STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345551	A. Building B. Wing	07/13/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pruitthealth-Carolina Point	5935 Mount Sinai Road Durham, NC 27705

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 14652 Based on record review, observation, Police, staff and resident interview, the facility failed to protect a resident's right to be free from mistreatment for 1 of 1 resident investigated for staff to resident abuse (Resident #14). Resident #14 sustained a scratch on her face and nose from the altercation with the staff and was crying stating that the altercation made her feel scared and anxious. Findings included: Resident #14 was admitted to the facility on [DATE] with multiple diagnoses including cerebro-vascular accident (CVA) with hemiplegia/paresis, major depressive disorder, generalized anxiety disorder, chronic respiratory failure dependence on trilogy (a volume -control and pressure control machine used to help people with respiratory diseases where a person needs assistance because they cannot breathe on their own) and supplemental oxygen and chronic post-traumatic stress disorder (PTSD) (a disorder in which a person has difficulty recovering after experiencing or witnessing a terrifying event). Resident #14's care plan (initiated on 7/12/21) was reviewed. The resident was care planned for the use of the Trilogy machine at bedtime and required continuous oxygen therapy related to respiratory failure with hypoxia. The quarterly Minimum Data Set (MDS) assessment dated [DATE] indicated that Resident #14's cognition was intact with Brief Interview for Mental Status (BIMS) score of 15, and she did not have any behaviors. The assessment further indicated that the resident was totally dependent on the staff for transfer and uses a wheelchair for mobility. Review of Facility Reported Incident (FRI) dated 3/3/22 revealed an allegation of abuse. The allegation detail was Nurse Aide (NA) #8 hit Resident #14 in the face. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	The facility's abuse investigation revealed that on 3/3/22 around 6 AM, NA #8 provided incontinent care for Resident #14. The resident requested to change her Trilogy mask to an oxygen tubing. The NA was unable to find the tubing and the resident became agitated, started yelling at the NA. The NA stated that the resident swung at her with her left arm and the NA instinctively grabbed resident's hand, leaned back, and let go of her hand. The resident pulled back and hit herself with her own left hand. The resident was wearing glasses and the nose piece of the glasses created the bruising under resident's eye. The resident stated that she felt anxious and expressed sadness that the altercation had happened. After conducting a thorough investigation, the allegation of abuse was substantiated, and NA #8 was terminated. The corrective actions taken following the incident were: the Nurse Practitioner (NP), Police, and the State were notified. Nurse #8 remained with the resident until the Police arrived for safety. Skin assessment conducted and Resident #14 was noted to have bruises under her right eye and nose and NA #8 was immediately suspended pending investigation. The facility had conducted an audit of all interviewable residents ensuring that residents were free from abuse. All staff were trained on preventing, identifying, and reporting allegations of abuse, neglect, misappropriation of resident property and injuries of unknown origin. The facility's corrective action did not include an audit of non-interviewable residents to ensure nobody had been affected and did not mention that a monitoring tool had been developed on what to audit, how to audit and who was responsible for the audit. Resident #14 was observed on 6/20/22 at 12:15 PM. She was up in wheelchair in her room and was on oxygen via nasal cannula. A Trilogy machine was observed at bedside. Resident #14 was observed to have right side paralysis. Resident #14 reported that sometime in March of 2022 (unable to remember exact date), NA #8 came to her room around 6 AM to provide incontinent care. She asked the NA to remove her Trilogy mask and to replace it with oxygen tubing. The NA stated that she looked and could not find an oxygen tubing in the room. The resident responded that the tubing was there last night and to look for it, but the NA insisted that she could not find it and for the resident to find it herself. When the NA was about to leave the room, the resident started yelling not to leave her without oxygen. Resident #14 stated that it scared her, she could not breath without the oxygen. The NA started yelling at her and hit her in the face causing her eyeglasses to break. She had scratches on her face that were bleeding when the nurse assessed her. The resident added that the Police was called, and he came and interviewed her. She added that she had a roommate at that time, but she was demented. Resident #14 indicated that the incident with NA #8 made her feel scared and anxious and she was crying, it reminded her of her history of abuse. She reported that she asked to be transferred to another nursing facility, but nobody was willing to accept her due to her Trilogy machine. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Nurse # 8 was interviewed by telephone on 6/21/22 at 9:58 AM. Nurse #8 reported that he was working the night when NA #8 and Resident #14 had an altercation. He was at the nurse's station when NA #8 reported that she had an altercation with Resident #14. He went to Resident #14's room and observed Resident #14 crying and alleging that NA #8 hit her. When he assessed the resident, she had a small laceration on her face (right side under the eye) and a scratch on her nose with slight bleeding on them. Nurse #8 added that Resident #14 was alert and oriented, used trilogy machine at night and oxygen vial nasal cannula at daytime. The Nurse stated around 6 AM, her Trilogy mask was switched to a nasal cannula. Resident #14 was dependent on oxygen. Nurse #8 indicated that NA #8 reported that during the altercation, Resident #14 tried to hit her with her arm, and when she tried to block it, the resident hit her face with her arm. The Police was called, and NA #8 was suspended and then was terminated. Review of Nurse #8 written statement dated 3/3/22 revealed that NA #8 came to report the incident with Resident #14. NA informed him that she went to the resident's room to provide incontinent care and the resident requested her trilogy mask be replaced with nasal cannula. The NA could not find the cannula in the room. The NA indicated that the resident was getting agitated and started swinging at the NA. While the NA was avoiding being hit, she grabbed the resident's hand and in the process the resident's hand went back and hit her glasses which caused an injury to the resident's right eye. Nurse #8 further stated that when interviewed, Resident #14 revealed that NA #8 woke her up to be changed. The resident requested for the Trilogy mask to be taken off and replaced with the nasal cannula, but the NA could not find the cannula in the room. The resident asked the NA to get another one, but the NA responded that she had no time for it and the altercation started. The resident stated that NA hit her in the process. The report indicated that the NA took the oxygen tubing from the resident's electric wheelchair and that was the tubing the resident was using when Nurse #8 entered the room. Nurse #9 was interviewed by telephone on 6/22/22 at 8:35 AM. The Nurse stated that she was assigned to Resident #14 when the altercation between NA #8 and Resident #14 happened. The Nurse reported that NA #8 came and informed her to check on Resident #14. She went to the resident's room around 6 AM on 3/3/22. Resident #14 was crying alleging NA #8 hit her. She has a scratch on her face with blood under her right eye. She could not remember whether the resident was on Trilogy mask or nasal cannula that morning. Nurse #9 explained that Resident #14 was on Trilogy machine at night and around 6 AM every day, the Trilogy mask was changed to a nasal cannula. NA #8 was in resident's room the morning of 3/3/22 providing care. The resident asked the NA to change her Trilogy mask to a nasal cannula. The NA could not locate the nasal cannula in the room and the resident asked the NA to get another one and the NA replied, I don't have time for that. The resident got mad and started yelling and claimed that the NA hit her. When she interviewed NA #8, the NA stated that when the resident started swinging her left arm, she grabbed her left arm and when she let it go, her left arm hit her face causing her eyeglasses to break. Nurse #9 reported that she notified the Police who came and interviewed the staff and the resident. Review of Nurse #9 written statement (undated) revealed that at 6 AM on 3/3/22, NA #8 asked Resident #14 if she needed to be changed. The resident requested if she could change her Trilogy mask to a nasal cannula/oxygen tubing and the NA replied that she could not find it. The resident asked her to look, and the NA replied, I don't have the time, it was not in here. The resident told the NA Well, you need to look and the NA replied, you need to get up and look your d--- self. The resident reported that the NA knocked her glasses on her face. The written statement further indicated that NA #8 informed Nurse #9 that she and Resident #14 had an issue. The resident tried to hit her, and she grabbed the resident's hand and the momentum had caused the injury. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	NA # 8 was interviewed by telephone on 6/22/22 at 10:10 AM. The NA reported that it was around 6 AM on 3/3/22 when she went to check on Resident #14 during her last round. Resident #14 asked to change her Trilogy mask to a nasal cannula. She looked and could not find a nasal cannula in her room. The resident got mad and was upset saying that she could not breath without oxygen. She left the resident's room and informed the nurse to check on the resident as she was angry. The NA was unable to remember if she left the resident on a mask or nasal cannula that morning. She explained that when the resident started swinging her left arm, she grabbed it. When she let the resident's left arm go, her arm hit her face causing her eyeglasses to break. When the resident started yelling you hit me and she saw a scratch on the resident's face, she panicked and left the room to get the nurse. NA #8 commented that she should have left the room when the resident started yelling and swinging but she did not. Review of NA #8 written statement dated 3/3/22 revealed that she went in to provide care to Resident #14. The resident asked to change her Trilogy mask to nasal cannula, and she could find the nasal cannula in the room. The resident started yelling that it was there, and she told her to stop yelling and to tell her where the nasal cannula was. The NA tried to finish providing incontinent care, when the resident swung her hand to her face telling her to look for the nasal cannula. The NA grabbed the resident's hand, and it went back to her glasses which cut/scratched her face. She then went to get the nurse for help. The Social Worker (SW) was interviewed on 6/22/22 at 10:35 AM. The SW reported that she interviewed Resident #14 on 3/3/22 regarding the abuse allegation with NA #8. The resident was tearful during the interview and expressed sadness and when she asked her how are you feeling now, she replied that she was feeling anxious. The SW stated that a written statement of the interview was completed. Review of the SW written statement dated 3/3/22 revealed that at 6 AM Resident #14 was sleeping when NA #8 entered her room to provide incontinent care. The resident asked the NA to change her Trilogy mask to an oxygen tubing. NA #8 indicate that she could not find the tubing anywhere and the resident insisted that it must be there as it was there last night. The NA became impatient unable to find the tubing, told the resident, don't yell at me. The resident responded, you yell at me first. NA then said, I'll just leave you here then you can get up and find it yourself. Resident replied, you can't do that, I can't breathe without the oxygen. The resident stated that the Trilogy mask was removed, and the tubing was not applied. The argument continued over whether oxygen tubing was there and whether the NA would look for it or bring another tubing. The resident stated that the NA reached out and hit her in the eye with her hand. The resident was wearing glasses and the nose pad scratched and bruised her eye. The resident yelled several times you hit me and the NA reiterated each time you hit me first. The resident stated that she was paralyzed on her right side and was unable to hit anyone with that hand. The NA replied, you hit at me, you can do that. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	The Facility's Nurse Consultant and the Director of Nursing (DON) were interviewed on 6/22/22 at 11:10 AM. They both reported that the Administrator was not coming to the facility on Wednesday (6/22/22) and Thursday (6/23/22) but he will be available by calling him. The DON called the Administrator, and he was interviewed by telephone. When asked about their corrective action plan for the abuse allegation dated 3/3/22, he stated that he investigated the abuse allegation dated 3/3/22 on Resident #14 and had sent the 24 hour and 5 - day report to the State. An audit was completed on 3/3/22 by the SW by interviewing alert and oriented residents regarding abuse. Investigation was completed and was substantiated, and NA #8 was terminated. All staff were in-serviced on abuse. The Administrator added that the allegation of abuse was discussed on their March 2022 Quality Assurance (QA) meeting. When asked about their monitoring tool and if abuse was incorporated to their QA, he stated that he had the QA and would send it to the DON. He added that all the documents regarding the allegation of abuse with Resident #14 were in the folder including the staff statements, audits, and in-service records. Review of the documents regarding the abuse allegation dated 3/3/22 with Resident #14, provided by the DON revealed that the audit was completed for alert and oriented residents only with BIMS above 9 and not for confused residents with BIMS below 9. The March 2022 QA revealed allegation of abuse 3/3/22 - results from Interdisciplinary team (IDT) daily compliance rounds to be reviewed ongoing during monthly Quality Assurance Performance Improvement (QAPI) meeting ensuring all residents free from abuse. Monitoring will be on-going x (times) 3 months and concerns identified will be addressed during monthly QAPI meetings. There was no monitoring tool developed as to what to audit, how to audit and who will audit. The Facility's Nurse Consultant and the Director of Nursing (DON) were interviewed on 6/22/22 at 11:15 AM. The DON stated that she started as DON of the facility in May 2022. She reviewed the abuse investigation dated 3/3/22 and she identified that the facility missed to audit the confused residents with BIMS below 9 to ensure nobody was affected. She explained that the facility should have completed a head-to-toe assessment for all residents with BIMS below 9. The DON stated that when a resident's behavior started to escalate, the staff was expected to step back and let the resident calm down. This abuse allegation was substantiated since NA #8 failed to deescalate the resident's behavior; she restrained the resident instead by grabbing her arm. The DON further indicated that she had been monitoring for abuse by reviewing the 24-hour report, but she did not have any monitoring tool to document her audit. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	The Police was interviewed by telephone on 6/23/22 at 10:38 AM. The Police verified that he was dispatched to the facility on [DATE] due to allegation of assault. He met with Resident #14 and she was crying. The Police stated that the interview from the resident, nurse and NA #8 were written on his report. Review of the Police report was conducted. The report indicated that on 3/3/22 at approximately 6:19 AM, the Police was dispatched to the facility on a report of an assault. On arrival, the Police met with Nurse #9 who indicated that NA #8 and Resident #14 were involved in an altercation. NA #8 stated that when she was in Resident #14's room attempting to change the oxygen tubing, the resident yelled at her. The NA stated that she could not find the tubing and that was when the resident yelled. The NA asked the resident to stop yelling at her and the resident tried to hit her. The NA reported that she grabbed resident's arm and pushed back to avoid being hit and the resident was hit in the face. The Police interviewed Resident #14. He observed the resident was crying which made it difficult to understand at first. Once the resident calmed down, the resident explained that the NA hit her in the face. The resident stated that when the NA could not find the tubing, she told the resident I should just leave you're a- and struck her in the right side of her face. The resident reported that the NA told her to go ahead and report her because she did not care. Nurse #9 came in and assessed the resident. The nurse saw the marks on resident's face and stated that they were not there last night when she put the Trilogy mask on the resident. The resident had a bruise on her right eye along with other red marks in the same area that was consistent with the recent trauma. The Police report revealed that NA #8 was charged for abuse on an elderly person.

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F 0660 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Plan the resident's discharge to meet the resident's goals and needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41437 Based on record review, and interviews with family, home health, and staff, the facility failed to assess a resident's home environment to identify and evaluate barriers at the discharge location and arrange for home health services to commence the day after discharge. Upon arrival home, the transport driver assisted Resident #222 out of the vehicle and onto the sidewalk in front of her residence. The residence had 6 stairs leading to the front door and no wheelchair ramp. The resident's husband was present at the residence. The facility transporter left before the resident ascended the stairs into the residence. Resident #222 was unable to ascend all the stairs due to weakness and her husband was unable to assist her. The Resident's husband called the Fire Department to assist with getting Resident #222 from the sidewalk into the residence. The resident was home for several hours but was unable to safely ambulate in her residence. Emergency Medical Services were called around 5:30 PM and transported the resident to the hospital where she was admitted for generalized weakness, dehydration, deconditioning and intravenous fluid administration. This deficient practice affected 1 of 2 residents (Resident #222) reviewed for discharge. Immediate jeopardy began on Friday, 4/1/2022 when Resident #222 was discharged from the facility and transported to her residence via facility transporter and facility transport van around 2:00 PM. The immediate jeopardy was removed on 7/14/2022 when the facility provided and implemented an acceptable credible allegation of immediate jeopardy removal. The facility remains out of compliance a lower scope and severity level of D (no actual harm with a potential for minimal harm that is not immediate jeopardy) to ensure monitoring of systems put into place related to the discharge planning process are effective and to complete staff training. The findings included: Resident #222 was admitted to the facility on [DATE] with diagnoses that included sepsis related to chronic venous ulcerations of bilateral lower extremities. Resident #222's admission care plan initiated 2/22/2022 had a focus for discharge but it did not indicate where the resident expected to discharge. The resident's discharge goal was left blank. The second goal for discharge indicated the resident, family, caregiver would be able to verbalize understanding of the resident's discharge summary. The care plan also had a focus for barriers to discharge but it was not completed. Interventions for discharge planning included: Evaluate the competency and capacity of the caregiver. Involve resident, resident representative, and caregiver in the discharge process. Anticipate resident's needs post discharge. Resident teaching (left blank) Progress notes provided by the Social Worker (SW) revealed the following information: (continued on next page)

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F 0660 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 3/11/2022 the SW spoke with resident regarding a notice of Medicare Non-Coverage (NOMNC). Resident and husband both desired her to have more therapy and stated they would wait and hope the NOMNC would not be issued. SW reminded them of the need to plan ahead and try to get a first-floor apartment. Husband stated he could not afford to hire a mover. SW available to continue to advise on options and assist as needed for safe discharge. On 3/11/2022 the SW also documented the resident lived in a single-story apartment with 5 steps at entrance. SW documented the resident functioned at a wheelchair level, would not be able to install a ramp at the apartment complex she resided in, and would need to be able to navigate the steps. SW indicated the steps presented a barrier to safe discharge at that time. The SW indicated the resident had no children, only her husband to provide care at time of discharge. On 3/14/2022 NOMNC served to resident by SW with last date of care 3/16/2022. The resident stated she did not feel like she was ready to go home as she had just started walking and had 6 steps to enter her apartment with no possibility of a ramp. Resident stated she was looking forward to working with physical therapy on stairs. Resident stated she would speak to her husband regarding appealing. On 3/15/2022 SW documented she faxed appeal as well as referral for home health in preparation for discharge. On 3/16/2022 SW documented she spoke with the resident's husband regarding discharge plans. He stated there was no room in the residence for a wheelchair and preferred to discuss discharge after learning the outcome of the appeal. The husband stated there was no first-floor apartment available until summer and the resident would have to come home if the appeal was lost. The SW inquired about Medicaid eligibility and the husband stated they would not qualify for Medicaid due to assets. The SW recommended paid caregiver services and the husband stated they had no money for paid caregiver services. On 3/16/2022 SW documented a conversation with resident separate from her husband. Resident stated she needed more therapy to be able to climb her stairs however stated she would return home regardless of safety concerns if she lost her appeal. SW spoke to resident regarding the potential to remain in the facility and apply for Medicaid. Resident refused. SW offered assistance finding a senior apartment, but resident refused. On 3/17/2022 SW documented she contacted the resident's apartment complex manager regarding policy for ramps. The SW then called the resident's husband who stated he could not afford ramp rentals. An appointment was set up with resident and her husband to discuss possibility of Medicaid application. 3/18/2022 Resident and her husband met with SW regarding options for a safe and orderly discharge. Both were open to making room in the residence for a wheelchair and exploring ramp installation. The resident and her husband were given the address and contact number for the department of social services as well as contact information for local ramp rental companies. On 3/23/2022 NOMNC served to resident and appeals instructions reviewed. (continued on next page)

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F 0660 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 3/28/2022 SW documented resident was making progress toward discharge goal of 6 stairs to enter residence. Husband unable to secure ramp for residence at that time. Stairs continued to be a barrier at that time. On 3/29/2022 resident was served NOMNC with last date of care 3/31/2022. Resident stated she did not wish to appeal and planned to discharge home on 4/1/2022. There was no ramp in place at that time, but the resident stated she felt comfortable navigating steps. The plan was for resident to continue working with physical therapy through home health. The Physician Assistant (PA) who assessed Resident #222 on 3/30/2022 at 12:52 PM documented in the resident's medical record she saw the resident for discharge planning. For disposition the PA documented the following: Patient suffers from weakness and debility which impairs her ability to use stairs to get in and out of her home. A cane or walker will not resolve these issues with transfers into her home because of instability and risk of falling. A ramp that allows her to get in and out of her home is medically necessary to prevent falls and allow her to attend her medical appointments without requiring transportation from an ambulance company. Resident #222's medical record included a physician's order dated 3/31/2022 that read, Patient to discharge home on 4/1/2022 with family and home health. PT/OT to evaluate and treat as indicated, nursing for medication and wound management, and CNA for ADL assistance. Start of Care: 4/5/2022. The occupational therapy (OT) discharge summary for Resident #222 with end of care date 3/31/2022 revealed the resident did not meet activities of daily living (ADL) goals and was discharged with 50% ADL impairment. Pertinent OT goals included the resident will be modified independent in all aspects of self-care and activities of daily living within the home in order to return home with spouse safely. The OT discharge summary indicated the goal was not met. The summary also indicated she was discharged home with recommendations of home health. Resident #222's discharge included a discharge summary by physical therapy (PT) with end of care date 3/31/2022. The discharge revealed the resident was able to maintain balance while sitting and standing. The resident required partial assistance from another for mobility indoors and stairs. The discharge summary also revealed the resident used a wheeled walker as assistive device. For mobility with 4 steps, the resident required verbal cues, steadying and or contact guarding assistance for completing activity. The summary indicated she was discharged home with home health. On 6/21/2022 at 12:25 PM an interview was conducted with the Physical Therapy Director. She recalled Resident #222 and stated the resident was able to ambulate with walker and navigate 3 steps with stand by assist. She further stated Resident #222's discharge was hindered by insurance not covering many things like durable medical equipment, home health, and additional days for rehabilitation. Her husband was adamant they would not pay out of pocket for additional days in the facility and he would not allow the SW to apply for assistance on the resident's behalf. The Physical Therapy Director stated the SW assisted Resident #222 with multiple appeals, but all appeals were denied. When asked about stairs, the Physical Therapy Director stated the resident was able to ascend and descend 3 steps with stand-by assistance, but she was concerned the resident's husband, who was also had mobility issues, would not be able to provide the standby assistance the resident needed. A progress note by the SW dated 3/31/2022 indicated Home Health Provider #1 was able to accept resident's insurance with a start of care date 4/5/2022. (continued on next page)

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F 0660 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	An interview was conducted with the SW on 6/22/2022 at 9:19 AM. She stated there was difficulty getting home health set up due to the resident's insurance. The soonest home health could start was 4/5/2022. The resident's husband was aware of the 4/5/2022 start date. She stated the facility attempted to assist the resident with getting a wheelchair ramp, but the resident lived in a second-floor apartment and either could not afford, or the complex would not allow them to place a ramp. She stated they tried to get them to move to an apartment on the floor level, but the husband stated there would not be an apartment available until August and he did not have a means to move all of their things down to a ground level apartment. She stated the resident's husband stated several times he did not want to spend money or accept assistance to make it so the resident could return to the apartment. The SW stated the resident was able to transfer herself, walk with a walker, and navigate steps when she was discharged . She felt like it was a safe discharge at the time and the resident's husband was not going to pay for the resident to stay additional days. A second interview was conducted with the SW on 7/1/2022 at 3:00 PM. She stated she did not complete a home assessment for Resident #222 to assess for barrier to discharge. She further stated the facility quit doing home assessments during the pandemic and had only recently started completing home assessments again. When asked if she was aware the resident did not have a ramp in place at the time of her discharge, she stated she was aware there was no ramp in place at the time of discharge. When asked if a referral was made to Adult Protective Services at the time of the resident's discharge, she stated she did not make a referral. On 7/1/2022 at 2:15 PM a telephone interview was conducted with the Admissions Coordinator for Home Health Provider #1. She stated she received the referral for Resident #222 on 3/31/2022 and accepted the referral with a start date of 4/5/2022. She further stated that was the first available date they could start services due to staff shortages. Documentation provided by the Administrator indicated Home Health Provider #2 accepted the referral for wound care with a start date of 4/3/2022 and a nurse visit was scheduled for 10:30 AM to address the resident's dressing changes. On 6/22/2022 at 11:24 AM an interview was conducted with the Treatment Nurse. She stated she recalled Resident #222. She stated the resident got daily wound care for venous ulcers of bilateral lower legs. The Treatment Nurse stated the resident's venous ulcers were healing when she left the facility. She stated the resident could transfer from bed to wheelchair on her on and could stand bedside on her own. She was steady with assistance when using a walker. She did not believe resident would be steady enough to go up or down stairs. She did recall seeing the resident's husband and he had decreased mobility as well. Resident #222's discharge orders dated 3/11/2022 included a wound care order for acetic acid solution, 0. 25%; amount 60 milliliters irrigation to be used as wound soak every other day on Monday, Wednesday, and Friday. On 7/6/2022 at 10:30 AM a telephone interview was conducted with the Admissions Coordinator for Home Health Provider #2. She stated she accepted the referral for Resident #222 on 3/31/2022 with start date of 4/3/2022. She could not recall if 4/3/2022 was the first date they could staff the referral or if that was the date the facility requested start of services. (continued on next page)

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	345551	A. Building B. Wing	07/13/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pruitthealth-Carolina Point	5935 Mount Sinai Road Durham, NC 27705

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F 0660 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The resident's discharge Minimum Data Set (MDS) with observation end date 4/1/2022 indicated the resident was cognitively intact. She required two persons assistance for transfers, walked in her room only once or twice during the assessment period, locomotion in room was with set up only, locomotion in the facility occurred only once or twice during the assessment period, required assistance of one for dressing and toileting, and required the assistance of two persons for personal hygiene during the assessment period. Progress notes dated 4/1/2022 revealed Resident #222 left the facility via facility transport with medications, orders, and all belongings in hand. Husband stated he would meet resident at the home. Resident stated she was ready to go home. On 6/21/2022 at 1:50 PM an interview was conducted with the Facility Transporter. He stated he took Resident #222 home on 4/1/2022. He stated he could not remember if the resident was discharged with a wheelchair or walker. He stated he assisted her out of the vehicle and up to the curb. Her husband was waiting for her and said he could help her inside. He recalled the resident was able to get up the steps, 3-4, and she was on the top step when he pulled away from the curb. On 6/21/2022 at 5:02 PM a phone interview was conducted with Resident #222's husband who was also her responsible party (RP). He stated the facility did not ask to perform a home visit. He stated Resident #222 was transported from the facility to her residence on 4/1/2022 around 2:00 PM by the facility transporter. The transporter provided standby assistance for Resident #222 when she exited the transport van and when she stepped onto the curb. At that time, the transporter got into the van and drove off before Resident #222 ever got up the 6 steps to the residence. The husband stated Resident #222 was able to go up the first 4 steps but was unable to make it up the final 2 steps and into the residence. The husband called the local fire department who assisted the resident into the residence. He stated the resident sat in a chair in the living area of the residence for several hours but was unable to ambulate around the residence due to weakness. He further stated he had to call Emergency Medical Services (EMS) to transport the resident back to the hospital the evening of 4/1/2022. Fire Department and EMS records dated 4/1/2022 indicated they arrived on scene at 2:06 PM for a lift assist call. Upon arrival they found the resident on the stairs. The firemen assisted the resident to a stand position, but she still could not get up the stairs. The resident was assisted onto a stair chair and was lifted up the stairs. A second attempt was made to assist resident into the apartment, but she was unable to get over the step at the threshold of the residence. She was placed back on the stair chair and assisted into the residence. The resident was assisted to a stand and pivot into a recliner. Emergency Medics advised resident she should allow them to transport her to the emergency room (ER) for evaluation, but the resident and her husband refused. A second call to EMS was made on 4/1/2022 at 5:37 PM when they found the resident sitting in a chair in her bedroom. She was found to be hypotensive and tachycardic and stated she was unable to get around her residence. The resident and her husband agreed to transport to hospital. Hospital records dated 4/1/2022 revealed Resident #222 was admitted to theER on [DATE] at 7:10 PM and was admitted to the hospital with what the admitting Physician referred to as , generalized weakness, deconditioning, and dehydration. Resident #222 was given intravenous fluids for dehydration and intravenous iron for anemia. The hospital discharge summary dated 4/5/2022 indicated Resident #222 was discharged to a skilled nursing facility for ongoing physical therapy, occupational therapy and daily wound care. (continued on next page)

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F 0660 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	An interview was conducted with Nurse Practitioner (NP) #2 on 6/23/2022 at 9:15 AM. She stated she provided care for Resident #222 while she was in the facility but did not see Resident #222 on the date of her discharge. She further stated the last time she saw Resident #222 she could stand and pivot, but she never personally saw the resident ambulate any distance. On 6/23/2022 at 9:28 AM an interview with the Director of Nursing (DON). She stated she was not the DON in the facility at the time of Resident #222's discharge. She further stated she would have handled the situation differently. She stated she had provided education to the staff regarding situations where the resident does not want to stay in the facility, but the facility did not feel like the resident was ready to safely discharge. The Administrator was notified of immediate jeopardy on 7/7/2022 at 8:20 AM. The facility provided the following credible allegation of immediate jeopardy removal. The facility discharged resident home on 4/1/2022 via facility van transportation. Prior to discharge the facility failed to assess a resident's home environment for any discharge barriers or level of caregiver support. As the result of the facility's failure, the resident required Emergency Medical Services assistance which ended with the resident transferring to the hospital on the same day of discharge. Residents who have been discharged from the facility and residents with potential discharge to the community have the potential to be impacted. The Social Worker completed a review on 7/6/2022 of all community discharges, from 4/1/2022 through 7/5/2022, validating home health was offered, Durable medical equipment was ordered if needed, education provided to resident / responsible party, and that the post discharge follow up phone calls made to the residents / responsible party after discharge. Seventeen residents where discharged home from 4/1/2022 to current. Of the seventeen residents, thirteen were provided home health services with three residents declining home health and Durable medical equipment. The purpose of this audit was to ensure all other residents discharging to the community received a thorough discharge assessment which appropriately identified and addressed potential barriers of the discharge and were provided appropriate equipment and resources. The purpose of this review was to identify no other resident was affected by this practice. Specify the action the entity will take to alter the process or system failure to prevent a serious adverse outcome from occurring or recurring, and when the action will be complete. The facility has two residents discharging on 7/6/2022, resident number one is being discharged to home with granddaughter who is her care giver and her daughter who is the Responsible Party has taken Family Medical Leave for this transition. The Responsible Party declined a home evaluation by therapy stating she already has needed items in place. Resident / Responsible Party has signed a form stating her refusal for a therapy home evaluation. Home Health has been confirmed to start on 7/7/2022, Therapy Services and wound care consultation has been set up for home discharge. Per Physician Assistant discharge summary dated 7/6/2022, the resident is medically stable and cleared for discharge. (continued on next page)

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F 0660 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Resident number two who is alert and oriented and his own Responsible Party, is being discharged home with a roommate, per their wishes, Against Medical Advice. They state they can receive the same services at home, and he will be able to sleep in his own bed and eat his own food. Therapy offered a home evaluation and resident has declined the evaluation. Resident was requested by the Nurse Navigator RN to stay in facility for at least twenty-four more hours for the facility to obtain home health services, but resident declined. Resident refused the medication when offered by the Director of Nursing stating he has everything he needs at home. The Physician Assistant saw the resident prior to discharge on 7/6/2022 and discussed risks involved with leaving the facility against medical advice. When the resident leaves the facility, Adult Protective Service APS was notified on 7/6/2022 by the Social Worker of the discharge against medical advice. The decision to make an APS referral was determined by the facility interdisciplinary team based on the resident's discharge against medical advice. This notification has been documented in the medical record. To correct the deficient practice the facility will initiate discharge planning upon admission with the resident and/or responsible party for determination of long-term placement or short-term placement with return to the community. For community discharges, community resources will be offered to include but not limited to Therapy screen to identify if a virtual, onsite home, or no site visit is needed for equipment and services needed at home, home health agencies, Therapy services, meals on wheels, community care services, outpatient clinics and social service agencies. Physician / Physician Extender will assess facility discharges to ensure that the resident is medically stable for discharge prior to discharge. For residents who choose to discharge back to the community against medical advice, the community resources will be offered to include but not limited to Therapy screen to identify if a virtual, onsite home, or no site visit is needed for equipment and services needed at home, home health agencies, Therapy services, meals on wheels, community care services, outpatient clinics and social service agencies. However, the decision to make an APS referral will be determined by the facility interdisciplinary team based on if the resident discharges against medical advice or if there is an unsafe situation creating a barrier to discharge. Interdisciplinary team will communicate the need for an APS referral to Social Worker / Nurse Navigator. Adult protective Services will be notified by a facility representative (Social Worker / Nurse Navigator) that the resident has discharged against medical advice. An Adult Protective Service referral may also be made if the Interdisciplinary team believes the resident may be in an unsafe situation. On 7/6/2022 the Home Safety Assessment screening form was reviewed and revised by the [NAME] President of Therapy Services and the Director of Clinical Operations for Therapy Services. This screening form includes a home safety assessment to determine the need for a virtual home visit, onsite home visit or if no visit is needed to determine residents' mobility within the home, equipment and or home modification needs in the home prior to discharge. This process ensures that the facility has thoroughly evaluated potential barriers of the discharge prior to discharge. The Therapy Outcome Coordinator began educating the Licensed Therapist on 7/6/2022 regarding the home screening evaluation, any therapist not educated by 11:00 pm 7/6/2022 will be removed from the schedule until education has been completed. The Therapy Outcome Coordinator will maintain a log of therapist educated and therapist not educated. (continued on next page)

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F 0660 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 7/6/2022 the Director of Health Services and / the clinical Competency Coordinator began educating the Interdisciplinary Team, including but not limited to the Social Worker, Activity Director, Nurse Managers / Coordinator, Therapy Outcomes Manager, Certified Dietary Manager, Nurse Navigator, Case Mix Director on discharge planning and making appropriate referrals per policy (Discharge Planning) to include the home safety assessment evaluations by therapy. Interdisciplinary Team members who have not been educated by 7/6/2022 11:00pm will be removed from the schedule until the education has been completed. The Director of Health Service is maintaining a log of employees educated. On 7/6/2022 the Director of Health Services and/or Clinical Competency Coordinator began education with the Social Worker and Nurse Navigator, on placing follow up phone calls to the community discharged residents / responsible party ensuring; resident is adapting back to home environment / prior level of care environment, appropriate level of caregiver support, and to identify any further resources they may require. These calls will be made 24 hours following discharge, then 72 hours post discharge, and then weekly for four weeks. Concerns voiced by the discharge resident and/or Responsible Party will be brought forth to the Interdisciplinary Team for follow up and any recommendations for additional services will be provided. On 7/6/2022 the Director of Health Services educated the van driver on ensuring residents are safely within the home prior to leaving the resident's property when the facility provides transportation. This includes assisting the resident into the home and that if the resident / responsible party refuses the van driver is to maintain visualization until the resident is inside the home. This education was provided to the one van driver currently employed. This education will be provided for all newly hired van drivers during general orientation prior to transporting residents. On 7/13/2022 the Director of Health Services educated the van driver on the discharge process to include, when facility is providing discharge transportation home, the resident is to be assisted into the home, and if assistance is refused, visualize the resident entering home. When the resident's family member / responsible party is to be providing transportation home, Therapy will assess, educate, and practice car transfers safely into and out of the vehicle. This process is already incorporated in the Discharge Location Checklist Form. When the resident is transported home through a contracted transportation company, Therapy will ensure a safe discharge by conducting a Home Safety Assessment and Safe Community Discharge checklist. The company will provide transportation to the resident's home and if the driver determines resident is unable to safely enter the dwelling, driver will notify the facility and/or EMS. Facility does post-discharge 24-hour follow-up calls for all discharges. The Administrator was responsible for the credible allegation. (continued on next page)

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F 0660 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The facility's credible allegation of Immediate Jeopardy removal was validated on 7/13/22. The validation was evidenced by staff interviews, record reviews and review of in-service documentation to verify education had been provided to staff that addressed the process of discharge planning and making appropriate referrals. Interviews were conducted with the facility's van driver, Therapy Outcomes Manager, Nurse Managers, Physician Assistant, and Medical Director to discuss their role to ensure a safe discharge for residents. Although the facility's Nurse Navigator was no longer employed by the facility (as of 7/12/22), interviews with the Clinical Competency Coordinator, Director of Nursing and Social Worker confirmed the discharge responsibilities of the Nurse Navigator were currently being shared among them. The interventions for a safe community discharge included offering resources such as a Therapy screen to identify if a home site visit was required to assess the equipment and services needed at home; the resident being assessed by the physician/physician extender prior to discharge; and making a referral to Adult Protective Services (APS) if the resident was discharged Against Medical Advice (AMA) and/or under circumstances which suggested an unsafe discharge. Further measures to ensure a safe discharge to the community included addressing the resident's mode of transportation to his/her home via the facility van, a family member/responsible party, or through a contracted transportation company. The staff interviews confirmed follow-up phone calls were also being made to the community discharged residents to ensure their needs were being met. The Administrator was notified on 7/13/22 the credible allegation for the immediate jeopardy removal was validated on this date (7/13/22) with a removal date of 7/14/22.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38077 Based on observation, record review and interviews with resident, staff, and transportation driver, the facility failed to: 1) Provide the necessary Activities of Daily Living (ADLs) assistance to ensure that Resident #39 was ready for a scheduled outpatient appointment for 1 of 5 residents reviewed for ADL care. Resident #39 missed his scheduled ophthalmology appointment because the staff did not prepare him to for the appointment; and 2) Provide incontinence care for 1 of 5 dependent residents (Resident #14) reviewed for ADL care. The findings included: 1. Resident #39 was admitted to the facility on [DATE] with diagnoses that included diabetes mellitus type 2 and dysarthria and anarthria (brain damage). Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #39 was assessed as having adequate vision and used corrective lens. Resident #39 was assessed as cognitively intact and needed limited assistance of one person for transfers, dressing and personal hygiene. The resident needed total assistance of one person physical assistance for toileting and extensive assistance of one person for bathing. Review of the revised care plan dated 5/4/22 revealed Resident #39 was care planned for ADL function and rehabilitation potential. ADL decline was related to recent hospitalization . The goals were to improve ADL function to maintain independence, ADL needs would be met, and independence potential maximized within constraints of disease. Interventions included encouraging resident to do as much as possible, setting up resident for ADLs and providing assistance devices as needed. Review of the appointment sheet revealed Resident #39 had an eye appointment on 6/20/22 at 9:50 AM. During an interview on 6/20/22 at 12:10 PM, Resident #39 stated he had a regular annual eye appointment scheduled on 6/20/22 at 10:00 AM. The appointment was scheduled in advance. Resident #39 further stated the assigned nurse had not informed the nurse aide (NA) about the appointment. Resident #39 indicated he was not ready when transportation had arrived to take him for the appointment. Resident #39 further indicated that because the nursing assistant had not gotten him ready in time, the appointment had to be rescheduled. The resident indicated he needed assistance with dressing and personal hygiene. Resident #39 further indicated when the transportation staff came to his room to pick him up, he was not yet dressed and ready for the appointment. During an interview on 6/20/22 at 3:06 PM, the transportation staff stated he came to the facility to pick up the resident between 9:15 to 9:20 AM on 6/20/22. The transportation staff further stated that when he went into the resident's room, he observed that the resident was still in bed and was not ready for his appointment. The transportation staff stated Resident #39 had indicated to him that the NA had not gotten him ready for the appointment. Transportation staff further stated that Resident #39 indicated, he was going to reschedule the appointment. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/20/22 at 12:40 PM, Nurse #1 stated Resident #39 had an eye appointment earlier that day, that he missed. Nurse #1 stated all appointment sheets were printed by the night shift (7PM -7AM) Nurses. The morning shift (7 AM - 7 PM) Nursing Assistant's (NAs) were responsible to check the appointment sheet and get the residents ready for their appointment when the transportation arrived. Nurse #1 indicated she was unaware that Resident #39 had an appointment that morning. Nurse #1 further indicated that the transportation staff had notified her that the resident had cancelled his appointment. During an interview on 06/20/22 at 1:30 PM, Nurse Aide (NA) #1 indicated she arrived at 9:00 AM on 6/20/22. Resident #39 was up in his bed as she entered the room at 9:30 AM and he stated that he had missed his appointment. She indicated she was not aware of the appointment. She had not checked the appointment sheets. During an interview on 6/20/22 at 3:30 PM, NA #2 stated she was assigned to Resident #39 that morning until NA #1 arrived. NA #2 indicated she was unaware that Resident #39 had an appointment that morning and did not get him ready. NA #2 stated usually the assigned nurse notified her when a resident had an appointment. NA #2 indicated she was not notified by the Nurse. NA #2 stated she woke him up and served him his breakfast tray. The resident did not mention he had an appointment. NA #2 indicated the resident needed limited assistance with dressing and personal hygiene. During an interview on 6/21/22 at 9:00 AM, the Appointment Scheduler indicated Resident #39 had a scheduled appointment on 6/20/22. Every Friday the appointment sheets of all residents for the upcoming week were printed. The scheduler stated a copy of the appointment sheet was given to the resident, and copies were given to the Nurses, Therapy Department, and Director of Nursing. A copy of the appointment sheet was also placed in the appointment folder near the nursing station. It also contained the transportation arrangement information. During an interview on 6/23/22 at 9:06 AM the Director of Nursing (DON) stated the nurses assigned to the resident were responsible to inform the nurse aides of any scheduled appointments for the day so the that the residents were ready . The DON further stated appointment folders were at the nursing stations the Friday prior. Nursing staff were responsible to ensure residents were ready when transportation arrived. 32394 2. Resident #14 was admitted to the facility on [DATE] with re-entry on 9/10/21 after a hospital stay. Her cumulative diagnoses included cerebrovascular accident (CVA) with hemiparesis/hemiplegia (mild to severe weakness on one side of the body), respiratory failure, heart failure and edema. The physician ' s medication orders for Resident #14 included an order initiated on 5/26/22 for 40 milligrams (mg) furosemide (a diuretic) to be administered to the resident once daily each morning. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The resident ' s most recent Minimum Data Set (MDS) was an annual assessment dated [DATE]. This assessment revealed Resident #14 was cognitively intact with a Brief Interview for Mental Status (BIMS) score of 15 out of 15. No behaviors were reported. The assessment also indicated Resident #14 required extensive assistance with bed mobility, transfers and personal hygiene with 1-person physical assistance for toileting occurring on 1-2 occasions during the 7-day look back period. The MDS assessment indicated Resident #14 was occasionally incontinent of bladder and frequently incontinent of bowel. Resident #14 ' s current care plan addressed a problem related to her risk for alteration in fluid balance related to the diagnosis of congestive heart failure, diabetes, and use of a diuretic medication (Last Reviewed/Revised on 6/21/22). The planned interventions indicated the resident ' s medications would be provided as ordered by the physician. Another problem addressed by the care plan read, Resident with manipulative behaviors such as often refusing care including showers and ADL (Activities of Daily Living) assistance such as bedmaking and will often state staff refused to provide care. The interventions included: Staff will offer ADL care daily and if refused will report to nurse and re-offer (Last Reviewed/Revised on 6/22/22). The resident ' s July 2022 Medication Administration Record (MAR) revealed Resident #14 ' s furosemide was last documented as administered on 7/13/22 at 6:21 AM. An interview was conducted on 7/13/22 at 1:52 PM with Nursing Assistant (NA) #13. The NA was observed as she was approaching the door to Resident #14 ' s room. When asked, the NA reported she was assigned to care for Resident #14 and her roommate on this hallway in addition to several residents on another hallway. At that time, the NA was asked when she last provided incontinence care for Resident #14. The NA responded by saying her shift started at 7:00 AM. She reported Resident #14 typically called out by using her call light to request incontinence care around 10:00 AM. However, the NA stated she was on the other side (referring to the other hall) and did not know whether or not the resident had used her call light. When the question was asked again, the NA reported she had not provided incontinence care to Resident #14 during her shift thus far. This answer was repeated to her for verification and the NA confirmed she had not provided incontinence care to the resident since she started her shift at 7:00 AM. An observation and interview was conducted on 7/13/22 at 1:55 PM with Resident #14. The resident verbalized she was upset, stating she had gone several hours without staff providing incontinence care for her. The resident estimated it had been more than 4 hours since she had been changed. At the time of this interview, an observation of the bottom sheet of Resident #14 ' s bed was visualized. The bottom sheet was visibly wet, starting from the area of the resident ' s right hip and continuing approximately 6 inches towards the edge of the bed. The resident was asked if she had spilled a liquid on herself or the bed. She stated No and reiterated the sheet was wet because she had not been changed for several hours. A lingering odor of urine was detected in the room at the time of this interview and observation. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	As the interview with Resident #14 continued, she reported putting on her call light three times on this date (7/13/22) to request incontinence care. The resident stated, I ' ve been ringing and ringing and no one answered. Upon further inquiry, she reported someone (not identified) came in each time she rang her call light and turned it off without providing the incontinence care. The resident was then asked when NA #13 had last been in her room. The resident responding by stating, I haven ' t seen her. A follow-up interview was conducted on 7/13/22 at 3:10 PM with NA #13. During the interview, the NA confirmed once again that she had not provided incontinence care for Resident #14 prior to 1:50 PM. However, the NA reported the resident was not correct when she reported to the surveyor that the NA had not been in the room. The NA stated she herself brought in the resident ' s breakfast and lunch trays. When she brought in Resident #14 ' s lunch tray, she stated the resident told her she needed incontinence care. The NA reported she told the resident staff were passing lunch trays at that time so she would have to come back to take care of it. When asked, the NA reported she did not have a chance to return to the room until she was observed preparing to do so at 1:50 PM. To her knowledge, the resident had not refused incontinence care that morning or afternoon. An interview was conducted on 7/13/22 at 3:34 PM with Nurse #1. Nurse #1 was assigned to Resident #14 ' s hall and reported she administered the medications for this resident around 9:00 AM that morning. Upon further inquiry, the nurse reported Resident #14 tended to want ADL care done on her terms. At the time of the medication administration, the resident was still in bed and did not express any care needs. When the Nurse Manager went back to check Resident #14 ' s blood sugar around 11:30 AM, the resident stated she was still on her computer and wasn ' t ready to get up out of bed. The resident reportedly did not say she was needing incontinence care at that time. When asked what time the lunch trays came out for Resident #14 ' s hall, the nurse reported the trays came out around 12:10 PM. When asked, Nurse #1 reported she did not go into Resident #14 ' s room today to answer the resident ' s call light. She also stated she had not been made aware of Resident #14 ' s call light being put on to request assistance on this date. An interview was conducted on 7/13/22 at 2:20 PM with the facility ' s Director of Nursing (DON). During the interview, the DON reported Resident #14 would refuse ADL care on occasions. However, the DON stated she would expect staff to address a resident ' s concern immediately when a call light was activated and for ADL care to be provided upon any request for incontinence care. If staff were not able to help the resident immediately, she expected them to tell the resident why and assure him/her they would return to provide the assistance needed. When asked how often she would expect staff to provide incontinence care or check on a resident, the DON stated routine checks with rounding should be conducted every two hours if the resident hadn ' t called out requesting assistance before that.

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	345551	A. Building B. Wing	07/13/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pruitthealth-Carolina Point	5935 Mount Sinai Road Durham, NC 27705

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41437 Based on record reviews, observations and staff interviews, the facility failed to ensure the alternating pressure reducing mattress was set according to the resident's weight for 1 of 4 (Resident #20) residents reviewed for pressure injuries. The findings included: Resident #20 was admitted on [DATE] for diagnoses that included advanced kidney disease and muscle weakness. The resident's quarterly Minimum Data Set (MDS) dated [DATE] indicated Resident #20 was severely cognitively impaired, required extensive assistance with all activities of daily living, and had one unstageable pressure injury that was not present on admission. Resident #20's care plan was last revised on 6/17/2022 and included a focus for pressure injuries to the heel and sacrum. Interventions included repositioning resident routinely. Record review revealed Resident #20's most recent weight was 121.8 lbs on 6/9/2022. On 6/22/2022 at 11:00 AM during a wound care observation, the resident was observed to be on an alternating pressure reducing air mattress. The console indicated the mattress should be set according to the resident's body weight. The mattress was set at 300 pounds (lbs). During the wound care observation on 6/22/2022 at 11:00 AM the wound care nurse was interviewed. When asked if the resident was 300lbs, she stated he was not. When asked who monitored the pressure reducing air mattresses for proper settings, she stated she did not know. She further stated she did check to make sure the air mattress was on and inflated. On 6/22/22 at 11:14 AM an interview was conducted with Nurse #10. She was assigned to Resident #20. She stated she did not monitor mattress settings. She did not know who monitored the alternating air mattress for proper setting. She stated she only made sure the air mattress was turned on. On 6/22/2022 at 11:38 AM an interview was conducted with the maintenance director. He stated he and his assistant placed air mattress on the bed, but they did not turn the mattress on or set the mattress to the resident's weight. On 6/23/2022 at 11:15 AM and interview was conducted with the Director of nursing. She stated she expected pressure reducing air mattresses to be set according to the resident's weight.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41437 Based on record reviews and interview with staff and the Nurse Practitioner, the facility failed to ensure as needed psychotropic medications were time limited in duration for 1 of 5 residents reviewed for unnecessary medications (Resident # 32). The findings included: Resident #32 was admitted [DATE] with diagnoses that included vascular dementia and anxiety. Resident #32's quarterly Minimum Data Set (MDS) dated [DATE] indicated the resident was severely cognitively impaired, was sometimes understood others but was rarely understood by others. She received antipsychotics 7 out of 7 days and received hospice care during the assessment period. The resident's comprehensive care plan, last revised 3/31/2022, included a focus for psychotropic drug use related to anxiety and agitation. Resident #32's active orders include an order for lorazepam 0.5mg oral as needed (prn) for restlessness and agitation with a start date of 6/2/2022 and no end date. The order was written by Nurse Practitioner #2. A pharmacy review was conducted 6/22/2022 and recommended an end for lorazepam 0.5mg oral prn for restlessness and agitation. A telephone interview was conducted with Nurse Practitioner #2 on 6/23/2022 at 4:30 PM. She stated she was not aware prn orders of lorazepam needed to have an end date when the resident was under hospice care. On 6/23/2022 at12:37 PM an interview was conducted with the Director of Nursing (DON). She stated she was aware prn orders of lorazepam required an end date even when the resident was under hospice care.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 14652 Based on observation and staff interview, the facility failed to label and date food items in 1 of 2 nourishment refrigerators (,d+[DATE] hall). The failure had the potential to affect food served to residents. Findings included: The ,d+[DATE] nourishment room was observed on [DATE] at 2:50 PM. The following food items were observed inside the nourishment room refrigerator: Cooked green beans in a plastic container- unlabeled and undated Cooked macaroni and cheese in a plastic container - unlabeled and undated Broccoli cheddar soup in a plastic container (opened)- unlabeled and dated [DATE] Sliced sharp cheddar (10 slices) in opened zip lock bag - unlabeled and undated Nurse #1 was interviewed on [DATE] at 2:54 PM. She stated that dietary department was responsible for checking the nourishment refrigerator. The Dietary Manager (DM) was interviewed on [DATE] at 2:55 PM. She indicated that nursing department was responsible for checking the nourishment refrigerators to ensure resident's food were dated and labeled and to discard expired food items. The DM observed the ,d+[DATE] nourishment refrigerator and observed the unlabeled and undated food items and stated that nursing was not checking the refrigerator. The DM was observed to discard the food items in the refrigerator that were unlabeled, undated, and expired. A follow up observation of the ,d+[DATE] hall nourishment refrigerator was conducted on [DATE] at 12:05 PM. There were 3 pieces of fried chicken in the box stored in the refrigerator that was undated. The Registered Dietician (RD) was interviewed on [DATE] at 1:01 PM. The RD stated that she expected the facility to follow the policy in dating and labeling of food items stored in the nourishment refrigerators. She added that the DM had already informed her of the undated/unlabeled food in the nourishment refrigerator and she would in-service the staff of the policy.

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. 38077 Based on observations, staff interviews, and record review the facility's Quality Assessment and Assurance (QAA) Committee failed to maintain implemented procedures and monitor the interventions that the committee put into place following a recertification survey in September 2019, April 2021 and subsequently recited in June 2022 on the current recertification and complaint survey. The recited deficiencies were in the areas of develop an accurate assessment (F641) and food procurement, Store/Prepare/Serve -sanitary (F812) These deficiencies were recited in the current recertification survey. The continued failure of the facility during three federal surveys of record shows a pattern of the facility's inability to sustain an effective Quality Assurance (QA) Program. The findings included: These tag were cross referenced to: F 641 - Accuracy of Assessment Based on record review and staff interviews, the facility failed to accurately code the Minimum Data Set (MDS) assessment for 3 of 18 residents whose MDS assessments were reviewed. (Resident #21, #223, #72) During the previous survey on 4/29/21, the facility failed to accurately code the Minimum Data Set (MDS) assessment to indicate the Preadmission Screening and Resident Review (PASRR) Level II status (Resident #61, Resident #52, Resident #2, Resident# 31, Resident#29) for 5 of 18 residents whose MDS assessments were reviewed. During the recertification survey on 9/20/19, the facility failed to accurately code Activities of Daily Living (ADL) on the Minimum Data Set (MDS) assessments for 2 of 21 residents reviewed for ADL's (Resident #84 and Resident # 111), F812 - Food Procurement, Store/Prepare/Serve- Sanitary Based on observation and staff interview, the facility failed to label and date food items in 1 of 2 nourishment refrigerators (300/400 hall). The failure had the potential to affect food served to residents. During the previous recertification survey on 4/29/21, the facility failed to keep clean and failed to label and date food for 1 of 2 nourishment refrigerator/freezers reviewed for food storage (400-hall). The facility was also cited during the 9/20/19 recertification survey for failure to maintain and clean following kitchen equipment; the stove, oven, steam table, plate warmer, plate/dome rack, refrigerator, and freezer. (continued on next page)

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 3/29/18 at 4:59 PM, the Administrator indicated 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. The Administrator indicated when problem areas were identified the quality assurance and performance improvement (QAPI) plan was laid out. Individual staff should report progress or lack of progress and reason for the lack of progress. The root cause should be analyzed, and all effort should be made to resolve this issue. The team should continuously monitor until the deficient area concerns have been resolved.