STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345061	A. BUILDING _____ B. WING _____	**07/14/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
PRUITTHEALTH-DURHAM	**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)
F 0657 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, staff interviews, and medical record reviews, the facility failed to review and revise a resident ' s care plan to accurately reflect the fall safety interventions required to be consistently implemented for 1 of 3 residents reviewed for Accidents/Falls (Resident #2). The findings included: Resident #2 was admitted to the facility on [DATE]. She was discharged to the hospital on [DATE] and re-entered the facility on 1/17/20. The resident ' s cumulative [DIAGNOSES REDACTED]. A review of Resident #2's plan of care revealed it included an area of focus related to falls (dated 1/18/20), noting the resident was at risk for falls related to decreased mobility, side effects from meds and overall disease process. The interventions included the following: assist for toileting and transfers as needed (start date 1/18/20); continue to cue for safety awareness (start date 1/18/20); keep environment safe (start date 1/18/20); place call light within reach (start date 1/18/20); and safety devices (no devices were specified) with a start date of 1/18/20. Use of a fall mat, bed in the low position, and scoop mattress were not included as interventions in the care plan. The resident's medical record included Nursing Notes which indicated fall safety interventions not included in the care plan were being implemented: --A Nursing Note dated 1/18/20 at 4:49 PM read, in part: .Bed remained in low position for safety precautions . --A Nursing Note dated 1/21/20 at 10:21 AM and on 1/24/20 at 3:01 PM included notations which read, .lying on her back in bed with [MEDICAL CONDITION] mat on floor. A Fall/Incident Report dated 3/27/20 at 1:48 PM described an unwitnessed incident when Resident #2 was found lying on the floor mat beside her bed. The resident stated she was trying to stand up and walk. There were no signs/symptoms of injuries at the time of the incident and Resident #2 denied having any pain or injury. The report indicated the care plan was updated and interventions were in place. However, a review of the resident's care plan revealed the use of a fall mat, bed in the low position, and scoop mattress were not included as interventions in her care plan. Resident #2 ' s medical record included additional Nursing Notes which indicated fall safety interventions not included in the care plan were being implemented: --A Nursing Note dated 3/29/20 at 8:11 AM reported, .Resident trying continuously to get out of bed tonight. Resident stated she was trying to get to the bathroom. Reminded resident that she doesn't walk. Resident cursed profusely at the staff. Resident's leg placed back in bed. Bed placed in lowest position with fall mats down . --A Nursing Note written on 3/30/20 at 4:14 AM read, in part: .No attempts to get out of bed this shift. Bed low with fall mat in place . --A Nursing Note dated 3/31/20 at 8:22 AM read, in part: .Continuously trying to get up. Bed in lowest position. Fall mat beside bed Resident #2 ' s most recent quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had severely impaired cognitive skills for daily decision making. Resident #2 required extensive assistance for bed mobility and dressing. She was totally dependent on staff for toileting and personal hygiene. Section J of the MDS assessment revealed the resident had one fall with no injury reported since the last assessment (dated 1/28/20). A Fall/Incident Report dated 5/28/20 at 3:45 PM described an unwitnessed incident when Resident #2 was observed sitting on the floor by the bedside. No injuries were reported. The report did not indicate if fall safety interventions were in place at the time of this fall. A notation made in the report indicated the Interdisciplinary Team met, discussed the resident and interventions, and updated the care plan. The resident's plan of care revealed the area of focus related to falls was revised to include an interdisciplinary referral to rehabilitation services with a start date of 5/29/20. Use of a fall mat, bed in the low position, and scoop mattress were not included as interventions in her care plan. Resident #2 ' s medical record indicated she was referred to Physical Therapy (PT) for the fall and was evaluated on 6/4/20. The PT evaluation notes reported fall interventions currently implemented included the following: .Patient with scoop mattress with raised side bolsters for falls deterrence; bed approximating wall on patient ' s right side, soft fall bedside mat on patient ' s left side, and bed kept at lowest setting when patient not provided with direct supervision, due to patient presenting with increased risk for displacement from bed 2/2 (secondary to) [MEDICAL CONDITION] disorder. Pt (patient) with recent fall and continued use of fall mats. Pt occasionally disoriented and attempts to get out of bed. Pt recently attempting to get herself out of bed and falling . An observation was conducted on 7/13/20 at 11:40 AM of the resident as she was lying awake in her bed. The resident's bed was not placed in the low position; no fall mat was in place. An observation was conducted on 7/13/20 at 2:20 PM of Resident #2 as she was lying in bed watching television. During the observation, the resident's bed was not placed in a low position; no fall mat was in place next to her bed. An interview was conducted on 7/13/20 at 2:30 PM with Nursing Assistant (NA) #1. NA #1 reported she was assigned to care for Resident #2. When asked about the fall safety interventions put into place for Resident #2, the NA reported the resident typically had a fall mat placed by the side of her bed and her bed was lowered at night (or when she was asleep). Accompanied by the Corporate Senior Nurse Consultant, an observation was made on 7/14/20 at 11:42 AM of Resident #2 while she was lying in her bed awake. The resident was observed to have a low profile scoop mattress on her bed, the bed was in a low position, and a fall mat was in placed by the side of the bed. An interview was conducted on 7/14/20 at 11:45 AM with the Corporate Senior Nurse Consultant. During the interview, the Consultant reported any intervention put into place to address a fall should be on the resident's care plan. Upon review of the resident's current care plan and Resident Profile (which served as a current care guide for the nursing assistants), the Consultant confirmed use of a scoop mattress, bed in the low position, and fall mat placed next to the bed were not included on either the care plan or Resident Profile as planned interventions for a problem area related to falls. An interview was conducted on 7/14/20 at 11:55 AM with the facility's Administrator. During the interview, the Administrator reported the Interdisciplinary Team (IDT) had previously reviewed Resident #2 and her falls. The Administrator reported he thought fall interventions were put into place for her, but stated the interventions may not have been saved and subsequently transferred over to the Resident Profile. When asked, the Administrator reported the care plan was a team responsibility. He reported the Director of Nursing (DON), Unit Manager, or MDS Nurse typically shared responsibility to update a resident's care plan on an as needed basis. A follow-up telephone interview was conducted on 7/14/20 at 3:45 PM with the facility's Administrator. During the interview, the Administrator reported the facility converted to electronic medication records (EMRs) approximately one year ago. The EMRs included resident care plans. Prior to the conversion, the facility was using paper records and a different system for documenting the resident care plans and care guides. The Administrator reported he discovered the facility staff were actually using all of these tools, including the old versions of Resident #2's care plans and care guides. He noted the old version of Resident #2's Care Guide did include keeping her bed in the low position, use of a fall mat, and scoop mattress (dated 5/16/18). When asked if he would have expected these fall interventions to be included on Resident #2's current care plan, the Administrator stated, Absolutely.

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

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.