

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  345061	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  06/13/2025
NAME OF PROVIDER OR SUPPLIER  Pruitthealth-Durham		STREET ADDRESS, CITY, STATE, ZIP CODE  3100 Erwin 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)		
<p>F 0580</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on record review, and staff, responsible party (RP), Hospice Nurse, and Physician interviews, the facility failed to notify the provider of a change in condition and x-ray results after a fall for one (Resident #1) of three residents reviewed for notification of falls. Resident #1 fell on 5/17/2025 and the facility failed to notify the provider of pain and a new inability to bear weight. X-ray results obtained midday on 5/19/2025 were not relayed to the on-call provider until after hours on 5/19/2025. Resident #1 sustained an acute impacted left femoral neck fracture (an acute impacted left femoral neck fracture is a break in the upper part of the thigh bone (femur), specifically at the neck, where it connects to the ball of the hip joint). Findings included:</p> <p>Resident #1 was admitted to the facility on [DATE] with diagnoses of history of cerebral vascular accident, hemiplegia, hemiparesis, and lung cancer. Hemiplegia is paralysis on one side while hemiplegia is weakness on one side of the body. Resident #1 started receiving Hospice services on 3/31/2025.</p> <p>Documentation on a timesheet for Nurse Aide (NA) #1 revealed she worked at the facility from 7:18 AM to 10:53 PM on 5/17/2025. Documentation on the corresponding nursing schedule revealed NA #1 was assigned to care for Resident #1 during that time period.</p> <p>NA #1 was interviewed on 6/10/2025 at 11:54 AM. NA #1 revealed the following information. Resident #1 had a fall on 5/17/2025. NA #1 heard Resident #1 fall, and she told Nurse #4.</p> <p>Nurse #4 was interviewed on 6/10/2025 at 6:41 PM and revealed the following information. Nurse #4 worked the 7:00 AM to 7:00 PM shift on 5/17/2025. Resident #1 fell on 5/17/2025 while trying to go to the bathroom. Nurse #4 did full range of motion assessments of all her limbs and took the vital signs of Resident #1. Nurse #4, with the assistance of NA #1, helped Resident #1 up off the floor and into her wheelchair. Nurse #4 was so busy with a new admission, helping residents eat, changing incontinence briefs, and administering medications that she was not able to document anything in the electronic medical record. Nurse #4 also stated that she forgot to notify anybody about the fall but, Resident #1 was without injury or pain after the fall on 5/17/2025.</p> <p>There was no documentation in Resident #1's electronic medical record of any fall, assessments, or notification of physician or family on 5/17/2025 for the 7:00 AM to 7:00 PM shift.</p> <p>(continued on next page)</p>		

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0580</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>An interview was conducted with the Responsible Party (RP) #1 for Resident #1 on 6/10/2025 at 2:06 PM. RP #1 provided the following information. RP #1, her husband, and her children went to visit Resident #1 on the morning of 5/18/2025. RP #1 barely got down the hallway when she was stopped by NA #1. NA #1 explained that she had not yet assisted Resident #1 out of bed and to get dressed. NA #1 said she knew that RP #1 would like to take Resident #1 outside. NA #1 then told RP #1 that Resident #1 fell yesterday (5/17/2025) but she was fine. RP #1 remarked to NA #1 that nobody had called to tell her about the fall. RP #1 went to see Resident #1 and to ask her about the fall. RP #1 stated that she and her husband were trying to help Resident #1 to get up, but it seemed like she was in pain, and she could not bear any weight. This was a change for Resident #1 because although she was weak on her left side she had always been able to stand. RP #1 revealed she assisted Resident #1 in dressing and then asked her about the fall she had on the previous day. Resident #1 told RP #1 that she was trying to get to the bathroom, and she twisted her left foot and fell. Resident #1 told RP #1 she did not hit her head. Resident #1 told RP #1 that a nurse and a nurse aide put her back into bed. RP #1 indicated Resident #1 seemed very sore and was protecting her left side. RP #1 stated she and her husband took Resident #1 to the bathroom, but Resident #1 was not able to stand or bear any weight. RP #1 indicated Resident #1 required her husband to pick her up and hold her to get on and off the toilet and back into the wheelchair. RP #1 then went to the nurse's desk and spoke to Nurse #4. RP #1 told Nurse #4 that Resident #1 told her she fell last night and she was now in pain. RP #1 said Nurse #4 acted like she didn't know what RP #1 was talking about. Nurse #4 told RP #1 that Resident #1 had not mentioned anything about a fall or pain to her. Nurse #4 stated she would check and see if Resident #1 fell last night and confirmed she did not see anything about a fall in the electronic medical record. Nurse #4 went down to Resident #1's room and gave her pain medication but did not do any assessment or do anything else for Resident #1. RP #1 revealed she told Nurse #4 that Resident #1 was unable to bear weight on her left side and Nurse #4 kept acting like she didn't know what she was talking about or with any concern. Resident #1 told RP #1 that Nurse #4 was the nurse who was in the room last night after the fall. RP #1 did take Resident #1 outside to get some air but Resident #1 seemed very sore anytime they moved her, and she required more assistance than usual.</p> <p>Nurse #4 was interviewed on 6/10/2025 at 6:41 PM. Nurse #4 confirmed she worked the 7:00 AM to 7:00 PM shift on 5/18/2025. Nurse #4 stated that RP #1 came to the desk on the morning of 5/18/2025 and told her Resident #1 was having back pain. Nurse #4 stated that Resident #1's fall that occurred on 5/17/2025 was not discussed at all with RP #1. Nurse #4 stated that Resident #1 was not injured so there was no reason to tell RP #1 about the fall. Nurse #4 confirmed she administered an ordered dose of Oxycodone to Resident #1 on the morning of 5/18/2025. Nurse #4 confirmed she did not do any documentation or notification of a physician on 5/18/2025 because she was too busy with nursing duties.</p> <p>RP #1 was interviewed on 6/10/2025 at 2:06 PM and revealed the following information. On the morning of 5/19/2025 RP #1 had concerns for Resident #1, so she sent a text message to Hospice Nurse #1 first thing in the morning. RP #1 told Hospice Nurse #1 that Resident #1 had a fall on 5/17/2025 and she was in pain. Hospice Nurse #1 told RP #1 that Resident #1 was the first person she would visit that day. RP #1 could see on 5/19/2025 in a video call to Resident #1 that she was in a lot of pain and was guarding her left side.</p> <p>(continued on next page)</p>		

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<p>F 0580</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Documentation in a Hospice Nurse as needed visit note dated 5/19/2025 at 1:46 PM revealed, Received message from [RP #1] that [Resident #1] had a fall over the weekend. Arrived [Resident #1's] room, [Resident #1] was sleeping. Called out her name and [Resident #1] woke up without difficulty. Asked [Resident #1] about the fall, [Resident #1] narrated saying, I called for someone to help me to bathroom, but no one came, I did not want to pee on myself, so I got up using my cane, but my left foot got caught and I tripped over and fell on my left side. I lay there until an aide came to help me up. [Resident #1] had an unwitnessed fall on Saturday 5/17/2025, consulted facility nurse for details but [Nurse #3] stated that he had no report of the fall from previous shift. Since then, she has complained of pain of 5 to 8 on numerical scale. [Resident #1] able to assist in turning, but pain prohibits turning to left side of body. [Resident #1] left leg and foot had no bruising, swelling, or hotness. [Resident #1] left side is the weak side from history of [Cerebral Vascular Accident]. Asked the facility provider [MD #1 (Physician)] for further management. Provider did an assessment and ordered STAT (immediate) X-ray of left leg and hip. Called Mobile service for STAT x-ray and collaborated with facility nurse for pain medication, to start with [as needed] acetaminophen. [Resident #1] was slightly tachycardic in 111-113 beats/minute with oximetry, oxygen saturation initially was 88 % on room air then after repositioning it came up to 93 %. (Tachycardia is a medical condition characterized by a rapid heart rate, typically defined as a resting heart rate of over 100 beats per minute.) Called family for update, to call Hospice and not to wait next time there was a concern.</p> <p>Hospice Nurse #1 was interviewed on 6/10/2025 at 5:20 PM. Hospice Nurse #1 revealed she was the case manager for Resident #1. Hospice Nurse #1 stated that on 5/19/2025 RP #1 sent her a text notifying her that Resident #1 had a fall over the weekend on 5/17/2025. Hospice Nurse #1 revealed she went to the facility, assessed Resident #1, and immediately contacted MD #1 (Physician), who was in the building. MD #1 looked at Resident #1 and ordered a STAT x-ray. Hospice Nurse #1 called mobile x-ray. Hospice Nurse #1 confirmed she asked Nurse #3 about Resident #1's fall on 5/17/2025 but he was unaware of the fall and did not see any documentation in the electronic medical record about the fall.</p> <p>MD #1 (Physician) was interviewed on 6/11/2025 at 8:06 AM and revealed the following information. MD #1 was doing his rounds at the facility on 5/19/2025 when a nurse approached him and asked him to look at Resident #1. MD #1 did an assessment of Resident #1 and noted her left leg was shorter and was externally rotated. MD #1 was certain that Resident #1 had a fracture, so he ordered a STAT x-ray of her left hip and made sure that Resident #1 had pain medication ordered and available. MD #1 requested to be contacted when the results of the x-ray came back for further orders. MD #1 expected a provider to be notified of any acute findings at the time they were available. MD #1 explained that Resident #1 was not one of his patients but for any change in condition; including x-ray results of a fracture, a provider should be notified to obtain additional orders. MD #1 confirmed notification was a key piece in the provision of care.</p> <p>Nurse #3 was interviewed on 6/10/2025 at 2:53 PM and provided the following information. Nurse #3 worked from 7:00 AM to 3:00 PM on 5/19/2025. Nurse #3 was told by Hospice Nurse #1 that Resident #1 had a fall on 5/17/2025 and that MD #1 had ordered a STAT x-ray of her left hip.</p> <p>Documentation on the x-ray results dated 5/19/2025 revealed Resident #1 had sustained an acute impacted left femoral neck fracture. The x-ray results were faxed to the facility at 2:50 PM on 5/19/2025.</p> <p>(continued on next page)</p>		

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<p>F 0580</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Nurse #2 was interviewed on 6/10/2025 at 2:38 PM and revealed the following information. Nurse #2 worked from 3:00 PM to 11:00 PM on 5/19/2025. Nurse #2 stated she was not aware at the start of her shift that Resident #1 had a fall over the weekend. Nurse #2 explained that she was also the facility wound care nurse and that at some point in her shift, she went to the fax machine to fax wound care orders. Nurse #2 went through all the faxes that were on the fax machine, and she noted the x-ray results for Resident #1. Nurse #2 did not know anything had happened to Resident #1. Nurse #2, at some point in the shift, went to Resident #1 to ask her why she had an x-ray because she was alert and oriented. Resident #1 told Nurse #2 she fell a few days ago. The on-call provider told Nurse #2 to follow up with the regular provider in the morning. Nurse #2 took her vital signs and did a pain assessment. Nurse #2 was alerted by the nurse aides that Resident #1 was in extreme pain when they turned her for incontinence care. Nurse #2 stated she gave pain medication to Resident #1. Nurse #2 explained that when Resident #1 first arrived at the facility she was weak and could not get up to go to the bathroom. Gradually Resident #1 gained strength and confidence and used her cane to go to the bathroom. Resident #1 was continent of bowel and bladder, but staff had to keep reminding her that she needed to ask for help to go to the bathroom so she would not fall. Nurse #2 noted it was a change for Resident #1 to be incontinent and to be provided with incontinent care by the nurse aides. Nurse #2 called the on-call physician with the x-ray results because it was after hours on 5/19/2025. The on-call provider asked if Resident #1 was stable. Nurse #2 told the on-call provider that Resident #1 was stable and was only in pain when she was moved or turned for incontinent care.</p> <p>Documentation in a nursing progress note dated 5/20/2025 at 12:09 AM written by Nurse #2 revealed the following information. Resident #1 fell a few days ago and was in pain when she was turned from side to side. Resident #1 received medication for breakthrough pain in the left hip area. The left hip x-ray results were received, and Resident #1 was noted to have an acute impacted left femoral hip neck fracture. The after-hours provider was contacted. The after-hours provider stated that if the resident was stable, to follow up in the morning with the nurse practitioner.</p> <p>Nurse #2 was interviewed again on 6/11/2025 at 1:31 PM. Nurse #2 conceded that Nurse #3 may have told her Resident #1 had a fall and to watch out for the x-ray results at the change of shift on 5/19/2025. Nurse #2 reiterated that she became aware of the x-ray results at an unknown time and she had many responsibilities that day as the wound care nurse for the facility.</p> <p>An interview was conducted with NA #6 on 6/11/2025 at 8:57 AM and the following information was provided. NA #6 was assigned to care for Resident #1 on 5/19/2025 from 3:00 PM until 7:00 AM on 5/20/2025. Resident #1 told NA #6 that she fell on Saturday. NA #6 asked her what happened because she was alert and oriented. Resident #1 told him she was trying to go to the bathroom and her foot twisted, and she fell. Resident #1 told NA #6 that a nurse and a nurse aide picked her up and put her in bed. NA #6 asked if RP #1 was called and Resident #1 said no. NA #6 called another nurse aide for help to provide incontinent care for her because she was in pain when she was moved. NA #6 stated he left the room to immediately tell Nurse #2 that Resident #1 had a fall over the weekend and she was in pain. Nurse #2 told NA #6 that there was no documentation in the electronic record of a fall sustained by Resident #1 over the weekend. NA #6 returned to Resident #1's room and told her that if she needed a bed pan to call him because he could not help her out of bed to the bathroom like he usually did. NA #6 said Resident #1 was crying in pain and he had to roll her little by little to provide incontinent care for her. NA #6 revealed he told Nurse #5 that Resident #1 had a fall and was in pain when moved.</p> <p>(continued on next page)</p>		

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F 0580  Level of Harm - Actual harm  Residents Affected - Few	<p>Nurse #5 was interviewed on 6/11/2025 at 7:27 AM and revealed the following information. Nurse #5 worked the 11:00 PM to 7:00 AM shift that ended on 5/20/2025. Nurse #5 revealed she notified the nurse practitioner in the morning on 5/20/2025 that the x-ray results were received by the facility and Resident #1 had an acute impacted left femoral neck fracture.</p> <p>Documentation in the nursing progress notes dated 5/20/2025 at 7:25 AM written by Nurse #5 revealed the nurse practitioner gave a verbal order to send Resident #1 to the emergency room for a left femoral neck fracture.</p> <p>The documentation on Resident #1's hospital Discharge summary dated [DATE] revealed Resident #1 underwent surgery to repair her femur fracture.</p> <p>An interview was conducted on 6/13/2025 at 1:11 PM with the current interim Director of Nursing (DON), who initiated employment with the facility on 5/27/2025. The DON explained she was made aware of the facility investigation for Resident #1 by the previous Administrator at the start of her employment. The DON stated she expected that the nursing staff would assess a resident who fell, and if there was a serious medical issue to contact the provider and herself. The DON elaborated that each nursing station had directions at the desk for what steps needed to be taken when a resident falls, including assessment, notification of provider, and charting.</p> <p>The facility provided a draft plan of correction for past non-compliance that was not acceptable to the state agency due to a lack of measures put into place for audits and monitoring of compliance.</p>		

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<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>Based on record review, and staff, resident, responsible party (RP), Hospice Nurse, Physician, and Medical Director interviews, the facility failed to provide ongoing assessments after a fall; failed to identify a change in condition that required medical evaluation and treatment; failed to notify a provider of a change in condition; failed to identify one leg shorter than the other and external leg rotation required medical evaluation and treatment; failed to communicate effectively to provide treatment; and failed to notify a provider of fracture x-ray fax results upon receipt for one (Resident #1) of three residents reviewed for abuse and/or neglect. Resident #1 sustained an acute impacted left femoral neck fracture. (an acute impacted left femoral neck fracture is a break in the upper part of the thigh bone (femur), specifically at the neck, where it connects to the ball of the hip joint). Findings included:</p> <p>This tag is cross referred to:</p> <p>F580: Based on record review, and staff, responsible party (RP), Hospice Nurse, and Physician interviews, the facility failed to notify the provider of a change in condition and x-ray results after a fall for one (Resident #1) of three residents reviewed for notification of falls. Resident #1 fell on 5/17/2025 and the facility failed to notify the provider of pain and a new inability to bear weight. X-ray results obtained midday on 5/19/2025 were not relayed to the on-call provider until after hours on 5/19/2025. Resident #1 sustained an acute impacted left femoral neck fracture. (An acute impacted left femoral neck fracture is a break in the upper part of the thigh bone (femur), specifically at the neck, where it connects to the ball of the hip joint.)</p> <p>F684: Based on record review, and staff, responsible party (RP), resident, Hospice Nurse, Physician, and Medical Director interviews the facility failed to provide ongoing assessments after a fall; failed to identify the change in condition required medical evaluation and treatment; failed to identify one leg shorter than the other and external leg rotation required medical evaluation and treatment; and failed to communicate effectively to provide treatment for one (Resident #1) of three residents reviewed for assessment after a fall. Resident #1 sustained an acute impacted left femoral neck fracture (an acute impacted left femoral neck fracture is a break in the upper part of the thigh bone (femur), specifically at the neck, where it connects to the ball of the hip joint). Findings included:</p>		

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<p>F 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement policies and procedures to prevent abuse, neglect, and theft.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on record review, and staff and a resident interview, the facility failed to immediately notify the Administrator of an abuse allegation made by a resident for one (Resident #2) of three residents reviewed for abuse investigations. Findings included:</p> <p>Documentation on the facility procedures for Reporting Patient Abuse, Neglect, Exploitation, Mistreatment, and Misappropriation of Property dated as last reviewed on 11/15/2024 revealed the following statement. Any allegations, suspicion, or identified occurrence identified involving patient abuse, neglect, exploitation, mistreatment, and misappropriation of property, including injuries of an unknown source, should be immediately reported to the Administrator of the provider entity.</p> <p>Resident #2 was admitted to the facility on [DATE] with diagnoses of schizophrenia, depression, dementia, and bipolar disorder.</p> <p>Documentation on a quarterly Minimum Data Set assessment dated [DATE] revealed Resident #2 was cognitively intact, always incontinent of bowel and bladder, and required substantial assistance with toileting hygiene.</p> <p>Resident #2 was interviewed on 6/10/2025 at 10:28 AM. Resident #2 revealed Nurse Aide (NA) #2 came into her room to provide incontinent care one evening. Resident #2 further revealed NA #2 made inappropriate actions of a sexual nature and made an inappropriate comment. Resident #2 stated she told Nurse #7 and Nurse Aide (NA) #8 what had happened to her. Resident #2 did not recall which day she told Nurse #7 or NA #8.</p> <p>Nurse #7 was interviewed on 6/11/2025 at 10:51 AM. Nurse #7 denied Resident #2 told her of the abuse allegation involving NA #2. Nurse #7 said she heard rumors of the abuse allegation made by Resident #2 regarding NA #2 but when she went to the Administrator it was already known to her. Nurse #7 stated Resident #2 was known to fabricate stories and was attention seeking although this may not have been documented in her medical record. Nurse #7 did not recall which day this occurred.</p> <p>NA #8 was interviewed on 6/11/2025 at 11:15 AM. NA #8 provided the following information. NA #8 was assisting Resident #2's roommate to eat lunch when she overheard the Activity Director (AD) #1 talking to Resident #2. Resident #2 told AD #1 that NA #2 inappropriately touched her when he was changing her. NA #8 did not recall what day this occurred. AD #1 then left the room telling Resident #2 she had to tell the Administrator. NA #8 continued assisting residents and performing her nurse aide duties. NA #8 realized at the end of her shift that nothing was happening, and nobody had come to talk to Resident #2 about the allegation she had made earlier. NA #8 went to a person she recognized to be a corporate person and told her she needed to talk to someone about an abuse allegation she heard. The corporate person directed NA #8 to interrupt a meeting the Administrator and the Director of Nursing were having at that time. NA #8 interrupted the meeting and informed the Administrator of the allegation of abuse Resident #2 told AD #1.</p> <p>(continued on next page)</p>		

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<p>F 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>AD #1 was interviewed on 6/11/2025 at 11:50 AM. AD #1 stated she entered Resident #2's room to give mail to Resident #2's roommate. Resident #2 stopped AD #1 and said she had something to tell her. Resident #2 relayed to AD #1 an allegation regarding NA #2 inappropriately touching her. AD #1 revealed that NA #8 looked at them from around the privacy curtain while assisting Resident #2's roommate. AD #1 said she told Resident #2 to stop talking so NA #8 would not hear anymore. AD #1 said she left Resident #2's room to tell the Administrator of the allegation of abuse but it slipped her mind as she got busy. AD #1 indicated she remembered on the way home from work the allegation Resident #2 made regarding NA #2. AD #1 decided that in the morning clinical meeting the next day she would inform the Administrator of the allegation made by Resident #2. AD #1 discovered the next morning that the Administrator already was aware of the allegation made by Resident #2 as she had been informed by NA #8 at the end of her shift.</p> <p>The facility's senior Nursing Corporate Consultant was interviewed on 6/11/2025 at 12:27 PM. The Nursing Corporate Consultant confirmed NA #8 came to her and told her she had an allegation of abuse to report. The Nursing Corporate Consultant instructed NA #8 to immediately go to the Administrator and interrupt her meeting to tell her of the abuse allegation.</p> <p>The previous Administrator, whose employment at the facility ended on 6/6/2025, did not respond to requests for an interview.</p> <p>The previous Director of Nursing (DON) was interviewed on 6/13/2025 at 1:27 PM. The previous DON confirmed NA #8 interrupted a meeting she was having with the previous Administrator to report an allegation of abuse Resident #2 had made in her presence. The previous DON confirmed NA #8 brought this information to the previous Administrator at the end of her shift at approximately 3:00 PM.</p> <p>Documentation on an initial investigation report sent to the state offices by the former Administrator faxed on 5/1/2025 at 4:09 PM revealed Resident #2 had made an allegation of abuse against NA #2 for an event occurring on either 4/28/2025 or 4/29/2025.</p> <p>The current Administrator was interviewed on 6/13/2025 at 1:15 PM. The Administrator stated that abuse was not tolerated at the facility. The Administrator confirmed all allegations of abuse must be immediately reported to her so that a full investigation can be completed.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  345061	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  06/13/2025
NAME OF PROVIDER OR SUPPLIER  Pruitthealth-Durham		STREET ADDRESS, CITY, STATE, ZIP CODE  3100 Erwin 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)		
<p>F 0684</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on record review, and staff, responsible party (RP), resident, Hospice Nurse, Physician, and Medical Director interviews the facility failed to provide ongoing assessments after a fall; failed to identify the change in condition required medical evaluation and treatment; failed to identify one leg shorter than the other and external leg rotation required medical evaluation and treatment; and failed to communicate effectively to provide treatment for one (Resident #1) of three residents reviewed for assessment after a fall. Resident #1 sustained an acute impacted left femoral neck fracture (an acute impacted left femoral neck fracture is a break in the upper part of the thigh bone (femur), specifically at the neck, where it connects to the ball of the hip joint). Findings included:</p> <p>Resident #1 was admitted to the facility on [DATE] with diagnoses of history of cerebral vascular accident, hemiplegia, hemiparesis, and lung cancer. Hemiplegia is paralysis on one side while hemiplegia is weakness on one side of the body. Resident #1 started receiving Hospice services on 3/31/2025.</p> <p>Documentation on an admission Minimum Data Set assessment dated [DATE] revealed Resident #1 had moderately impaired cognition with a range of motion impairment on one side of the upper and lower extremities. Resident #1 was also assessed as using a cane or a wheelchair. Resident #1 was evaluated as always incontinent of bowel and bladder. It was unknown if Resident #1 had a history of falls with no falls since her admission.</p> <p>Documentation on a timesheet for Nurse Aide (NA) #1 revealed she worked at the facility from 7:18 AM to 10:53 PM on 5/17/2025. Documentation on the corresponding nursing schedule revealed NA #1 was assigned to care for Resident #1 during that time period.</p> <p>NA #1 was interviewed on 6/10/2025 at 11:54 AM. NA #1 revealed the following information. Resident #1 had a fall on 5/17/2025. NA #1 heard Resident #1 fall, and she told Nurse #4. Any other information would have to be obtained from Nurse #4 and NA #1 declined to make a statement about whether Resident #1 was in pain. NA #1 insinuated she provided the facility with a statement regarding Resident #1's fall on 5/17/2025.</p> <p>The facility provided a statement handwritten by NA #1 on 5/21/2025 regarding the events of 5/17/2025. The documentation on the statement by NA #1 revealed the following information. NA #1 walked into Resident #1's room to collect the evening meal tray. NA #1 noted Resident #1 stood up with her cane. NA #1 requested Resident #1 to wait for her to set the meal tray down before ambulating. NA #1 turned around and she heard Resident #1 fall. NA #1 called for Nurse #4 who stood over Resident #1. NA #1 asked Nurse #4 what to do. Nurse #4 and NA #1 assisted Resident #1 to rise and placed her in bed. Nurse #4 sat in a chair while NA #1 made Resident #1 comfortable in the bed. Nurse #4 then left the room.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Nurse #4 was interviewed on 6/10/2025 at 6:41 PM and revealed the following information. Nurse #4 worked the 7:00 AM to 7:00 PM shift on 5/17/2025. Resident #1 fell on 5/17/2025 while trying to go to the bathroom. Nurse #4 did full range of motion assessments of all her limbs and took the vital signs of Resident #1. Nurse #4, with the assistance of NA #1, helped Resident #1 up off the floor and into her wheelchair. NA #1 wheeled Resident #1 to the bathroom. Resident #1 stood up, pivoted, and sat on the commode. After finishing, Resident #1 stood, pivoted, and sat in the wheelchair. NA #1 then helped Resident #1 back to the bed, where Resident #1 stood, pivoted, and sat on the bed. Nurse #4 was adamant that Resident #1 was fine and in no pain. Nurse #4 was so busy with a new admission, helping residents eat, changing incontinence briefs, and administering medications that she was not able to document anything in the electronic medical record. Nurse #4 also stated that she forgot to document or notify anybody about the fall but, Resident #1 was without injury or pain after the fall on 5/17/2025.</p> <p>The facility provided a statement handwritten by Nurse #4 on 5/21/2025 regarding the events of 5/17/2025. The documentation on the statement revealed the following information. Nurse #4 was called to Resident #1's room by NA #1 because the resident had fallen. When Nurse #4 arrived, Resident #1 was sitting up against the nightstand by her bed. Resident #1 stated that she fell while going to the bathroom. Resident #1 had one leg flat, and one leg off the floor. Nurse #4 asked Resident #1 to move her arms and legs and she complied. Nurse #4 took the vital signs of Resident #1. NA #1 assisted Resident #1 into the wheelchair and took her to the bathroom. Resident #1 stood up holding onto the rail in the bathroom and NA #1 put her back into the wheelchair. NA #1 assisted Resident #1 back into bed. Resident #1 did not complain of pain.</p> <p>There was no documentation in Resident #1's electronic medical record of any fall, assessments, or notification of physician or family on 5/17/2025 for the 7:00 AM to 7:00 PM shift.</p> <p>Resident #1 was interviewed over the phone on 6/11/2025 at 3:31 PM. Resident #1 confirmed she remembered what happened when she fell on 5/17/2025 in the evening. Resident #1 stated she was going to the bathroom with her cane when her foot twisted causing her to fall. Resident #1 added that eventually someone came to assist her but not right away. Resident #1 stated she was picked up off the floor and placed back into bed. Resident #1 indicated the nurse did not do any assessment of her arms or legs nor take any vital signs. Resident #1 denied she was taken to the bathroom after the fall. Resident #1 was able to confirm the fall caused her pain but was not able to elaborate on that.</p> <p>Nurse #2 was interviewed on 6/10/2025 at 2:38 PM. Nurse #2 confirmed she worked from 7:00 PM to 11:00 PM on 5/17/2025. Nurse #2 stated she had no knowledge on 5/17/2025 that Resident #1 had fallen on the previous shift. Nurse #2 stated that she did recall that Resident #1 took her nighttime medication, had no complaints, and went to sleep.</p> <p>Documentation on the physician orders revealed Resident #1 had an order initiated on 4/8/2025 for 5 milligrams (mg) of Oxycodone to be administered as one tablet by mouth every 4 hours as needed for moderate pain at a level of 4 to 6 out of 10. Oxycodone is a prescription opioid pain medication used to relieve severe pain.</p> <p>Documentation on a controlled drug record for Resident #1 revealed Nurse #2 removed one dose of the ordered oxycodone at 9:15 PM on 5/17/2025. There was no corresponding documentation on the MAR to confirm the dose was administered to Resident #1.</p> <p>(continued on next page)</p>

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<p>F 0684</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Nurse #2 was interviewed again on 6/11/2025 at 1:31 PM. Nurse #2 revealed the nurse aides came to her to tell her on 5/17/2025 that Resident #1 was in pain when they provided care. Nurse #2 confirmed she gave Resident #1 her ordered oxycodone pain medication at her request.</p> <p>Nurse #5 was interviewed on 6/11/2025 at 7:27 AM. Nurse #5 confirmed she worked the 11:00 PM to 7:00 AM shift beginning on 5/17/2025 and ending on 5/18/2025. Nurse #5 stated she was not informed on 5/17/2025 that Resident #1 had a fall earlier that evening. Nurse #5 indicated Resident #1 slept and had no complaints on her shift ending on the morning of 5/18/2025.</p> <p>Documentation on a timesheet for NA #1 revealed she worked at the facility from 8:31 AM to 3:10 PM on 5/18/2025. Documentation on the corresponding nursing schedule revealed NA #1 was assigned to care for Resident #1 during that time.</p> <p>An interview was conducted with the Responsible Party (RP #1) for Resident #1 on 6/10/2025 at 2:06 PM. RP #1 provided the following information. RP #1, her husband, and her children went to visit Resident #1 on the morning of 5/18/2025. RP #1 barely got down the hallway when she was stopped by NA #1. NA #1 explained that she had not yet assisted Resident #1 out of bed and to get dressed. NA #1 said she knew that RP #1 would like to take Resident #1 outside. NA #1 then told RP #1 that Resident #1 fell yesterday (5/17/2025) but she was fine. RP #1 remarked to NA #1 that nobody had called to tell her about the fall. RP #1 went to see Resident #1 and to ask her about the fall. RP #1 stated that she and her husband were trying to help Resident #1 to get up, but it seemed like she was in pain, and she could not bear any weight. This was a change for Resident #1 because although she was weak on her left side she had always been able to stand. RP #1 revealed she assisted Resident #1 in dressing and then asked her about the fall she had on the previous day. Resident #1 told RP #1 that she was trying to get to the bathroom, and she twisted her left foot and fell. Resident #1 told RP #1 she did not hit her head. Resident #1 told RP #1 that a nurse and a nurse aide put her back into bed. RP #1 indicated Resident #1 seemed very sore and was protecting her left side. RP #1 stated she and her husband took Resident #1 to the bathroom, but Resident #1 was not able to stand or bear any weight. RP #1 indicated Resident #1 required her husband to pick her up and hold her to get on and off the toilet and back into the wheelchair. RP #1 then went to the nurse's desk and spoke to Nurse #4. RP #1 told Nurse #4 that Resident #1 told her she fell last night and she was now in pain. RP #1 said Nurse #4 acted like she didn't know what RP #1 was talking about. Nurse #4 told RP #1 that Resident #1 had not mentioned anything about a fall or pain to her. Nurse #4 stated she would check and see if Resident #1 fell last night and confirmed she did not see anything about a fall in the electronic medical record. Nurse #4 went down to Resident #1's room and gave her pain medication but did not do any assessment or do anything else for Resident #1. RP #1 revealed she told Nurse #4 that Resident #1 was unable to bear weight on her left side and Nurse #4 kept acting like she didn't know what she was talking about or with any concern. Resident #1 told RP #1 that Nurse #4 was the nurse who was in the room last night after the fall. RP #1 did take Resident #1 outside to get some air but Resident #1 seemed very sore anytime they moved her, and she required more assistance than usual.</p> <p>Nurse #4 was interviewed on 6/10/2025 at 6:41 PM. Nurse #4 confirmed she worked the 7:00 AM to 7:00 PM shift on 5/18/2025. Nurse #4 stated that RP #1 came to the desk on the morning of 5/18/2025 and told her Resident #1 was having back pain. Nurse #4 stated that Resident #1's fall that occurred on 5/17/2025 was not discussed at all with RP #1. Nurse #4 stated that Resident #1 was not injured so there was no reason to tell RP #1 about the fall. Nurse #4 confirmed she administered an ordered dose of Oxycodone to Resident #1 on the morning of 5/18/2025.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Documentation on the medication administration record (MAR) revealed Nurse #4 administered an ordered dose of Oxycodone to Resident #1 on 5/18/2025 at 10:47 AM for a pain level of 8 out of 10.</p> <p>Nurse #6 was interviewed on 6/11/2025 at 9:07 AM. Nurse #6 confirmed she worked on 5/18/2025 from 7:00 PM to 11:00 PM. Nurse #6 stated she did not know on 5/18/2025 that Resident #1 fell on 5/17/2025. Nurse #6 stated Resident #1 did not complain of any pain, nor did she have any complaints at all on 5/18/2025 on her shift.</p> <p>Nurse #5 was interviewed on 6/11/2025 at 7:27 AM. Nurse #5 confirmed she worked the 11:00 PM to 7:00 AM shift beginning on 5/18/2025 and ending on 5/19/2025. Nurse #5 revealed she was unaware on her shift that began on 5/18/2025 that Resident #1 had a fall the previous day on 5/17/2025. Nurse #5 stated that Resident #5 was sleeping during that shift and did not complain of any pain.</p> <p>RP #1 was interviewed on 6/10/2025 at 2:06 PM and revealed the following information. On the morning of 5/19/2025 RP #1 had concerns for Resident #1, so she sent a text message to Hospice Nurse #1 first thing in the morning. RP #1 told Hospice Nurse #1 that Resident #1 had a fall on 5/17/2025 and she was in pain. Hospice Nurse #1 told RP #1 that Resident #1 was the first person she would visit that day. RP #1 could see on 5/19/2025 in a video call to Resident #1 that she was in a lot of pain and was guarding her left side.</p> <p>Documentation in a Hospice Nurse as needed visit note dated 5/19/2025 at 1:46 PM revealed, Received message from [RP #1] that [Resident #1] had a fall over the weekend. Arrived [Resident #1's] room, [Resident #1] was sleeping. Called out her name and [Resident #1] woke up without difficulty. Asked [Resident #1] about the fall, [Resident #1] narrated saying, I called for someone to help me to bathroom, but no one came, I did not want to pee on myself, so I got up using my cane, but my left foot got caught and I tripped over and fell on my left side. I lay there until an aide came to help me up. [Resident #1] had an unwitnessed fall on Saturday 5/17/2025, consulted facility nurse for details but [Nurse #3] stated that he had no report of the fall from previous shift. Since then, she has complained of pain of 5 to 8 on numerical scale. [Resident #1] able to assist in turning, but pain prohibits turning to left side of body. [Resident #1] left leg and foot had no bruising, swelling, or hotness. [Resident #1] left side is the weak side from history of [Cerebral Vascular Accident]. Asked the facility provider [MD #1 (Physician)] for further management. Provider did an assessment and ordered STAT (immediate) X-ray of left leg and hip. Called Mobile service for STAT x-ray and collaborated with facility nurse for pain medication, to start with [as needed] acetaminophen. [Resident #1] was slightly tachycardic in 111-113 beats/minute with oximetry, oxygen saturation initially was 88 % on room air then after repositioning it came up to 93 %. (Tachycardia is a medical condition characterized by a rapid heart rate, typically defined as a resting heart rate of over 100 beats per minute.) Called family for update, to call Hospice and not to wait next time there was a concern.</p> <p>Hospice Nurse #1 was interviewed on 6/10/2025 at 5:20 PM. Hospice Nurse #1 revealed she was the case manager for Resident #1. Hospice Nurse #1 stated that on 5/19/2025 RP #1 sent her a text notifying her that Resident #1 had a fall over the weekend on 5/17/2025. Hospice Nurse #1 revealed she went to the facility, assessed Resident #1, and immediately contacted MD #1 (Physician), who was in the building. MD #1 looked at Resident #1 and ordered a STAT x-ray. Hospice Nurse #1 called mobile x-ray.</p> <p>(continued on next page)</p>		

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F 0684  Level of Harm - Actual harm  Residents Affected - Few	<p>MD #1 (Physician) was interviewed on 6/11/2025 at 8:06 AM and revealed the following information. MD #1 was doing his rounds at the facility on 5/19/2025 when a nurse approached him and asked him to look at Resident #1. MD #1 did an assessment of Resident #1 and noted her left leg was shorter and was externally rotated. MD #1 was certain that Resident #1 had a fracture, so he ordered a STAT x-ray of her left hip and made sure that Resident #1 had pain medication ordered and available. MD #1 requested to be contacted when the results of the x-ray came back for further orders.</p> <p>Nurse #3 was interviewed on 6/10/2025 at 2:53 PM and provided the following information. Nurse #3 worked from 7:00 AM to 3:00 PM on 5/19/2025. Nurse #3 was told by Hospice Nurse #1 that Resident #1 had a fall on 5/17/2025 and that MD #1 had ordered a STAT x-ray of her left hip. Nurse #3 stated that Hospice Nurse #1 contacted the mobile x-ray, and the x-ray was taken on his shift on the morning of 5/19/2025. Resident #1 was in pain on his shift, and he gave her pain medication. Nurse #3 stated that he notified Nurse #2, the next shift nurse, that Resident #1 had a fall and the facility was still waiting on the x-ray results.</p> <p>Documentation on a controlled drug record for Resident #1 revealed Nurse #3 removed one dose of the ordered Oxycodone at 9:00 AM on 5/19/2025 and another dose at 2:00 PM on 5/19/2025. There was no corresponding documentation on the MAR to confirm the dose was administered to Resident #1.</p> <p>NA #3 was interviewed on 6/10/2025 at 1:04 PM and revealed the following information. NA #3 was assigned to care for Resident #1 on 5/19/2025 for the 7:00 AM to 3:00 PM shift. NA #3 had not worked that weekend, but when he came back to work on 5/19/2025 he had heard Resident #1 had a fall. NA #3 stated Resident #1 was in pain, and he told Nurse #3 she was in pain. NA #3 stated that every time he turned Resident #1 for incontinent care, she was in pain, and it was hard. NA #3 stated he had to talk Resident #1 through it. Resident #1 didn't want to turn because she was in pain.</p> <p>Documentation on the x-ray results dated 5/19/2025 revealed Resident #1 had sustained an acute impacted left femoral neck fracture. The x-ray results were faxed to the facility at 2:50 PM on 5/19/2025.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Nurse #2 was interviewed on 6/10/2025 at 2:38 PM and revealed the following information. Nurse #2 worked from 3:00 PM to 11:00 PM on 5/19/2025. Nurse #2 stated she was not aware at the start of her shift that Resident #1 had a fall over the weekend. Nurse #2 explained that she was also the facility wound care nurse and that at some point in her shift she went to the fax machine to fax wound care orders. Nurse #2 went through all the faxes that were on the fax machine, and she noted the x-ray results for Resident #1. Nurse #2 did not know anything had happened to Resident #1. Nurse #2, at some point in the shift, went to Resident #1 to ask her why she had an x-ray because she was alert and oriented. Resident #1 told Nurse #2 she fell a few days ago. Nurse #2 took her vital signs and did a pain assessment. Nurse #2 was alerted by the nurse aides that Resident #1 was in extreme pain when they turned her for incontinence care. Nurse #2 stated she gave pain medication to Resident #1. Nurse #2 explained that when Resident #1 first arrived at the facility she was weak and could not get up to go to the bathroom. Gradually Resident #1 gained strength and confidence and used her cane to go to the bathroom. Resident #1 was continent of bowel and bladder, but staff had to keep reminding her that she needed to ask for help to go to the bathroom so she would not fall. Nurse #2 noted it was a change for Resident #1 to be incontinent and to be provided with incontinent care by the nurse aides. Nurse #2 called the on-call physician with the x-ray results because it was after hours on 5/19/2025. The on-call provider asked if Resident #1 was stable. Nurse #2 told the on-call provider that Resident #1 was stable and was only in pain when she was moved or turned for incontinent care. The on-call provider told Nurse #2 to follow up with the regular provider in the morning.</p> <p>Nurse #2 was interviewed again on 6/11/2025 at 1:31 PM. Nurse #2 conceded that Nurse #3 may have told her Resident #1 had a fall and to watch out for the x-ray results at the change of shift on 5/19/2025. Nurse #2 reiterated that she became aware of the x-ray results at an unknown time and she had many responsibilities that day as the wound care nurse for the facility.</p> <p>Documentation in a nursing progress note dated 5/20/2025 at 12:09 AM written by Nurse #2 revealed the following information. Resident #1 fell a few days ago and was in pain when she was turned from side to side. Resident #1 received medication for breakthrough pain in the left hip area. The left hip x-ray results were received, and Resident #1 was noted to have an acute impacted left femoral hip neck fracture. The after-hours provider was contacted. The after-hours provider stated that if the resident was stable, to follow up in the morning with the nurse practitioner.</p> <p>Documentation on a controlled drug record for Resident #1 revealed Nurse #2 removed one dose of the ordered Oxycodone at 9:15 PM on 5/19/2025. There was no corresponding documentation on the MAR to confirm the dose was administered to Resident #1.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>An interview was conducted with NA #6 on 6/11/2025 at 8:57 AM and the following information was provided. NA #6 was assigned to care for Resident #1 on 5/19/2025 from 3:00 PM until 7:00 AM on 5/20/2025. Resident #1 told NA #6 that she fell on Saturday. NA #6 asked her what happened because she was alert and oriented. Resident #1 told him she was trying to go to the bathroom and her foot twisted, and she fell. Resident #1 told NA #6 that a nurse and a nurse aide picked her up and put her in bed. NA #6 asked if RP #1 was called and Resident #1 said no. NA #6 called another nurse aide for help to provide incontinent care for her because she was in pain when she was moved. NA #6 stated he left the room to immediately tell Nurse #2 that Resident #1 had a fall over the weekend and she was in pain. Nurse #2 told NA #6 that there was no documentation in the electronic record of a fall sustained by Resident #1 over the weekend. NA #6 returned to Resident #1's room and told her that if she needed a bed pan to call him because he could not help her out of bed to the bathroom like he usually did. NA #6 said Resident #1 was crying in pain and he had to roll her little by little to provide incontinent care for her. NA #6 revealed he told Nurse #5 that Resident #1 had a fall and was in pain when moved.</p> <p>Nurse #5 was interviewed on 6/11/2025 at 7:27 AM and revealed the following information. Nurse #5 worked the 11:00 PM to 7:00 AM shift that ended on 5/20/2025. On the last rounds where the nurse aides provided incontinence care to the residents, one of the nurse aides came to Nurse #5 and told her Resident #1 was grimacing when she was moved during care. Nurse #5 stated she knew Resident #1 had an order for Oxycodone because she was receiving Hospice services. Nurse #5 revealed she offered a dose of Oxycodone to Resident #1, but she refused. The dose of Oxycodone was not administered to Resident #1, and it was wasted.</p> <p>Documentation on the MAR revealed Nurse #5 administered a dose of Oxycodone to Resident #1 on 5/20/2025 at 5:49 AM for a pain level of 10 out of 10.</p> <p>Documentation on the controlled drug record for ordered Oxycodone for Resident #1 dated 5/20/2025 revealed the Oxycodone dose offered by Nurse #5 was refused.</p> <p>Documentation in the nursing progress notes dated 5/20/2025 at 7:25 AM written by Nurse #5 revealed the nurse practitioner gave a verbal order to send Resident #1 to the emergency room for a left femoral neck fracture.</p> <p>The nurse practitioner, whose employment ended on 5/30/2025, did not respond to requests for an interview.</p> <p>Documentation in the nursing progress notes written as a late entry on 5/20/2025 at 7:43 AM by Nurse #3 for 5/19/2025 revealed Resident #1 had an x-ray completed due to complaints of increased pain in the left thigh.</p> <p>Documentation on an Emergency Medical Services record dated 5/20/2025 at 7:54 PM revealed Resident #1 received non-emergent transport to the hospital. Resident #1 was noted to only be in pain when moved and declined pain medication during transport.</p> <p>The documentation on Resident #1's hospital Discharge summary dated [DATE] revealed Resident #1 underwent surgery to repair her femur fracture. It was noted that a non-operative femur fracture would have led to significant pain in the long term. Resident #1 was to return to the facility.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER  Pruitthealth-Durham		STREET ADDRESS, CITY, STATE, ZIP CODE  3100 Erwin 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.			
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<p>F 0684</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>An interview was conducted with RP #2 on 6/10/2025 at 11:31 AM. RP #2 stated that when Resident #1 was released from the hospital and she returned to the facility the resident cried every day because she was scared. RP #2 explained that the hospital was not able to secure another bed in another facility prior to her discharge.</p> <p>An interview was conducted with RP #1 on 6/10/2025 at 2:06 PM. RP #1 stated that x-ray results revealing Resident #1 had a fracture were not conveyed to her until 5/20/2025. RP #1 had the concern that Resident #1 was in pain until a transfer to the hospital. RP #1 revealed on 5/23/2025 she contacted the facility to express her opinion that Nurse #4 was neglectful. RP #1 confirmed that Resident #1 was not happy about returning to the facility, but the hospital was unable to find another facility at the time of her discharge from the hospital.</p> <p>Documentation in a care plan for Resident #1 updated on 5/28/2025 revealed a focus area for a risk for falls related to disease process, generalized weakness, contractures, history of cerebral vascular accident, incontinence, and medication side effects with an actual fall on 5/19/2025. The approach added on 5/28/2025 was for Resident #1 to be reminded to call for assistance with transfers.</p> <p>Documentation in the electronic medical record revealed Resident #1 was transferred to another facility on 6/6/2025.</p> <p>The previous Administrator, whose employment at the facility ended on 6/6/2025, did not respond to requests for an interview.</p> <p>The facility Medical Director, was interviewed on 6/11/2025 at 8:06 AM via telephone. The Medical Director revealed that after looking at the electronic medical record he was able to see that Resident #1 had no complaints of pain and received very little pain medication from 5/17/2025 to 5/19/2025. The Medical Director conceded that the documentation for the fall on 5/17/2025 was poor. The Medical Director stated that perhaps Resident #1 had an underlying issue due to paralysis on her left side that delayed her expressing pain and required treatment. The Medical Director also indicated that he was aware the family had transferred Resident #1 to the bathroom on the morning of 5/18/2025 and may have caused injury to the resident. The Medical Director felt the x-ray being completed by 5/19/2025 and Resident #1 being sent to the hospital for treatment of the fracture on 5/20/2025 was an appropriate time frame for a resident on Hospice who was not expressing any pain. The Medical Director praised the Hospice services for assuring Resident #1 received assessment and treatment.</p> <p>An interview was conducted on 6/13/2025 at 1:11 PM with the current interim Director of Nursing (DON), who initiated employment with the facility on 5/27/2025. The DON explained she was made aware of the facility investigation for Resident #1 by the previous Administrator at the start of her employment. The DON stated she expected that the nursing staff would assess a resident who has had a fall and if there was a serious medical issue to contact the provider and herself. In addition, the DON had the expectation that an attempt would be made to contact the family of a resident who had fallen. The DON elaborated that each nursing station had directions at the desk for what steps needed to be taken when a resident falls, including assessment, notification of provider, and charting. The DON also stated that she expected communication to occur between nurses to make sure x-ray results were conveyed to a provider as soon as received.</p> <p>(continued on next page)</p>		

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F 0684  Level of Harm - Actual harm  Residents Affected - Few	The facility provided a draft plan of correction for past non-compliance that was not acceptable to the state agency due to a lack of measures put into place for communication between nursing shifts, education of expectations for nurse aides, audits, and monitoring of compliance.		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>Based on record review and staff interviews, the facility failed to effectively document in the electronic medical record for conveyance of medical information for two (Resident #1 and Resident #5) of three residents reviewed for accidental falls. Resident #1 lacked initial documentation of a fall by Nurse #4, initial physical assessments by Nurse #4, and administration of pain medication by Nurse #2 and Nurse #3. Resident #1 had incorrect documentation of the administration of pain medication by Nurse #5. Resident #5 lacked documentation of a nursing physical assessment after a fall. Findings included:</p> <p>1. a. Documentation on a timesheet for Nurse Aide (NA #1) revealed she worked at the facility from 7:18 AM to 10:53 PM on 5/17/2025. Documentation on the corresponding nursing schedule revealed NA #1 was assigned to care for Resident #1 during that time period.</p> <p>NA #1 was interviewed on 6/10/2025 at 11:54 AM. NA #1 revealed the following information. Resident #1 had a fall on 5/17/2025. NA #1 heard Resident #1 fall, and she told Nurse #4.</p> <p>Nurse #4 was interviewed on 6/10/2025 at 6:41 PM and revealed the following information. Nurse #4 worked the 7:00 AM to 7:00 PM shift on 5/17/2025. Resident #1 fell on 5/17/2025 while trying to go to the bathroom. Nurse #4 did full range of motion assessments of all her limbs and took the vital signs of Resident #1. Nurse #4, with the assistance of NA #1, helped Resident #1 up off the floor and into her wheelchair. Nurse #4 was so busy with a new admission, helping residents eat, changing incontinence briefs, and administering medications that she was unable to document anything in the electronic medical record. Nurse #4 also stated that she forgot to document the fall, the assessment, or notify anybody about the fall but, Resident #1 was without injury or pain after the fall on 5/17/2025.</p> <p>There was no documentation in Resident #1's electronic medical record of any fall, assessments, or notification of physician or family on 5/17/2025 for the 7:00 AM to 7:00 PM shift.</p> <p>Nurse #4 was interviewed on 6/10/2025 at 6:41 PM. Nurse #4 confirmed she worked the 7:00 AM to 7:00 PM shift on 5/18/2025. Nurse #4 revealed that she was very busy caring for the residents on 5/18/2025 and did not document any information about the fall in the electronic medical record.</p> <p>b. Documentation on the physician orders revealed Resident #1 had an order initiated on 4/8/2025 for 5 milligrams (mg) of Oxycodone to be administered as one tablet by mouth every 4 hours as needed for moderate pain at a level of 4 to 6 out of 10. Oxycodone is a prescription opioid pain medication. It was used to relieve severe pain.</p> <p>Documentation on a controlled drug record for Resident #1 revealed Nurse #2 removed one dose of the ordered oxycodone at 9:15 PM on 5/17/2025. There was no corresponding documentation on the Medication Administration Record (MAR) to confirm the dose was administered to Resident #1.</p> <p>(continued on next page)</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Nurse #2 was interviewed again on 6/11/2025 at 1:31 PM. Nurse #2 revealed the nurse aides came to her to tell her on 5/17/2025 that Resident #1 was in pain when they provided care. Nurse #2 confirmed she gave Resident #1 her ordered Oxycodone pain medication at her request. Nurse #2 conceded that she got busy and forgot to follow through to document on the MAR that she administered Oxycodone to Resident #1.</p> <p>c. Documentation on a controlled drug record for Resident #1 revealed Nurse #3 removed one dose of the ordered Oxycodone at 9:00 AM on 5/19/2025 and another dose at 2:00 PM on 5/19/2025. There was no corresponding documentation on the MAR to confirm the dose was administered to Resident #1.</p> <p>Nurse #3 was interviewed on 6/11/2025 at 11:05 AM. Nurse #3 confirmed he administered the doses of Oxycodone to Resident #1 at 9:00 AM on 5/19/2025 and at 2:00 PM on 5/19/2025. Nurse #3 stated he either forgot to document the administration of the medication or just didn't document it because he was busy.</p> <p>d. Documentation on a controlled drug record for Resident #1 revealed Nurse #2 removed one dose of the ordered Oxycodone at 9:15 PM on 5/19/2025. There was no corresponding documentation on the MAR to confirm the dose was administered to Resident #1.</p> <p>Nurse #2 was interviewed again on 6/11/2025 at 1:31 PM. Nurse #2 confirmed she did administer Oxycodone to Resident #1 at 9:15 PM on 5/19/2025. Nurse #2 revealed she normally did document the administration of medication on the MAR, but she must have gotten busy and didn't follow through.</p> <p>Nurse #5 was interviewed on 6/11/2025 at 7:27 AM and revealed the following information. Nurse #5 worked the 11:00 PM to 7:00 AM shift that ended on 5/20/2025. On the last rounds where the nurse aides provided incontinence care to the residents, one of the nurse aides came to Nurse #5 and told her Resident #1 was grimacing when she was moved during care. Nurse #5 stated she knew Resident #1 had an order for Oxycodone because she was receiving Hospice services. Nurse #5 revealed she offered a dose of Oxycodone to Resident #1, but she refused. The dose of Oxycodone was not administered to Resident #1, and it was wasted.</p> <p>Documentation on the MAR revealed Nurse #5 administered a dose of Oxycodone to Resident #1 on 5/20/2025 at 5:49 AM for a pain level of 10 out of 10.</p> <p>Documentation on the controlled drug record for ordered Oxycodone for Resident #1 dated 5/20/2025 revealed the Oxycodone dose offered by Nurse #5 was refused.</p> <p>Nurse #5 was interviewed again on 6/11/2025 at 12:22 PM. Nurse #5 explained that the nurse aides came to her to tell her Resident #1 was in pain when they turned her so she removed Oxycodone out of the locked box, signed out the medication on the controlled drug record, and checked off on the MAR that she administered the medication to Resident #1. Nurse #5 explained that Resident #1 did not want Oxycodone, and the medication was wasted in view of Nurse #3. Nurse #5 further explained that after she documented the Oxycodone as administered to Resident #1 on the MAR, there was no way of undoing it that she knew of.</p> <p>(continued on next page)</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>The Physician for Resident #1, who was also the facility Medical Director (MD #2), was interviewed on 6/11/2025 at 8:06 AM via telephone. MD #2 revealed that after looking at the electronic medical record he was able to see that Resident #1 had no complaints of pain and per the documentation received very little pain medication from 5/17/2025 to 5/19/2025. MD #2 conceded that the documentation for the fall on 5/17/2025 was poor.</p> <p>The Director of Nursing (DON), who initiated her employment with the facility on 5/27/2025, was interviewed on 6/11/2025 at 10:33 AM. The DON explained that the process for medication administration and documentation was as follows: pull the narcotic medication, make sure it was the correct person, correct drug, correct dose, sign out the narcotic medication on the controlled medication record, administer the medication, and then document on the MAR. The DON further explained that the final step was to monitor the effectiveness of the medication and document this on the MAR.</p> <p>An additional interview with the DON was conducted on 6/13/2025 at 1:11 PM. The DON explained that she expected that the nursing staff follow the fall risk cheat sheet that was posted at every nursing station for directions and a listing of the required documentation after a fall. The DON expected that the nursing staff would document their assessments to include vital signs, range of motion assessments, pain, as well as medication administration.</p> <p>2. Documentation in the nursing progress notes dated 6/11/2025 at 11:55 PM written by Nurse #10 revealed Resident #5 had a fall on the floor from his wheelchair observed by his roommate. The documentation further revealed the resident denied pain, did not hit his head, and was assisted back to bed. Notification of the responsible party and the provider was also documented. There was no documentation in the nursing progress note of any range of motion assessment or any assessment of vital signs.</p> <p>A Review of the electronic medical record did not reveal any recording of vital signs on 6/11/2025 for the time period for the fall sustained by Resident #5.</p> <p>There was no documentation on the situation, background, assessment, and recommendation (SBAR) form initiated on 6/11/2025 at 11:55 PM by Nurse #10.</p> <p>An interview was conducted with Nurse #10 at 9:01 AM on 6/13/2025. Nurse #10 revealed she was new to the electronic medical record system the facility used and had been employed at the facility for four months. Nurse #10 confirmed she did take the vital signs of Resident #5 when he fell on 6/11/2025 in addition to performing the range of motion assessments on his limbs before assisting him back to bed. Nurse #10 indicated she thought she documented her assessments of Resident #10 on the same form for which she documented notification of the physician but was unable to recall which form that was. Nurse #10 confirmed Resident #5 was uninjured when she performed her assessments on 6/11/2025 after he fell.</p> <p>An interview with the DON was conducted on 6/13/2025 at 1:11 PM. The DON explained she expected that the nursing staff to follow the fall risk cheat sheet posted at every nursing station for directions and listing of the required documentation after a fall. The DON expected that the nursing staff would document their assessments to include vital signs and range of motion assessments after a fall.</p>		