physician/physician extender for orders, regarding newly identified skin impairments and/or worsening skin impairments for wound treatment orders. This includes the observations and measurements are necessary as a monitoring tool to determine if there are any changes in the wound that would require a change in the treatment plan.

The Clinical Competency Coordinator was notified on 10/21/22 by the Licensed Nursing Home Administrator to add the skin observations and documentation in the electronic health record education to the Nurse general orientation upon hire with emphasis that the nurse who identifies the skin integrity issue completes the wound documentation, physician notification, initiates treatment per physician order for changes in skin integrity. Any Nurse will not be allowed to work after 10/21/22 until they receive the education.

The Director of Health Services and Nurse Managers educated the Certified Nursing Assistants on daily skin checks during personal care. This education includes notification to the nurse of any skin impairment and/or new dressing noted on resident's skin.

On 10/20/22 and 10/21/22 the Director of Health Services and Nurse Managers educated the Certified Nursing Assistants on daily skin checks during personal care. This education includes

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 10/27/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEALTH-DURHAM	3100 ERWIN 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 580	Continued From page 18	F 580		

notification to the nurse of any skin impairment and/or new dressing noted on resident's skin. The Certified Nursing Assistant will obtain a paper body diagram at the beginning of their shift from the nursing station on each unit and maintain in their possession throughout the day. The Nursing assistant will utilize a body diagram for each resident daily during resident care, for nurse notification of skin integrity issues. The Certified Nursing Assistant will circle the area of the body, on the body diagram, with the skin integrity issue with a pen / pencil and notify nurse regarding skin integrity issue. The Nurse will complete body observation on residents the certified nursing assistance have identified with new skin integrity issues and notify physician for treatment orders. The Clinical Competency Coordinator was notified on 10/21/2022 by the Licensed Nursing Home Administrator, to add the education regarding the Body diagrams and utilization of a body diagram for each resident daily for nurse notification of skin integrity issues to the general orientation of the Certified Nursing Assistant. Any Certified Nursing Assistant will not be allowed to work after 10/21/22 until they receive the education regarding the Body diagrams and utilization of a body diagram for each resident daily for nurse notification of skin integrity issues.

The Clinical Competency Coordinator/RN was notified by the Licensed Nursing Home Administrator on 10/21/22, that they are responsible for ensuring education is completed prior to the start of any Licensed Nurse and/or Certified Nursing Assistant working the floor after 10/21/22.

On 10/21/22 The Licensed Nursing Home Administrator notified the Director of Health

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 10/27/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEALTH-DURHAM	3100 ERWIN 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 580	Continued From page 19	F 580		

Services and/or Nursing Leadership to review the weekly skin observations (weekly focus observation), in the electronic medical record under observation section, to validate all areas identified have physician notification, treatments orders are written, wound is monitored for changes weekly for four weeks then monthly thereafter.

Alleged date of immediate jeopardy removal: 10/22/22

On 10/27/22 the credible allegation of immediate jeopardy was validated by onsite verification. Record reviews and interviews were conducted which verified the audits were completed. Interview with the Minimum data set (MDS) Nurse revealed skin assessments were completed daily. Nurse Assistants (NA) complete a skin audit daily and if there is an issue with a resident's skin, the NA notifies the charge nurse who then documents, notifies the Physician, and obtains order if needed. MDS Nurse also indicated they notify the responsible party (RP)/family.

A review of the audits revealed all residents' orders were reviewed and any discrepancies were corrected.

A review of the education training revealed education was provided to staff as stated in the credible allegation.

Interviews with staff indicated they had been educated by facility that NAs are to report any issues with skin to charge nurse. The Nurse then assesses resident's skin and documents, notifies wound nurse, Physician and RP/family. Interviews further indicated knowledge of completing a daily

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 10/27/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEALTH-DURHAM	3100 ERWIN 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 580	Continued From page 20 body audit sheet for any issues with a resident's skin and notifying the charge nurse if observes any skin issues. Interview was conducted with Wound Nurse on 10/27/2022 at 11:12 am who indicated NAs had to do full skin audits on every shift. If identified any areas, including redness, they notify the nurse and audits were turned into the nurse who reviews and signs off the skin audit and skin audit given to DON. Nurses review audit sheets and if anything observed, they are to do a SBAR, assess wound, inform Physician and RP, and transcribe any order in computer. Nurses put information in wound communication book and treatment nurse checks the book every day for any new areas on skin that were identified. Interviews with staff revealed that education was provided. The immediate jeopardy removal date of 10/22/2022 was validated on 10/27/22.	F 580		
F 623 SS=C	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in	F 623		11/21/22

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 10/27/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEALTH-DURHAM	3100 ERWIN 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 623	Continued From page 21	F 623		

accordance with paragraph (c)(2) of this section; and
(iii) Include in the notice the items described in paragraph (c)(5) of this section.

§483.15(c)(4) Timing of the notice.
(i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged.
(ii) Notice must be made as soon as practicable before transfer or discharge when-
(A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section;
(B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section;
(C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section;
(D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or
(E) A resident has not resided in the facility for 30 days.

§483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following:
(i) The reason for transfer or discharge;
(ii) The effective date of transfer or discharge;
(iii) The location to which the resident is transferred or discharged;
(iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which

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 10/27/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEALTH-DURHAM	3100 ERWIN 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 623	Continued From page 22	F 623		

receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request;
(v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;
(vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and
(vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act.

§483.15(c)(6) Changes to the notice.
If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available.

§483.15(c)(8) Notice in advance of facility closure
In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as

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 10/27/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEALTH-DURHAM	3100 ERWIN 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 623	Continued From page 23 well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to provide written notice of discharge to the ombudsman for 4 of 4 residents discharge to the hospital. (Resident #39. Resident #443, Resident #193, and Resident #194). The findings included: 1.Resident #39 was admitted on 7/8/22 readmitted on 9/14/22. Review of nursing note dated 9/12/22, revealed Resident #39 was sent to the hospital for stomach pain. Resident #39 returned to facility on 9/14/22. Resident #39 discharged on 9/20/22 to the hospital for urinary tract infection and sexual assault allegation and did not return to facility. During a telephone interview on 10/13/22 at 11:43 AM, the Ombudsman stated the previously assigned Ombudsman to the county had left in June 2022. The main office had sent out a letter to all facilities assigned to the county area regarding who the backup person (ombudsman name) would be for them to submit any documents. Ombudsman further stated she had not received any copy of discharge notices from the facility since June 2022. During an interview on 10/12/22 at 5:23 PM the Administrator stated she was responsible for sending the letter / copy notification of discharges to the Ombudsman. Administrator indicated the county currently did not have an Ombudsman	F 623	Corrective action for the residents found to be affected by the deficient practice. The Ombudsman was sent a written notice of discharge/transfer to the hospital for resident #39, #443, #193 and #194 on 11/9/2022. Corrective action for other residents having the potential to be affected by the same deficient practice. All residents have the potential to be affected by the same deficient practice. The Licensed Nursing Home Administrator (LNHA) in-serviced the Social Worker (SW) on the requirement to provide written notice of all discharges, including hospital transfers/discharges to the Ombudsman on 11/8/2022. The in-service also included the initiation of the monthly log to record discharges/transfers on daily. Per the 2567 the Ombudsman□s office indicated they last received any copy of discharge notices from the facility since June 2022. On 11/9/2022 the Licensed Nursing Home Administrator (LNHA) conducted an 100% audit of all discharges/transfers to the hospital from 06/01/2022 □ 10/31/2022. During this time there were 162 discharges/transfers and 162 were not sent to the Ombudsman. On 11/09/2022 the 162	

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 10/27/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEALTH-DURHAM	3100 ERWIN 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 623	Continued From page 24 and was not sending the notification of discharge. Administrator stated she was unaware as to whom to send the copy of discharge. 2.Resident # 443 was admitted on 8/4/22. Review of nursing note dated 08/25/2022, revealed Resident #443 went out to a cancer center for appointment today. Resident did not return to facility and was sent to hospital for further evaluation directly from the appointment. During a telephone interview on 10/13/22 at 11:43 AM, the Ombudsman stated the previously assigned Ombudsman to the county had left in June 2022. The main office had sent out a letter to all facilities assigned to the county area regarding who the backup person (ombudsman name) would be for them to submit any documents. Ombudsman further stated she had not received any copy of discharge notices from the facility since June 2022. During an interview on 10/12/22 at 5:23 PM the Administrator stated she was responsible for sending the letter / copy notification of discharges to the Ombudsman. Administrator indicated the county currently did not have an Ombudsman and was not sending the notification of discharge. Administrator stated she was unaware as to whom to send the copy of discharge charge. 3. Resident #193 was readmitted to the facility on 7/7/22. Review of a nurse's note dated 7/24/22 revealed Resident #193 was found to be unresponsive and was sent to the hospital for evaluation. Resident #193 was discharged to the hospital on	F 623	discharges/transfers were faxed to the Ombudsman. Education will be provided in new hire orientation for any new Social Worker (SW) hired regarding the procedure for notifying the Ombudsman of a resident□s discharge/transfer. Systemic changes made to ensure that the deficient practice will not recur. The Administrator contacted the facility Ombudsman on 11/8/2022 and was instructed to fax notifications of transfers/discharges monthly. The Social Worker (SW) will initiate a log on the 1st day of each month to record all discharges/transfers. Each day the discharges/transfers will be documented on the log and reviewed during the daily department managers meeting that is held Monday □ Friday. On Monday□s, the Social Worker (SW) will add the discharges/transfers from Saturday and Sunday. Plans to monitor its performance to make sure that the solutions are sustained. The Social Worker (SW) will report the analysis of the transfer/discharge log to the Quality Assurance Performance Improvement (QAPI) Committee monthly for review and revision monthly x 3 months or until substantial compliance is achieved. Date of compliance: 11/21/22	

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 10/27/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEALTH-DURHAM	3100 ERWIN 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 623	Continued From page 25	F 623		

7/24/22 and did not return to the facility.

During a telephone interview on 10/13/22 at 11:43 AM, the Ombudsman stated the previously assigned Ombudsman to the county had left in June 2022. The main office had sent out a letter to all facilities assigned to the county area regarding who the backup person (ombudsman name) would be for them to submit any documents. Ombudsman further stated she had not received any copy of discharge notices from the facility since June 2022.

During an interview on 10/12/22 at 5:23 PM the Administrator stated she was responsible for sending the letter / copy notification of discharges to the Ombudsman. Administrator indicated the county currently did not have an Ombudsman and was not sending the notification of discharge. Administrator stated she was unaware as to whom to send the copy of discharge charge.

4. Resident #194 was admitted to the facility on 7/27/22.

Review of a nurse's note dated 8/22/22 revealed Resident #194 was sent to the hospital for evaluation due to worsening alert mental status.

Resident #194 was discharged to the hospital on 8/22/22 and did not return to the facility.

During a telephone interview on 10/13/22 at 11:43 AM, the Ombudsman stated the previously assigned Ombudsman to the county had left in June 2022. The main office had sent out a letter to all facilities assigned to the county area regarding who the backup person (ombudsman name) would be for them to submit any

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 10/27/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEALTH-DURHAM	3100 ERWIN 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 623	Continued From page 26 documents. The Ombudsman further stated she had not received any copy of discharge notice from the facility since June 2022. During an interview on 10/12/22 at 5:23 PM the Administrator stated she was responsible for sending the letter / copy notification of discharges to the Ombudsman. Administrator indicated the county currently did not have an Ombudsman and was not sending the notification of discharge. Administrator stated she was unaware as to whom to send the copy of discharge charge.	F 623		
F 625 SS=D	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for	F 625		11/21/22

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 10/27/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEALTH-DURHAM	3100 ERWIN 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 625	Continued From page 27 hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on staff interviews and record review, the facility failed to provide the bed hold policy to 2 of 2 residents discharged to the hospital (Resident #39 and Resident #292). The findings included: 1.Resident #39 was admitted to the facility on 7/28/22 and discharged to the hospital on 9/20/22. The diagnoses included diabetes, and dementia. The admission Minimum Data Set (MDS) dated 7/14/22, indicated Resident #39 cognition was impaired. Review of nursing note dated 9/20/2022 at 10:38 AM, documented Emergency Medical Services (EMS) arrived at 06:20 AM and stated that resident called, and she needed to go to the hospital. Responsible Party (RP) was called and writer unable to leave message due to voicemail box being full. The resident remained hospitalized at the time of the survey. A telephone interview was conducted on 10/12/22 at 9:40 AM with the resident's RP who stated the facility had not offered Resident #39 or the family the bed hold policy. An interview was conducted on 10/13/22 at 11:38 AM with Nurse #1 who stated the resident called Emergency Medical Services (EMS) and insisted on going to the hospital. Nurse #1 stated she	F 625	Corrective action for the residents found to be affected by the deficient practice. Resident #39 did not return to the facility from the hospital as she was discharged home with daughter. Resident #292 did not return to the facility from the hospital and was discharged to another skilled nursing facility. Corrective action for other residents having the potential to be affected by the same deficient practice. The Director of Health Services (DHS) and/or Nurse Managers conducted in-servicing with all licensed nurses regarding including the Bed Hold process on 11/8/22. When a resident is discharged to the hospital, the nurse responsible for initiating the emergency transfer to the hospital will copy and place the original bed hold authorization form with the discharge paperwork and place documents inside the INTERACT (Interventions to Reduce Acute Care Transfers) Acute Care Transfer Checklist folder. Medical Records will upload a copy of the bed hold authorization form to the electronic medical record.	

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 10/27/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEALTH-DURHAM	3100 ERWIN 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 625	Continued From page 28 gave the EMS the transfer packet which included the bed hold policy and instruction, face sheet and medication list/diagnoses. Nurse #1 stated she called the RP an hour after resident left, discussed the bed hold policy. The RP stated she never did a bed hold before and they would see if her mother was returning when she got to the hospital. The nurse did not have written documentation the bed hold policy had been discussed or provided to the resident and/or responsible person. An interview was conducted on 10/13/22 at 11:55 AM, the Director of Nursing (DON) stated standard process was for the bed hold policy to be included in the transfer packet and the nurse would go over the information with the resident/responsible person at time of discharge. An interview was conducted on 10/13/22 at 10:00 AM, the Administrator stated there was no documentation of the family or resident being informed of the bed hold policy. She stated the business office manager would call families/resident and review bed hold policy on admission. The discharging nurse and/or business office manager/social worker would also go over the bed hold policy if the family/resident was present and able to make decision for return placement to the facility. 2. Resident # 292 admitted to the facility on 8/18/22 and had diagnoses including cerebral infarction, hemiplegia, atrial fibrillation, hypertension, congestive heart failure, asthma, and a chronic kidney disease. A review of the medical record reveled Resident #292 was able to make needs known. No minimum data set (MDS) was completed.	F 625	The Administrator conducted in-servicing on 11/17/22 to the Social Worker (SW), Director of Health Services (DHS), Financial Counselor (FC) and Department Managers regarding the bed hold process. The Social Worker (SW), Financial Counselor and/or Department Manager will place a call to the Responsible Party following discharges to the hospital within 24 hours of the transfer and provide a written copy of the bed hold via mail and document in the resident□s electronic medical record that such notice was sent. Education will be provided in new hire orientation for any new licensed nurses, Administrator, Medical Records, Social Worker (SW), Director of Health Service (DHS), Financial Counselor (FC) and Department Managers hired regarding the procedure for bed holds. Systemic changes made to ensure that the deficient practice will not recur. Discharges to the hospital will be documented on the hospital discharge log and discussed daily during the morning IDT meeting Monday through Friday to review all residents discharged to the hospital were given a copy of the bed hold authorization form was sent with the resident to the hospital, Social Worker (SW) placed follow-up call and written copy to resident and/or Responsible Party (RP) within 24 hours regarding his/her bed on hold at the facility.	

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 10/27/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEALTH-DURHAM	3100 ERWIN 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 625	Continued From page 29 A review of nursing progress note dated 8/29/22 read in part Resident #292 was transported to the hospital and Physician and responsible party was notified. On 10/11/22 at 9:25 AM an interview was conducted with Resident # 292's family member and it was indicated she did not receive written notice about the facility's bed hold policy when Resident # 292 transferred to the hospital. On 10/13/22 at 11:55 AM an interview was conducted with the Director of Nursing (DON), and she indicated the standard process is for the bed hold policy to be included in the transfer packet and the nurse would go over the information with the resident/responsible party (RP) at time of discharge or telephone call. On 10/13/22 at 10:49 AM an interview was conducted with the Administrator, and she indicated there was no documentation of the family or resident being informed of the bed hold policy. She stated the Business office manager would call family/resident and review the bed hold policy on admission. She indicated the discharging nurse; Business office manager social worker would also go over the bed hold policy if the family/resident was present and able to make the decision. An interview was conducted on 10/13/22 at 12:57 PM with the Business Office Manager (BOM) and it was indicated she did not offer Resident # 292 a bed holds because she was informed by the Administrator Resident was not returning to the facility.	F 625	Plans to monitor its performance to make sure that the solutions are sustained. The Administrator and/or Director of Health Services (DHS) will report the analysis of the hospital discharge log to the Quality Assurance Performance Improvement (QAPI) Committee for review and revision monthly x 3 months or until substantial compliance is achieved. Date of compliance: 11/21/22	

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 10/27/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEALTH-DURHAM	3100 ERWIN 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 626	Continued From page 30	F 626		
F 626 SS=D	Permitting Residents to Return to Facility CFR(s): 483.15(e)(1)(2) §483.15(e)(1) Permitting residents to return to facility. A facility must establish and follow a written policy on permitting residents to return to the facility after they are hospitalized or placed on therapeutic leave. The policy must provide for the following. (i) A resident, whose hospitalization or therapeutic leave exceeds the bed-hold period under the State plan, returns to the facility to their previous room if available or immediately upon the first availability of a bed in a semi-private room if the resident- (A) Requires the services provided by the facility; and (B) Is eligible for Medicare skilled nursing facility services or Medicaid nursing facility services. (ii) If the facility that determines that a resident who was transferred with an expectation of returning to the facility, cannot return to the facility, the facility must comply with the requirements of paragraph (c) as they apply to discharges. §483.15(e)(2) Readmission to a composite distinct part. When the facility to which a resident returns is a composite distinct part (as defined in § 483.5), the resident must be permitted to return to an available bed in the particular location of the composite distinct part in which he or she resided previously. If a bed is not available in that location at the time of return, the resident must be given the option to return to that location upon the first availability of a bed there.	F 626		11/21/22

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 10/27/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEALTH-DURHAM	3100 ERWIN 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 626	Continued From page 31 This REQUIREMENT is not met as evidenced by: Based on family interview, staff interviews and record review, the facility failed to permit the return 1 of 2 resident discharged to the hospital (Resident #39 and #292). The findings included: 1.Resident #39 was admitted to the facility on 7/28/22 and discharged to the hospital on 9/20/22. The diagnoses included diabetes, hypertension multiple sclerosis, deep venous thrombosis, paranoid/delusional disorder, and dementia. The admission Minimum Data Set (MDS) dated 7/14/22, indicated Resident #39 cognition was impaired and required extensive assistance with activities of daily living. Care plan dated 9/2/22 identified the problem as Resident #39 had dementia with behaviors and a history of paranoia, hallucinations, anxiety and panic attacks and active behaviors problems as evidence by making false statements- stating that someone assaulted her after receiving anisole treatment. Calling 911 without allowing nursing to complete full assessment. Family stated she has a history of claiming sexual and physical assault by man and woman, refusing medications because she states its poisoned. On 9/19/22 the detective called facility to let Administrator know Resident #39 called 10 to 14 times a day stating a male and female aide in the building has been hired by her ex-husband to kill her and called 911 for vaginal burning. The goal included Resident #39 would not harm self or others. The approaches included Psych referral as needed, report behavior changes to physician/physician assistant and nurse practitioner (MD/PA/NP) as	F 626	Corrective action for the residents found to be affected by the deficient practice. Resident #39 is no longer here to correct the alleged deficiency. Resident was discharged home with daughter. Resident #292 is no longer here to correct the alleged deficiency. Resident was discharged to another skilled nursing facility. Corrective action for other residents having the potential to be affected by the same deficient practice. All residents have the potential to be affected by the alleged deficient practice. The Administrator completed an audit on 11/17/22 of all discharges/transfers to the hospital for the last 30 days, no other residents were denied readmission to the facility. On 11/17/22 the PruittHealth Senior Nurse Consultant (SNC) in-serviced the Director of Health Services (DHS), Administrator, Social Worker, and Unit Manager on the Regulation of permitting residents to return to the facility according to the bed hold policy. On 11/8/22, the Director of Health Services (DHS) and/or Nurse Managers in-serviced all nurses on the Bed-hold policy related to discharges and hospital stays. All residents are allowed to return	

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 10/27/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEALTH-DURHAM	3100 ERWIN 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 626	Continued From page 32 warranted. Resident would be redirected to facts. Review of nursing note dated 9/20/2022 at 10:38 AM, documented emergency medical service (EMS) arrived at 6:20 AM and stated that resident called and stated "she needed help that her vaginal was burning. EMS escorted to resident room. Resident #39 stated she needed to go to the hospital. EMS was told that resident had psych issues and this behavior is ongoing. Resident calls 911 at least twice a week. The daughter was called and writer unable to leave message due to voicemail box being full. A telephone interview was conducted on 10/12/22 at 9:40 AM, the daughter stated that her mother was denied access to return to the facility on 9/20/22. She reported the facility liaison and administrator told the hospital Resident #39 could not return to the facility to due to her sexual allegations and a psychological evaluation needed to be done before she could return. The Responsible Person (RP) further stated the Resident #39 was cleared for return on 9/20/22, but the night shift nurse told the hospital social workers the bed had already been given to another resident. The hospital caseworker contacted the facility on 9/23/22 and was informed the psychology evaluation had been completed and Resident #39 was again ready for return to the facility. The RP further stated Resident #39 remains in the hospital due to facility denial for return. The RP stated she believed Resident #39 was inappropriately denied return to facility and it was the obligation of the facility to assist Resident #39 with obtaining proper psychological assistance and medication management once returned to the facility.	F 626	according to the Bed-hold policy. Systemic changes made to ensure that the deficient practice will not recur. All nurses are required to follow the bed-hold policy and allow residents to return from the hospital or therapeutic leave. The Admission Director will keep the Administrator and/or Director of Health Service (DHS) informed of a resident□s status while in the hospital and their expected date of return to the facility. The Admissions Director will follow-up with the Case Manager at assigned hospital for each hospital discharge on an anticipated return date. Discharges to the hospital will be documented on the hospital discharge log and discussed daily during the morning IDT meeting Monday through Friday to review all residents discharged to the hospital and their anticipated return date by the Administrator and/or Director of Health Services (DHS). The Administrator will audit discharges/transfers to the hospital to ensure the resident returns to the facility when medically cleared. This will occur weekly for 4 weeks then monthly times one. Ongoing education will be provided to newly hired Director of Health Services, Administrator, Social Worker, Licensed Nurse□s, and Unit Managers during general orientation. Plans to monitor its performance to make	

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 10/27/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEALTH-DURHAM	3100 ERWIN 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 626	Continued From page 33 A telephone interview was conducted on 10/12/22 at 9:58 AM, the facility Nurse Liaison stated she had spoken with the hospital case manager at the time of Resident #39's initial admission on 9/20/22 and stated the resident was unable to return due to sexual allegation. She added the administrator had informed her of a report from law enforcement that Resident #39 continued to make allegations of staff poisoning her at the facility. Therefore, Resident #39 was denied return on 9/20/22. The Nurse Liaison further stated she did ask the hospital case managers to complete a psychological evaluation on the resident before any further discussion would be held regarding her return. The Nurse Liaison indicated she had not follow-up with the hospital case manager of the status of Resident #39 to determine if the return would be appropriate. The final decision for Resident #39 was made by the administrator and corporate office. An interview was conducted on 10/13/22 at 10:00 AM, the Administrator stated she did not have any documentation of the direct discussion from the officer that the Resident #39 continued to make verbal statements of specific staff would poison her. She stated Resident #39's accusatory behavior and frequent calls to 911 was a problem and the facility could not meet her behavior needs. The resident would need to be stable psychologically before she could return. She did not feel she could meet her needs due to her allegations of staff poisoning her and providing care if the resident refused. She stated she did tell the liaison that the resident would not be accepted for return after speaking with management. She was not aware of the follow-up conversation held with the liaison that the resident was ready for return at this time. She had not	F 626	sure that the solutions are sustained. The Administrator and/or Director of Health Services (DHS) will report the analysis of the hospital discharge log to the Quality Assurance Performance Improvement (QAPI) Committee for review and revision monthly x 3 months or until substantial compliance is achieved. Date of compliance: 11/21/22	

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 10/27/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEALTH-DURHAM	3100 ERWIN 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 626	Continued From page 34	F 626		

done any follow-up or discussion with anyone at this point. There was no documentation with the family or resident being informed of Resident #39's return to the facility.

Telephone interview was conducted on 10/13/22 at 10:58 AM, the hospital Case Manager (CM) stated Resident #39 was admitted on 9/20/22 for urinary tract infection as well as psychological issues. The resident was treated in the ED and was cleared for return to the facility. The Case Manager called back to the facility around 7 PM to discuss with the facility nurse and prepare transportation for resident return, Nurse #10 on duty at 11:15 PM, was informed the resident was medically cleared for return. The CM was told the resident could not return because the bed was not available and given to another resident. CM called the daughter to see if they had spoken with anyone about a bed hold and the daughter reported she had not spoken with anyone from the facility regarding the bed hold policy. CM called back to the facility around 2 AM, to discuss transfer back and again nurse stated there was no bed available and she would have to speak with DON /Management about resident not returning. Spoke with facility Liaison at 6:45 AM on 9/21/22, who stated the resident would not be returning due to the resident paranoid/delusion, accusation of sexual assault worsening. The resident would not be accepted back to the facility. The Liaison requested a complete medical clearance and psych eval clearance before the resident could return to the facility. CM called facility back and spoke with the liaison on 9/23/22 and informed her the resident had been cleared medically and psychologically for return and was again told that management decided not to accept the resident back because they could

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 10/27/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEALTH-DURHAM	3100 ERWIN 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 626	Continued From page 35	F 626		

not meet her needs. The CM stated the resident had been at hospital due to facility refusal to accept resident, they had not given resident 30-day notice and alternate placement had not been found at this time. Discussion had been held with resident and daughter regarding placement in area near daughter, however, there had been no success. CM further stated because they were told flat out the resident would not be accepted for return placement options had been limited. CM was not aware of the resident contacting any outside source or making references of individuals poisoning her since her initial admission. the medications had been adjusted and resident had been stable for return since 9/23/22.

An interview was conducted on 10/13/22 at 11:55 AM, the Director of Nursing (DON) stated she did receive a call from the 3rd shift nurse who stated she received a call from the hospital stating Resident #39 was ready for return. The DON stated the resident was sent to the hospital for a psych eval and vaginal discomfort and it was not anticipated the resident would return that evening. The resident would have needed to return to a room that required isolation and that room had been given to another resident. DON stated she spoke with the Administrator who stated they would not be accepting the resident back based on the behaviors/accusation and constant calling the police. DON further stated the liaison would have followed up with the hospital and assessed the resident to determine whether the resident would be appropriate for return.

A telephone interview was conducted on 10/13/22 at 12:43 PM, the Nurse #10 stated the hospital called and stated the resident was ready for

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 10/27/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEALTH-DURHAM	3100 ERWIN 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 626	Continued From page 36	F 626		

returned. She told the emergency department staff the bed the resident was discharged from was currently occupied and there was no other bed available. She stated she had spoken with the DON who stated the resident could not return until a psych eval was done. She stated she did not have another room that the resident could be placed on isolation since another resident had been put in her previous room.
2. Resident # 292 admitted to the facility on 8/18/22 and had diagnoses including cerebral infarction, hemiplegia, atrial fibrillation, hypertension, congestive heart failure, asthma, and a chronic kidney disease.

A review of the medical record reveled Resident #292 was able to make needs known. No minimum data set (MDS) was completed.

Resident # 292 discharged to hospital on 8/29/22 and discharged from the hospital to another skilled nursing facility.

On 10/11/22 at 9:25 am an interview was conducted with Resident # 292's family member and it was indicated the facility would not allow Resident # 292 to return to the facility due to her calling the state agency and the company corporate complaint line.

An interview was conducted on 10/13/22 at 12:15 pm with the facility hospital liaison and it was indicated she was in charge of coordinating resident's return to facility after hospitalization and Resident # 292 did not return to the facility and went to another skilled nursing facility. She indicated she received the directive that Resident #292 was not returning to the facility from the Administrator due to the facility not being able to

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 10/27/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEALTH-DURHAM	3100 ERWIN 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 626	Continued From page 37 meet Resident's needs. She indicated on 9/1/22 she contacted the hospital case manager and informed her that the facility would not be taking the Resident back due to not being able to meet Resident #292 needs. An interview was conducted on 10/13/22 at 12:58 pm with the Administrator and it was indicated Resident #292's family member made an allegation of neglect on the facility to the company compliance line. She indicated it was decided not to bring Resident # 292 back because the family complained the facility was not taking care of the Resident.	F 626		
F 636 SS=B	Comprehensive Assessments & Timing CFR(s): 483.20(b)(1)(2)(i)(iii) §483.20 Resident Assessment The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. §483.20(b) Comprehensive Assessments §483.20(b)(1) Resident Assessment Instrument. A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following: (i) Identification and demographic information (ii) Customary routine. (iii) Cognitive patterns. (iv) Communication. (v) Vision. (vi) Mood and behavior patterns. (vii) Psychological well-being.	F 636		11/21/22

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 10/27/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEALTH-DURHAM	3100 ERWIN 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 636	Continued From page 38 (viii) Physical functioning and structural problems. (ix) Continence. (x) Disease diagnosis and health conditions. (xi) Dental and nutritional status. (xii) Skin Conditions. (xiii) Activity pursuit. (xiv) Medications. (xv) Special treatments and procedures. (xvi) Discharge planning. (xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS). (xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and nonlicensed direct care staff members on all shifts. §483.20(b)(2) When required. Subject to the timeframes prescribed in §413.343(b) of this chapter, a facility must conduct a comprehensive assessment of a resident in accordance with the timeframes specified in paragraphs (b)(2)(i) through (iii) of this section. The timeframes prescribed in §413.343(b) of this chapter do not apply to CAHs. (i) Within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or therapeutic leave.) (iii)Not less than once every 12 months. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the	F 636	Corrective action for the residents found	

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 10/27/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEALTH-DURHAM	3100 ERWIN 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 636	Continued From page 39 facility failed to complete admission Minimum Data Set (MDS) assessments within 14 calendar days after the residents' admission to the facility for 3 of 36 residents (Residents #393, #14, and #92) whose MDS assessments were reviewed. The findings included: 1. Resident #393 was admitted to the facility on 9/15/22. Her cumulative diagnoses included diabetes and a history of falls. Review of Resident #393's admission Minimum Data Set (MDS) revealed the assessment reference date (ARD, the last day of the look-back period) was 9/18/22. The facility's electronic MDS system indicated the due date for Resident #393's admission MDS was 9/28/22. This admission MDS was not signed or dated by the Registered Nurse (RN) Assessment Coordinator to verify the assessment had been completed as of the date of the review (10/12/22). An interview was conducted on 10/12/22 at 3:35 PM with the facility's Administrator. During the interview, the Administrator reported she was aware of concerns regarding multiple MDS assessments being completed late. Upon their request, an interview was conducted on 10/12/22 at 5:05 PM with the facility's Administrator and Regional MDS Consultant. During the interview, the Administrator reported the facility had identified concerns with MDS assessments being overdue. It was reported the facility had staffing challenges in the MDS Department and could not meet the work demands to complete all assessments. The Consultant reported outside assistance has	F 636	to be affected by the deficient practice. Resident #393 is no longer in the facility. She had an open admission assessment with an Assessment Reference Date (ARD) of 9/18/22 and was completed on 10/12/22. Resident #14□s admission Minimum Data Set (MDS) was closed and signed by the Registered Nurse (RN) on 07/14/22, which was 23 days after his admission date. Resident #92□s admission Minimum Data Set (MDS) assessment was in open status on 10/13/2022 and was completed and closed by the Registered Nurse on 10/14/2022, which was 31 days after his admission date. Corrective action for other residents having the potential to be affected by the same deficient practice. All residents have the potential to be affected by the alleged deficient practice. The facility will identify other residents having the potential to be affected by the same deficient practice by an audit conducted by the Case Mix Coordinator of 100% of all current residents to ensure an admission assessment was completed within 14 calendar days of the residents□ admission to the facility per Resident Assessment Instrument (RAI) guidelines. This audit was completed on 11/16/22. There were no residents noted as affected by admission assessments not completed timely.	

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 10/27/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEALTH-DURHAM	3100 ERWIN 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 636	Continued From page 40 helped the facility to catch up on "quite a few" assessments. When asked what the anticipated date of compliance was for the MDS assessments to be up to date, the Regional MDS Consultant stated it was "on-going." She added there was a meeting planned for 10/14/22 and she anticipated a date of compliance may be set at that time. 2. Resident #14 was admitted to the facility on 6/21/22. His cumulative diagnoses included chronic obstructive pulmonary disease. Review of Resident #14's admission Minimum Data Set (MDS) revealed the assessment reference date (ARD, the last day of the look-back period) was 6/27/22. This admission MDS was signed and dated by the Registered Nurse (RN) Assessment Coordinator to verify the assessment had been completed on 7/14/22 (23 days after his admission date). An interview was conducted on 10/12/22 at 3:35 PM with the facility's Administrator. During the interview, the Administrator reported she was aware of concerns regarding multiple MDS assessments being completed late. Upon their request, an interview was conducted on 10/12/22 at 5:05 PM with the facility's Administrator and Regional MDS Consultant. During the interview, the Administrator reported the facility had identified concerns with MDS assessments being overdue. It was reported the facility had staffing challenges in the MDS Department and could not meet the work demands to complete all assessments. The Consultant reported outside assistance has helped the facility to catch up on "quite a few"	F 636	The Regional Clinical Reimbursement Consultant (CRC) in-serviced the facility Interdisciplinary Team (IDT) on timely completion of all Minimum Data Set (MDS) assessments according to the Resident Assessment Instrument (RAI) guidelines on 11/15/22. Case Mix Coordinator will review the Minimum Data Set Section Status daily in Matrix Care to assure all assessments are completed and signed within the timeframe allotted for each assessment type. A spreadsheet has also been developed by the Regional Corporate Clinical Reimbursement Team and will be used by the Minimum Data Set (MDS) nurses to track all assessments for type and Assessment Reference Date (ARD) dates as well as utilizing the Resident Minimum Data Set (MDS) 3.0 Status Report daily from Matrix Care. Education will be provided in new hire orientation for any new Licensed Nurse Assessment Coordinator hired regarding the timely completion of all Minimum Data Set (MDS) assessments per Center for Medicare and Medicaid Services (CMS) guidelines. Systemic changes made to ensure that the deficient practice will not recur. A spreadsheet has been developed by the Regional Corporate Clinical Reimbursement Consultant Team and will be used by the Minimum Data Set (MDS) nurses for tracking all assessments for type and Assessment Reference Date	

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 10/27/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEALTH-DURHAM	3100 ERWIN 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 636	Continued From page 41 assessments. When asked what the anticipated date of compliance was for the MDS assessments to be up to date, the Regional MDS Consultant stated it was "on-going." She added there was a meeting planned for 10/14/22 and she anticipated a date of compliance may be set at that time. 3. Resident #92 was admitted to the facility on 9/13/22. Resident #92's baseline care plan was completed on 9/13/22. Review of the admission MDS dated 9/18/22 indicated the assessment was in process and incomplete. On 10/13/22 at 3:23 PM with the Regional MDS Consultant and facility MDS nurse were interviewed. The Regional MDS Consultant stated that the assessment was not completed and was late. She added the resident's baseline care plan was completed within the 48 hours of admission. An interview was conducted on 10/12/22 at 5:05 PM with the facility's Administrator and Regional MDS Consultant. During the interview, the Administrator reported the facility had identified a couple of areas they have been working on which included MDS concerns. In discussing the MDS concerns identified, the Regional MDS Consultant stated the facility had staffing challenges in the MDS Department and could not meet the work demands to complete all assessments. MDS nurses from sister facilities have been utilized to assist this facility. The Regional MDS Consultant reported the outside assistance had helped the facility to catch up on "quite a few" assessments. She stated, "the goal when we started was trying to catch up on the late assessments" and two weeks ago they needed to regroup to ensure the facility also kept up the current assessments needing to be completed. The Administrator and	F 636	(ARD) dates as well as utilizing the Resident Minimum Data Set (MDS) 3.0 Status Report daily from Matrix Care. This spreadsheet will be utilized daily and discussed during the daily Interdisciplinary Team meeting. Plans to monitor its performance to make sure that the solutions are sustained. The Licensed Nurse Assessment Coordinator will report the analysis of the tracking spreadsheet during the Quality Assurance Performance Improvement (QAPI) Committee meeting for review and revision monthly x 3 months or until substantial compliance is achieved. Date of compliance: 11/21/22	

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 10/27/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEALTH-DURHAM	3100 ERWIN 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 636	Continued From page 42 the Regional MDS Consultant were asked what the anticipated date of completion for all MDS assessments.	F 636		
F 637 SS=D	Comprehensive Assessment After Signifcant Chg CFR(s): 483.20(b)(2)(ii) §483.20(b)(2)(ii) Within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a "significant change" means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to complete a significant change Minimum Data Set (MDS) assessment within 14 calendar days after the facility determined there had been a significant change for 1 of 1 significant change MDS reviewed (Resident #442). The findings included: Resident #442 was admitted to the facility on 5/29/21 with re-entry from a hospital on 9/2/22. A Hospice referral was made for Resident #442 on 9/2/22. His cumulative diagnoses included cerebral infarction (stroke) affecting his left non-dominant side.	F 637	Corrective action for the residents found to be affected by the deficient practice. Resident #442 no longer resides in the facility. He had a significant change assessment with an Assessment Reference Date (ARD) of 9/8/22 and completed 9/30/22. Corrective action for other residents having the potential to be affected by the same deficient practice. All residents have the potential to be affected by the alleged deficient practice. The facility will identify other residents having the potential to be affected by the	11/21/22

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 10/27/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEALTH-DURHAM	3100 ERWIN 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 637	Continued From page 43 Review of Resident #442's significant change Minimum Data Set (MDS) revealed the assessment reference date (ARD, the last day of the look-back period) was 9/8/22. This significant change MDS was signed/dated on 9/30/22 by the Registered Nurse (RN) Assessment Coordinator to verify the assessment had been completed (28 days after Resident #442 returned from the hospital and was referred to Hospice). An interview was conducted on 10/12/22 at 3:35 PM with the facility's Administrator. During the interview, the Administrator reported she was aware of concerns regarding multiple MDS assessments being completed late. Upon their request, an interview was conducted on 10/12/22 at 5:05 PM with the facility's Administrator and Regional MDS Consultant. During the interview, the Administrator reported the facility had identified concerns with MDS assessments being overdue. It was reported the facility had staffing challenges in the MDS Department and could not meet the work demands to complete all assessments. The Consultant reported outside assistance has helped the facility to catch up on "quite a few" assessments. When asked what the anticipated date of compliance was for the MDS assessments to be up to date, the Regional MDS Consultant stated it was "on-going." She added there was a meeting planned for 10/14/22 and she anticipated a date of compliance may be set at that time.	F 637	same deficient practice by an audit conducted by the Case Mix Coordinator of 100% of all current residents to ensure a significant change assessment was completed per RAI guidelines. This audit was completed on 11/16/22. There were four residents noted as affected by a significant change assessment not completed timely. These four significant change assessments will be completed by 11/21/22. The Regional Clinical Reimbursement Consultant (CRC) in-serviced the Interdisciplinary Team (IDT) on timely completion of all Minimum Data Set (MDS) assessments according to the Resident Assessment Instrument (RAI) guidelines on 11/15/22. Case Mix Coordinator will review the Minimum Data Set (MDS) Section Status daily in Matrix Care to assure all assessments are completed and signed within the timeframe allotted for each assessment type. A spreadsheet has also been developed by the Regional Corporate Clinical Reimbursement Team and will be used by the Minimum Data Set (MDS) nurses to track all assessments for type and Assessment Reference Date (ARD) dates as well as utilizing the Resident Minimum Data Set (MDS) 3.0 Status Report daily from Matrix Care. Education will be provided in new hire orientation for any new Licensed Nurse Assessment Coordinator hired regarding the timely completion of all Minimum Data Set (MDS) assessments per Center for	

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 10/27/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEALTH-DURHAM	3100 ERWIN 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 637	Continued From page 44	F 637	Medicare and Medicaid Services (CMS) guidelines. Systemic changes made to ensure that the deficient practice will not recur. A spreadsheet has been developed by the Regional Corporate Clinical Reimbursement Consultant (CRC) Team and will be used by the Minimum Data Set (MDS) nurses for tracking all assessments for type and Assessment Reference Date (ARD) dates as well as utilizing the Resident Minimum Data Set (MDS) 3.0 Status Report daily form Matrix Care. This spreadsheet will be utilized daily and discussed during the Interdisciplinary Team meeting. Plans to monitor its performance to make sure that the solutions are sustained. The Licensed Nurse Assessment Coordinator will report the analysis of the tracking spreadsheet during the Quality Assurance Performance Improvement (QAPI) Committee meeting for review and revision monthly x 3 months or until substantial compliance is achieved. Date of compliance: 11/21/22	
F 638 SS=B	Qrtly Assessment at Least Every 3 Months CFR(s): 483.20(c) §483.20(c) Quarterly Review Assessment A facility must assess a resident using the quarterly review instrument specified by the State and approved by CMS not less frequently than once every 3 months. This REQUIREMENT is not met as evidenced by:	F 638		11/21/22

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 10/27/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEALTH-DURHAM	3100 ERWIN 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 638	Continued From page 45 Based on record review and staff interviews, the facility failed to complete quarterly Minimum Data Set (MDS) assessments at least every 92 days following the previous MDS assessment and/or within 14 days of the Assessment Reference Date (ARD, the last day of the look-back period) for 13 of 36 residents whose MDS assessments were reviewed (Residents #7, #60, #3 #40, #4, #1, #2, #5, #74, #26, #61, #53, and #77). The findings included: 1-a. Resident #7 was admitted to the facility on 11/4/20 with reentry on 7/24/21 from a hospital. Her cumulative diagnoses included Alzheimer's disease and malnutrition. Review of the resident's Minimum Data Set (MDS) assessments revealed a quarterly MDS had an Assessment Reference Date (ARD, the last day of the look-back period) of 1/27/22. The quarterly MDS dated 1/27/22 was signed/dated on 4/7/22 by the Registered Nurse (RN) Assessment Coordinator to verify the assessment was completed (70 days after the ARD). An interview was conducted on 10/12/22 at 10:26 AM with the facility's MDS Coordinator and the Regional MDS Consultant. During the interview, both the MDS Coordinator and the Regional MDS Consultant reported the MDS assessment was overdue if it had been signed as completed more than 14 days after the ARD date. An interview was conducted on 10/12/22 at 3:35 PM with the facility's Administrator. During the interview, the Administrator reported she was aware of concerns regarding multiple MDS	F 638	Corrective action for the residents found to be affected by the deficient practice. Resident #7 was admitted to the facility on 11/04/20 with reentry on 07/24/21 from a hospital. The coding for the quarterly assessment for Resident #7 was completed on 10/14/22. The assessment was transmitted to Quality Improvement and Evaluation System (QIES) database and showing accepted status. Resident #60 was admitted to the facility was admitted to the facility from a hospital on 10/26/21. The coding for the quarterly assessment for Resident #60 with an Assessment Reference Date (ARD) of 6/17/22 was completed on 07/12/22. The assessment was transmitted to Quality Improvement and Evaluation System (QIES) database and showing accepted status. Resident #3 was admitted to the facility 06/04/19. The coding for the quarterly assessment for Resident #3 with an Assessment Reference Date (ARD) of 8/22/22 was completed on 11/10/22. The assessment was transmitted to Quality Improvement and Evaluation System (QIES) database and showing accepted status. Resident #40 was admitted to the facility on 4/26/19 with the most recent reentry on 5/3/22. The coding for the quarterly assessment for Resident #40 with an Assessment Reference Date (ARD) of 8/9/22 was completed on 9/3/22. The	

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 10/27/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEALTH-DURHAM	3100 ERWIN 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 638	Continued From page 46	F 638		

assessments being completed late.

Upon their request, an interview was conducted on 10/12/22 at 5:05 PM with the facility's Administrator and Regional MDS Consultant. During the interview, the Administrator reported the facility had identified concerns with MDS assessments being overdue. It was reported the facility had staffing challenges in the MDS Department and could not meet the work demands to complete all assessments. The Consultant reported outside assistance has helped the facility to catch up on "quite a few" assessments. When asked what the anticipated date of compliance was for the MDS assessments to be up to date, the Regional MDS Consultant stated it was "on-going." She added there was a meeting planned for 10/14/22 and she anticipated a date of compliance may be set at that time.

1-b. Resident #7 was admitted to the facility on 11/4/20 with reentry on 7/24/21 from a hospital. Her cumulative diagnoses included Alzheimer's disease and malnutrition. Review of the resident's Minimum Data Set (MDS) assessments revealed a quarterly MDS had an Assessment Reference Date (ARD, the last day of the look-back period) of 4/21/22. The quarterly MDS dated 4/21/22 was signed/dated on 5/23/22 by the Registered Nurse (RN) Assessment Coordinator to verify the assessment was completed (32 days after the ARD).

An interview was conducted on 10/12/22 at 10:26 AM with the facility's MDS Coordinator and the Regional MDS Consultant. During the interview, both the MDS Coordinator and the Regional MDS Consultant reported the MDS assessment was

assessment was transmitted to Quality Improvement and Evaluation System (QIES) database and showing accepted status.

Resident #4 was admitted to the facility on 5/3/18. The coding for the quarterly assessment for Resident #4 with an Assessment Reference Date (ARD) of 8/23/22 was completed on 10/19/22. The assessment was transmitted to Quality Improvement and Evaluation System (QIES) database and showing accepted status.

Resident #1 was admitted to the facility on 4/11/22. The coding for the quarterly assessment for Resident #1 with an Assessment Reference Date (ARD) of 8/19/22 was completed on 10/19/22. The assessment was transmitted to Quality Improvement and Evaluation System (QIES) database and showing accepted status.

Resident #2 was admitted to the facility on 9/3/21. The coding for the quarterly assessment for Resident #2 with an Assessment Reference Date (ARD) of 8/18/22 was completed on 10/12/22. The assessment was transmitted to Quality Improvement and Evaluation System (QIES) database and showing accepted status.

Resident #5 was admitted to the facility on 1/19/21. The coding for the quarterly assessment for Resident #5 with an Assessment Reference Date (ARD) of

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 10/27/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEALTH-DURHAM	3100 ERWIN 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 638	Continued From page 47	F 638		

overdue if it had been signed as completed more than 14 days after the ARD date.

An interview was conducted on 10/12/22 at 3:35 PM with the facility's Administrator. During the interview, the Administrator reported she was aware of concerns regarding multiple MDS assessments being completed late.

Upon their request, an interview was conducted on 10/12/22 at 5:05 PM with the facility's Administrator and Regional MDS Consultant. During the interview, the Administrator reported the facility had identified concerns with MDS assessments being overdue. It was reported the facility had staffing challenges in the MDS Department and could not meet the work demands to complete all assessments. The Consultant reported outside assistance has helped the facility to catch up on "quite a few" assessments. When asked what the anticipated date of compliance was for the MDS assessments to be up to date, the Regional MDS Consultant stated it was "on-going." She added there was a meeting planned for 10/14/22 and she anticipated a date of compliance may be set at that time.

2-a. Resident #60 was admitted to the facility from a hospital on 10/26/21. His cumulative diagnoses included end stage renal disease requiring hemodialysis.

Review of the resident's Minimum Data Set (MDS) assessments revealed a quarterly MDS had an Assessment Reference Date (ARD, the last day of the look-back period) of 3/17/22. The quarterly MDS dated 3/17/22 was signed/dated on 4/26/22 by the Registered Nurse (RN) 8/18/22 was completed on 10/7/22. The assessment was transmitted to Quality Improvement and Evaluation System (QIES) database and showing accepted status.

Resident #74 was admitted to the facility on 10/14/21 with the most recent reentry on 6/15/22. The coding for the quarterly assessment for Resident #74 with an ASSESSMENT REFERENCE DATE of 9/21/22 was completed on 11/6/22. The assessment was transmitted to Quality Improvement and Evaluation System (QIES) database and showing accepted status.

Resident #26 was admitted to the facility on 8/31/16. The coding for the quarterly assessment for Resident #26 with an ASSESSMENT REFERENCE DATE of 4/30/22 was completed on 5/24/22. The assessment was transmitted to Quality Improvement and Evaluation System (QIES) database and showing accepted status.

Resident #61 was admitted to the facility on 11/2/21. The coding for the quarterly assessment for Resident #61 with an ASSESSMENT REFERENCE DATE of 6/18/22 was completed on 07/12/2022. The assessment was transmitted to Quality Improvement and Evaluation System (QIES) database and showing accepted status.

Resident #53 was admitted to the facility on 12/6/19. The coding for the quarterly

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 10/27/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEALTH-DURHAM	3100 ERWIN 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 638	Continued From page 48 Assessment Coordinator to verify the assessment was completed (40 days after the ARD). An interview was conducted on 10/12/22 at 10:26 AM with the facility's MDS Coordinator and the Regional MDS Consultant. During the interview, both the MDS Coordinator and the Regional MDS Consultant reported the MDS assessment was overdue if it had been signed as completed more than 14 days after the ARD date. An interview was conducted on 10/12/22 at 3:35 PM with the facility's Administrator. During the interview, the Administrator reported she was aware of concerns regarding multiple MDS assessments being completed late. Upon their request, an interview was conducted on 10/12/22 at 5:05 PM with the facility's Administrator and Regional MDS Consultant. During the interview, the Administrator reported the facility had identified concerns with MDS assessments being overdue. It was reported the facility had staffing challenges in the MDS Department and could not meet the work demands to complete all assessments. The Consultant reported outside assistance has helped the facility to catch up on "quite a few" assessments. When asked what the anticipated date of compliance was for the MDS assessments to be up to date, the Regional MDS Consultant stated it was "on-going." She added there was a meeting planned for 10/14/22 and she anticipated a date of compliance may be set at that time. 2-b. Resident #60 was admitted to the facility from a hospital on 10/26/21. His cumulative diagnoses included end stage renal disease	F 638	assessment for Resident #53 with an ASSESSMENT REFERENCE DATE of 8/13/22 was completed on 9/15/2022. The assessment was transmitted to Quality Improvement and Evaluation System (QIES) database and showing accepted status. Resident #77 was admitted to the facility on 5/20/22. The coding for the quarterly assessment for Resident #77 with an ASSESSMENT REFERENCE DATE of 9/8/22 was completed on 9/29/2022. The assessment was transmitted to Quality Improvement and Evaluation System (QIES) database and showing accepted status. Corrective action for other residents having the potential to be affected by the same deficient practice. All residents have the potential to be affected by the alleged deficient practice. The facility will identify other residents having the potential to be affected by the same deficient practice by an audit conducted by the Case Mix Coordinator of 100% of all current residents to ensure a quarterly assessment was completed per RAI guidelines. This audit was completed on 11/16/22. One resident was noted as affected by quarterly assessments not completed timely with the quarterly assessment to be completed by 11/21/22. The Regional Clinical Reimbursement Consultant (CRC) in-serviced the Interdisciplinary Team (IDT) on timely	

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 10/27/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEALTH-DURHAM	3100 ERWIN 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 638	Continued From page 49 requiring hemodialysis. Review of the resident's Minimum Data Set (MDS) assessments revealed a quarterly MDS had an Assessment Reference Date (ARD, the last day of the look-back period) of 6/17/22. The quarterly MDS dated 6/17/22 was signed/dated on 7/12/22 by the Registered Nurse (RN) Assessment Coordinator to verify the assessment was completed (26 days after the ARD). An interview was conducted on 10/12/22 at 10:26 AM with the facility's MDS Coordinator and the Regional MDS Consultant. During the interview, both the MDS Coordinator and the Regional MDS Consultant reported the MDS assessment was overdue if it had been signed as completed more than 14 days after the ARD date. An interview was conducted on 10/12/22 at 3:35 PM with the facility's Administrator. During the interview, the Administrator reported she was aware of concerns regarding multiple MDS assessments being completed late. Upon their request, an interview was conducted on 10/12/22 at 5:05 PM with the facility's Administrator and Regional MDS Consultant. During the interview, the Administrator reported the facility had identified concerns with MDS assessments being overdue. It was reported the facility had staffing challenges in the MDS Department and could not meet the work demands to complete all assessments. The Consultant reported outside assistance has helped the facility to catch up on "quite a few" assessments. When asked what the anticipated date of compliance was for the MDS assessments to be up to date, the Regional MDS	F 638	completion of all Minimum Data Set (MDS) assessments according to the Resident Assessment Instrument (RAI) guidelines on 11/15/22. Case Mix Coordinator will review the Minimum Data Set (MDS) Section Status daily in Matrix Care to assure all assessments are completed and signed within the timeframe allotted for each assessment type. A spreadsheet has also been developed by the Regional and Corporate Clinical Reimbursement Consultant (CRC) team and will be used by the Minimum Data Set (MDS) nurses for tracking all assessments for type and Assessment Reference Date (ARD) dates as well as utilizing the Resident Minimum Data Set (MDS) 3.0 Status Report daily from Matrix Care. Education will be provided in new hire orientation for any new Licensed Nurse Assessment Coordinator hired regarding the timely completion of all Minimum Data Set (MDS) assessments per Center for Medicare and Medicaid Services (CMS) guidelines. Systemic changes made to ensure that the deficient practice will not recur. A spreadsheet has been developed by the Regional and Corporate Clinical Reimbursement Consultant (CRC) team and will be used by the Minimum Data Set (MDS) nurses for tracking all assessments for type and Assessment Reference Date (ARD) dates as well as utilizing the Resident Minimum Data Set	

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 10/27/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEALTH-DURHAM	3100 ERWIN 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 638	Continued From page 50 Consultant stated it was "on-going." She added there was a meeting planned for 10/14/22 and she anticipated a date of compliance may be set at that time. 4. Resident #3 was admitted to the facility on 6/14/19. His cumulative diagnoses included a history of cerebrovascular accident (stroke). Review of the resident's Minimum Data Set (MDS) assessments revealed a quarterly MDS had an Assessment Reference Date (ARD, the last day of the look-back period) of 8/22/22. The quarterly MDS dated 8/22/22 was still "in process" as of the date of the review (10/11/22). This assessment was not signed or dated by the Registered Nurse (RN) Assessment Coordinator to verify the assessment had been completed (50 days after the ARD). 5. Resident #4 was admitted to the facility on 5/3/18. Review of the resident's MDS assessment dated 6/5/22 was as quarterly assessment and was signed as being completed on 6/10/22. A review of Resident #4's most recent quarterly MDS assessment dated 8/23/22 revealed the assessment was in progress and not completed. Further review of the assessment revealed Section Z for signature of Registered Nurse assessment coordinator verifying assessment as complete was noted to be blank and no date entry noted. On 10/13/22 at 3:23 PM with the Regional MDS Consultant and facility MDS nurse were interviewed. The Regional MDS consultant stated that the assessments were incomplete. She added the quarterly assessment was overdue since it has not been completed within 14 days	F 638	(MDS) 3.0 Status Report daily from Matrix Care. Plans to monitor its performance to make sure that the solutions are sustained. An analysis of the Minimum Data Set (MDS) assessment completion tracking sheet will be brought to the monthly Quality Assurance Performance Improvement (QAPI) Committee meeting for review and revision monthly x 3 months or until substantial compliance is achieved. Date of compliance: 11/21/22	

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 10/27/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEALTH-DURHAM	3100 ERWIN 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 638	Continued From page 51	F 638		

since the ARD date.

6. Resident #1 was admitted on 4/11/22. Review of the resident's MDS assessment dated 5/23/22 was a discharge assessment and was signed as being completed on 6/6/22.Resident #1 was readmitted on 7/3/22. Resident #1 did not have a comprehensive MDS assessment after readmission.

A review of Resident #1's most recent quarterly MDS assessment dated 8/19/22 revealed the assessment was in progress and not completed. Further review of the assessment revealed section C (cognitive patterns) was incomplete and section Z (Assessment administration) for signature of Registered Nurse assessment coordinator verifying assessment as complete was noted to be blank and no date entry noted.

On 10/13/22 at 3:23 PM with the Regional MDS Consultant and facility MDS nurse were interviewed. The Regional MDS consultant stated that the assessment was incomplete. She added the quarterly assessment was overdue since it has not been completed within 14 days since the ARD date.

7. Resident #2 was readmitted on 9/3/21. A review of the quarterly MDS assessment dated 8/18/22 revealed the assessment was signed by the Registered Nurse assessment coordinator to certify that it was complete on 10/12/22.

On 10/13/22 at 3:23 PM with the Regional MDS Consultant and facility MDS nurse were interviewed. The Regional MDS consultant stated that the assessments were completed late.

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 10/27/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEALTH-DURHAM	3100 ERWIN 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 638	Continued From page 52	F 638		

8. Resident #5 was admitted on 1/19/21. A review of the quarterly MDS assessment dated 8/18/22 revealed the assessment was signed by the Registered Nurse assessment coordinator to certify that it was complete on 10/7/22.

On 10/13/22 at 3:23 PM with the Regional MDS Consultant and facility MDS nurse were interviewed. The Regional MDS Consultant stated that the assessments were completed late. The Regional MDS Consultant stated Resident #5's assessment was completed on 10/7/22 and transmitted on 10/10/22.

9. Resident #74 was readmitted on 6/15/22.

A review of Resident #74's most recent quarterly MDS assessment dated 9/21/22 revealed the assessment was in progress and not completed. Further review of the assessment revealed section C (cognitive patterns) was incomplete and section Z (Assessment administration) for signature of Registered Nurse assessment coordinator verifying assessment as complete was noted to be blank and no date entry noted.

An interview was conducted on 10/12/22 at 5:05 PM with the facility's Administrator and Regional MDS Consultant. During the interview, the Administrator reported the facility had identified a couple of areas they have been working on which included MDS concerns. In discussing the MDS concerns identified, the Regional MDS Consultant stated the facility had staffing challenges in the MDS Department and could not meet the work demands to complete all assessments. MDS nurses from sister facilities have been utilized to assist this facility. The Regional MDS Consultant reported the outside assistance had helped the

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 10/27/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEALTH-DURHAM	3100 ERWIN 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 638	Continued From page 53	F 638		

facility to catch up on "quite a few" assessments. She stated, "the goal when we started was trying to catch up on the late assessments" and two weeks ago they needed to regroup to ensure the facility also kept up the current assessments needing to be completed. The Administrator and the Regional MDS Consultant were asked what the anticipated date of completion for all MDS assessments to be up to date. The Regional MDS Consultant stated it was "on-going."
10. Resident #26 was admitted to the facility on 8/31/2016.

Review of Resident #26's medical record revealed the resident had a quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD, last day of the assessment period) of 4/30/2022. The quarterly MDS was signed as completed on 5/24/2022.

An interview with the MDS Coordinator and the Clinical Reimbursement Consultant was conducted on 10/13/2022 at 3:23 P.M. The Clinical Reimbursement Consultant indicated if the MDS assessment was signed as completed more than 14 days after the ARD date it was late.

An interview with the Administrator and the Clinical Reimbursement Consultant was conducted on 10/12/2022 at 5:06 P.M. The Administrator indicated resident MDS assessments should be completed within the required time.

11. Resident #61 was admitted to the facility on 11/02/2021.

Review of Resident #61's medical record revealed the resident had a quarterly Minimum

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 10/27/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEALTH-DURHAM	3100 ERWIN 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 638	Continued From page 54	F 638		

Data Set (MDS) with an Assessment Reference Date (ARD, the last day of the look-back period) of 6/18/2022. The quarterly MDS was signed as completed on 7/12/2022.

An interview with the MDS Coordinator and the Clinical Reimbursement Consultant was conducted on 10/13/2022 at 3:23 P.M. The Clinical Reimbursement Consultant indicated if the MDS assessment was signed as completed more than 14 days after the ARD date it was late.

An interview with the Administrator and the Clinical Reimbursement Consultant was conducted on 10/12/2022 at 5:06 P.M. The Administrator indicated resident MDS assessments should be completed within the required time.

12. Resident #53 was admitted to the facility on 12/06/2019.

Review of Resident # medical record revealed the resident had a quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD, the last day of the look-back period) of 8/13/2022. The quarterly MDS was signed as completed on 9/15/2022.

An interview with the MDS Coordinator and the Clinical Reimbursement Consultant was conducted on 10/13/2022 at 3:23 P.M. The Clinical Reimbursement Consultant indicated if the MDS assessment was signed as completed more than 14 days after the ARD date it was late.

An interview with the Administrator and the Clinical Reimbursement Consultant was conducted on 10/12/2022 at 5:06 P.M. The

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 10/27/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEALTH-DURHAM	3100 ERWIN 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 638	Continued From page 55 Administrator indicated resident MDS assessments should be completed within the required time. 13. Resident #77 was admitted to the facility on 5/20/2022. Review of Resident #77's medical record revealed the resident had a quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD, the last day of the look-back period) of 9/8/2022. The quarterly MDS was signed as completed on 9/29/2022 (21 days after the ARD). An interview with the MDS Coordinator and the Clinical Reimbursement Consultant was conducted on 10/13/2022 at 3:23 P.M. The Clinical Reimbursement Consultant indicated if the MDS assessment was signed as completed more than 14 days after the ARD date it was late. An interview with the Administrator and the Clinical Reimbursement Consultant was conducted on 10/12/2022 at 5:06 P.M. The Administrator indicated resident MDS assessments should be completed within the required time.	F 638		
F 642 SS=B	Coordination/Certification of Assessment CFR(s): 483.20(h)-(j) §483.20(h) Coordination. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. §483.20(i) Certification. §483.20(i)(1) A registered nurse must sign and certify that the assessment is completed.	F 642		11/21/22

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 10/27/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEALTH-DURHAM	3100 ERWIN 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 642	Continued From page 56 §483.20(i)(2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. §483.20(j) Penalty for Falsification. §483.20(j)(1)Under Medicare and Medicaid, an individual who willfully and knowingly- (i) 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 (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment. §483.20(j)(2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to complete an annual MDS assessment within 14 days of the Assessment Reference Date (ARD, the last day of the look-back period) for 1 of 36 residents (Resident #7) whose MDS assessments were reviewed. The findings included: Resident #7 was admitted to the facility on 11/4/20 with reentry on 7/24/21 from a hospital. Her cumulative diagnoses included Alzheimer's disease and malnutrition. Review of the resident's Minimum Data Set (MDS) assessments revealed an annual MDS had an Assessment Reference Date (ARD) of 10/30/21. Her last quarterly MDS had an ARD	F 642	Corrective action for the residents found to be affected by the deficient practice. Resident #7 was admitted to the facility on 11/04/2020 with reentry on 07/24/2021 from a hospital. The coding for the Annual Assessment for Resident #7 was completed on 10/14/2022. The assessment was transmitted to Quality Improvement and Evaluation System (QIES) database and showing accepted status. Corrective action for other residents having the potential to be affected by the same deficient practice. All residents have the potential to be affected by the alleged deficient practice.	

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 10/27/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEALTH-DURHAM	3100 ERWIN 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 642	Continued From page 57 date of 5/31/22. Further review of Resident #7's MDS assessments indicated an annual Minimum Data Set (MDS) with an assessment reference date (ARD) of 8/31/22 was still "in process" on the date of the review (10/12/22). This assessment was not signed or dated by the Registered Nurse (RN) Assessment Coordinator to verify the assessment had been completed. An interview was conducted on 10/12/22 at 10:26 AM with the facility's MDS Coordinator and Regional MDS Consultant. Upon review of Resident #7's annual MDS dated 8/31/22, the coordinator confirmed this assessment was late and had not yet been completed. An interview was conducted on 10/12/22 at 3:35 PM with the facility's Administrator. During the interview, the Administrator reported she was aware of the concerns regarding multiple MDS assessments being completed late. Upon their request, an interview was conducted on 10/12/22 at 5:05 PM with the facility's Administrator and Regional MDS Consultant. During the interview, the Administrator reported the facility had identified concerns with MDS assessments being overdue. It was reported the facility had staffing challenges in the MDS Department and could not meet the work demands to complete all assessments. The Consultant reported outside assistance has helped the facility to catch up on "quite a few" assessments. When asked what the anticipated date of compliance was for the MDS assessments to be up to date, the Regional MDS Consultant stated it was "on-going." She added there was a meeting planned for 10/14/22 and she anticipated a date of compliance may be set	F 642	The facility will identify other residents having the potential to be affected by the same deficient practice by an audit conducted by the Case Mix Coordinator of 100% of all current residents to ensure a Registered Nurse conducted and coordinated each assessment with the appropriate participation of the Interdisciplinary Team. This audit was completed on 11/16/22. There were no residents noted as affected. The Regional Clinical Reimbursement Consultant (CRC) in-serviced the Interdisciplinary Team (IDT) on timely completion of all Minimum Data Set (MDS) assessments according to the Resident Assessment Instrument (RAI) guidelines on 11/15/22. Case Mix Coordinator will review the Minimum Data Set (MDS) Section Status daily in Matrix Care to assure all assessments are completed and signed within the timeframe allotted for each assessment type. A spreadsheet has also been developed by the Regional and Corporate Clinical Reimbursement Consultant (CRC) team and will be used by the Minimum Data Set (MDS) nurses for tracking all assessments for type and Assessment Reference Date (ARD) dates as well as utilizing the Resident Minimum Data Set (MDS) 3.0 Status Report daily from Matrix Care. Education will be provided in new hire orientation for any new Licensed Nurse Assessment Coordinator, hired regarding the timely completion of all Minimum Data	

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 10/27/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEALTH-DURHAM	3100 ERWIN 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 642	Continued From page 58 at that time.	F 642	Set (MDS) assessments per Center for Medicare and Medicaid Services (CMS) guidelines. Systemic changes made to ensure that the deficient practice will not recur. A spreadsheet has been developed by the Regional and Corporate Clinical Reimbursement Consultant (CRC) team and will be used by the Minimum Data Set (MDS) nurses for tracking all assessments for type and Assessment Reference Date (ARD) dates as well as utilizing the Resident Minimum Data Set (MDS) 3.0 Status Report daily from Matrix Care. Plans to monitor its performance to make sure that the solutions are sustained. An analysis of the Minimum Data Set (MDS) assessment completion tracking sheet will be brought to the monthly Quality Assurance Performance Improvement (QAPI) Committee meeting for review and revision monthly x 3 months or until substantial compliance is achieved. Date of compliance: 11/21/22	
F 655 SS=B	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	F 655		11/21/22

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 10/27/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEALTH-DURHAM	3100 ERWIN 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 655	Continued From page 59	F 655		

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 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:

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 10/27/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEALTH-DURHAM	3100 ERWIN 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 655	Continued From page 60 Based on record review, resident interview, family interview, and staff interviews, the facility failed to provide the resident and their representative with a summary of the baseline care plan for 2 of 2 residents reviewed for care plans. (Resident #46 and Resident #94) Findings included: 1.Resident #46 was admitted to the facility on 8/22/22. Review of care plan dated 8/22/22 revealed Resident #46 was care planned for behavior symptoms, falls, Activity of Daily Living (ADL) deficit, seizure disorder, and mobility. The Minimum Data Set (MDS) five-day admission assessment dated 8/29/22 revealed Resident #46 was moderately cognitively. During an interview on 10/10/22 at 2:10 PM, Resident #46's representative indicated that the resident was admitted to the facility 8 weeks ago. The resident representative stated he does not recollect having received care plan documentation provided to him after resident's admission to the facility. During an interview on 10/13/22 at 1:57 PM the Social Worker stated she was unavailable during the time of Resident #46's admission and was unsure if any documentation of the baseline care plan was provided to the resident's representative. During an interview on 10/13/22 at 5:10 PM, the Director of Nursing (DON) indicated she was unsure if the baseline care plan was reviewed	F 655	Corrective action for the residents found to be affected by the deficient practice. Resident #46 no longer resides in the facility. On 11/15/2022 the Interdisciplinary Team (IDT) held a care plan review meeting with resident #92 and he was provided a copy of his Comprehensive Care Plan Summary. Corrective action for other residents having the potential to be affected by the same deficient practice. The current Social Worker (SW) began employment January 2022 and was not aware that each admission was to receive a copy of his/her baseline care plan. All residents were reviewed for documentation of providing the resident and/or Responsible Party a copy of the baseline care plan and none were noted. On 11/15/2022 the Clinical Reimbursement Consultant (CRC) in-serviced the Interdisciplinary Team (IDT) on providing the resident and/or Responsible Party (RP) with a copy of the baseline care plan to include at a minimum healthcare information necessary to care for the resident during the 48-hour Post-Acute Care (PAC) meeting that is held within 48-hours post admission. The Social Worker (SW) will document in the medical record that the baseline care plan meeting was held, and a copy given to the resident and/or the	

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 10/27/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEALTH-DURHAM	3100 ERWIN 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 655	Continued From page 61 with the resident's representative and a copy of the care plan was provided to them. The DON stated she thought MDS staff were responsible for care plan meetings and documentation. On 10/13/22 at 3:23 PM with the Regional MDS Consultant and facility MDS nurse were interviewed. The Regional MDS consultant stated the baseline care plan was completed by different departments within 48 hours of admission, however the MDS staff were not responsible for setting up any meeting or providing documentation to residents and family members for baseline care plans. The MDS department was only responsible for setting up interdisciplinary team meetings with the resident or family for quarterly, annual and any change in resident's care plan. During an interview on 10/13/22 at 5:10 PM the Administrator did not identify the staff responsible to conduct and provide baseline care plan documents to the residents or their representatives. The Administrator stated the resident's representative should be provided with the written summary of the baseline care plan and should be completed within 48 hours of admission to the facility. 2. Resident #92 was admitted to the facility on 9/13/22. Review of the care plan dated 9/13/22 revealed the resident was care planned for Activity of Daily Living (ADL) decline, falls, medical conditions, and behaviors. Review of the admission Minimum Data Set (MDS) dated 9/18/22 indicated the resident was	F 655	Responsible Party (RP) during the 48-hour Post-Acute Care (PAC) meeting. Education will be provided in new hire orientation for any new Social Worker (SW) hired regarding the procedure for providing each admission with a copy of his/her baseline care plan. Systemic changes made to ensure that the deficient practice will not recur. The Social Worker (SW) will audit each admission for documentation that a copy of the baseline care plan was provided to the resident and/or the Responsible Party (RP) during the 48-hour Post-Acute Care (PAC) meeting. This audit will be conducted daily x 4 weeks then three times a week x 4 weeks then once a week x 4 weeks. Plans to monitor its performance to make sure that the solutions are sustained. The Social Worker (SW) will report the analysis of the baseline care plan delivery/documentation audit to the Quality Assurance Performance Improvement (QAPI) Committee monthly for review and revision x 3 months or until substantial compliance is achieved. Date of compliance: 11/21/22	

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 10/27/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEALTH-DURHAM	3100 ERWIN 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 655	Continued From page 62 assessed as cognitively intact. During an interview on 10/10/22 at 12:30 PM, Resident #92 stated he does not recollect having received care plan documentation provided to him after his admission to the facility. During an interview on 10/13/22 at 1:57 PM the Social Worker stated she had a baseline care plan meeting with the resident and resident family member in the presence of the Administrator. She indicated she was unsure if any documentation was provided to the resident or his family member. During an interview on 10/13/22 at 5:10 PM, the Administrator stated she and the Social Worker had a meet and greet meeting with the resident and the resident's family member when the resident was admitted to the facility. The Administrator indicated it was not a base line care plan meeting and no documentation was provided to the resident or the family member. The Administrator was unable to identity the staff responsible to conduct the baseline care plan meeting and provide documentation to resident or resident's responsible party. The Administrator stated the resident or resident's representative should be provided with the written summary of the baseline care plan and should be completed within 48 hours of admission to the facility.	F 655		
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.	F 657		11/21/22

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 10/27/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEALTH-DURHAM	3100 ERWIN 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 657	Continued From page 63 (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 resident interview, staff interviews, and record review the facility failed to the facility failed to allow the Resident the right to participate in care planning for 1 of 28 residents reviewed for care planning (Resident #43). Findings included: Resident # 43 admitted to the facility on 8/25/21 and had diagnoses including chronic congestive heart failure, atrial fibrillation, peripheral vascular disease, and chronic pain syndrome A review of Resident #43's comprehensive care revealed care plan last reviewed on 5/24/22.	F 657	Corrective action for the residents found to be affected by the deficient practice. Resident #43 was admitted to the facility on 08/25/2021 and readmitted on 10/21/2021. The Interdisciplinary Team (IDT) held a care plan meeting on 10/25/2022 with resident to review her current comprehensive care plan. Corrective action for other residents having the potential to be affected by the same deficient practice. The current Minimum Data Set (MDS)	

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 10/27/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEALTH-DURHAM	3100 ERWIN 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 657	Continued From page 64 A review of Resident #43's annual minimum data set (MDS) dated 8/8/22 revealed Resident was cognitively intact. During an interview with Resident #43 on 10/10/22 at 11:25 am it was indicated she has not had a care plan meeting since admitting to the facility in August 2021. Resident #43 indicated she would like to have a care plan meeting to go over her care. An interview was conducted with Administrator and MDS Regional Nurse on 10/13/22 at 12:58 pm and it was indicated they were re-structuring the care plan meetings since hiring new staff in the SW and MDS departments as they current process was not adequate. During an interview with the Social Worker (SW) on 0/13/22 at 1:58 pm it was indicated follow up interview she has not had a care plan meeting with the interdisciplinary team (IDT), but the disciplines would go in individually and have discussions regarding care and medications with residents/family. She indicated she was the only person in the department for a while and they recently have hired another SW and they have put a plan in place to conduct care plan meetings with the IDT. Social worker indicated Resident # 43 was on the list for this month for a care plan meeting. An interview was conducted on 10/13/22 at 5:06 pm with the Administrator and she indicated she expected the facility to have care plan meetings quarterly and as needed.	F 657	nurse began employment September 2022 and initiated the care plan review process to include resident and/or Responsible Party (RP) participation. As of 11/10/2022, the Minimum Data Set (MDS) nurses reviewed all residents for documentation of a comprehensive care plan meeting with the resident and/or Responsible Party (RP) and 23 of 92 have been done. The remaining residents will have a care plan meeting scheduled to review his/her care by 11/21/22. The Minimum Data Set (MDS) nurses and/or the Social Worker (SW) have completed and mailed care plan meeting letters to all residents and/or Responsible Party (RP) notifying them of scheduled care plan meeting date and time and/or care plans already scheduled by 11/21/2022. If by 11/21/22 the facility has not heard from the resident and/or Responsible Party (RP), the Minimum Data Set (MDS) nurses and/or the Social Worker (SW) will follow up with a phone call to schedule a care plan meeting. The Interdisciplinary Team is to review each care plan during the care plan meeting with the resident and/or Responsible Party (RP). Systemic changes made to ensure that the deficient practice will not recur. The Case Mix Coordinator will schedule the comprehensive care plan meeting for each resident as assigned quarterly, annually and with a significant change and	

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 10/27/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEALTH-DURHAM	3100 ERWIN 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 657	Continued From page 65	F 657	distribute the care plan letter invitation to the resident and/or Responsible Party (RP). The Case Mix Coordinator will discuss the assigned care plans daily during the Interdisciplinary Team (IDT) meeting. The Interdisciplinary Team (IDT) will review each care plan during the care plan meeting with the resident and/or the Responsible Party (RP). The Social Worker (SW) will review and document via a log all scheduled care plan meetings weekly x 4 weeks and then monthly x 3 months ensuring care plans are conducted quarterly, annually and with a significant change with the resident and/or Responsible Party (RP). In-servicing was conducted on 11/15/2022 with the Interdisciplinary Team (IDT) by the Regional Clinical Reimbursement Consultant (CRC) on the care plan meeting process to include mailing care plan invitation letters quarterly, annually and with a significant change and including the resident and/or Responsible Party (RP) participation of the comprehensive care plan. Plans to monitor its performance to make sure that the solutions are sustained. Results of the monitoring/log will be presented by the Social Worker (SW) to the Quality Assurance Performance Improvement (QAPI) Committee monthly for review and revision x 3 months or until substantial compliance is achieved. Date of compliance: 11/21/22	

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 10/27/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEALTH-DURHAM	3100 ERWIN 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 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) 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: Based on observations, staff interviews and record review the facility failed to assure resident's fingernails were trimmed for 1 of 7 residents dependent on staff for Activity of Daily Living (ADL) care (Resident #91). Findings included: Resident #91 was admitted to the facility on 9/19/22 with diagnoses that included Subluxation (an injury) of C1/C2 cervical (the neck) vertebrae (bone(s) in the spinal column), Chronic respiratory failure with hypoxia, Chronic obstructive pulmonary disease, and Cervical disc degeneration. Review of the Admission Minimum Data Set (MDS) assessment dated 9/19/22 revealed Resident #91 was assessed as cognitively intact. Resident #91 was assessed as requiring limited assistance with one-to-two-person assistance Activities of Daily Living (ADL) care. Review of the care plan dated 9/15/22 revealed Resident #91 was care planned for potential for ADL decline. Goal indicated the resident's ADL needs would be met and independence potential maximized within constraints of the disease. Interventions included providing assistance with ADL care as needed and encouraging the resident to do as much as possible.	F 677	Corrective action for the residents found to be affected by the deficient practice. Resident # 91 had his fingernails cleaned and trimmed on 10/12/2022 by a Certified Nurse Aide (CNA). Resident is not in the facility currently. Corrective action for other residents having the potential to be affected by the same deficient practice. All dependent residents have the potential to be affected by the alleged deficient practice. On 11/17/22, Director of Health Services (DHS), completed a 100% audit of all dependent residents to ensure fingernails are trimmed. 32 of 63 dependent residents were noted with fingernails needing to be trimmed and were trimmed on 11/17/22. Systemic changes made to ensure that the deficient practice will not recur. Education began on 11/17/22 by the Director of Health Services (DHS) and/or Nurse Managers for the Certified Nursing Assistants (CNA) and Licensed Nurses on ensuring dependent resident□s fingernails are trimmed accordingly. Education is to be completed by 11/21/22. Any Licensed	11/21/22

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 10/27/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEALTH-DURHAM	3100 ERWIN 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 677	Continued From page 67 During an observation on 10/10/22 at 10:51AM, Resident #91 was observed lying in bed. Observation of resident's fingers revealed resident with approximately one-inch-long fingernails (10 of 10 fingernails). There was black color debris under the nails. When the resident was asked if he liked his fingernails trimmed, Resident # 91 did not respond to surveyor's question. On 10/10/22 at 1:08 PM, Resident #91 was observed during lunch. Resident was eating his lunch in his room and was able to feed self. The lunch tray consisted of corn bread and fried okra as part of his meal. The resident was observed eating these foods with his hands. The resident's fingernails (10 of 10 fingernails) were observed with black color debris and had food particles under them. During an interview on 10/12/22 at 10:28 AM, Nurse Aide (NA) #6 indicated she was assigned to the resident. NA #6 further indicated Resident #91 required extensive to total assistance with one-person physical assist for ADL care. NA #6 The NA stated the residents' fingernails and toenails were trimmed after a shower or a bed bath. Unless the resident was a diabetic patient, when the assigned nurse would trim the fingernails and toenails of the resident. NA #6 further stated she had provided a bed bath to the resident and had not noticed the resident's fingernails to be long and dirty. NA #6 indicated the resident did not refuse care. She added the resident returned to the facility after hospitalization over the weekend. On 10/12/22 at 10:44 AM, Nurse #3 upon	F 677	Nurses and/or certified nursing assistants not completing education by 11/21/22 will be required to complete education prior to the start of his/her next scheduled shift. The Nurse managers, weekend manager and/or weekend nursing supervisor, or Director of Health Services (DHS) will audit 5 dependent residents for fingernails trimmed 3 times a week x 4 weeks, then two times a week x 4 weeks, then weekly x 1 month or until compliance is achieved. Plans to monitor its performance to make sure that the solutions are sustained. The Director of Health Services (DHS) will report the analysis of the trimming of fingernails audit to the Quality Assurance Performance Improvement (QAPI) Committee monthly for review and revision x 3 months or until substantial compliance is achieved. Date of compliance: 11/21/22	

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 10/27/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEALTH-DURHAM	3100 ERWIN 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 677	Continued From page 68 observation of resident's fingernails stated the resident's nails should have been trimmed when the resident was offered a bed bath or when offered a shower. Nurse #3 then asked the resident if he would like his fingernails to be trimmed and the resident responded "sure". Nurse #3 indicated she would ensure the resident's fingernails were trimmed and cleaned. Nurse #3 stated the resident was readmitted to the facility on 10/8/22 from the hospital. The resident had a decline in health and was placed under hospice care. During an interview on 10/12/22 at 11:00 AM, The Director of Nursing (DON), she indicated the resident's fingernails and toenails should be trimmed as needed, when the resident was offered a shower or a bed bath. She indicated unless the resident was a diabetic resident, the NA could trim residents' fingernails or toenails. If the resident was a diabetic, then the assigned nurse was responsible for trimming both fingernails and toenails. The DON stated the resident's fingernails should have been trimmed and cleaned by staff as needed. The resident could also be placed on the podiatrist list so that his toenails could be trimmed.	F 677		
F 684 SS=K	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered	F 684		11/21/22

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 10/27/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEALTH-DURHAM	3100 ERWIN 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 684	Continued From page 69 care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on record review, staff interviews, physician assistant and physician interviews, the facility failed to identify/assess a wound for 1 of 3 residents (Resident #293). Nurse #11 identified a wound on Resident's right leg on 7/27/22. There were no orders for wound care. From 7/27/22 to 8/12/22 Nurses failed to complete the weekly body observations that included wound observations and measurements. On 8/12/22 Nurse # 7 noted an open wound to posterior right leg with foul smelling odor with some bleeding and, Nurse #7 failed to address/communicate/report/document the condition/status/size/appearance of the wound. On 8/13/22 Resident #293's condition changed, and Resident #293 was hospitalized. Resident #293 required treatment for septicemia and osteomyelitis related to the right leg wound. Immediate Jeopardy began on 7/27/22 when Nurse #11 identified a wound to Resident's posterior right leg, and necessary care and services were not provided. The Immediate Jeopardy was removed on 10/22/22 when the facility provided an acceptable credible allegation of immediate jeopardy removal. The facility will remain out of compliance at a scope and severity E (not actual harm with potential for more than minimal harm that is not immediate jeopardy) to ensure monitoring and all staff have been in-serviced. Findings included: Resident #293 admitted to the facility on 6/8/22.	F 684	Corrective action for the residents found to be affected by the deficient practice. Resident #293 no longer resides in the facility. Corrective action for other residents having the potential to be affected by the same deficient practice. All residents have the potential to be affected by the alleged deficient practice. The Director of Health Services (DHS) initiated 100% body audits on all residents within the facility on 10/20/22. There were no new skin integrity issues identified by comparing the known (current) skin integrity (wounds) on the wound manager report, in the electric medical record, currently in house to the body audits completed by the nurses on 10/20-21/2022. The Director of Health Services (DHS) and/or Nurse Managers have reviewed the wound audit conducted on 10/20-21/22 and reviewed the documentation to ensure residents with skin impairments had an order for treatment to areas. The Director of Health Services (DHS) and Nurse Managers reviewed residents with skin impairments identified on their 10/20/22 and 10/21/22 body audits to ensure the resident had a treatment order in place, physician notification, and document of the condition/status/size/appearance of the wound.	

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 10/27/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEALTH-DURHAM	3100 ERWIN 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 684	Continued From page 70 A review of admission observation for Resident #293 dated 6/8/22 revealed no skin alterations. A review of Resident #293's June electronic medication record (EMAR) revealed no order for skin observations for the month of June. A review of the medical record revealed no documented weekly skin observations from July 2022 to August 2022. A review of Resident #293's July EMAR revealed an order dated for 7/15/22 to observe and examine Resident's skin from head to toe and complete accompanying observations. It was noted on the EMAR for 7/15/22 it was initialed by Nurse #7, on 7/22/22 by Nurse #10, and on 7/29/22 by Nurse #7, however there was no documentation to verify they were complete. During an interview with Nurse #10 on 10/13/22 at 12:45 pm, it was indicated she did not remember doing a skin observation on Resident #293 on 7/22/22. She indicated the skin observations should be documented in the computer. An interview with Nurse #7 was conducted on 10/13/22 at 1:43 pm, it was indicated she did not recall doing skin observations on Resident # 293 on 7/15/22 and 7/29/22. She further indicated when she did skin observations, she would sign off she completed the skin observation on the EMAR and document the skin observation in the computer. A review of Nursing progress note dated 7/27/22 at 7:24 pm by Nurse #11 read in part Resident #293 had an open wound to his right leg. No	F 684	The Director of Health Services (DHS) and/or Nurse Managers began education to the Nurses on 10/20/22 regarding weekly skin observations and documentation in the electronic health record of same. When a new skin impairment is noted, the Nurse will complete the wound documentation in the electronic medical record that includes description and measurement of area and contact the physician/physician extender for orders, regarding newly identified skin impairments and/or worsening skin impairments for wound treatment orders. This includes the observations and measurements are necessary as a monitoring tool to determine if there are any changes in the wound that would require a change in the treatment plan. The Clinical Competency Coordinator (CRC) was notified on 10/21/22 by the Licensed Nursing Home Administrator (LNHA) to add the skin observations and documentation in the electronic health record education to the nurse general orientation upon hire with emphasis that the nurse who identifies the skin integrity issue completes the wound documentation, physician notification, initiates treatment per physician order for new / changes in skin integrity. On 10/20/22 and 10/21/22 the Director of Health Services (DHS) and Nurse Managers educated the Certified Nursing Assistant (CNA) on daily skin checks during personal care. This education includes notification to the nurse of any skin impairment and/or new dressing noted on resident□s skin. The Certified	

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 10/27/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEALTH-DURHAM	3100 ERWIN 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 684	Continued From page 71 treatment orders were found. Wound was packed with normal saline, damp to dry sterile gauze, and covered with sterile gauze secured by kerlix. Resident tolerated well. Repositioned off right side following cleaning and linen change after bowel movement. An interview was made on 10/11/22 at 4:33 pm with NA #4, and she indicated she recalled working one night, (however could not recall the exact date) with Nurse #11 and reported to her about the wound to Resident's right leg and Nurse #11 put a bandage on it. During a telephone interview on 10/11/22 at 5:48 pm with Nurse #11 it was indicated on 7/27/22 she assisted NA #4 provide activities of daily living (ADL) care on Resident #293 and when they went to turn the Resident, she observed an open wound on Resident's right leg that was about 1/2 inch in diameter and 2 inches long. She indicated she cleaned the wound and put a dressing on it. She indicated she observed Resident's skin and did not see any other wounds on Resident. Nurse #11 indicated she reported the wound to Nurse #1 who was in the facility at the time, and Nurse #1 stated she would let the wound Physician know about the wound the next morning. Nurse #11 indicated she asked Nurse #1 if she wanted her to measure the wound or get orders and she stated Nurse #1 informed her she would take care of it and instructed her to put a dressing on the wound. On 10/11/22 at 3:21 pm an interview was conducted with Nurse #1, and she indicated Resident #293 had no skin concerns on admission. She indicated the floor nurses were responsible for performing skin assessments	F 684	Nursing Assistant (CNA) will obtain a paper body diagram at the beginning of their shift from the nursing station on each unit and maintain in their possession throughout the day. The Nursing assistant will utilize a body diagram for each resident daily during resident care, for nurse notification of skin integrity issues. The Certified Nursing Assistant (CNA) will circle the area of the body, on the body diagram, with the skin integrity issue with a pen / pencil and notify nurse of skin integrity issue. The Nurse will complete body observation on residents the Certified Nursing Assistants (CNA) have identified with new skin integrity issues and notify physician for treatment orders. The Clinical Competency Coordinator (CCC) was notified on 10/21/2022 by the Licensed Nursing Home Administrator (LNHA), to add the education of the Body diagrams and utilization of a body diagram for each resident daily for nurse notification of skin integrity issues to the general orientation of the Certified Nursing Assistant (CNA). Any Certified Nursing Assistant (CNA) will not be allowed to work after 10/21/22 until they receive the education of the Body diagrams and utilization of a body diagram for each resident daily for nurse notification of skin integrity issues. Systemic changes made to ensure that the deficient practice will not recur. On 10/21/22 The Director of Health Services (DHS) notified the Wound Nurse and the Nurse Practitioner (NP) to meet weekly to discuss and review all residents	

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 10/27/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEALTH-DURHAM	3100 ERWIN 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 684	Continued From page 72 weekly on the residents and to document any abnormal findings in the wound communication books located at each nurse's desk. Nurse #1 indicated she did not recall the conversation with Nurse #11. Resident #293's Quarterly minimum data set (MDS) dated 7/28/22 revealed cognition assessment was not assessed. Further review of the MDS revealed Resident #293 was able to make needs known and required extensive assistance with 1-person physical assist with bed mobility, toilet use, personal hygiene, bathing, and supervision with setup help with eating. Resident #293 had no wounds identified on this assessment. A review of August EMAR for Resident #293 revealed on 8/5/22 it was initialed by Nurse #2 Resident's skin observation was completed; however, no documentation was found to verify it was complete. On 10/13/22 at 3:30 pm an interview was conducted with Nurse #2, and it was indicated he did not remember doing a skin observation on Resident #293 on 8/5/22. He indicated he did not recall Resident having a wound. A review of care plan last revised on 8/12/22 revealed Resident #293 had a potential for impaired skin integrity related to decreased mobility, incontinence, and obesity. A goal was for Resident to remain free from development of pressure injury. The interventions included observe skin with daily care, report open, reddened, excoriated, sore areas to nurse, diet as ordered, report meal refusals to nurse, moisture barrier cream if indicated, provide peri care	F 684	with wounds and both parties will sign the weekly wound manager report. On 10/21/22 The Licensed Nursing Home Administrator (LNHA) notified the Director of Health Services (DHS) and/or Nursing Leadership to review the weekly skin observations (weekly focus observation), in the electronic medical record under observation section, to validate all areas identified have physician notification, treatments orders are written, wound is monitored for changes weekly for four weeks then monthly thereafter. Plans to monitor its performance to make sure that the solutions are sustained. The facility wound manager report will be brought to the monthly Quality Assurance Performance Improvement (QAPI) Committee meeting by the Director of Health Services for review and revision monthly x 3 months or until substantial compliance is achieved. Date of compliance: 11/21/22	

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 10/27/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEALTH-DURHAM	3100 ERWIN 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 684	Continued From page 73	F 684		

following incontinent episodes, provide turning/positioning assistance with care rounds and as needed, use pillows as tolerated/indicated for offloading.

An interview was made on 10/11/22 at 4:33 pm with NA #4 and she indicated she was assigned to Resident # 293 on 8/12/22. She indicated when she came to work on the 11pm shift on 8/12/22 and while doing her rounds she went to check Resident and saw drainage on his sheets and noted a bandage on his right leg. She indicated she reported her findings to Nurse #7.

A review of Nursing progress note dated 8/12/22 at 10:00 pm by Nurse #7 read in part Resident # 293 was found to have an open wound on right leg (calf) with a foul-smelling odor, and some bleeding noted. Observations left in wound care and Physician book for further evaluation.

On 10/11/22 at 4:10 pm an interview was conducted with Nurse #7, and she indicated she was the Nurse that worked on 8/12/22. She indicated it was reported by the NA #4 assigned to Resident # 293 that he had blood on his sheets. She indicated she went to check Resident and observed a bandage wrapped on his right leg. Nurse #7 indicated the bandage had no date on it and when she removed the bandage, she observed wound to right calf that had bloody, greenish drainage. She indicated she observed the wound to be to the bone. Nurse #7 indicated it was the end of her shift and she had to leave.

During a follow up interview with Nurse #7 it was clarified that on 8/12/22 she found Resident #293 with a dressing on Resident's right calf area, and it had no date, the dressing was soiled, and a foul

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 10/27/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEALTH-DURHAM	3100 ERWIN 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 684	Continued From page 74	F 684		

smelling bloody greenish colored drainage was on the sheet.

Review of electronic medical record revealed on 8/12/22 a SBAR (situation, background, assessment, resident evaluation) completed by Nurse #7 communication form read in part a change in condition symptoms or signs observed was wound to right leg, and it started on 8/12/22. Wound was evaluated to have drainage and foul smell. The responsible party (RP) was notified on 8/13/22 at 4:50 pm, and Physician notified.

A review of Nursing progress note dated 8/13/22 at 1:28 pm by Nurse #7 read in part, "Spoke to Physician, and received an order for x-ray of wound to right leg due to pain and to rule out osteomyelitis. The orders were transcribed for Doxycycline (an antibiotic to treat bacterial infections) 200 milligrams (mg) by mouth twice a day for 7 days, and wound care orders for Dakin's solution and Santyl ointment daily. Also received lab orders for a Complete blood count and basic metabolic panel for Monday 8/15/22. The RP was notified."

A review of Nursing progress note dated 8/13/22 at 6:37 pm by Nurse #7 read in part Resident #293 sent to emergency department for further evaluation due to wound on right leg and uncontrolled pain per Physician request. Director of Nursing (DON) and RP notified. Temperature (T) was 97.3, pulse (P) was 134, respirations (R) was 18, blood pressure (B/P) was 120/72, and oxygen level was 100% on room air. X-ray was done and results of right leg findings suggest further assessment with a computerized tomography (CT)/magnetic resonance imaging (MRI). The results were left in the Physician book

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 10/27/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEALTH-DURHAM	3100 ERWIN 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 684	Continued From page 75	F 684		

and reported to floor nurse.

A review of physician orders revealed on 8/13/22 orders received to clean right leg with normal saline pat dry, apply Dakin's solution, moistened gauze, and cover with calcium alginate and dry dressing once daily.

On 10/11/22 at 3:21 pm an interview was conducted with Nurse #1, and she indicated she was called on 8/13/22 and Nurse #7 informed her of Resident #293's wound to right leg. She indicated she informed Nurse #7 to call the Physician.

On 10/11/22 at 4:10 pm an interview was conducted with Nurse #7, and she indicated she returned to work on 8/13/22 and went to check on the Resident and then went and called the Physician. She indicated she received orders for x-ray of right leg, antibiotics, and blood work. She stated she went back into Resident's room later in the shift and Resident was in pain despite receiving pain medication and she called the Physician back and received orders to send Resident to hospital for evaluation of wound to rule out osteomyelitis. She further indicated she called the DON and RP to inform them of the above information.

During an interview on 10/12/22 at 1:38 pm with Nurse #9, it was indicated she was the Nurse assigned to Resident #293 on 8/13/22 and helped Nurse #7 send Resident #293 to the hospital. Nurse #9 also indicated she was assigned to Resident #293 on 8/12/22. She indicated she received report of the wound from Nurse #7 and Nurse #7 stated she had worked with the Resident the night before and she was going to

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 10/27/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEALTH-DURHAM	3100 ERWIN 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 684	Continued From page 76	F 684		

notify the Physician because she had found the wound the evening before. She indicated she was informed by Nurse #7 she had received an order on 8/13/22 to send Resident to the hospital for evaluation. Nurse # 9 indicated she had not seen a wound on the Resident prior to 8/13/22 and had only observed the wound on 8/13/22 with Nurse #7 while she did the treatment to the wound. She indicated she observed the wound on Residents right calf, and she could see the muscle. She indicated it had a small amount of bloody drainage on the bandage. She indicated she did not recall doing a skin observation on Resident #293. She indicated the skin observation was on the EMAR and was to be completed weekly. She also indicated they were supposed to sign off on the EMAR once the observation of the skin was completed and document in the observation section in the computer. Nurse #9 indicated she did not recall Resident #293 having any wounds.

On 10/12/22 at 10:28 am a telephone interview was conducted with the primary Physician of Resident #293, and he indicated as of 9/17/22, he no longer worked at the facility and no longer had access to Resident #293' s records. He indicated he recalled the call from Nurse #7 on 8/13/22 concerning Resident's wound. He indicated he gave Nurse #7 orders, (however did not remember exactly what orders), and eventually sent Resident to the hospital for further evaluation. He indicated he did not recall anything further about Resident #293.

During an interview on 10/11/22 at 4:04 pm with NA #10 it was indicated she worked with Resident #293 on occasion and last worked with Resident in July. She indicated Resident would barely let

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 10/27/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEALTH-DURHAM	3100 ERWIN 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 684	Continued From page 77	F 684		

anyone touch him, was difficult to turn, would often refuse to be turned, bathed, or touched. She indicated she notified the nurses when Resident refused care. NA #10 indicated Resident #293 had a bandage on back of his leg and buttocks. She indicated she did not know what was under the bandages.

A telephone interview was conducted on 10/12/22 at 10:15 am with the Physician Assistant (PA) and it was indicated she longer worked in the facility and did not have access to her notes. She indicated she did not recall personally seeing any wounds on Resident #293.

During an interview on 10/13/22 at 1:06 pm with the DON she indicated the process for when a wound was identified was to notify the Physician and RP, get an order for treatment of the wound from the Physician and transcribe the order in the computer. She also indicated the Nursing staff should put any new wounds identified in the wound communication book to notify the wound nurse. She indicated she reviews the activity report in the computer and 24-hour report to see if anything was reported of any abnormal findings. She indicated she was not aware of this incident until 8/13/22 and after this occurred, she did a performance improvement plan (PIP) which included education to Nursing staff on completing body audits, skin assessments in a timely manner, to ensure residents are provided quality care to promote optimum outcomes and decrease the occurrence of new acquired wounds, education of doing skin observations, and they did wound checks on the residents on 8/24/22 as part of the PIP.

During an interview on 10/13/22 at 5:10 pm with

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 10/27/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEALTH-DURHAM	3100 ERWIN 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 684	Continued From page 78	F 684		

the Administrator it was indicated it was her expectation when a new wound was identified was to notify the Physician, get orders to treat the wound, and notify the family. She further indicated it was her expectation skin observations were to be done weekly and documented in the computer.

A review of hospital emergency department records read in part Resident #293 presented to hospital on 8/13/22 ill-appearing, in acute distress, had diffuse pain, and had a wound to the right lower leg, that was covered. Resident's vital signs were as follows T-99.6, P-119, R-20, B/P-105/63. On exam it was noted Resident meet systemic inflammatory response (SIRS)criteria and was started on intravenous fluids and antibiotics. On 8/15/22 MRI of Resident #293's right lower leg was done, and results revealed MRI along posterolateral upper leg with sinus tract to bone with osteomyelitis.

The Administrator was notified of immediate jeopardy on 10/20/22 at 6:07 pm.

On 10/22/22 the facility provided the following credible allegation of Immediate Jeopardy removal:

Identify those recipients who have suffered, or are likely to suffer, a serious adverse outcome because of the noncompliance.

Resident #293 no longer resides in the facility. On 7/27/22 Nurse #11 noted wound to posterior right lower leg, applied dressing but failed to notify physician, her supervisor and did not report off to on-coming nursing staff. From 7/27/22 to 8/12/22 Nurses failed to complete the weekly body

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 10/27/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEALTH-DURHAM	3100 ERWIN 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 684	Continued From page 79	F 684		

observations that included wound observation and measurements of the resident's skin integrity status for this same period of time. On 8/12/22 Nurse noted an open wound to posterior right lower leg with foul smelling odor with some bleeding noted, the Nurse placed a written communication in the Physician and Wound Care book for further evaluation and failed to address/communicate/report/document the condition/status/size/appearance of the wound.

On 8/13/22 nurse spoke with physician and new orders were obtained for antibiotics and wound care orders with an x-ray to right leg. X-ray dated 8/13/22 identified lytic lesion, and resident #293 was transferred to the Hospital Emergency Room. The Residents admitting diagnosis to the Hospital was rule out osteomyelitis. Nurse #11 is no longer employed by this facility.

The Director of Health Services initiated 100% body audits on all residents within the facility on 10/20/22. There were no new skin integrity issues identified by comparing the known (current) skin integrity (wounds) on the wound manager report, in the electric medical record, currently in house to the body audits completed by the nurses on 10/20-21/2022.

All residents have the potential to suffer a serious adverse outcome as a result of the failure to address/communicate/report/document the identification/condition/status/size/appearance of the wound on a weekly basis.

Actions taken by the facility to alter to alter the process or system failure to prevent a serious adverse outcome from reoccurring and when the action will be completed.

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 10/27/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEALTH-DURHAM	3100 ERWIN 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 684	Continued From page 80	F 684		

The Director of Health Services and/or Nurse Managers have reviewed the wound audit conducted on 10/20-21/22 and reviewed the documentation to ensure residents with skin impairments had an order for treatment to areas. The Director of Health Services and Nurse Managers reviewed residents with skin impairments identified on their 10/20/22 and 10/21/22 body audits to ensure the resident had a treatment order in place, physician notification, and document of the condition/status/size/appearance of the wound.

The Director of Health Services and/or Nurse Managers began education to the Nurses on 10/20/22 regarding weekly skin observations and documentation in the electronic health record of same. When a new skin impairment is noted, the Nurse will complete the wound documentation in the electronic medical record that includes description and measurement of area and contact the physician/physician extender for orders, regarding newly identified skin impairments and/or worsening skin impairments for wound treatment orders. This includes the observations and measurements are necessary as a monitoring tool to determine if there are any changes in the wound that would require a change in the treatment plan.

The Clinical Competency Coordinator was notified on 10/21/22 by the Licensed Nursing Home Administrator to add the skin observations and documentation in the electronic health record education to the Nurse general orientation upon hire with emphasis that the nurse who identifies the skin integrity issue completes the wound documentation, physician notification, initiates

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 10/27/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEALTH-DURHAM	3100 ERWIN 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 684	Continued From page 81	F 684		

treatment per physician order for new / changes in skin integrity. Any Nurse will not be allowed to work after 10/21/22 until they receive the education.

On 10/21/22 The Director of Health Services notified the Wound Nurse and the Nurse Practitioner to meet weekly to discuss and review all residents with wounds.

On 10/20/22 and 10/21/22 the Director of Health Services and Nurse Managers educated the Certified Nursing Assistants on daily skin checks during personal care. This education includes notification to the nurse of any skin impairment and/or new dressing noted on resident's skin. The Certified Nursing Assistant will obtain a paper body diagram at the beginning of their shift from the nursing station on each unit and maintain in their possession throughout the day. The Nursing assistant will utilize a body diagram for each resident daily during resident care, for nurse notification of skin integrity issues. The Certified Nursing Assistant will circle the area of the body, on the body diagram, with the skin integrity issue with a pen / pencil and notify nurse regarding skin integrity issue. The Nurse will complete body observation on residents the certified nursing assistants have identified with new skin integrity issues and notify physician for treatment orders. The Clinical Competency Coordinator was notified on 10/21/2022 by the Licensed Nursing Home Administrator, to add the education regarding the Body diagrams and utilization of a body diagram for each resident daily for nurse notification of skin integrity issues to the general orientation of the Certified Nursing Assistant. Any Certified Nursing Assistant will not be allowed to work after 10/21/22 until they receive the

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 10/27/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEALTH-DURHAM	3100 ERWIN 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 684	Continued From page 82	F 684		

education regarding the Body diagrams and utilization of a body diagram for each resident daily for nurse notification of skin integrity issues.

The Clinical Competency Coordinator/RN was notified by the Licensed Nursing Home Administrator on 10/21/22, that they are responsible for ensuring education is completed prior to the start of any Licensed Nurse and/or Certified Nursing Assistant working the floor after 10/21/22.

On 10/21/22 The Licensed Nursing Home Administrator notified the Director of Health Services and/or Nursing Leadership to review the weekly skin observations (weekly focus observation), in the electronic medical record under observation section, to validate all areas identified have physician notification, treatments orders are written, wound is monitored for changes weekly for four weeks then monthly thereafter.

Date when corrective action will be completed: 10/22/22.

On 10/27/22 the credible allegation of immediate jeopardy was validated by onsite verification. Record reviews and interviews were conducted which verified the audits were completed. Interview with the Minimum data set (MDS) Nurse revealed skin assessments were completed daily. Nurse Assistants (NA) complete a skin audit daily and if there is an issue with a resident's skin, the NA notifies the charge nurse who then documents, notifies the Physician, and obtains order if needed. MDS Nurse also indicated they notify the responsible party (RP)/family.

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 10/27/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEALTH-DURHAM	3100 ERWIN 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 684	Continued From page 83	F 684		

A review of the audits revealed all residents' orders were reviewed and any discrepancies were corrected.

A review of the education training revealed education was provided to staff as stated in the credible allegation.

Interview was conducted with staff on 10/27/2022 at 10:18 am who indicated they had been educated by facility that NAs are to report any issues with skin to charge nurse. The Nurse then assesses resident's skin and documents, notifies wound nurse, Physician and RP/family.

Interview was conducted with staff on 10/27/2022 at 10:22 am who indicated knowledge of completing a daily body audit sheet for any issues with a resident's skin and notifying the charge nurse if observes any skin issues.

Interview was conducted with Wound Nurse on 10/27/2022 at 11:12 am who indicated NAs had to do full skin audits on every shift. If identified any areas, including redness, they notify the nurse and audits were turned into the nurse who reviews and signs off the skin audit and skin audit given to DON. Nurses review audit sheets and if anything observed, they are to do a SBAR, assess wound, inform Physician and RP, and transcribe any order in computer. Nurses put information in wound communication book and treatment nurse checks the book every day for any new areas on skin that were identified.

Interviews with staff revealed that education was provided.

The immediate jeopardy removal date of

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 10/27/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEALTH-DURHAM	3100 ERWIN 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 684	Continued From page 84 10/22/2022 was validated on 10/27/22.	F 684		
F 686 SS=G	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, Nurse Practitioner interview, and record review, the facility failed to provide the necessary care and services for a pressure ulcer including failure to complete weekly skin assessments and treatments as ordered. The facility failed to identify a pressure ulcer before it was significant enough to have depth (7/10/22). Three days later the wound was with slough, debris, and necrosis. On 8/3/22, the wound was assessed to be deteriorated and a stage three. The wound continued to deteriorate. On 10/11/22, a nurse detected odor in the wound and did not seek medical attention. This was for 1 of 3 residents reviewed for pressure ulcer prevention and treatment (Resident #83). The findings included:	F 686	Corrective action for the residents found to be affected by the deficient practice. Resident #83 no longer resides in the facility. Corrective action for other residents having the potential to be affected by the same deficient practice. All residents have the potential to be affected by the alleged deficient practice. The Director of Health Services (DHS) initiated 100% body audits on all residents within the facility on 10/20/22. There were no new skin integrity issues identified by comparing the known (current) skin	11/21/22

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 10/27/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEALTH-DURHAM	3100 ERWIN 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 686	Continued From page 85 Resident #83 was initially admitted to the facility on 3/25/08 and readmitted to the facility on 10/7/22. Diagnoses included sacral pressure ulcer, type two diabetes mellitus without complications, left and right leg above knee amputations, and muscle weakness. The quarterly minimum data set (MDS) dated 7/5/22 revealed Resident #83 was at risk for pressure ulcer development. She had no pressure ulcers at the time of assessment. Weekly skin assessment documentation was not provided. A wound note by Nurse #1 dated 7/10/22 revealed Resident #83 had a new sacral wound, and she was started on supplements to promote wound healing. The wound had a light amount of exudate (drainage) and was noted to have the following measurements: length 2.5 centimeters (cm), width 4.5 cm, and depth 0.3 cm. A physician order for wound treatment dated 7/10/22 stated clean sacral wound with normal saline or wound cleanser and pat dry. Apply Medi honey to the wound bed and cover with a dry dressing once daily. Review of a wound note by Nurse Practitioner (NP) #1 dated 7/13/22 revealed Resident #83 was assessed for a new sacral wound. Resident #83 required extensive staff assistance with mobility, followed some commands, and was not combative. NP #1 indicated the wound exhibited some yellow slough and debris. Therefore, depth of the wound was estimated to be 0.4 cm. The length was measured to be 2.2 cm and the width	F 686	integrity (wounds) on the wound manager report, in the electric medical record, currently in house to the body audits completed by the nurses on 10/20-21/2022. The Director of Health Services (DHS) and/or Nurse Managers have reviewed the wound audit conducted on 10/20-21/22 and reviewed the documentation to ensure residents with skin impairments had an order for treatment to areas. The Director of Health Services (DHS) and Nurse Managers reviewed residents with skin impairments identified on their 10/20/22 and 10/21/22 body audits to ensure the resident had a treatment order in place, physician notification, and document of the condition/status/size/appearance of the wound. The Director of Health Services (DHS) and/or Nurse Managers began education to the Nurses on 10/20/22 on weekly skin observations and documentation in the electronic health record of same. When a new skin impairment is noted, the Nurse will complete the wound documentation in the electronic medical record that includes description and measurement of area and contact the physician/physician extender for orders, newly identified skin impairments and/or worsening skin impairments for wound treatment orders. This includes the observations and measurements are necessary as a monitoring tool to determine if there are any changes in the wound that would	

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 10/27/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEALTH-DURHAM	3100 ERWIN 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 686	Continued From page 86	F 686		

was 5.8 cm. There was a presence of necrotic tissue (tissue death) and a mild amount of drainage noted. The plan was to apply topical Medi honey gel that would promote debridement. NP #1 recommended use of an air mattress to promote optimal offloading of the resident's weight on her sacrum, as well as repositioning. The NP indicated the origin of the pressure ulcer as in-house and marked "no" for unavoidable.

Review of a wound note by NP #1 dated 8/3/22 indicated the sacral wound had a slight deterioration in appearance. It was noted to be a stage three pressure injury and measured length 1.5 cm, width 3.5 cm, and depth 0.2 cm. There was a mild amount of exudate, and a debridement was performed. It was noted that offloading weight should continue as well as nutritional support measures.

Resident #83's care plan, revised on 8/4/22, revealed a focus area for pressure ulcers. The goal was for Resident #83's pressure ulcer to heal without complications. Interventions included monitored pressure ulcer for signs and symptoms of infection, informed the physician or nurse practitioner of any changes, and provided treatments as ordered.

A wound note by NP #1 dated 8/10/22 indicated Resident #83's wound was deteriorating. The was a mild amount of exudate and measurements were as follows: length 6cm, width 5 cm, and depth 0.2 cm. The resident was noted to be dependent for transfers and urinary diversion with catheter placement was addressed.

A wound note by NP #1 dated 8/24/22 indicated Resident #83's wound healing demonstrated

require a change in the treatment plan.

The Clinical Competency Coordinator (CCC) was notified on 10/21/22 by the Licensed Nursing Home Administrator (LNHA) to add the skin observations and documentation in the electronic health record education to the Nurse general orientation upon hire with emphasis that the nurse who identifies the skin integrity issue completes the wound documentation, physician notification, initiates treatment per physician order for new / changes in skin integrity.

On 10/20/22 and 10/21/22 the Director of Health Services (DHS) and Nurse Managers educated the Certified Nursing Assistant (CNA) on daily skin checks during personal care. This education includes notification to the nurse of any skin impairment and/or new dressing noted on resident□s skin. The Certified Nursing Assistant (CAN) will obtain a paper body diagram at the beginning of their shift from the nursing station on each unit and maintain in their possession throughout the day. The Certified Nursing Assistant (CAN) will utilize a body diagram for each resident daily during resident care, for nurse notification of skin integrity issues. The Certified Nursing Assistant (CNA) will circle the area of the body, on the body diagram, with the skin integrity issue with a pen / pencil and notify of skin integrity issue. The Nurse will complete body observations on residents the Certified Nursing Assistant (CNA) have identified with new skin integrity issues

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 10/27/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEALTH-DURHAM	3100 ERWIN 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 686	Continued From page 87 slight deterioration from previous assessments. There was a mild amount of exudate, and the wound measurements were as follows: length 6.5 cm, width 5 cm, and depth 0.2 cm. NP #1 indicated Resident #83 remained dependent for positioning and transfers. Review of MDS documentation revealed Resident #83 was hospitalized from 9/1/22 - 9/5/22. A physician's order dated 9/5/22 revealed Resident #83 was ordered a low air loss mattress for her stage three pressure ulcer. The quarterly MDS dated 9/12/22 revealed Resident #83 was severely cognitively impaired. She required extensive staff assistance with bed mobility and had a stage three unhealed pressure ulcer. She was noted to receive pressure ulcer care and a pressure reducing device for the bed. The resident weighed 179 pounds. Review of a wound note by NP #1 dated 9/14/22 indicated the wound was again deteriorating, but stable in appearance. There was a mild amount of exudate, and the measurements were as follows: length 6.5 cm, width 7 cm, and depth 0.2 cm. It was noted that there was a lack of significant improvement and treatments were changed. A physician's order dated 9/14/22 for wound care revealed cleanse sacral wound with wound cleanser, pat dry, apply two hydrocolloid dressings, and secure with bordered gauze three times a week. A wound note by Nurse #1 dated 9/21/22 revealed Resident #83 had a stage three	F 686	and notify physician for treatment orders. The Clinical Competency Coordinator (CCC) was notified on 10/21/2022 by the Licensed Nursing Home Administrator (LNHA), to add the education on the Body diagrams and utilization of a body diagram for each resident daily for nurse notification of skin integrity issues to the general orientation of the Certified Nursing Assistant (CNA). Any Certified Nursing Assistant (CNA) will not be allowed to work after 10/21/22 until they receive the education on the Body diagrams and utilization of a body diagram for each resident daily for nurse notification of skin integrity issues. Systemic changes made to ensure that the deficient practice will not recur. On 10/21/22 The Director of Health Services (DHS) notified the Wound Nurse and the Nurse Practitioner (NP) to meet weekly to discuss and review all residents with wounds. On 10/21/22 The Licensed Nursing Home Administrator (LNHA) notified the Director of Health Services (DHS) and/or Nursing Leadership to review the weekly skin observations (weekly focus observation), in the electronic medical record under observation section, to validate all areas identified have physician notification, treatments orders are written, wound is monitored for changes weekly for four weeks then monthly thereafter.	

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 10/27/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEALTH-DURHAM	3100 ERWIN 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 686	Continued From page 88 pressure ulcer, and treatments would be continued. There was a moderate amount of drainage and measurements were as follows: length 4.5 cm, width 3 cm, and depth 0.3 cm. A Physical Therapy (PT) progress note dated 9/26/22 revealed Resident #83 was noted to be supine in bed. She participated in rolling to her side and was repositioned with pillows to promote offloading of weight. There was a large red patch surrounding the sacral wound and the resident had a soiled brief. The area was assessed by applying pressure with the nail tip to surrounding tissues with no response from the resident. It was unable to be determined if this was due to confusion or poor sensitivity. A PT progress note dated 9/27/22 revealed Resident #83 was noted to be supine in bed. The resident participated in rolling to her side and was repositioned with pillows to promote offloading of weight. There was increased redness around the sacral wound and the therapist questioned Resident #83's sensation. A physician's order dated 9/28/22 revealed sacral wound care daily and as needed for soiled or loose dressing. The order further indicated to cleanse the wound with wound cleanser, pat dry, and pack the cavity with Dakin's solution moist gauze. The wound was to be covered with a dry dressing. There was not an order for calcium alginate. Review of a wound note by NP #1 dated 9/28/22 indicated the sacral wound was larger when assessed and it was deteriorating. It was evaluated to have changed from a stage three to stage four pressure ulcer. NP #1 suggested	F 686	Plans to monitor its performance to make sure that the solutions are sustained. The facility wound manager report will be brought to the monthly Quality Assurance Performance Improvement (QAPI) Committee meeting by the Director of Health Services (DHS) for review and revision monthly x 3 months or until substantial compliance is achieved. Date of compliance: 11/21/22	

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 10/27/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEALTH-DURHAM	3100 ERWIN 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 686	Continued From page 89	F 686		

nurses utilized a wedge pillow to optimize offloading considering Resident #83's immobility and body habitus. There was a mild amount of drainage and an increase in necrotic tissue was present. A debridement was performed, and the wound measurements were as follows: length 5 cm, width 4cm, and depth 1 cm.

A PT progress note dated 9/28/22 revealed Resident #83 was noted to be supine in bed. She complained of back pain and participated in the PT session. Resident #83 stated she felt better after she was repositioned with a pillow to promote offloading of weight.

A wound note by Nurse #1 dated 9/28/22 revealed Resident #83 had a stage four pressure ulcer with moderate drainage. There was necrotic tissue present, and the following measurements were documented: length 5cm, width 4 cm, and depth 1 cm. Treatment orders included Dakin's solution daily.

A PT note dated 9/29/22 revealed Resident #83 was repositioned to her side at the end of the session for optimal wound pressure relief. Skin around the wound was noted to be red.

Review of documentation revealed Resident #83 was hospitalized from 10/1/22 - 10/6/22.

The medication administration record (MAR) dated 10/1/22 - 10/12/22 revealed Resident #83 was in the facility 10/7/22 - 10/12/22. Wound care was not documented on 10/8/22.

An observation on 10/10/22 11:42 AM revealed Resident #83 was in bed lying on her back.

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 10/27/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEALTH-DURHAM	3100 ERWIN 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 686	Continued From page 90	F 686		

An observation on 10/10/22 1:20 PM revealed Resident #83 was in bed with a pillow under her right hip.

An observation on 10/10/22 at 4:00 PM revealed the resident was in bed lying on her back.

An interview was conducted with Nurse #8 on 10/11/22 at 3:17 PM. Nurse #8 stated Resident #83 developed a pressure ulcer in July 2022 and received dressing changes daily, unless she refused care. The treatment nurse typically performed wound care, but nurses were responsible when the treatment nurse was absent.

During an observation on 10/11/22 at 3:55 PM, Nurse #7 was observed providing pressure ulcer care for Resident #83. The resident had a pillow under her right hip. Dressing supplies and cleansing solution were placed on the resident's bedside table. Resident #83's sacral dressing had an unreadable (smeared) date and was wet with brown exudate. Nurse #7 removed the dressing and commented on the strong presence of an odor from the wound. Nurse #7 cleansed the wound with Dakin's solution-soaked gauze, packed the wound with calcium alginate, and applied a foam dressing. Resident #83's air mattress was set to normal pressure for a weight of 350 pounds. Resident #83 did not have a catheter at the time of the observation.

During an interview with Nurse #7 on 10/11/22 at 3:55 PM, she stated she checked physician's orders before providing pressure ulcer care. She did not know who was responsible for setting up Resident #83's air mattress and was not sure of the last time she provided pressure ulcer care for

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 10/27/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEALTH-DURHAM	3100 ERWIN 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 686	Continued From page 91	F 686		

Resident #83. There was no odor when she last performed wound care.

An interview was conducted with NA#9 on 10/11/22 at 3:55 PM. He stated Resident #83 was mostly calm. She received incontinence care as needed. If the resident's dressing was loose or soiled, he would notify the nurse.

An interview was conducted with Nurse #1 on 10/11/22 at 4:03 PM. She stated Resident #83 developed a pressure ulcer in July 2022 after going to the hospital. At the time of the resident's return, she had a small red area on her back. About a week later, the area was open, it was assessed, and treatments were ordered including dressing changes and an air mattress. Nurse #1 further explained nurses should adjust the settings on the air mattress. Nurse #1 indicated the air mattress should not be set at 350 pounds for Resident #83. Resident #83 has been hospitalized several times causing interruptions in treatments. Nurse #1 last saw Resident #83 two weeks ago.

During an interview with NA #4 on 10/11/22 at 4:32 PM, she stated Resident #83 did not like to lie flat. The NA stated Resident #83 was turned and repositioned every 2 hours.

An observation on 10/12/22 at 7:34 AM revealed Resident #83 was in bed lying on her back. Appeared calm when staff were engaging with her. The air mattress was set to 160/200-pound setting, normal pressure.

An interview and observation of care were conducted with NP #1 on 10/12/22 at 8:05 AM. NP #1 stated Resident #83 had recently been

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 10/27/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEALTH-DURHAM	3100 ERWIN 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 686	Continued From page 92	F 686		

hospitalized. She indicated pressure settings on the air mattress should reflect the resident's weight to promote optimal wound healing. NP #1 assessed the wound and determined the treatment with Dakin's solution should continue. Nurse #1 was present and noted there was some odor when the dressing was removed. NP #1 had not been notified of an odor from the previous day. The NP was unsure if the wound had deteriorated and stated she would need to review previous notes. NP #1 indicated physical therapy would see the resident to help keep her off her back and to reduce pressure. Resident # 83 was cooperative with the care that was provided and positioned on her back after the pressure ulcer assessment and treatment was completed.

An observation on 10/12/22 at 10:50 AM revealed Resident #83 was in bed lying on her back with the head of the bed slightly elevated.

During a follow up interview on 10/12/22 at 12:45 PM, NP #1 stated she was unsure if the wound had deteriorated since her last assessment, and she would need to review previous notes. NP #1 indicated Resident #83's pressure ulcer had been assessed by the hospital's general surgeon and infection preventionist during her recent hospitalization (10/1/22 - 10/6/22). It was not infected at the time of that assessment and surgical debridement was not needed.

An observation on 10/12/22 at 1:17 PM revealed Resident #83 was in bed lying on her back with the head of the bed slightly elevated.

An observation on 10/12/22 at 3:00 PM revealed Resident #83 was in bed lying on her back with the head of the bed slightly elevated.

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 10/27/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEALTH-DURHAM	3100 ERWIN 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 686	Continued From page 93 During an interview with nurse aide (NA) #2 on 10/12/22 at 3:00 PM, she stated she turned resident #83 during a bath before lunch and returned her to her back. NA #2 stated Resident #83 did not want a pillow under her. An observation on 10/13/22 at 9:58 AM revealed Resident #83 was lying on her back with the head of the bed slightly elevated. An interview was conducted with Physical Therapist (PT) #1 on 10/13/22 at 11:30 AM. She stated she received a referral to evaluate Resident #83's stage four pressure ulcer. She would assess the resident for wound healing modalities and bed mobility for optimal relief of pressure area. PT #1 indicated she had seen the pressure ulcer earlier in the day and stated it appeared worse than the last time she saw it. Resident #83 had not rejected any treatments that were provided in the past. An observation on 10/13/22 at 12:15 PM revealed Resident #83 was lying in bed on her back. During an interview with the Director of Nursing (DON) and a follow up interview with Nurse #1 on 10/13/22 at 12:23 PM, the DON stated nurses should provide pressure ulcer care as ordered. The DON and Nurse #1 confirmed nurses should verify settings on air mattress beds. During an interview with the Administrator on 10/13/22 at 5:07 PM, she stated wound care should be provided as ordered and bed settings should be correct and accurate.	F 686		
F 759 SS=D	Free of Medication Error Rts 5 Prcnt or More	F 759		11/21/22

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 10/27/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEALTH-DURHAM	3100 ERWIN 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 759	Continued From page 94 CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, and record review, the facility failed to have a medication error rate of less than 5% as evidenced by 2 medication errors out of 30 opportunities, resulting in a medication error rate of 6.6% for 1 of 4 residents (Resident #40) observed during medication pass. The findings included: 1. On 10/12/21 at 8:06 AM, Nurse #8 was observed as she prepared medications for administration via a gastrostomy tube (G-Tube) to Resident #40. The medications included, in part: 2 milliliters (ml) of 250 milligrams (mg) / 5 ml gabapentin (an antiseizure medication) put into a separate medication (med) cup with approximately 5 ml water and 2.5 ml of 5 mg / 5 ml oxycodone (an opioid pain medication) also put into a separate med cup with approximately 5 ml water. The medications prepared for administration also included: one - 6.25 milligrams (mg) tablet of carvedilol (an anti-hypertensive medication); one - 20 mg tablet of famotidine (a medication used to treat gastro-esophageal reflux disease); and one - 1 mg tablet of glycopyrrolate (a medication used to reduce secretions). Nurse #8 was observed as she crushed the tablets together, placed them in a medication cup, then added approximately 10	F 759	Corrective action for the residents found to be affected by the deficient practice. Nurse #8 was immediately in-serviced on administration of medications via a g-tube and Levemir FlexTouch pen when made aware of medication errors. On 10/26/22 the Pharmacy Consultant observed a medication pass for five residents, totaling 25 medications administered by Nurse #8. There were no identified issues related to the cited deficiency. Corrective action for other residents having the potential to be affected by the same deficient practice. All residents receiving medications via a gastrostomy tube (g-tube) and Levemir FlexTouch pen have the potential to be at risk for the alleged deficiency. All licensed nurses have been in-serviced by the Director of Health Services (DHS) and/or the Clinical Competency Coordinator (CCC) on following the medication administration of a Levemir FlexTouch pen and medication	

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 10/27/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEALTH-DURHAM	3100 ERWIN 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 759	Continued From page 95 ml of water into the med cup to dissolve the crushed tablets. Nurse #8 was observed as she brought the medications into Resident #40's room for administration on 10/12/21 at 8:25 AM. The nurse connected a syringe to the resident's G-tube and first poured the oxycodone mixed with water into the syringe followed by the gabapentin mixed with water. The crushed tablets mixed with water were administered last followed by 15 ml of plain water. Plain water flushes were not observed to be given prior to the first administration of the medications or between the medications being administered via G-tube. A review of Resident #40's current orders included the following, in part: "During medication administration times, flush tube with 15 milters water before and after medications and 5 milters with each medication" (Start date 5/16/22). An interview was conducted on 10/12/22 at 9:30 AM with Nurse #8. During the interview, the medication concerns identified during the med administration observation for Resident #40 were discussed. When discussing the resident's medications being crushed then administered together and failure to flush the G-tube as indicated by the physician's order, the nurse stated she was aware of the orders. However, Nurse #8 stated she felt Resident #40 could best tolerate the medications as she had administered them. An interview was conducted on 10/12/22 at 3:35 PM with the facility's Administrator and Regional Nurse Consultant. During the interview, concerns identified during the medication administration	F 759	administration via a g-tube per pol0icy. This education was completed on 11/21/22. Any Licensed Nurses not completing education by 11/21/22 will be required to complete education prior to the start of his/her next scheduled shift. The Pharmacy Consultant will continue to educate nursing and make any recommendations monthly regarding medication administration via a g-tube and Levemir FlexTouch pens. All new hired nurses will receive the medication administration via g-tube and Levemir FlexTouch pen education during orientation. Systemic changes made to ensure that the deficient practice will not recur. The Director of Health Services (DHS), Clinical Competency Coordinator (CCC) and/or Pharmacy Consultant will observe medication administration via a g-tube for five nurses three times a week x 4 weeks, once a week x 4 weeks, then monthly times 3 months or until compliance is achieved. The Director of Health Services (DHS), Clinical Competency Coordinator (CCC) and/or Pharmacy Consultant will observe medication administration via a Levemir FlexTouch pen for five nurses three times a week x 4 weeks, once a week x 4 weeks, then monthly times 3 months or until compliance is achieved.	

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 10/27/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEALTH-DURHAM	3100 ERWIN 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 759	Continued From page 96 observation were discussed. The Regional Consultant stated she was aware meds administered via G-tube were to be given one medication at a time with water flushes in between each medication. An interview was conducted on 10/13/22 at 12:10 PM with the facility's Director of Nursing (DON). During the interview, the DON stated she was aware of the med pass observations and was disappointed in the results. When asked, the DON reported the facility staff had been educated to administer one medication at a time via G-tube with a water flush given between each medication. She also stated that if the medications were supposed to be instilled via tube differently than the usual practice, there needed to be a physician's order specifying how the meds needed to be administered. 2. On 10/12/21 at 8:06 AM, Nurse #8 was observed as she prepared medications for administration to Resident #40 via G-tube. After these medications were administered to the resident, the nurse prepared the insulin for administration. Nurse #8 was observed as she withdrew a Levemir FlexTouch prefilled insulin pen from the medication cart, placed a needle on the pen, and turned the dose selector to select 8 units of insulin in preparation for the injection. The nurse did not prime the insulin pen. Nurse #8 was observed as she injected the insulin into the resident's right upper arm. The manufacturer's Full Prescribing Information for the Levemir FlexTouch pen included "Instructions for Use." These instructions indicated the insulin pen needed to be primed with 2 units of insulin prior to each use.	F 759	Plans to monitor its performance to make sure that the solutions are sustained. The Director of Health Services and/or the Clinical Competency Coordinator (CCC) will report to the Quality Assurance Performance Improvement Committee (QAPI) x 3 months for review and revision monthly x 3 months or until substantial compliance is achieved. Date of compliance: 11/21/22	

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 10/27/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEALTH-DURHAM	3100 ERWIN 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 759	Continued From page 97 An interview was conducted on 10/12/22 at 9:30 AM with Nurse #8. During the interview, the medication concerns identified during the med administration observation for Resident #40 were discussed. When asked about priming the Levemir FlexTouch insulin pen, the nurse stated she normally did prime the pen but acknowledged she did not prime it this time. An interview was conducted on 10/13/22 at 12:10 PM with the facility's Director of Nursing (DON). During the interview, the DON stated she was aware of the med pass observations and was disappointed in the results. When asked, the DON stated the Levemir insulin pen needed to be primed with 2 units of insulin prior to each use.	F 759		