STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345371	A. BUILDING _____ B. WING _____	C 08/26/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEALTH-TRENT	836 HOSPITAL DRIVE NEW BERN, NC 28560

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record review, the facility failed to provide incontinent care or change wet bed linens for 1 of 3 residents (Resident #2) reviewed for activities of daily living. Findings included: Resident #2 was admitted to the facility on 6/29/15 with diagnoses that included brain injury, generalized muscle weakness and hemiplegia on his dominant side. Resident #2 ' s Admission Minimum Data Set (MDS), dated 7/6/15, indicated the resident required extensive assistance for toilet use and personal hygiene. The resident's care plan, last reviewed on 8/10/15, identified Resident #2 as having a potential for an alteration in skin integrity. Approaches to prevent skin breakdown included providing incontinent care. The care plan also identified Resident #2 was incontinent of bowel and bladder. Approaches listed to manage his incontinence included the use of briefs, applying a moisture barrier and changing wet or soiled clothing promptly. An observation was made on 8/25115 at 10:52 AM. Resident #2 ' s bed had a wet spot that extended from one side to the other of the bottom sheet and covered approximately 2 feet in	F 312	This plan of correction constitutes a written allegation of compliance. Preparation and submission of this plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or the correctness of the conclusions set forth on the statement of deficiencies. The plan of correction is prepared and submitted solely because of requirements under state and federal law. What Corrective action will be accomplished for the residents found to have been affected by the deficient practice? Resident was provided incontinent care and linens were changed by C.N.A. and Director of Health Services on 8/26/15. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? All residents are at risk	9/18/15

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		09/16/2015

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F 312	Continued From page 1 diameter from the top of the bed to the bottom of the bed. The pad that was laying on top of the sheet also appeared wet. A brown stain was observed around the outer circumference of the large wet area on the sheet. Nursing Assistant (NA) #1 entered the room at 10:55 AM and acknowledged the indicator line on the brief was yellow which meant the resident was wet. The NA acknowledged the pad was wet, the sheets were wet and acknowledged the brown edges of the larger wet area on the sheet. Nurse #1 observed Resident #2 ' s bed on 8/25/15 at 11:05 AM and acknowledged the pads and sheets were wet with a brown ring on the circumference of the wet area on the sheet. Nurse #2 observed Resident #2 ' s bed on 8/25/15 at 11:06 AM. The nurse acknowledged the pad and sheets were wet with brown edges. The nurse stated it would take hours for a brown stain to develop on the edges of a wet sheet. Nurse #1 added the expectation was for NA ' s to check residents at least every 2 hours for incontinence. She added with the brown stain, she would say the sheets had been left by the 11:00 PM to 7:00 AM shift. The nurse stated the resident ' s brief may have been changed, but the wet sheets had not been changed. The nurse added lying on urine soaked sheets could eat away at Resident #2 ' s skin. NA #1 was interviewed on 8/25/15 at 11:15 AM. She stated she had checked on Resident #2 when she arrived at the beginning of the shift and he had not been wet and the sheets were not wet. She added then she had to get 2 other resident ' s ready for an appointment, had been called to another room and had not gotten back to Resident #2 until she was ready to bathe him at 10:55 AM. The NA stated since his brief was dry, he must have urinated on the bed. She had	F 312	On 8/26/15 the Director of Health Services, Administrative Nurses and Administrator completed a 100% audit of bed linen to ensure linens are clean and dry. On 8/26/15 the Director of Health Services, Administrative Nurses and Administrator completed a 100% audit of residents that are up in a chair for incontinence care. All identified issues were corrected immediately by changing the linen or completing incontinence care. What measures will be put in place or what systemic changes will be made to ensure that the deficient practice will not reoccur? Education began on 9/14/15 by the Clinical Competency Coordinator, Director of Health Services, and Unit Managers for the Licensed Nurses, certified nursing assistance, and Housekeeping on insuring linens are kept clean and dry and if linens are soiled or wet, then linens are to be changed immediately. Education to be completed by 9/18/15, any Licensed Nurses, certified nursing assistant, and housekeeping not completing education will be removed from the schedule until education is completed. Education began on 9/14/15 by the Clinical Competency Coordinator, Director of Health Services, and Unit Manager for the certified nursing assistance on	

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F 312	Continued From page 2 no reason why she had earlier stated the brief was wet as identified using the indicator strip and now said he was dry. Nurse #1 on 8/25/15 at 11:53 AM. The nurse again she had observed Resident #2 ' s wet sheets that morning. She stated from experience the brown edge on the sheet around the wet area would lead one to believe it was dried urine. The nurse added while she was not sure how long it would take to make a brown ring, she was sure it would take longer than 2 hours. Nurse #1 stated she felt the resident had received incontinent care since the brief was dry, but unsure how long the wet sheets had been on the bed. The nurse added the danger of Resident #2 lying on wet sheets would be skin breakdown. A continuous observation started on 8/26/15 at 8:20 AM and ended at 11:40 AM. The resident was seen sitting in a geri-chair at the nurse's station. Resident #2 was dressed with no signs and symptoms of incontinence. NA #1 was interviewed on 8/26/15 at 8:44 AM. She stated the resident had been trying to get out of bed so she had bathed and dressed him and placed him in his chair at the nurse ' s station. At 9:18 AM on 8/26/15, the Director of Nursing (DON) stopped to speak to the resident. There was no incontinent check noted. At 11:30 AM on 8/26/15, the resident remained in the geri- chair at the nurse's station. Incontinent care had not been offered. 11:40 AM the DON was observed pushing the resident to his room. On interview, she stated she had checked the color strip at the waist of Resident #2 ' s brief earlier in the day and since the strips had not changed colors, she assumed he was not wet. She stated she had been able to visualize the color strips when she adjusted the resident ' s clothing. She acknowledged she was	F 312	completing incontinent care including but not limited to changing residents when they are soiled or wet. Education to be completed by 9/18/15, any certified nursing assistant not completing education will be removed from the schedule until education is completed. The Unit managers, Clinical Competency Coordinator, week-end manager and/or week-end nursing supervisor, and housekeeping will audit bed linen daily x 7 days, weekly x 4 weeks, and then monthly x 3 or until compliance is achieved. The Unit managers, Clinical Competency Coordinator, Licensed Nurses, and/or week-end nursing supervisor will audit residents up in w/c and bed bound incontinent residents to ensure incontinent care is provided in a timely manner, daily x 7 days, weekly x 4 weeks, and then monthly x 3 or until compliance is achieved. How will the corrective action be monitored to assure that the deficient practice will not reoccur, i.e., what quality assurance program will be put in place for monitoring to assure continued compliance. The Director of Health Service will review and track and trend the audits completed for clean linen and incontinent care, finding will be presented to the to the Quality Assurance and Performance Improvement Committee monthly for recommendations and changes for six	

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F 312	Continued From page 3 unable to visualize the indicator lines near the bottom of the brief. The DON stated her expectation was for residents to be checked for incontinence every 2 hours and 3 1/2 hours, from 8:20 AM to 11:40 AM was too long to go without being checked for incontinence. The DON stated at this time Resident #2 was wet and required incontinence care. The DON was interviewed on 8/26/15 at 2:48 PM. She stated Resident #2 ' s family member had expressed concerns to her that included finding his sheets wet when she came to visit. She stated she had tried to explain to the family member that Resident #2 would urinate on his sheets and shred his brief. An interview was held with NA #1 on 8/26/15 at 3:00 PM. She stated she had placed the resident at the nurse's station around 8:00 AM. The NA acknowledged she had not checked the resident for incontinence between 8:00 AM and noon. She stated the reason she had not checked Resident #2 for incontinence was because she had 2 emergencies and then another resident wanted to get up. The NA stated she had not reported her inability to check the resident for incontinence to the nurse. The DON stated in interview on 8/26/15 at 3:05 PM that if a NA needed assistance completing her assignment she would have expected the NA to notify someone to request help.	F 312	months or until continued compliance is achieved.	