STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345515	A. Building B. Wing	06/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pruitthealth-Town Center	6300 Roberta Road Harrisburg, NC 28075

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37281 Based on record review, Ombudsman, and Social Work interviews, the facility failed to provide a letter of transfer or discharge to residents (Resident #39) for 1 of 3 residents reviewed for transfer and discharge and failed to send a summary of discharge and transfer residents to the Ombudsman (Resident #47) for 1 of 2 residents reviewed for hospitalization . The findings included: 1. Resident #39 was admitted to the facility 10/8/2021. Review of the medical record for Resident #39 revealed on 6/7/2024 she was transferred to the hospital for evaluation after experiencing shortness of breath. The medical record documented Resident #39 returned to the facility on [DATE]. Review of the medical record for Resident #39 revealed no letter of transfer or discharge was in the medical record. The Social Worker (SW) was interviewed on 6/19/2024 at 11:42 AM. The SW explained the facility had not been sending letters of transfer or discharge to residents who were sent to the hospital for treatment or discharged from the facility. The SW explained she was not aware the letters should be sent. The Senior Nurse Consultant was interviewed on 6/19/2024 at 12:33 PM and she reported it was policy to send a letter of transfer or discharge to any resident who was admitted to the hospital or was discharged from the facility. 2. Resident #47 was admitted to the facility 4/29/2024. Resident #47 was transferred to the hospital on 5/7/2024 and readmitted to the facility 5/14/2024. Review of the hospital discharge note revealed Resident #47 was admitted for complications of post-hemorrhagic anemia. During a phone interview with the Ombudsman on 6/14/2024 at 8:39 AM, she reported the facility had not sent her a monthly report regarding the facility transfers or discharges for many months. The Ombudsman did not recall the last time she received a report from the facility. (continued on next page)

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

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Social Worker (SW) was interviewed on 6/19/2024 at 11:42 AM. When asked for the reports of resident transfer and discharge from the facility, the SW provided lists from January 2024 to May 2024 and reported she had just faxed the discharge and transfer lists to the Ombudsman from January 2024 to May 2024 on 6/19/2024. Resident #47 was noted to be included in the transfer list for May 2024. The SW explained she had not sent a transfer or discharge summary to the Ombudsman at all in 2024. The SW was unable to explain why the summary reports were not sent, other than to report she had gotten behind in tasks.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35758 Based on observations, record review and staff interview the facility failed to accurately code the significant change in status Minimum Data Set (MDS) assessments for 1 of 5 residents reviewed for MDS accuracy (Resident #47). Findings included: Resident # 47 was readmitted to the facility on [DATE] with diagnoses that included cognitive communication deficit and cerebral vascular accident (CVA). Review of a form titled Observation Detail List Report dated 05/14/24 at 10:40 PM revealed Resident #47 had moderate difficulty hearing and the speaker had to increase volume and speak distinctly. Resident #47 was recorded to use bilateral hearing aids. A review of the most recent Minimum Data Set (MDS) significant change assessment dated [DATE] revealed Resident # 47 was cognitively intact. The MDS assessment was not coded to reflect Resident #47 had a moderate ability to hear at section B0200 and he utilized hearing Aid or other hearing appliance used to hear at section B0300 as required by the RAI manual (Resident Assessment Instrument). An observation of Resident #47 on 06/16/24 at 11:35AM revealed Resident #47 seated in his room with bilateral hearing aids in place. An interview with Nurse #2 conducted on 06/18/24 at 11:08 AM revealed Resident #47 had always worn bilateral hearing aids and he needed them to be able to hear adequately. An interview conducted with MDS Nurse #1 and MDS Nurse #2 on 06/19/24 at 2:29 PM revealed Residents were coded as they were assessed during the MDS assessment look back review period. The Area [NAME] President was interviewed on 06/19/24 at 4:29 PM. She revealed that MDS coding was to be accurate and reflect each resident's conditions.

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37281 Based on record review, observations, staff, and physician interviews, the facility failed to provide care in a safe manner when a resident fell out of bed during incontinence care for 1 of 3 residents reviewed for accidents (Resident #11). Resident #11 sustained a laceration to the right side of his forehead requiring 6 sutures and a C-1 (cervical vertebra #1) fracture that required long-term use of a cervical collar for neck support. Resident #11 did not experience any neurological changes. The findings included: Resident #11 was admitted to the facility 11/6/2019 with diagnoses including Parkinson' disease. A quarterly Minimum Data Set (MDS) assessment dated [DATE] documented Resident #11 was severely cognitively impaired, and he required substantial to maximum assistance for bed mobility and incontinence care. A review of the medications for Resident #11 revealed an order dated 11/19/2019 for aspirin 81 milligrams daily. A nursing note dated 2/15/2024 written by Nurse #1 documented the nurse was called to Resident #11's room by Nursing Assistant (NA) #1 and Resident #11 was on the floor between his bed and the wall and there was a large amount of blood noted. The note documented Resident #11 was turned over to his back and he had a laceration to the right side of his head, and pressure was applied to stop the bleeding. The note documented the facility nurse supervisor was notified, and Emergency Medical Services (EMS) was called. The note documented NA #1 reported she was providing incontinence care to Resident #11, and he slipped off the bed. EMS arrived at the facility and Resident #11 was transported to the hospital for evaluation. Hospital records dated 2/15/2024 documented Resident #11 was evaluated in the emergency room for injuries sustained after he had rolled out of bed. The note documented Resident #11 had a laceration to his right forehead and the CT of his head revealed a scalp contusion without fracture. A CT of his neck revealed nondisplaced fractures of the bilateral C1 posterior arch at the foramen, transverse area (fracture of the first vertebra of the spine). The note documented neurosurgery was consulted and a neck collar was used to provide stabilization to the neck. The note documented Resident #11 was at his neurological baseline. Resident #11 was hospitalized from 2/15/2024 until 2/17/2024. The hospital discharge note dated 2/17/2024 documented Resident #11 had received 6 sutures to the right forehead laceration, and he was to continue wearing the neck collar until his follow up with the neurologist. The discharge note documented Resident #11 was at his baseline and did not have neurological deficits related to the vertebral fracture. The neck collar was the only new order for Resident #11. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Care plans for Resident #11 were reviewed and the fall care plan dated 2/16/2024 documented that due to the recent fall of Resident #11, he would require 2-person assistance for all activities of daily living, including bed mobility and incontinence care. The care plan documented the use of the neck collar, fall mats, bed in the low position, and frequent observations for safety. A statement written by NA #1 dated 2/17/2024 documented she was providing Resident #11 with incontinence care and had him turned onto his left side, when he kicked out his leg and rolled out of the bed. The note documented NA #1 yelled for the nurse to come to the room. A follow-up neurologist note dated 4/16/2024 documented Resident #11 was not having pain after the injury and C-1 fracture. The note documented a follow up CT scan of the spine had been completed on 4/4/2024 indicated the spinal alignment was within normal limits and stable. The note indicated a repeat CT scan would be completed 6 weeks later and the plan would be to wean Resident #11 from the neck collar use. The most recent significant change MDS assessment dated [DATE] assessed Resident #1 to be severely cognitively impaired and to require substantial to maximum assistance with incontinence care. A CT scan of the cervical spine completed on 6/6/2024 indicated the spinal alignment was stable. Resident #11 was observed on 6/16/2024 at 11:32 AM sitting up in a geri-chair. Resident #11 was wearing a neck collar, and his feet were elevated. Resident #11's bed was noted to have a scoop mattress in place, fall mats were on the floor, and the bed was in a low position. The facility physician (MD) was interviewed on 6/18/2024 at 10:14 AM. The MD reported Resident #11 had a very serious accident when he rolled out of the bed during incontinence care, and he could have been more seriously injured. The MD reported he was contacted immediately after the accident. Nurse #1 was interviewed on 6/18/2024 at 10:42 AM by phone. Nurse #1 explained she had been in a room across from Resident #11's room on 2/16/2024 and she heard NA #1 calling out for help. Nurse #1 reported she went into Resident #11's room and he was on the floor between the bed and the wall on his stomach. Nurse #11 reported there was a large amount of blood under his head and she and NA #1 turned him over so she could assess the wound on his head. Nurse #1 explained she applied pressure to the laceration to stop the bleeding and called the nurse supervisor and EMS. Nurse #1 revealed they had not attempted to move Resident #11 until EMS arrived because they didn't know the extent of his injuries. A phone interview was conducted with NA #1 on 6/18/2024 at 12:29 PM. NA #1 reported she had provided care to Resident #11 on 2/15/2024 and had been providing incontinence care. NA #1 explained she had provided care to Resident #11 before 2/15/2024 and he was a 1-person assistance with bed mobility and incontinence care. NA #1 reported she had Resident #11 on his side, and she was securing him with her arm when he kicked his leg and rolled out of the bed and fell on to the floor. NA #1 reported she went to the door of the room and yelled for help and Nurse #1 arrived to assess Resident #11. NA #1 reported that after the accident, Resident #11 required 2-person assistance for all activities of daily living. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	An interview was conducted with the Occupational Therapist on 6/18/2024 at 2:36 PM. The Occupational Therapist explained prior to the accident on 2/15/2024, Resident #11 was safe to use 1 person assistance for bed mobility and care. NA #2 was interviewed on 6/18/2024 at 4:31 PM. NA #2 explained after the accident on 2/15/2024, Resident #11 required 2 people for all activities of daily living. The facility submitted the following corrective action: 1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice. On 2/15/24 at 8:45pm nursing assistant (NA) #1was providing resident care when a resident kicked his left leg out and started to roll off the bed. NA #1 attempted to catch the resident but was unable to. The NA #1 got the nurse and assisted with caring for him after the fall until EMS arrived. A nursing note documented at 8:45pm on 2/15/2024, the nurse was called to resident room per NA #1, upon arrival, resident noted laying on his right side on the floor with a large amount of blood present, once resident was turned onto his back, noted a large laceration to right side of head, ice and pressure applied to area, facility nurse supervisor notified, resident remains alert and responsive, ROM and neuro-checks are within resident baseline, V/S 196/84-98.4-70-16-93%, 9pm Medic called, Responsible Party called x5, no answer, at 9:05pm resident out to ER for evaluation, at 9:50pm resident Responsible Party returned call, notified of resident's incident and transfer to ER, CNA stated that while providing incontinent care, she was attempting to turn resident to left side, resident slipped off bed. A root cause analysis was conducted on 2/16/2024. The facility reviewed the training of all staff including NA #1 who had received training on turning and positioning with observations, during general orientation and training, and re-educated on turning the resident toward you never away from you after the event. The Certified Nursing Assistant was found to use poor judgment during care of the resident and no longer worked for the facility. The resident was returned to the facility on [DATE] with an open wound to scalp and a closed fracture of the 1st cervical vertebrae with neck collar intact. 2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice. All residents have the potential to be affected. Facility Administrator, Director of Health Services, Clinical Competency Coordinator and Nurse Managers reviewed bed mobility status for all residents in the facility to identify residents' level of assistance required during bed mobility. Of the 69 in-house, 1 resident required a change from 1 person assistance to two-person assistance, 68 residents maintained their current level of bed mobility assistance. The one resident requiring a change to two-person assistance care plan and resident profile was reviewed and updated. 3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	The Clinical Competency Coordinator and/ or Nurse Managers began education on 2/17/24 for the Certified Nursing Assistants regarding resident's plan of care to include neck collar, safety bolster cover (a overlay that goes onto the bed with elevated sides to identify the boundaries of the bed), turning and positioning in bed, and 2 staff assist with activities of daily living in bed and transfers. This education continues with newly hired certified nursing assistants. The Clinical Competency Coordinator and/or Nurse Managers began education 2/17/24 related to turning and repositioning a resident was provided through our [NAME] university online learning coordinator module and competencies reviewed with certified nursing assistants by the clinical competency. This education includes turning the resident toward you and asking for assistance from coworkers when two persons assist in required. The Nursing Management Team and/or Administrator began observation of turning and repositioning a resident on 2/17/24. This is completed for 5 residents per week for 1 week, then 3 residents a week for 4 weeks, then 4 residents per month ongoing. 4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained; and The Nursing Management Team and/or Administrator began observation of turning and repositioning a resident on 2/17/24. This is completed for 5 residents per week for 1 week, then 3 residents a week for 4 weeks, then 4 residents per month ongoing. The Nursing Management and Interdisciplinary team met on 2/21/24 to discuss resident at risk for events and interventions applied. The Interdisciplinary team discussed the Nurse Managers observations of residents being turned and repositioned with the Interdisciplinary team on 2/21/24 to identify any areas requiring revision. The Interdisciplinary team did not identify any revisions to the observation review at that time (2/21/24). The plan of correction compliance was presented to the Quality Assurance Committee on March 12, 2024. The Administrator and or Director of Health Services presented the findings of the observation for turning and positioning to the Quality Assurance and Performance Committee meeting on March 12, 2024, and will continue to report findings monthly for further recommendations. Completion date: February 22, 2024 The facility corrective action plan of 2/22/2024 was validated on 6/18/2024 by reviewing the audits conducted, reviewing the education provided to nurses and NAs, observation of incontinence care and bed mobility for Resident #11, interviewing NAs and nurses, and reviewing the Quality Assurance and Performance Committee meeting notes.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35758 Based on observations, record reviews, and staff and resident interviews, the facility failed to post precautionary and safety signs that indicated the use of oxygen for 5 of 5 residents reviewed for respiratory care (Resident #47, Resident #55, Resident # 26, Resident # 20, and Resident # 3). The findings included: 1. Resident # 47 was readmitted to the facility on [DATE] with diagnoses that included bacterial pneumonia, chronic systolic (congestive) heart failure and pneumonitis due to inhalation of food and vomit. A review of the most recent Minimum Data Set (MDS) significant change assessment dated [DATE] revealed Resident # 47 was cognitively intact. Review of Resident # 47's physician orders dated 06/13/24 revealed an order for continuous oxygen delivered at 2 liters per nasal cannula. An observation of Resident #47 on 06/16/24 at 11:35AM revealed Resident #47 seated in his room visiting with family. Resident #47 was observed with oxygen delivered at 2 liters via nasal cannula. There were no precautionary or safety signs to indicate that oxygen was in use noted in Resident #47's room, on his room door, or anywhere near his environment. A review of the care plan for Resident #47 updated 06/17/24 revealed in part that he had the potential respiratory declines and or declines related to chronic systolic congestive heart failure. The goal read in part to maintain adequate air exchange with no respiratory distress. Interventions included assess for fluid excess such as shortness of breath and encourage self-care as tolerated. An interview with Nurse #2 conducted on 06/18/24 at 11:08 AM revealed that oxygen use signs were to be posted outside of each resident's room where oxygen was being utilized and the nurse was to obtain the sign from the oxygen supply room. Nurse #2 revealed she was not aware there was no oxygen safety sign posted outside of individual resident rooms. An interview with Nurse Assistant (NA) #1 on 06/18/24 11:43 AM revealed that she was not aware of the oxygen safety signs and did not pay attention to them. Nurse #1 was interviewed on 06/18/24 at 12:12 PM. Nurse #2 revealed all residents that used oxygen were supposed to have oxygen safety signs posted at the door to their rooms. Nurse #1 was not able to explain why Resident #47 did not have an oxygen safety sign on his door previously because Resident #47 always used oxygen at 2 liters nasal cannula. On 06/19/24 at 2: 57 during an interview conducted with the Director of Nursing revealed in part that it was her understanding if the facility posted no smoking signs on the facility entrance and exit doors that the oxygen safety signs were not required to be posted on individual rooms of residents using oxygen. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The Area [NAME] President was interviewed on 06/19/24 at 4:29 PM. She revealed in part that it was her understanding that if the facility posted no smoking signs on the entrance and exit doors of the facility that there was not a need to post oxygen safety signs on each individual resident rooms where oxygen was in use. 2. Resident #55 was readmitted to the facility on [DATE] with diagnoses that included pneumonia, systolic congestive heart failure, acute cough, and chronic obstructive pulmonary disease (COPD). Review of a significant change Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #55 had no cognitive impairment. Review of care plans for Resident #55 initiated 05/30/24 included in part Resident #55 had potential for inadequate air exchange and respiratory decline. With a goal that he would have effective respiratory rate, depth, and rhythm without unresolved shortness of breath. Interventions included to assess signs of ineffective breathing pattern, and to encourage rest periods. A physician order dated 06/16/24 included oxygen at 2 liters via nasal cannula as needed for shortness of breath. An interview with Nurse #2 conducted on 06/18/24 at 11:08 AM revealed that oxygen use signs were to be posted outside of each resident's room where oxygen was being utilized and the nurse was to obtain the sign from the oxygen supply room. Nurse #2 revealed she was not aware there was no oxygen safety sign posted outside of individual resident rooms. An interview with Nurse Assistant (NA) #1 on 06/18/24 11:43 AM revealed that she was not aware of the oxygen safety signs and did not pay attention to them. A subsequent observation and interview with Resident #55 conducted on 06/17/24 at 10:05 AM revealed Resident #55 seated up in bed with oxygen 2 liters nasal cannula. Resident #55 revealed he only used oxygen when he became short of breath. There was a red oxygen safety sign posted on the door of Resident #55's room door. An interview with Nurse #2 conducted on 06/18/24 at 11:08 AM revealed that oxygen use signs were to be posted outside of each resident's room where oxygen was being utilized and the nurse was to obtain the sign from the oxygen supply room. Nurse #2 revealed she was not aware there was no oxygen safety sign posted outside of individual resident rooms. On 06/19/24 at 2: 57 during an interview conducted with the Director of Nursing revealed in part that it was her understanding if the facility posted no smoking signs on the facility entrance and exit doors that the oxygen safety signs were not required to be posted on individual rooms of residents using oxygen. The Area [NAME] President was interviewed on 06/19/24 at 4:29 PM She revealed in part that it was her understanding that if the facility posted no smoking signs on the entrance and exit doors of the facility that there was not a need to post oxygen safety signs on each individual resident rooms where oxygen was in use. 49055 (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. Resident #26 was admitted to the facility on [DATE] with diagnoses that included chronic obstructive pulmonary disease (COPD) with acute exacerbation, acute on chronic respiratory failure with hypoxia, and solitary pulmonary nodule. A review of Resident #26's physician orders dated 06/04/24 revealed an order for continuous oxygen at 5 liters per minute (LPM) via nasal cannula. Resident #26's Oxygen Use care plan dated 06/04/24 revealed that his oxygen use was related to COPD with acute exacerbation, and acute on chronic respiratory failure. Interventions included saturated oxygen monitoring, ample time to perform activities of daily living (ADL), and notifying his physician of any changes. A review of Resident #26's Scheduled 5-day Minimum Data Set (MDS) assessment dated [DATE] rated Resident #26 as cognitively intact. He received oxygen therapy during the MDS assessment period. An observation of Resident #26 on 06/16/24 at 11:22 AM found him sitting in his wheelchair, with his eyes closed and the tv on. Continuous oxygen was being delivered at 5 LPM via nasal cannula; however, there were no precautionary or safety signs to indicate that oxygen was in use posted in his room, on his door, or anywhere in his environment. A subsequent observation of Resident #26 on 06/16/24 at 11:39 AM revealed him sitting up in his wheelchair, talking with visitors. No posted precautionary or safety signs to indicate that oxygen was in use were observed. An interview with Nurse #4 on 06/18/24 at 4:06 PM disclosed that oxygen in use signage was to be posted at admission, by the nurse. She stated she was not sure why no signs were posted on behalf of her residents. In addition, she reported that oxygen signs were moved with residents who changed rooms. An interview with the Director of Nursing on 06/17/24 at 4:40 PM reported that nurses were responsible for posting oxygen signage outside of residents' rooms; and acknowledged that some resident rooms were missed when signage was to have been posted. During an interview with the Area [NAME] President on 06/19/24 at 3:44 PM, she stated the policy was to have No Smoking signs posted at the entrances to the facility, thus signage was not required to be posted at individual rooms of residents receiving oxygen. 4. Resident #20 was admitted to the facility on [DATE] with diagnoses that included chronic obstructive pulmonary disease (COPD) and heart failure. A review of Resident #20's physician orders dated 05/06/24 revealed an order for oxygen at 3 liters per minute (LPM) via nasal cannula continuous. Resident #20's care plan dated 05/06/24 exhibited potential for respiratory distress related to congestive heart failure (CHF), COPD, and atrial fibrillation, with interventions that included encouraging frequent rest periods, saturated oxygen (SaO2) monitoring, daily weights with variances reported, and reportable signs and symptoms. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident #20's 5-day Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #20 was cognitively intact and received continuous oxygen therapy during the MDS assessment period. An observation of Resident #20 on 06/16/24 at 11:34 AM revealed Resident #20 sitting in her wheelchair. She received 3 LPM of continuous oxygen via nasal cannula. However, no precautionary or safety signs were posted in her room, on her door, or anywhere in her environment. An interview with Nurse #4 on 06/18/24 at 4:06 PM disclosed that oxygen in use signage was to be posted at admission, by the nurse. She stated she was not sure why no signs were posted on behalf of her residents. In addition, she reported that oxygen signs were moved with residents who changed rooms. An interview with the Director of Nursing on 06/17/24 at 4:40 PM reported that nurses were responsible for posting oxygen signage outside of residents' rooms; and acknowledged that some resident rooms were missed when signage was to have been posted. During an interview with the Area [NAME] President on 06/19/24 at 3:44 PM, she stated the policy was to have No Smoking signs posted at the entrances to the facility, thus signage was not required to be posted at individual rooms of residents receiving oxygen. 5. Resident #3 was admitted to the facility on [DATE]. Her diagnoses included chronic obstructive pulmonary disease (COPD), pulmonary embolism without acute cor pulmonale, and acute respiratory failure with hypoxia. A review of Resident #3's physician order dated 06/07/24 included oxygen at 2 liters per minute (LPM) via nasal cannula continuous due to malignant neoplasm of lower lobe, right bronchus or lung, and COPD. A review of Resident #3's Quarterly Minimum Data Set (MDS) assessment dated [DATE] indicated she had mild cognitive impairment and received oxygen therapy during the MDS assessment period. Resident #3's care plan dated 01/12/23 included potential for respiratory declines/distress related to COPD, congestive heart failure (CHF), and history of respiratory failure. Interventions included monitoring oxygen saturation every shift, encouraging frequent rest periods, assessing for changes in level of consciousness, monitoring lung sounds as needed, and reportable signs and symptoms. An observation of Resident #3 on 06/16/24 at 11:32 am found her in bed, sleeping and receiving continuous oxygen via nasal cannula. There were no precautionary or safety signs to indicate that oxygen was in use in her room, on her door, or anywhere in her environment. A subsequent observation of Resident #3 on 6/16/24 at 2:31 pm found her sitting in her wheelchair, outside of her room, coloring. Resident #3 received 2 LPM continuous oxygen via nasal cannula. No posted precautionary or safety signs to indicate that oxygen was in use were observed. An interview with Nurse #4 on 06/18/24 at 4:06 PM disclosed that oxygen in use signage was to be posted at admission, by the nurse. She stated she was not sure why no signs were posted on behalf of her residents. In addition, she reported that oxygen signs were moved with residents who changed rooms. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345515	A. Building B. Wing	06/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pruitthealth-Town Center	6300 Roberta Road Harrisburg, NC 28075

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview with the Director of Nursing on 06/17/24 at 4:40 PM reported that nurses were responsible for posting oxygen signage outside of residents' rooms; and acknowledged that some resident rooms were missed when signage was to have been posted. During an interview with the Area [NAME] President on 06/19/24 at 3:44 PM, she stated the policy was to have No Smoking signs posted at the entrances to the facility, thus signage was not required to be posted at individual rooms of residents receiving oxygen.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
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. 37281 Based on observations and staff interviews, the facility failed to remove a dented canned good item stored for use, seal open-to-air frozen food, ensure pans were dry before being stacked, and cover facial hair for 2 of 2 kitchen observations. These practices had the potential to affect food served to residents in the facility. The findings included: a. The kitchen was toured on 6/16/2024 at 10:55 with the Assistant Dietary Manager. The rack of canned goods was observed, and a can of spaghetti sauce was noted to have a large dent on the side of the can. The dent was approximately 3 inches long and dented approximately 1/2 inch into the can, and the paper label on the can was torn in the dent. The Assistant Dietary Manager explained dented cans should be removed from the rack and placed on the shelf labeled dented cans. The Assistant Dietary Manager did not know why the can had not been removed. b. The freezer was observed with [NAME] #1 at 11:15 AM on 6/16/2024. The freezer was observed to have an open box of beef patties, an open box of cube steak, and an open box of fish nuggets. Inside each of the open boxes, the plastic bag containing the frozen food was open to air. [NAME] #1 explained when a box was opened from the freezer storage, the bags needed to be closed. [NAME] #1 reported he did not know why the open bags of food were not closed. c. The dry dish rack was observed with the Assistant Dietary Manager at 11:24 AM on 6/16/2024. Five steamer pans were noted to be stacked wet. The Assistant Dietary Manager explained the dishes were to be air dried before they were stacked for storage, and she did not know why the metal steamer pans were stacked wet. d. The kitchen was toured again on 6/17/2024 at 2:07 PM with the Dietary Manager (DM). The freezer was observed to have an open box cube steak with the bag inside the box open. The DM reported the plastic bags should have been closed. e. During the tour of the kitchen on 6/17/20024 at 2:07 PM, the DM and Dietary Aide #1 were noted to have uncovered facial hair. Dietary Aide #1 was observed to serve canned peaches without covering his facial hair and the DM reminded him to cover his facial hair. The DM explained he thought coverings for facial hair were required only when directly preparing food. The Registered Dietitian (RD) was interviewed on 6/19/2024 at 1:35 PM. The RD reported the dented can should have been removed from rack and the plastic bags in the freezer closed. The RD reported the steamer pans should be completely dry before stacking for storage. The Registered Dietician explained the DM had been instructed to cover his facial hair when he was in the kitchen. Dietary Aide #1 was interviewed on 6/19/2024 at 2:21 PM. Dietary Aide #1 explained he was not aware he had to cover his facial hair when in the kitchen. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The DM was interviewed on 6/19/2024 at 2:30 PM and he reported the kitchen staff should have removed the dented can and closed the bags of food in the freezer. The DM explained the RD had told the males in the kitchen with facial hair to cover their facial hair, but he thought it was only during food preparation. The DM explained the kitchen had limited drying space for dishes out of the dishwasher and he thought the kitchen staff had stacked the wet metal steamer pans too soon after washing.