STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345538	A. Building B. Wing	11/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pruitthealth-Raleigh	2420 Lake Wheeler Road Raleigh, NC 27603

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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 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow resident to participate in the development and implementation of his or her person-centered plan of care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35122 Based on record review, and resident, family and staff interviews, the facility failed to offer the resident the right to participate in the person-centered planning process for 2 of 5 residents reviewed for care plans (Residents #96 and Resident #21). Findings included: 1. Resident #96 was admitted to the facility on [DATE] with diagnoses including heart failure, diabetes, and depression. Resident #96's most recent quarterly Minimum Data Set (MDS) assessment dated [DATE] indicated she was cognitively intact and required substantial to dependent assistance with most activities of daily living (ADL). Resident #96's care plans were noted as last reviewed or revised on 11/11/24. Review of Resident #96's record did not indicate care plan meetings had been conducted. On 11/12/24 at 10:32 AM an interview was conducted with Resident #96 who deferred all questions to her Family Member. Her Family Member stated early in Resident #96's admission he had participated in a care plan meeting, but it had been a while since he was last invited or participated in a care plan meeting. He explained he would like to participate with her care planning. On 11/14/24 at 3:30 PM an interview with the MDS Nurse was conducted. She stated the MDS department had been short staffed and have gotten behind on care plan meetings with residents and families. After record review, she explained that only a few care plan meetings had been held in July, August and September which had not included Resident #96. On 11/15/24 at 1:52 PM an interview with the Administrator and Corporate Nurse Consultant was conducted. The Administrator explained the MDS department had gotten behind with conducting care plan meetings and were currently working to get caught up. 2. Resident #21 was admitted to the facility on [DATE] with diagnoses including cerebrovascular accident (stroke), heart failure, diabetes, and depression. (continued on next page)

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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F 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #21's most recent quarterly Minimum Data Set (MDS) assessment dated [DATE] indicated he was cognitively intact and required varying levels of assistance with his activities of daily living (ADL). Resident #21's care plans were noted as last reviewed or revised on 11/12/24. Review of Resident #21's record did not indicate care plan meetings had been conducted. An interview with Resident #21 was conducted on 11/12/24 at 2:09 PM. He stated he did not recall being invited to participate in his care planning. On 11/14/24 at 3:30 PM an interview with the MDS Nurse was conducted. She stated the MDS department had been short staffed and have gotten behind on care plan meetings with residents and families. After record review, she explained that only a few care plan meetings had been held in July, August and September which had not included Resident #21. On 11/15/24 at 1:52 PM an interview with the Administrator and Corporate Nurse Consultant was conducted. The Administrator explained the MDS department had gotten behind with conducting care plan meetings and were currently working to get caught up.

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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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35122 Based on record review and staff interviews the facility failed to accurately code the Minimum Data Set (MDS) in the areas of Gradual Dose Reduction (Residents #74 and #15), Discharge Location (Resident #146), and Restraints (Resident #44) for 4 of 26 residents reviewed. Findings included: 1. Resident #74 was admitted on [DATE]. His diagnoses included tactile hallucination and delusion. A psychiatry progress note dated 7/30/24 recorded Resident #74 was to continue taking quetiapine (an antipsychotic medication used to treat mental health conditions) 25 milligrams (mg) for tactile hallucination and delusion. His medications were reviewed for possible Gradual Dose Reduction (GDR to reduce the dose or discontinue the medication) of psychotropics (includes several classifications of medications used to treat mental illness), and noted a GDR was not recommended at this time. Review of Resident #74's August 2024 Medication Administration Record revealed he had received quetiapine daily. A psychiatry progress note dated 8/15/24 recorded Resident #74 was receiving quetiapine 25 mg, his medications were reviewed for possible GDR of psychotropics, and noted a GDR was not recommended at this time. Resident #74's most recent quarterly MDS assessment dated [DATE] indicated he had received antipsychotic medication routinely and a GDR had not been documented by a physician as clinically contraindicated. On 11/14/24 at 3:30 PM an interview with the MDS Nurse was conducted. She stated when completing Resident #74's 8/19/24 MDS assessment she may have only looked at the scanned records and did not see the 8/15/24 psychiatry note as it had not been scanned into the medical record at that time. After further record review she stated she should have used the information from the 7/30/24 psychiatry note which indicated a GDR was contraindicated. She explained the assessment had been coded wrong. On 11/15/24 at 1:52 PM an interview with the Administrator and Corporate Nurse Consultant was conducted. The Administrator stated she expected MDS assessments to be accurate. 2. Resident #15 was admitted on [DATE]. Her diagnoses included major depressive disorder and unspecified convulsions. A psychiatry note dated 8/15/24 recorded Resident #15 was receiving risperidone (an antipsychotic medication used to treat mental health conditions) 1 milligram (mg). Her medications were reviewed for possible Gradual Dose Reduction (GDR to reduce the dose or discontinue the medication) of psychotropics (includes several classifications of medications used to treat mental illness), and noted a GDR was not recommended at this time. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #15's October 2024 Medication Administration Record revealed she had received risperidone 1 mg twice daily and divalproex (an anticonvulsant medication used for the treatment of seizures and can also be used to treat mood disorders) 125 mg three times a day until 10/26/24 when it was reduced to twice a day. Resident #15's most recent quarterly MDS assessment dated [DATE] indicated she had received antipsychotic medication routinely, did not indicate she had received anticonvulsant medication, and a GDR had been attempted on 10/23/24. On 11/14/24 at 3:30 PM an interview with the MDS Nurse was conducted. She stated another nurse had completed this assessment. She explained it appeared the nurse had considered the dose reduction of the divalproex a GDR, but this was not an antipsychotic medication. She stated the GDR had been coded incorrectly. On 11/15/24 at 1:52 PM an interview with the Administrator and Corporate Nurse Consultant was conducted. The Administrator stated she expected MDS assessments to be accurate. 49502 3. Resident #146 was admitted to the facility on [DATE]. Review of the discharge Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #146 was discharged to a short-term general hospital. Review of a nursing note dated 10/7/24 indicated Resident #146 was discharged home with family. An interview with the MDS Nurse on 11/14/24 at 9:45 a.m. was conducted. She stated the discharge MDS for Resident #146 dated 10/7/24 should have been coded as discharged home. She explained she had inaccurately miscoded the MDS in error. During an interview with the Administrator on 11/15/24 at 3:04 p.m. she indicated the MDS should be completed accurately. 50234 4. Resident # 44 was admitted to the facility on [DATE] with diagnoses including Alzheimer's dementia. Resident #44's quarterly Minimum Data Set (MDS) dated [DATE] indicated she had severe cognitive impairment, had no behaviors, and needed supervision for ambulating around the unit. The MDS also documented that Resident #44 required a trunk restraint (a restraint on the torso that prevents a resident from getting up out of a chair) once during the observation period. Review of Resident #44's physician's orders from 7/1/24-11/14/24 did not reveal an order for a restraint. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #44's progress notes from 7/1/24-11/14/24 did not reveal notes that she had any behaviors or any indications of a need for a restraint. The notes did not document that a restraint was used. In an interview on 11/12/24 at 12:22 PM, Nurse #4, Resident #44's regular charge nurse, said Resident #44 never had a restraint. In an interview on 11/15/24 at 1:20 PM, Nurse #5 said she completed the MDS for Resident #44. She said she could not find any documentation that the resident had a restraint. Nurse #5 indicated that she made a coding error on Resident #44's MDS when she documented that a trunk restraint was used.

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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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49159 Based on observations, staff interviews, and record reviews, the facility failed to keep a urinary catheter bag from touching the floor to reduce the risk of infection for 1 of 2 residents (Resident #5) reviewed with urinary catheters. The findings included: Resident #5 was admitted to the facility on [DATE] with diagnoses that included end stage renal disease (the final, permanent stage of chronic kidney disease, where kidney function has declined to the point that the kidneys can no longer function on their own), obstructive and reflux uropathy (when urine cannot drain through the urinary tract and urine backs up into the kidneys), artificial openings of urinary tract (a medical condition where a surgical procedure has created an opening in the urinary system to allow urine to exit the body when the normal pathway is blocked or damaged), and urinary tract infection (UTI). Resident #5's care plan dated 10/3/2024 revealed focus areas for catheter care and at risk for infection. Interventions included not allowing urinary catheter bag tubing or any part of the drainage system to touch the floor, positioning the urinary catheter bag below the level of the bladder, and reporting signs/symptoms of a UTI. An admission Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #5 was moderately cognitively impaired. The assessment indicated Resident #5 was dependent upon staff for all his activities of daily living (ADL). Resident #5 was coded for an indwelling catheter. An initial observation was conducted on 11/12/2024 at 12:17 PM of Resident #5. He was observed lying in his bed. His urinary catheter bag was hanging off the bedframe on the resident's right side of the bed, resting on the floor. An interview was conducted on 11/12/2024 at 12:21 PM with Nurse #1 assigned to care for Resident #5. When asked about the position of Resident #5's urine catheter bag, he stated the CNA (certified nursing assistant) may have put the bed too low because of fall precautions. A subsequent observation was conducted on 11/13/2024 at 8:09 AM. Resident #5's urinary catheter bag was observed hanging off the bedframe on the resident's right side of the bed, resting on the floor. An interview was conducted with the Infection Preventionist on 11/13/2024 at 3:19 PM regarding Resident #5's urinary catheter bag observations. She stated that a urinary catheter bag resting on the floor is a concern and she would initiate re-education with staff. She further stated she would discuss this with the Clinical Competency Coordinator (Nurse Educator) so she may assist in staff re-education. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted on 11/14/2024 2:19 PM with Nurse Aide #1 who was assigned to care for Resident #5. She stated urinary catheter bags should be kept below the bladder on the bed and off the floor. Attempts to interview the resident were unsuccessful. During an interview with the Director of Nursing (DON) on 11/14/2024 at 1:33 PM, she stated urinary catheter bags should be kept below the bladder, on side of bed, and should be placed off floor. She further stated all nursing staff received training regarding the care of urinary catheters in a web-based clinical competency education training system, as well as during skills fairs offered throughout the year.

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Some	Post nurse staffing information every day. 50234 Based on observations and interviews with staff, the facility failed to complete the daily staff posting sheet for 4 of 4 days observed (11/12 through 11/15/24). The daily staff posting sheet did not include the resident census of the facility. The findings included: Observation on 11/12/24 at 2:00 p.m. revealed the daily staffing posting at the front desk did not include the census. Observation on 11/13/24 at 9:15 a.m. revealed the daily staffing posting at the front desk did not include the census. Observation on 11/14/24 at 8:15 a.m. revealed the daily staffing posting at the front desk did not include the census. Observation on 11/15/24 at 8:15 a.m. revealed the daily staffing posting at the front desk did not include the census. In an interview on 11/15/24 at 3:27 p.m., the Staffing Coordinator said she did not know how to access the census for that day, so when she came in at 5 a.m., she would make rounds and fill out the accurate information and then wait for after the meeting to put in the census on the daily staffing posting. She would sometimes get busy helping residents and would forget to go back to enter the census. In an interview on 11/15/24 at 3:20 p.m., the Administrator said she was not aware the census hadn't been posted on the daily staffing posting but it should have been included.

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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 0842 Level of Harm - Potential for minimal harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50234 Based on record reviews and staff interviews, the facility failed to have a complete and accurate medication and treatment administration record for 1 of 7 residents (Resident #399) reviewed for medical record accuracy. The findings included: Resident #399 was admitted to the facility on [DATE] with diagnoses including chronic pain syndrome, high cholesterol, yeast infection of skin and nails, and non-pressure chronic ulcer of the right lower leg. Resident #399's physician orders revealed the following: - An order dated 11/02/23 for a pain evaluation every shift - An order dated 11/02/23 for atorvastatin (a statin medication used for high cholesterol) 80 milligrams (mg) one tablet at bedtime. - An order dated 11/02/23 for behavior monitoring. - An order dated 11/02/23 for miconazole nitrate (an antifungal) 2 % powder to apply twice a day to skin folds. - An order dated 11/03/23 for COVID-19 Monitoring twice a day. - An order dated 11/30/23 for oxycodone (used for pain) 5 mg one tablet twice a day. - An order dated 12/04/23 to place plastic eye shield over left eye each night at bedtime until seen by surgeon. - An order dated 12/09/23 for acetaminophen (used for pain) 325 mg two tablets twice a day. Resident #399's January 2024 Medication and Treatment Administration Record (MAR and TAR) revealed the right leg wound care, the miconazole nitrate 2% powder, the COVID-19 monitoring, the pain evaluation, and the behavior monitoring evaluation had not been documented as completed or refused by Resident #399 for the day shift on 1/18/24. In an interview on 11/15/24 at 2:41 PM, Nurse #6 stated she worked with Resident #399 on the day shift but did not remember why she did not document on the MAR and TAR on 1/18/24. The January 2024 MAR revealed placement of the plastic eye shield, the acetaminophen, the atorvastatin, and the oxycodone had not been documented as completed or refused by Resident #399 for the night shift on 1/18/24. (continued on next page)

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F 0842 Level of Harm - Potential for minimal harm Residents Affected - Some	Attempts to interview Nurse #7, who worked with Resident #399 on the night shift on 1/18/24, were unsuccessful. The Director of Nursing (DON) and Administrator were interviewed on 11/15/24 at 3:00 PM. They were not aware there were blanks in the MARs and TARs, but said they expected documentation to be complete and accurate.