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 01/12/2024

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 and complaint investigation survey was conducted on 1/8/24 through 1/12/24. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID # VXDR11	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 1/8/24 through 1/12/24. Event ID# VXDR11. The following intakes were investigated: Intake Numbers: NC00198951, NC00199010, NC00199090, NC00199237, NC00199330, NC00199418, NC00200069, NC00200553, NC00200938, NC00201472, NC00202003, NC00202404, NC00203557, NC00203385, NC00203847, NC00204114, NC00204834, NC00205922, NC00206204, NC00206813, NC00207094, NC00207305, NC00208808, NC00209011, NC00210661, NC00210831, NC002111312, NC00211452 72 of the 72 complaint allegations did not resulted in deficiency.	F 000		
F 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or	F 578		1/27/24

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

Electronically Signed | 01/23/2024

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F 578	Continued From page 1 inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to ensure advanced directive information was accurate throughout resident's electronic and paper medical records for 1 of 1 resident (Resident #97) reviewed for advanced directives.	F 578	Corrective action for the residents found to be affected by the deficient practice. Resident #97 still resides in the facility. Code status was updated on all accounts on 1/10/24.	

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F 578	Continued From page 2 Findings included: Resident #97 was admitted to the facility on 8/14/23. Resident #97's electronic medical record (EMR) revealed a physician's order dated 8/14/23 that read "full code." This order was still active on 1/10/24. Resident #97's quarterly Minimum Data Set (MDS) assessment dated 9/11/23 revealed Resident #97 was moderately cognitively impaired. Review of a physician progress note dated 1/3/24 read in part "spoke with (Guardian), agrees with DNR status." Resident #97's EMR showed a communication banner on the top of Resident #97's opened EMR and her code status read DNR (Do Not Resuscitate). Resident #97's EMR showed no copy of a signed DNR form scanned into the medical record. Review of the code status binder located at the nurse's station showed Resident #97 had a signed DNR form dated 1/3/24 located in the binder. An interview was conducted on 1/10/24 at 12:22 P.M. with Nurse #2 who was assigned to provide care to Resident #97 on 1/10/23. When asked, Nurse #2 opened Resident #97's EMR and stated Resident #97 was a DNR based on the banner at the top of Resident #97's record. Resident #97's EMR was reviewed with Nurse #2 who confirmed	F 578	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. On 1/10/24 an audit was initiated by the DHS to review all resident□s charts for code status to ensure all information is accurate throughout the residents□ electronic and paper medical record. Systemic Changes made to ensure that the deficient practice will not recur. On 1/22/24 the Administrator and the Director of Health Services initiated education for all licensed nurses, social workers and MDS nurses on the requirement of completing correct code status in the medical record for electronic and paper charts in a timely manner. Education was completed on 1/24/24. Any newly hired licensed nurses, social workers or MDS staff will be educated on the requirement of completing correct code status in the medical record specified by the state and approved CMS by the Administrator and/or the Director of Health Services during new hire orientation. The Administrator, the Director of Health Services and Social Workers will review all new admits, and residents with significant changes 5 days a week for 4 weeks on a continuing basis to ensure code status is completed and updated in a timely manner. The licensed nursing staff,	

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F 578	Continued From page 3 she was unable to find a physician order for Do Not Resuscitate and she could not find a copy of the DNR form in the medical record. Nurse #2 stated had she been aware there was a discrepancy in Resident #97's medical chart, she would have contacted the physician to verify Resident #97's code status. Nurse #2 stated when Resident #97's DNR form was signed on 1/3/24, the physician orders should have been updated to show Resident #97 was a DNR. An interview was conducted on 1/10/24 at 12:27 P.M. with the Unit Manager. During the interview, the Unit Manager stated when the physician signed Resident #97's DNR paperwork on 1/3/24 and gave it to the nursing staff, it was the responsibility of either the assigned nurse to Resident #97 or the Unit Manager to update Resident #97's physician orders and the code status on the communication banner in Resident #97's EMR. The Unit Manager explained Resident #97's signed DNR paperwork should have been scanned into her EMR the same day the paperwork was completed before the DNR form was filed into the coded status binder at the nurse's station. The Unit Manager was unsure why Resident's #97's medical record was not updated on 1/3/24 when the DNR paperwork was signed and felt it was an oversight. During the interview, the Unit Manager stated the electronic medical record should be updated with a copy of the DNR paperwork. The Unit Manager further explained if there was a discrepancy between physician orders, the code status on the banner in the EMR, and the DNR binder at the nurse's station, the nursing staff were responsible to follow up with the resident/responsible party to determine the correct code status.	F 578	social workers and MDS nurses have been informed by the Administrator of their responsibility of ensuring correct code status are completed in a timely manner specified by the state and approved by CMS. Plans to monitor its performance to make sure that the solutions are sustained. The Administrator, the Director of Health Services and Social Workers will review all new admissions and residents with significant changes for correct code status during daily standup meetings for 4 weeks and then weekly for 2 months and then monthly thereafter until 6 consecutive months of compliance is maintained. The Administrator will report any findings of non-compliance to the Quality Assurance and Performance Improvement Committee monthly for 3 months and then quarterly to ensure compliance is maintained. Date of compliance: 1/27/24	

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F 578	Continued From page 4 An interview was conducted on 1/11/23 at 8:35 A.M. with the Director of Nursing (DON). During the interview, the DON stated a resident's advanced directives should be up to date throughout the medical chart with the same information to prevent confusion if a code was called. The DON was unable to provide a reason why Resident #97's EMR did not have her DNR form scanned in or a physician order for her DNR code status. An interview was conducted on 1/11/24 at 2:08 P.M. with the Administrator. During the interview, the Administrator stated a resident's code status should be accurate throughout the resident's medical record to include the physician orders, the communication banner in the EMR, scanned documents, and the code status binder at the nursing station.	F 578		
F 640 SS=B	Encoding/Transmitting Resident Assessments CFR(s): 483.20(f)(1)-(4) §483.20(f) Automated data processing requirement- §483.20(f)(1) Encoding data. Within 7 days after a facility completes a resident's assessment, a facility must encode the following information for each resident in the facility: (i) Admission assessment. (ii) Annual assessment updates. (iii) Significant change in status assessments. (iv) Quarterly review assessments. (v) A subset of items upon a resident's transfer, reentry, discharge, and death. (vi) Background (face-sheet) information, if there is no admission assessment. §483.20(f)(2) Transmitting data. Within 7 days	F 640		1/27/24

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F 640	Continued From page 5 after a facility completes a resident's assessment, a facility must be capable of transmitting to the CMS System information for each resident contained in the MDS in a format that conforms to standard record layouts and data dictionaries, and that passes standardized edits defined by CMS and the State. §483.20(f)(3) Transmittal requirements. Within 14 days after a facility completes a resident's assessment, a facility must electronically transmit encoded, accurate, and complete MDS data to the CMS System, including the following: (i)Admission assessment. (ii) Annual assessment. (iii) Significant change in status assessment. (iv) Significant correction of prior full assessment. (v) Significant correction of prior quarterly assessment. (vi) Quarterly review. (vii) A subset of items upon a resident's transfer, reentry, discharge, and death. (viii) Background (face-sheet) information, for an initial transmission of MDS data on resident that does not have an admission assessment. §483.20(f)(4) Data format. The facility must transmit data in the format specified by CMS or, for a State which has an alternate RAI approved by CMS, in the format specified by the State and approved by CMS. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews, the facility failed to complete a Discharge Minimum Data Set (MDS) assessment within the required time frame for 2 of 3 residents (Resident # 93, and Resident # 99) selected for Resident Assessments and for 1 of 9 residents whose	F 640	Corrective action for the residents found to be affected by the deficient practice. Residents #93, #99 and #13 have all been discharged from the facility. The resident discharge assessments were completed	

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F 640	Continued From page 6 closed records were reviewed (Resident #13). Findings included: 1. Resident # 93 was admitted on 8/08/23. The last MDS assessment completed and transmitted was an admission MDS dated 8/15/23. Review of the progress note date 8/28/23 revealed the resident was sent to the emergency room. Review of the discharge return anticipated MDS assessment revealed an Assessment Reference Date (ARD) of 8/28/23. The assessment indicated it was still in process. During an interview on 1/11/24 at 1:51 PM, the MDS Nurse #2 indicated the resident was discharged to the hospital on 8/28/23 and the discharge MDS was not completed. MDS Nurse #2 stated she received the "missing assessment" report from the Nurse Consultant on 1/10/24 and the resident's assessment was noted in the report. The MDS Nurse #2 further stated she checks the MDS assessments to ensure the assessments were complete before she signs the assessments. She indicated the assessment was completed and signed today (1/11/24). The MDS Nurse stated the assessment must have slipped through the cracks. During an interview on 1/11/24 at 4:04 PM, the Administrator stated the facility had staffing challenges in the MDS Department. The department had lost some staff last year, and the corporate staff were assisting to ensure the	F 640	and transmitted on 1/11/24 by the MDS Nurse #1. 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. On 1/22/24, the MDS Nurse #1, MDS Nurse #2 and the DHS initiated a review of all discharge residents since 7/1/23 for discharge assessments. The review was completed by 1/24/24 and any discharge assessments not completed and transmitted will be completed by 1/27/24 by the MDS nurses. Systemic Changes made to ensure that the deficient practice will not recur. On 1/22/24, the Administrator and the Director of Health Services initiated education for the MDS nurses on the requirement of completing and transmitting discharge assessments timely as specified by the state and approved by CMS. Education was completed on 1/22/24. Any newly hired MDS staff will be educated on the requirement of completing and transmitting discharge assessments timely as specified by the state and approved CMS by the Administrator and/or the Director of Health Services during new hire orientation. The Administrator, the Director of Health Services will review all discharges 5 days	

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F 640	Continued From page 7 assessments were completed in a timely manner. The Administrator stated it was her expectation that all assessments were completed and transmitted on time. 2. Resident # 99 was admitted on 8/15/23. The last MDS assessment completed and transmitted was an admission MDS dated 8/18/23. Review of the progress note date 9/22/23 revealed the resident was discharged home. Review of the discharge return not anticipated MDS assessment revealed an ARD of 9/22/23. The assessment indicated it was still in process. During an interview on 1/11/24 at 1:51 PM, the MDS Nurse #2 indicated the resident was discharged home on 9/22/23 and the discharge MDS was not completed. MDS Nurse #2 stated she received the "missing assessment" report from the Nurse Consultant on 1/10/24 and the resident's assessment was noted in the report. The MDS Nurse #2 further stated she checks the MDS assessments to ensure the assessments were complete before she signs the assessments. She indicated the assessment was completed and signed today (1/11/24). The MDS Nurse stated the assessment must have slipped through the cracks. During an interview on 1/11/24 at 4:04 PM, the Administrator stated the facility had staffing challenges in the MDS Department. The department had lost some staff last year, and the corporate staff were assisting to ensure the assessments were completed in a timely manner.	F 640	a week for 4 weeks on a continuing basis to ensure discharge assessments are completed and transmitted timely. MDS nurses have been informed by the Administrator of their responsibility of ensuring discharge assessments are completed and transmitted in the format specified by the state and approved by CMS. Plans to monitor its performance to make sure that the solutions are sustained. The Administrator, the Director of Health Services will review discharge assessments for all discharges during daily standup meetings for 4 weeks and then weekly for 2 months and then monthly thereafter until 6 consecutive months of compliance is maintained. The Administrator will report any findings of non-compliance to the Quality Assurance and Performance Improvement Committee monthly for 3 months and then quarterly to ensure compliance is maintained. Date of compliance: 1/27/24	

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F 640	Continued From page 8 The Administrator stated it was her expectation that all assessments were completed and transmitted on time. 3. Resident #13 was admitted to the facility on 4/26/19. A review of the resident's electronic medical record (EMR) indicated Resident #13 was discharged to another facility on 11/1/23. Further review of Resident #13's EMR was conducted on 1/8/24. During the review, the status of resident's discharge Minimum Data Set (MDS) assessment dated 11/1/23 was noted as: "In Process." An interview was conducted on 1/11/24 at 2:25 PM with the facility's MDS nurses. During the interview, inquiry was made about the status of Resident #13's discharge MDS dated 11/1/23. Upon review of the resident's discharge MDS, the nurses confirmed the MDS should not be in process. MDS Nurse #1 stated, "It got missed, it will be done today." An interview was conducted on 1/11/24 at 3:34 PM with the facility's Director of Nursing (DON). During the interview, the failure to complete/transmit Resident #13's discharge MDS (dated 11/1/23) was discussed. The DON stated her expectation would be for the MDS to be completed accurately and closed/transmitted timely.	F 640		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced	F 641		1/27/24

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F 641	Continued From page 9 by: Based on staff interviews and record reviews, the facility failed to accurately complete a Minimum Data Set (MDS) assessment to reflect a resident's admission to Hospice for 1 of 2 residents (Resident #13) reviewed who had received Hospice services. The findings included: Resident #13 was admitted to the facility on 4/26/19. A review of the resident's electronic medical record (EMR) revealed Resident #13 was admitted to Hospice on 10/12/23. Further review of Resident #13's EMR revealed a significant change Minimum Data Set (MDS) assessment dated 10/18/23 was completed. The MDS section on "Health Conditions" indicated Resident #13 had a life expectancy of less than 6 months. However, the MDS section on "Special Treatments, Procedures, and Programs" did not report the resident received Hospice services while she was a resident. An interview was conducted on 1/11/24 at 2:25 PM with the facility's MDS nurses. When asked what prompted the significant change MDS to be completed for Resident #13 on 10/18/23, the nurses reported the significant change was due to the resident's admission to Hospice on 10/12/23. Upon further inquiry, the MDS Nurses reviewed the resident's significant change MDS assessment and confirmed it did not indicate the resident received Hospice services (the reason for her significant change). When asked if Hospice should have been checked as provided, MDS Nurse #2 stated, "Yes, it should be." MDS Nurse #1 added that a modification to the	F 641	Corrective action for the residents found to be affected by the deficient practice. Resident #13 has been discharged from the facility. The resident assessment for admission to hospice services was completed and transmitted on 1/11/24 by the MDS Nurse #1. 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. On 1/22/24, the MDS Nurse #1, MDS Nurse #2 and the DHS initiated a review of any resident that could have needed an assessment for admission to hospice services since 9/1/23. The review will be completed by 1/24/24 and any admission assessment for admission to hospice services not completed and transmitted will be completed by 1/27/24 by the MDS nurses. Systemic Changes made to ensure that the deficient practice will not recur. On 1/22/24, the Administrator and the Director of Health Services initiated education for the MDS nurses on the requirement of completing and transmitting admission assessments to hospice services timely as specified by the state and approved by CMS. Education was completed on 1/22/24. Any newly hired MDS staff will be educated on	

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F 641	Continued From page 10 10/18/23 MDS would need to be submitted to indicate Resident #13 had been admitted to Hospice. An interview was conducted on 1/11/24 at 3:34 PM with the facility's Director of Nursing (DON). During the interview, the failure to accurately complete Resident #13's significant change MDS dated 10/18/23 was discussed. The DON stated her expectation would be for the MDS to be completed accurately and closed/transmitted timely.	F 641	the requirement of completing and transmitting admission assessments to hospice services timely as specified by the state and approved CMS by the Administrator and/or the Director of Health Services during new hire orientation. The Administrator, the Director of Health Services will review all admissions for hospice services 5 days a week for 4 weeks on a continuing basis to ensure admission assessments are completed and transmitted timely. MDS nurses have been informed by the Administrator of their responsibility of ensuring admission assessments to hospice services are completed and transmitted in the format specified by the state and approved by CMS. Plans to monitor its performance to make sure that the solutions are sustained. The Administrator, the Director of Health Services will review all admission assessments to hospice services during daily standup meetings for 4 weeks and then weekly for 2 months and then monthly thereafter until 6 consecutive months of compliance is maintained. The Administrator will report any findings of non-compliance to the Quality Assurance and Performance Improvement Committee monthly for 3 months and then quarterly to ensure compliance is maintained. Date of compliance: 1/27/24	

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F 761	Continued From page 11	F 761		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observations, interviews with staff, and record reviews, the facility failed to: 1) Label a medication stored on 1 of 2 medication (med) carts (300 Long Hall Med Cart) with the minimum information required, including the resident's name; 2) Store medications in accordance with the manufacturer's storage instructions on 1 of 2 med carts (300 Long Hall Med Cart); and 3) Maintain clean and sanitary conditions for the	F 761	Corrective action for the residents found to be affected by the deficient practice. All residents had the potential to be affected. On 1/10/24 all 4 medication carts and 2 treatment carts were checked/audited by the Director of Health Services, Unit Managers and the Clinical Competency Coordinator. Any unlabeled	1/27/24

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F 761	Continued From page 12 storage of medications on 1 of 2 medication carts observed (200 Short Hall Med Cart). The findings included: 1. An observation was conducted on 1/10/24 at 2:40 PM of the 300 Long Hall Medication (Med) Cart in the presence of Nurse #4. The observation revealed the following medications were stored on the med cart: a. An opened vial of Novolog insulin was stored on the med cart. Neither the insulin vial itself nor the medication vial it was stored in was labeled with the minimum information required, including the name of the resident the insulin had been dispensed for. b. An unopened bottle of 1% prednisolone acetate ophthalmic suspension (a steroid eye drop medication) dispensed for Resident #95 was stored lying on its side in the medication cart. The manufacturer's storage instructions printed on the label of the eye drops provided instructions to store the bottle in an upright position. c. An opened bottle of 1% prednisolone acetate ophthalmic suspension (a steroid eye drop medication) dispensed from the pharmacy on 11/14/23 for Resident #30 was stored lying on its side in the medication cart. The manufacturer's storage instructions printed on the label of the eye drops provided instructions to store the bottle in an upright position. An interview was conducted with Nurse #4 on 1/10/24 at 2:55 PM. Upon review of the vial of Novolog insulin found on the medication cart, the nurse confirmed the resident's name on the vial	F 761	medications and/or 1%prednisone acetate ophthalmic suspension (steroid eye drop medication) not stored upright must be removed and returned to the pharmacy per policy. 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. On 1/10/24 all 4 medication carts and 2 treatment carts were checked/audited by the Director of Health Services, Unit Managers, and the Clinical Competency Coordinator. Any unlabeled medications and/or 1%prednisone acetate ophthalmic suspension (steroid eye drop medication) not stored upright must be removed and returned to the pharmacy per policy. Systemic Changes made to ensure that the deficient practice will not recur. On 1/11/24 the Clinical Competency Coordinator and the Director of Health Services educated the Licensed Nurses on Labeling/Storage of Drugs and Biologicals. All licensed nurses were educated by 1/12/24. The licensed nurses will review their assigned medications rooms and medication carts for unlabeled medications and any medications not stored properly per manufacture guidelines daily for 5 days a week for weeks and then weekly for 4 weeks then monthly thereafter. The licensed nurse review will be given to the Director Health	

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F 761	Continued From page 13 of insulin was not legible and that there were no other identifiers on the medication vial it was stored in. When asked about the storage of the prednisolone eye drops, Nurse #4 reported she was not aware that these eye drops should be stored in an upright position. Nurse #1 joined the interview with Nurse #4. At that time, Nurse #1 also stated she was not aware the manufacturer's storage instructions indicated the prednisolone suspension eye drops should be stored in an upright position. An interview was conducted on 1/10/24 at 3:56 PM with the facility's Director of Nursing (DON). During the interview, the DON stated she would expect insulin vials to be labeled with a resident's name both directly on the insulin vial itself and on the medication vial it was stored in. The DON also reported that the manufacturer's storage instructions for the prednisolone suspension eye drops were new to the facility. She indicated staff would need to be educated on the manufacturer's storage instructions for suspension eye drops such as prednisolone. 2. An observation was conducted on 1/10/24 at 3:05 PM of the 200 Short Hall Medication (Med) Cart in the presence of Nurse #6. The observation revealed the third drawer on the right side of the medication cart contained liquid stock medications and compounded solutions. However, this drawer was observed to have a thick, crusty, and sticky substance on the entire bottom of the drawer. This substance appeared to consist of multi-colored solutions that had dried on the bottom of the drawer. At that time of the observation, Nurse #6 was asked what her thoughts were about the condition of the drawer. The nurse stated, "That needs a deep cleaning."	F 761	Services to validate the removal of all unlabeled and not properly stored medications, and biologicals. The Consultant Pharmacist will review the medication carts and medication rooms for any unlabeled or medications not properly stored per manufacturer guidelines. This audit will occur monthly. Plans to monitor its performance to make sure that the solutions are sustained. The Director of Health Services and/or Nurse Managers will validate the License Nurse review of the Medication rooms and the Medication carts daily for 5 days a week for 4 weeks and then weekly for 4 weeks then monthly thereafter. The Consultant Pharmacist will review the medication rooms and medication carts for unlabeled and stored improperly medications and biologics monthly. The Director of Health Services will present an analysis of their review to the Quality Assurance Performance Improvement committee monthly until 3 consecutive months of compliance is sustained then quarterly. Date of compliance: 1/27/24	

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F 761	Continued From page 14 An interview was conducted on 1/10/24 at 3:56 PM with the facility's Director of Nursing (DON). During the interview, the DON reported that as a courtesy, she would expect the medication carts to be wiped down between nursing shifts.	F 761		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews and interviews the facility failed to maintain the ice scoop holder clean, failed to have deep fryer cleaned and free of food crumbs, failed to maintain the walk-in freezer clean, failed to discard expired food from reach-in refrigerator, failed to label, and date food placed in 2 of 2 nourishment refrigerator. Failed to ensure dietary	F 812	Corrective action for the residents found to be affected by the deficient practice. On January 8, 2024, the ice scoop holder was cleaned. On January 8, 2024, the deep fryer equipment and the floor below the	1/27/24

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F 812	Continued From page 15 staff covered their facial hair. These practices had the potential to affect food served to residents. Findings included: 1. On 1/8/24 at 6:10 AM, observation of the ice scoop holder placed beside the ice machine in the kitchen revealed black colored stains on the base of the scoop holder. During an interview on 1/8/24 at 6:10 AM, the dietary manager stated the scoop holder should be washed daily. Review of the "Cleaning Schedule form- Daily" for 1/6/24 and 1/7/24 revealed the ice scoops were cleaned and sanitized. There was no mention of the ice scoop holder. 2. On 1/8/24 at 6:15 AM, during an observation of the deep fryer equipment. The fryer had dried food crumbs on the top panel of the equipment. The floor below the equipment and behind the equipment was dirty and greasy. During an interview on 1/8/24 at 6:10 AM, the dietary manager stated the deep fryer and other equipment were cleaned weekly and were due to be cleaned "today" (1/8/24). She indicated the staff that assisted in cleaning the deep fryer and removing the oil was on vacation the previous week. She indicated the deep fryer oil was changed and deep cleaned weekly. Review of the "Cleaning Schedule Form -Weekly" revealed large equipment which included range and drip pan, oven, steamer, fryer, steam kettle and hot box etc. would be detail clean and	F 812	equipment was cleaned. On January 8, 2024, the floor mat was removed from the walk-in freezer and the floor was cleaned. On January 8, 2024, the expired yogurt was discarded by the dietary manager. On January 10, 2024, the pink colored insulated lunch box in the 200-hall nourishment room refrigerator was discarded by the dietary manager. On January 10, 2024, the following items were discarded by the dietary manager from the 300-hall nourishment room refrigerator a frozen ready meal, a clear plastic box containing crackers etc., and a 12-ounce energy drink. On January 10, 2024, the Dietary Cook and staff were observed in the kitchen without beard covers. On January 10, 2024, the dietary cook and staff were given beard covers and educated/in serviced on policy and procedures regarding hair coverings in the kitchen. 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. Systemic Changes made to ensure that the deficient practice will not recur.	

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F 812	Continued From page 16 sanitized. Review of the menu for week 4 revealed Fried chicken was served for lunch on 1/7/24. During an interview with the dietary manager on 1/10/24 at 2:00 PM, the dietary manager was unable to state as to why the equipment was not cleaned after the meal on 1/7/24. She stated the staff should be cleaning all equipment after each meal. Deep cleaning of all equipment was done weekly. She further stated the floor behind the equipment was pressure washed once a week. She indicated these were cleaned on 1/8/24. 3. On 1/8/24 at 6:25 AM, during an observation of the walk-in freezer, the freezer floor had a floor mat that was dirty and sticky. There was ice, and dried food stains on the floor. During an interview with the dietary manager on 1/8/24 at 6:25 AM, the dietary manager stated she was unsure why there was a floor mat on the floor. She further stated she had placed a work order with the maintenance department so to ensure the freezer floor was free of ice and the floor mat could be removed. During an interview on 1/11/24 at 11:36 AM, the maintenance director stated he had received a work order related to ice formed in the freezer. He indicated the service consultant had checked the freezer on 1/8/24 and indicated the air circulation duct was blocked with the boxes, preventing the air from circulating in the freezer and causing ice on the floor. The maintenance director indicated he was notified by the dietary manager to remove the floor mat so that the floor could be cleaned.	F 812	On January 10, 2024, the dietary manager educated all dietary staff that it is their responsibility to monitor the nourishment rooms to ensure compliance, in-services completed on cleaning equipment, cleaning the walk-in cooler, cleaning ice scoop holder, checking expiration dates on all products and wearing of hair coverings. This in-service will be part of the orientation process for all newly hired dietary employees. The Certified Dietary Manager will monitor these areas daily for 4 weeks and then weekly for 4 weeks then monthly thereafter. The Certified Dietary Manager will give these audits to the Administrator. The Administrator will review all the daily audits completed by the certified dietary manager for 4 weeks and then weekly for 4 weeks and then monthly thereafter until 6 consecutive months of compliance is maintained. Plans to monitor its performance to make sure that the solutions are sustained. The Administrator will report the analysis of the findings related to F812 to the Quality Assurance and Performance Improvement Committee monthly for 3 months and then quarterly to ensure compliance is maintained. Date of compliance: 1/27/24	

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4. On 1/8/24 at 6:20 AM, an observation of the reach- in refrigerator revealed 2 yogurt cups with expiration date of 10/19/23.

During an interview on 1/10/24 at 11:40 AM, the dietary manager stated the kitchen does not order yogurts unless it was on the menu. She further stated had been a long time since yogurt was on the menu. The staff should discard expired food in any refrigerator.

5a. Observation of the nourishment refrigerator #1 on 200 hallway on 1/10/24 at 1:11 PM, revealed a pink colored insulated lunch box in the refrigerator with no name or date on it.

During an interview with the dietary manager on 1/10/24 at 1:11 PM, she stated staff should not be placing personal food in the resident's nourishment refrigerator. All resident's food placed in the nourishment refrigerator should be dated and labelled.

5b. Observation of the nourishment refrigerator #2 on 300 hallway on 1/10/24 at 1:20 PM revealed a frozen ready to eat meal box with no name or date; A clear plastic box containing crackers, deli meat and cheese with no resident's name or date, a 12-ounce energy drink can with no name or date on it.

During an interview with the dietary manager on 1/10/24 at 1:20 PM, she indicated she was unsure if the food belonged to staff or residents. All food placed in the refrigerator should be labelled and dated.

During an interview on 1/10/24 at 1:23 PM, Nurse #1 (Unit Manager - 300 hallway) stated that the

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clear container belonged to a resident. The resident had purchased this box yesterday (1/9/24). Staff who assisted in keeping the box in the nourishment refrigerator should had labeled the box with resident name and date prior to placing the food in the refrigerator. She was unsure who the frozen meal box and energy drink belonged to.

6 a. During an observation on 1/10/24 at 11:45 AM, Dietary Cook was observed in the kitchen cooking the lunch meal. The staff had facial hair (beard) that was not covered.

During an interview with the dietary cook on 1/10/24 at 11:45 AM, he indicated the kitchen had ran out of beard guards and hence had not worn it.

6 b. During an observation on 1/10/24 at 2:00 PM, male Dietary aide was observed assisting with washing dishes. The dietary aide had facial hair (beard) that was not covered.

During an interview with the dietary aide on 1/10/24 at 2:00 PM, he indicated there were no beard guards available in the kitchen.

During an interview on 1/11/24 at 01:22 PM, the dietary manager stated there were adequate beard guards available for staff use. Approximately 3 cases of beard guards were available for staff. The staff had overlooked and not checked properly.

During an interview on 1/11/24 at 4:00 PM the Administrator stated that all cooking equipment, ice scoop holders and kitchen floors should be cleaned per schedule and as needed. The

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F 812	Continued From page 19 Administrator further stated all expired food items should discarded, and staff should not be placing their personal food in the nourishment refrigerators that were meant for the residents. Any food brought in by family or residents should be labeled with resident's name and dated. The food should be discarded per policy if not consumed by the resident. The Administrator stated that hairnets and beard guards should be worn by dietary staff.	F 812		
F 867 SS=D	QAPI/QAA Improvement Activities CFR(s): 483.75(c)(d)(e)(g)(2)(i)(ii) §483.75(c) Program feedback, data systems and monitoring. A facility must establish and implement written policies and procedures for feedback, data collections systems, and monitoring, including adverse event monitoring. The policies and procedures must include, at a minimum, the following: §483.75(c)(1) Facility maintenance of effective systems to obtain and use of feedback and input from direct care staff, other staff, residents, and resident representatives, including how such information will be used to identify problems that are high risk, high volume, or problem-prone, and opportunities for improvement. §483.75(c)(2) Facility maintenance of effective systems to identify, collect, and use data and information from all departments, including but not limited to the facility assessment required at §483.70(e) and including how such information will be used to develop and monitor performance indicators.	F 867		1/27/24

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§483.75(c)(3) Facility development, monitoring, and evaluation of performance indicators, including the methodology and frequency for such development, monitoring, and evaluation.

§483.75(c)(4) Facility adverse event monitoring, including the methods by which the facility will systematically identify, report, track, investigate, analyze and use data and information relating to adverse events in the facility, including how the facility will use the data to develop activities to prevent adverse events.

§483.75(d) Program systematic analysis and systemic action.

§483.75(d)(1) The facility must take actions aimed at performance improvement and, after implementing those actions, measure its success, and track performance to ensure that improvements are realized and sustained.

§483.75(d)(2) The facility will develop and implement policies addressing:
(i) How they will use a systematic approach to determine underlying causes of problems impacting larger systems;
(ii) How they will develop corrective actions that will be designed to effect change at the systems level to prevent quality of care, quality of life, or safety problems; and
(iii) How the facility will monitor the effectiveness of its performance improvement activities to ensure that improvements are sustained.

§483.75(e) Program activities.

§483.75(e)(1) The facility must set priorities for its

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performance improvement activities that focus on high-risk, high-volume, or problem-prone areas; consider the incidence, prevalence, and severity of problems in those areas; and affect health outcomes, resident safety, resident autonomy, resident choice, and quality of care.

§483.75(e)(2) Performance improvement activities must track medical errors and adverse resident events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the facility.

§483.75(e)(3) As part of their performance improvement activities, the facility must conduct distinct performance improvement projects. The number and frequency of improvement projects conducted by the facility must reflect the scope and complexity of the facility's services and available resources, as reflected in the facility assessment required at §483.70(e). Improvement projects must include at least annually a project that focuses on high risk or problem-prone areas identified through the data collection and analysis described in paragraphs (c) and (d) of this section.

§483.75(g) Quality assessment and assurance.

§483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must:

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F 867	Continued From page 22 (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (iii) Regularly review and analyze data, including data collected under the QAPI program and data resulting from drug regimen reviews, and act on available data to make improvements. This REQUIREMENT is not met as evidenced by: Based on staff interviews and record review, the facility's quality assurance (QA) process failed to implement, monitor, and revise as needed the action plan developed for the recertification surveys dated 10/27/22 in order to achieve and sustain compliance. These were for recited deficiencies cited during a recertification survey on 1/12/24. The deficiencies were in the following areas: comprehensive assessment, quarterly assessment, and encoding. The continued failure during two federal surveys of record showed a pattern of the facility's inability to sustain an effective quality assurance program. The findings included: This tag is cross-referenced to: 1. F636- Based on staff interviews and record review, the facility failed to complete a comprehensive Minimum Data Set (MDS) assessment within 14 days of the Assessment Reference Date (the last day of the assessment period) for 1 of 32 residents (Residents #51) whose MDS assessments were reviewed. During a previous recertification and complaint investigation on 10/27/22, the 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	F 867	Corrective action for the residents found to be affected by the deficient practice. 1. Resident #55 still resides in the facility. The comprehensive MDS was completed by the MDS nurse on 1/11/24. 2. Resident #69 still resides in the facility. The significant change MDS was completed by the MDS nurse on 1/11/24. 3. Resident #59 still resides in the facility. The quarterly MDS was completed by the MDS nurse on 1/11/24. 4. Resident #13 has been discharged from the facility. The MDS assessment to reflect the resident□s admission to hospice was completed by the MDS nurse on 1/11/24. 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. Systemic Changes made to ensure that the deficient practice will not recur.	

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	345061	A. BUILDING _____ B. WING _____	C 01/12/2024

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 867	Continued From page 23 residents whose MDS assessments were reviewed. 2. F637- 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 2 residents reviewed for significant change (Resident #69). During a previous recertification and complaint investigation on 10/27/22, 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. 3. F638- Based on record review and staff interviews, the facility failed to complete quarterly Minimum Data Set (MDS) assessments within 14 days of the Assessment Reference Date (ARD, the last day of the look-back period) for 1 of 3 residents reviewed for resident assessment (Residents #58). During a previous recertification and complaint investigation on 10/27/22, 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. 4. F641- Based on staff interviews and record	F 867	The Administrator and the Director of Health Services educated the members of QA committee on the Quality Assurance and Performance Improvement policy/process emphasis on identifying areas that may lead to deficiency practice. Education will be completed by 1/24/24. Administrator will lead Quality Assurance and Performance Improvement meeting with emphasis and focus on ensuring that any areas on non-compliance are addressed to prevent further deficient practices related completing comprehensive MDS, significant change MDS, quarterly MDS and MDS admission assessments for residents admitted to hospice services. At least a member of the regional team that includes senior nurse consultant, clinical reimbursement consultant or area vice president will attend QAPI meetings for 3 quarters. The Quality Assurance and Performance Improvement committee will continually monitor implemented procedures and monitor the plan of correction (POC) put in place for Tag F636, Tag F637, Tag F638 and Tag F641 monthly until 3 consecutive months of compliance is maintained then quarterly thereafter. The Quality Assurance and Performance Improvement committee will meet monthly to review the tracking and trending analysis of areas that led to repeat tag/deficiencies. The facility will develop a retrospective plan to examine facility standards and ensure no repeat citations. Plans to monitor its performance to make	

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F 867	Continued From page 24 reviews, the facility failed to accurately complete a Minimum Data Set (MDS) assessment to reflect a resident's admission to Hospice for 1 of 2 residents (Resident #13) reviewed who had received Hospice services. During a previous recertification and complaint investigation on 10/27/22, the facility failed to accurately code the Minimum Data Set (MDS) assessment in the area of discharge status for 2 of 8 discharged residents whose MDS assessments were reviewed. During the phone interview on 1/12/24 at 2:30 PM, the Administrator stated the Quality Assurance (QA) committee 1) identifies areas of concern, 2) does a root cause analysis, 3) develops a plan, audits, and monitors that plan and 4) discusses the outcome. System changes and additional tasks would be put in place as needed to resolve the issue. Regarding the repeated citations the Administrator stated there was a high turnover with staff. The Administrator further stated there was also high turnover with the Director of Nursing staff and accountability was not present, leading to repeated deficiencies. The facility has a new management team, which has oversight and guidance from the corporate. The Administrator indicated the corporate was also directing and helping staff with daily issues and concerns, helping in identifying issues, helping with analysis the root cause, and putting monitoring systems in place. The facility's new staff were working to ensure that high-quality resident care and services were provided. The Administrator stated the old plan would be revisited and analyzed to see where the failures and breakdowns happened. The repeated deficiencies would be monitored closely so that they do not recur.	F 867	sure that the solutions are sustained. The administrator will lead the Quality Assurance and Performance Improvement meetings monthly with emphasis and focus on areas that have led to repeat deficiencies (Tag F636, Tag F637, Tag F638 and Tag F641). This will ensure the facility is identifying areas on non-compliance and addressing them as needed to prevent further deficient practice related to completing comprehensive MDS, significant change MDS, quarterly MDS and MDS admission assessments for residents admitted to hospice services. A member of the regional team that includes the senior nurse consultant, clinical reimbursement consultant or area vice president will attend QAPI meetings for the next 3 months and then quarterly for 3 quarters to ensure the QAPI process is effective. The administrator will report to the Quality Assurance and Performance Improvement Committee any areas of non-compliance monthly for 3 months and then quarterly and/or as needed for 3 quarters for further recommendations until compliance is sustained. Date of compliance: 1/27/24	

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STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # 345061	MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	DATE SURVEY COMPLETE: 1/12/2024

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

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 636	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. (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.

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of

The above isolated deficiencies pose no actual harm to the residents

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ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES

F 636

Continued From Page 1

This REQUIREMENT is not met as evidenced by:
Based on staff interviews and record review, the facility failed to complete a comprehensive Minimum Data Set (MDS) assessment within 14 days of the Assessment Reference Date (the last day of the assessment period) for 1 of 32 residents (Residents #51) whose MDS assessments were reviewed.

The findings included:

Resident #51 was initially admitted to the facility on 6/8/22. His cumulative diagnoses included schizophreniform disorder (a mental health condition that causes symptoms of psychosis lasting one to six months in duration), chronic pain, and generalized muscle weakness.

A review of Resident #51's Minimum Data Set (MDS) assessments was conducted on 1/8/24. This review revealed the last comprehensive assessment completed for Resident #51 was dated 12/16/22. The resident's electronic medical record (EMR) indicated the status of his next comprehensive MDS assessment (an annual MDS dated 12/15/23) was "In Process."

An interview was conducted on 1/11/24 at 2:25 PM with the facility's MDS nurses. During the interview, an inquiry was made regarding the status of Resident #51's annual MDS dated 12/15/23. Upon review of the resident's 12/15/23 MDS, the nurses confirmed this assessment was "In Process." When asked if this MDS should still be in process, MDS Nurse #1 stated, "No, it should not." The nurses stated that the MDS section on Assessment Administration had not been signed off by the Registered Nurse (RN) verifying completion of the assessment. They reported the MDS assessment should have been signed off by 12/29/23 (within 14 days of the Assessment Reference Date or ARD).

An interview was conducted on 1/11/24 at 3:34 PM with the facility's Director of Nursing (DON). During the interview, the failure to complete Resident #51's annual comprehensive MDS (dated 12/15/23) within 14 days of the ARD was discussed. The DON stated her expectation would be for the MDS to be completed accurately and closed / transmitted timely.

F 637

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

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F 637	Continued From Page 2 Data Set (MDS) assessment within 14 calendar days after the facility determined there had been a significant change for 1 of 2 residents reviewed for significant change (Resident #69). The findings included: Resident #69 was admitted to the facility on 10/23/20 with re-entry from a hospital on 5/5/22. A Hospice referral was made for Resident #69 on 10/11/23. Her diagnoses included Alzheimer's disease with early onset; Dysphagia and adult failure to thrive. Review of Resident #68's Significant change Minimum Data Set (MDS) revealed the assessment reference date (ARD, the last day of the look-back period) was 10/13/23. This MDS was signed/dated on 1/11/24 by the Registered Nurse (RN) Assessment Coordinator to verify the assessment had been completed. During an interview on 1/11/24 at 2:32 PM, MDS Nurse #2 stated the resident was admitted to hospice service on 10/13/23. She added the assessment was missed and was not completed by another staff member (from sister facility) who was assisting with MDS assessments. During an interview on 1/11/24 at 2:35 PM, MDS Nurse #1 stated they had missed out on the assessment, and it was an error. She indicated she was made aware by the Consultant that some assessments were incomplete. She further stated that she had just signed of on the assessment as completed. During the interview on 1/11/24 at 3:57 PM, the Administrator stated the facility had staffing challenges in the MDS Department due to staff turnover and hiring. The Administrator indicated it was her expectation that whenever there was any significant change in resident's health then a significant change MDS should be completed.
F 638	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: Based on record review and staff interviews, the facility failed to complete quarterly Minimum Data Set (MDS) assessments within 14 days of the Assessment Reference Date (ARD, the last day of the look-back period) for 1 of 3 residents reviewed for resident assessment (Residents #58). The findings included: Resident #58 was admitted to the facility on 6/14/19 with reentry on 7/24/21 from a hospital. His cumulative

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F 638	Continued From Page 3

diagnoses included Hemiplegia and hemiparesis following cerebral infarction affecting right dominant side and Diabetes mellitus Type 2.

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 10/30/23. The quarterly MDS dated 10/30/23 was in process and signed/dated on 1/11/24 by the Registered Nurse (RN) Assessment Coordinator to verify the assessment was completed 72 days after the ARD.

During an interview on 1/11/24 at 1:45 PM, MDS Nurse #1 stated in October 2023, the facility computers were down due to some issues. Some of the resident's assessments that needed to be transmitted were not transmitted. The computers were out of commission for almost 2 weeks. MDS Nurse #1 further stated this had caused some of the assessments to be transmitted late and some assessments were not transmitted. MDS Nurse #1 stated the resident's assessment was one of the assessment that was late. She indicated that the assessment was signed as completed today (1/11/24) and was in the process of been transmitted.

During an interview on 1/11/24 at 1:51 PM, the MDS Nurse #2 stated she received the "missing assessment" report from the Nurse Consultant on 1/10/24 and the resident's assessment was noted in the report. The MDS Nurse #2 further stated she checks the MDS assessments to ensure the assessments were complete before she signs the assessments. She indicated the assessment was completed and signed today (1/11/24). The MDS Nurse stated the assessment must have slipped through the cracks.

During an interview on 1/11/24 at 4:04 PM, the Administrator stated the facility had staffing challenges in the MDS Department. The corporate staff were assisting to ensure the assessments were completed in a timely manner. The Administrator stated it was her expectation that all assessments were completed and transmitted on time.