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	01/15/2026

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

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interviews with resident and staff, the facility failed to ensure a dependent resident could access a light switch located behind her bed for 1 of 1 resident reviewed for accommodation of needs (Resident #141).The findings included:Resident #141 was admitted to the facility on [DATE].An admission Minimum Data Set (MDS) dated [DATE] revealed Resident #141 to be cognitively intact.During an observation on 1/12/2026 at 11:03 am revealed Resident #141 in bed, the overhead light was on, but no string was attached to overhead light. The light was attached to the wall, behind Resident #141's head.During an interview on 1/12/2026 at 11:04 am with Resident #141, the Resident stated that the string on her overhead light had been broken since she was admitted to the facility in December. Resident #141 stated that she slept with the light on all night and that she was able to sleep fine with the light on. Resident #141 further indicated that although the light being on did not bother her, she would like the option to turn it off. The Resident further stated that she did not recall submitting any grievances or reporting the overhead light to the staff. Resident stated she did not recall asking staff to turn the light off. During a joint observation and subsequent interview with the Maintenance Director on 1/14/2026 at 4:34 pm the Maintenance went to Resident #141's room and acknowledged that there was no way for Resident #141 or for the staff to turn the overhead light on or off, including during nighttime hours. When asked if there were any open work orders, he stated there were none for the hall Resident #141 resided. He stated that the overhead light issue was a simple fix. He stated that the process for reporting work orders required nursing staff to notify maintenance either verbally or by entering a work order. Maintenance Director stated that he had recently replaced lights on that hall but had not replaced the light in Resident #141 room because the facility was going to convert it to an office.An interview with Nurse Aide (NA) #1 on 1/15/2026 at 9:30 am, revealed that NA #1 assisted residents into bed during her 7:00 am to 7:00 pm shift. NA #1 stated that she asked residents whether they wanted the light on or off. NA #1 further stated that if there was a problem with a light, she would notify Maintenance. NA #1 stated that she was not aware that Resident #141 did not have a string or a way to control the overhead light, and she had not noticed the string was broken. She stated that if she had noticed the issue, she would have contacted Maintenance. NA #1 indicated the Resident had not informed her that the light string was broken or that she could not turn the overhead light on or off. NA #1 indicated that she was the NA that typically worked that hall and that she assisted Resident #141 to bed when she worked that hall.During an interview conducted on 1/15/2026 at 9:47 am, the Director of Nursing (DON) revealed she was not aware Resident #141 did not have a string on the overhead light. The DON stated she had not received any complaints from Resident #141 regarding the overhead light. The DON indicated that a work order would have been done if Resident #141 had told someone she was not able to operate the light. The interview further revealed that many residents sleep with a light on so nursing staff may not have immediately noticed that residents were (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	unable to turn off the light.An interview was conducted with the Administrator on 1/15/2026 at 3:32 pm. The Administrator stated that Resident #141 did not complain about the light, thereby not alerting staff to the fact she could not turn it on or off. Administrator stated had the staff been aware, the light would have been promptly fixed.

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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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interviews, the facility failed to ensure medications were administered according to the physician's orders and manufacturer's instructions for method of administration for 1 of 10 residents reviewed for medication administration (Resident #118). Findings included:Resident #118 was admitted to the facility on [DATE] with diagnoses that included Parkinsons disease, dementia and weakness.On 11/29/2025, the admission Minimum Data Set (MDS) assessment revealed Resident #118 was severely cognitively impaired. Eating and oral hygiene required substantial/maximal assistance. On 12/25/2025 a physician order stated that the resident takes medications whole in applesauce. A review of January 2026 active medications orders included Aspirin 81 milligrams (mg) delayed-release 1 tablet once a day, Carbidopa-levodopa 25-100 mg 2 tablets at 6:00 am, 10:00 am and 4:00 pm and Bisacodyl (stimulant laxative) 5 mg delayed-release 1 tablet at bedtime. Review of Resident #118's January 2026 Medication Administration Record (MAR) revealed there were no instructions to administer the medications whole in applesauce.A review of manufacturer's instructions (Kaiser Permanente) dated 1/26/2026 for delayed-release Aspirin and Bisacodyl indicated that the medications must never be chewed, crushed or broken as crushing destroys the enteric-coating and may cause severe stomach irritation. A review of nursing documentation revealed inconsistent medication administration practices. Nursing notes entered by Nurse #3 on 01/01/2026 at 11:55 am, 01/05/2026 at 11:56 am, 01/06/2026 at 06:57 pm and 01/09/2026 at 06:15 pm documented that Resident #118 resident tolerated medications administered whole in applesauce. A nursing note documented by Nurse #7 on 12/30/2025 at 11:56 pm indicated Resident #118 received medications crushed in applesauce. Nurse #3 documented on 1/11/2026 at 4:16 pm and 1/14/2026 2:06 pm Resident #118 received medications crushed in applesauce and Nurse #3 gave the resident his medications crushed in applesauce due to slow alertness. On 1/15/2026 at 4:17 pm, a phone interview with Nurse #4 revealed that she crushed all Resident #118's medications during second shift on 1/2/2026 (time unspecified) knowing the physician order regarding medication administration indicated whole in applesauce. She further stated that she crushed all medications without identifying which medications were safe to crush, despite acknowledging that some medications were extended release (Aspirin and Bisacodyl). Nurse #4 stated that even though Resident #118 could take his medication whole in applesauce, she felt Resident #118 took his medications best when they were crushed. On 1/15/2026 at 4:56 pm, a phone interview with Nurse #3 revealed that although she understood the order to be for medications to be given whole in applesauce, she crushed the resident's medications when the resident was having a slow day and he was taking more time to swallow the medication because of Parkinson's disease. Nurse #3 stated that resident was not having difficulty swallowing when she crushed the meds on 1/11/2026 and 1/14/2026. She stated that resident swallowed slowly or held the medicine in his mouth before swallowing. She stated she did not notify the physician or document a change in condition because Resident #118 was not having difficulty swallowing. Nurse #3 stated that she believed that she could use nurse discretion without contacting the provider.On 01/14/2026, attempts were made to contact Nurse #7 who was assigned to Resident #118 on 12/30/2025 from 7:00 pm to 7:00 am but were unsuccessful.A phone interview on 1/16/2025 at 3:38 pm with Nurse Practitioner (NP) revealed that a resident being slow to take medications was not an indication that medications needed to be crushed. She stated that resident had Parkinson's and his symptoms may wax and wane. The NP indicated if nursing staff felt he was having difficulty swallowing, they should write her a communication and she would evaluate resident. NP states that she did not receive any communication that Resident #118 was having difficulty swallowing or taking medications. The NP did not see a reason why Resident #118 could (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	not take medications whole in applesauce as ordered. On 1/15/2026 at 3:58 pm, an interview with the Director of Nursing (DON) revealed that nurses were expected to administer medications as ordered. She stated that if a nurse determined it was unsafe for a resident to take medications whole, the nurse was expected to notify the physician or request a swallowing evaluation and obtain a new order.

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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 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, and staff interviews, the facility failed to provide an ongoing resident centered activities program in the memory care unit of the facility for 1 of 1 resident reviewed for activities (Resident #27). The findings included: Resident #27 was admitted to the facility on [DATE] with diagnoses which included dementia and depression. She resided on the memory care unit of the facility (a locked unit for individuals with dementia). The Minimum Data Set (MDS) annual assessment dated [DATE] revealed Resident #27 had severe cognitive impairment. Resident #27's assessment of daily and activity preferences revealed it was important for her to have reading material, listen to music, be around pets, keep up with news, be around groups of people, go outside and participate in religious services. Resident #27's care plan last reviewed on 11/18/25 revealed no goals or interventions related to activities. Review of the Kardex (resident care guide) for Resident #27 revealed no mention of activities. Review of Resident #27's record revealed no documentation of attendance at group activities, 1-1 individual sessions or self-directed activities. An observation conducted on 1/12/26 at 2:57 PM revealed Resident #27 was sitting in the hallway looking out the window. An observation conducted on 1/14/26 at 2:53 pm revealed Resident #27 was sitting in the common area of the memory care unit. The unit television was on but Resident #27 was not watching it. An interview was conducted with Nurse #1 on 1/14/26 at 3:37 pm who revealed the Activities staff did not conduct activities in the memory care unit. She stated sometimes staff would bring supplies to the unit. Nurse #1 reported that sometimes nursing staff would play music or cut on the television for the residents. She stated sometimes nursing staff would assist the residents in playing bingo, but it would be at times that would cause minimum disruption to the unit. Nurse #1 stated activities such as bingo in the late afternoon would make getting residents ready for bed difficult. She stated the activities were not individualized for each resident as noted on the MDS and were based on requests from residents who would make a request to the nurses on the unit for a movie or to play bingo. Nurse #1 stated there was no documentation for activities provided by nursing staff on the memory care unit. The Activity Director was interviewed on 1/14/26 at 3:58 pm who reported that he was unable to conduct activities in the memory care unit because he provided activities to the main units of the facility. He stated staff in the memory care unit would provide activities such as painting or bingo to the residents. The Activities Director stated there was a Life Enrichment Coordinator who also assisted with activities on the main units of the facility. He reported there was no calendar for activities in the memory care unit because he was not providing activities to the residents. The Activities Director stated he had not been doing activity assessments for residents in the memory care unit because he did not know they needed to be done. An unsuccessful attempt was made to contact the Life Enrichment Coordinator on 1/15/26 at 1:01 PM. During an interview with the Administrator and Corporate Nurse Consultant on 1/14/26 at 4:24 pm the Corporate Nurse Consultant revealed during a pre-survey review conducted on 1/6/26 the Corporate Nurse Consultant identified issues with the activities program in the memory care unit such as the Activities Director not having necessary certification, no activity assessments completed, no specialized activities in the memory care unit and no one to one activity documentation for residents. The Administrator stated prior to the pre-survey review she believed the Life Enrichment Coordinator was assisting with activities in the memory care unit. She stated in talking with the Activities Director during the survey, she discovered this was not accurate. The Administrator further stated she believed the Activities Director did not receive the necessary education for his role. The Administrator reported the Activity Director had been employed as the Activity Assistant in the past, but she believed the former Activities (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Director had not educated him fully on what the role entailed. The Activities Director received his Activity Director certification on 1/9/26.