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 11/03/2021

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
E 000	Initial Comments An unannounced recertification survey was conducted on 10/25/21 through 11/3/21. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #RLQ311.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint survey was conducted from 10/25/21 through 11/3/21. 7 of the 18 complaint allegations were substantiated resulting in deficiencies. Immediate Jeopardy was identified at: CFR 483.10 at tag F580 at a scope and severity (K) CFR 483.12 at tag F600 at a scope and severity (K) CFR 483.25 at tag F684 at a scope and severity (K) CFR 483.35 at tag F726 at a scope and severity (K) The tags F600 and F684 constituted Substandard Quality of Care. Immediate Jeopardy began on 9/24/20 and was removed on 10/29/21 for tags F580, F600, F684 and removed on 10/30/21 for tag F726. An extended survey was conducted.	F 000		
F 580 SS=K	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is-	F 580		12/3/21

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE
(X6) DATE: 11/23/2021

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.

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 11/03/2021

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F 580	Continued From page 1 (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various	F 580		

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	345371	A. BUILDING ______ B. WING ______	C 11/03/2021

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

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F 580 Continued From page 2

locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9).
This REQUIREMENT is not met as evidenced by:
Based on staff, physician, nurse practitioner, and police officer interviews, and record review the facility failed to notify the physician of an open wound that progressively deteriorated from 9/24/20 through 1/10/21. This failure resulted in the resident receiving no physician evaluation of the wound and no physician ordered treatments to the wound. Resident #200 was identified by Emergency Medical Services (EMS) and police on 1/10/21 to have a large tunneling wound under his left arm at the time of death with no observed dressing present. This was for 1 of 3 residents reviewed for wound care (Resident #200).

Immediate Jeopardy began on 9/24/20 when Resident #200's wound to his left axillary (armpit) opened and the Wound Care Nurse failed to notify the physician or nurse practitioner. Immediate jeopardy was removed on 10/29/21 when the facility provided and implemented an acceptable allegation of Immediate Jeopardy removal. The facility remains out of compliance at a lower scope and severity of "E" (no harm with the potential for more than minimal harm that is not immediate jeopardy) to ensure monitoring systems put in place are effective.

Findings included:

Resident #200 was admitted to the facility on 6/20/20 with diagnoses that included anemia, contracture of the right and left knee, stage II pressure ulcers of the right and left buttock, and

F 580

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 truth of the facts alleged or the corrections 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.

"Corrective action will be accomplished for those residents found to have been affected by the deficient practice.

Resident # 200 no longer resides in the facility.

"How the facility will identify other residents having the potential to be affected by the same deficient practice

The Director of Health Services initiated 100% body audits on all residents within the facility on 10/27/21. This audit reveals no wounds without physician/physician extender notification.

"Measure□s facility put into place or systemic changes made to ensure that the deficient practice will not recur;

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 11/03/2021

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 580

Continued From page 3

hidradenitis suppurativa (a chronic skin condition featuring skin lesions which develop because of inflammation and infection of sweat glands).

Resident #200's quarterly minimum data set assessment dated 10/22/20 revealed he was assessed as cognitively intact. He required extensive assistance with bed mobility and toilet use. He was totally dependent on staff for dressing and personal hygiene. He had two stage II pressure ulcers present upon admission. He had application of non-surgical dressings, pressure ulcer care, and a pressure reducing device to bed and chair. He also had application of ointment and treatments.

Review of Resident #200's Treatment Orders and Treatment Administration Records from June 2020 through January 10th, 2021 revealed on 8/20/20 the physician ordered to have Resident #200's left inner armpit cyst, related to hidradenitis, cleansed with normal saline and apply a dry dressing every day. This order was discontinued on 9/24/20 by Physician #1 and was transcribed by the Wound Care Nurse.

A physician note dated 9/9/20 by Physician #1 revealed Resident #200's hidradenitis had improved with a course of antibiotics and they would resume antibiotics if the inflammation reoccurred.

Review of physician and nurse practitioner notes from September 2020 through 1/10/21 revealed no mention of any wound to Resident #200's left armpit.

Review of Resident #200's chart revealed between the time of 9/24/20 through 1/10/21 no

F 580

The Director of Health Services and/or Nurse Managers began education on 10/27/21 regarding notification to physician and/or physician extender regarding newly identified skin impairments and/or worsening skin impairments for wound treatment orders or all change in conditions (utilizing the Situation, Background, Assessment, Recommendation form when a change in skin impairment or change of condition is noted. This education has been added the Licensed Nurse general orientation upon hire. License Nurses not educated by 10/28/21 will be educated prior to their next scheduled shift.

The Director of Health Services and Nurse Managers educated the Certified Nursing Assistants on daily skin checks during personal care. This education includes notification to the nurse of any skin impairment and/or new dressing noted on resident□s skin. The Certified Nursing assistant will utilize a body diagram for nurse notification. This education has been added to the Certified Nursing Assistant general orientation upon hire. Certified Nursing Assistants not educated by 10/28/21 will be educated prior to their next scheduled shift.

The Director of Health Services / Nurse Managers are reviewing the residents weekly skin review to ensure physician notification is completed for all new skin impairments or deteriorating skin impairments. This will occur weekly for four weeks then monthly thereafter.

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 11/03/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 580

Continued From page 4

communication was documented between the facility staff and Physician #1 or Nurse Practitioner #1 related to a wound to Resident #200's left armpit.

The EMS record dated 1/10/21 indicated EMS was dispatched to the facility for Resident #200. He was observed with a large gaping hole in his left armpit that was bleeding.

The police case narrative dated 1/11/21 revealed Police Officer #1 arrived at the facility in response to a death in the facility on 1/10/21. Police Officer #1 documented he was informed by EMS upon arrival that it appeared to be a case of neglect based on the deceased's condition and EMS personnel wanted to ensure a report was on file. Resident #200 had one large open wound under his left arm that was "several inches wide and extended up inside his body." The officer documented the open wound that was not bandaged and showed no signs of care. There were additional sores on the resident's side that were smaller but were still noticeable. The officer photographed the body. There were abrasions and sores under his right arm as well though not as pronounced.

During an interview on 10/16/21 at 6:20 PM Police Officer #1 stated he was contacted by his dispatch that EMS had requested an officer respond for an unattended death at the facility. He stated he arrived at 5:03 AM on 1/10/21 and EMS informed him Resident #200 had several open sores on his body that they discovered when they took off his gown. The most notable sore was to his left armpit. The officer observed the area. The gown that was around that area was soaked in a pink fluid. The wound was

F 580

The Director of Health Services / Nurse Managers are reviewing the Certified Nurse Aide skin checks completed during resident□s personal care, weekly to ensure physician has been notified by the Licensed Nurse of new or worsening skin impairment. This will occur weekly for four weeks then monthly thereafter.

"How the facility plans to monitor its performance to make sure that solutions are sustained.

The Director of Health Services will present the analysis of the weekly Licensed Nurse skin review to ensure physician notification to the Quality Assurance and Performance Committee meeting monthly for three months, then quarterly thereafter until six months of continued compliance is sustained.

The Director of Health Services will present the analysis of the weekly Certified Nursing Assistant skin check completed during personal care review to ensure physician notification to the Quality Assurance and Performance Committee meeting monthly for three months, then quarterly thereafter until six months of continued compliance is sustained.

Date when corrective action will be completed: 12/3/2021

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 11/03/2021

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 580	Continued From page 5	F 580		

approximately two inches wide and three inches long. The wound continued into Resident #200's body towards his head which was open and large enough of a cavity that he could visualize inside the resident's body under his armpit. It was approximately 4 inches deep to his collarbone and was approximately 1.5 inches wide. The cavity ran along the outside of his rib cage and ended at his collarbone. The flesh that was visible in the cavity was a whitish pink. There were additional smaller sores located around the wound. He was informed by EMS that this wound did not have any dressing present when they arrived. He stated the staff could not explain why the wound was not cared for at that time.

Review of the police report photographs taken on 1/10/21 at 5:28 AM at the time of Resident #200's death provided to the surveyor by Police Officer #1 revealed Resident #200 had an open wound under his left armpit. The wound could be observed to be approximately 1.5 inches wide and 2 inches long. Tunneling (Tunneling is when a wound has formed passageways underneath the surface of the skin.) could be observed at 12 o'clock. The tunneling was approximately 0.5 inches in diameter from medial (towards the center of the body) to lateral (away from the center of the body) edges of the tunneling and 1 inch in diameter from anterior (towards the front of the body) to posterior (towards the back of the body) edges of the tunneling. This tunneling extended up under his armpit an indeterminant length as the end of the tunneling was outside of the view of the camera. The wound presented as pale pink and the wound bed had yellow slough present (yellow/white material in the wound bed; usually wet but can be dry. It generally has a soft texture. It can be thick and adhered to the wound

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 11/03/2021

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 580	Continued From page 6	F 580		

bed, present as a thin coating, or patchy over the surface of the wound. It consists of dead cells that accumulate in the wound drainage.).

During an interview the Wound Care Nurse on 10/26/21 at 9:43 AM stated she remembered Resident #200. She stated she was the Wound Care Nurse at the time he was at the facility, and he was on her caseload. She further stated on 9/24/20 the treatment was discontinued to the wound in his left armpit. The Wound Care Nurse stated she informed Nurse Practitioner (NP) #1 Resident #200's wound was not healed, that she was completing the treatment without an order, and that the dressing she was using on the wound would not stay on due to the drainage from the wound. This information was from her recollection and she could not recall the exact timeframe she notified NP #1 of this information. The Wound Care Nurse indicated NP #1 informed her (unable to recall a specific date) to keep an eye on the wound and keep her up to date with any changes, but she had not ordered any treatment. She stated that she recalled notifying NP #1 at some point in December 2020 that the wound continued to not heal. The Wound Care Nurse reported she observed Resident #200's wound and provided the non-ordered treatment to his left armpit up until his death (1/10/21) and it progressively deteriorated. She indicated that a couple of days before Resident #200's death, his left armpit wound had developed an odor. She indicated the wound was the size of a nickel and was about 0.1 centimeters deep. The Wound Care Nurse reported that she told NP #1 about the size and the odor that had developed. She stated it was concerning to her that the wound had deteriorated in size and developed an odor, yet

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 11/03/2021

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 580	Continued From page 7	F 580		

NP #1 had not ordered any care for the wound. She indicated she had not shared this concern with any other staff at the facility. The Wound Care Nurse revealed she had no documentation of any communication with NP #1 related to Resident #200's left armpit wound from 9/24/20 through 1/10/21, and she was unable to provide a date of the last time she visualized the wound.

During an interview on 10/26/21 at 10:50 AM Nurse Practitioner #1 stated she remembered Resident #200. She further stated she remembered he had hidradenitis suppurativa especially under his arms. She stated Resident #200 had been given antibiotics a couple of different times when the lesions were infected. She further stated these areas did not typically open very much and were usually raised with a small area that was draining. She continued to state in September 2020 at the conclusion of his antibiotic treatment she had been told the wounds had gotten better. The Wound Care Nurse's interview that indicated she informed Nurse Practitioner #1 she was completing treatments without an order and that the wound had opened and deteriorated was shared with Nurse Practitioner #1. Nurse Practitioner #1 denied ever being notified after September 2020 by the Wound Care Nurse or any other staff at the facility that the wound to Resident #200's left armpit had opened, deteriorated, or was receiving treatments without orders. She stated if the resident's wound under his left arm had opened, she should have been notified and she would have ordered another round of antibiotic treatment and possible referral to surgery for treatment. She also stated she should have been notified the treatments were being done without an order.

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 11/03/2021

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 580	Continued From page 8	F 580		

Nurse Practitioner #1 provided a signed statement dated 10/28/21 which again attested Nurse Practitioner #1 "was not aware or notified by any staff that [Resident #200's] wound had opened up or gotten worse since the completion of antibiotics in September 2020."

During an interview on 10/27/21 at 8:58 AM Physician #1 stated Resident #200 had a condition of hidradenitis which was a chronic problem that was very difficult to control. He further stated the areas to Resident #200's underarms would close and then would rupture and drain. He further stated if one of the wounds was open, he would want to be made aware that the wound was open. The physician indicated he would order antibiotics to attempt to provide treatment to the area and he would leave the area open to allow it to drain better. He stated he was not made aware of any open areas to Resident #200's left armpit and did not know there was a wound to Resident #200's left armpit after September 2020.

During an interview on 10/27/21 at 1:35 PM the Director of Nursing stated if a wound was open or required treatment the wound should be reported to the nurse practitioner or doctor. She further stated if the Wound Care Nurse had concerns about wound treatments, lack of response from the nurse practitioner or physician, or concerns about wound care in general the Wound Care Nurse could and should inform the Director of Nursing and escalate her concerns with the wound in question. She further stated to her knowledge, Resident #200 was admitted with wounds to his right underarm which eventually closed in September of 2020. He also developed

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 11/03/2021

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 580	Continued From page 9	F 580		

an area under his left arm during his stay that to her knowledge was closed and treatment was completed in September of 2020. She further stated up until his death on 1/10/21 she was not made aware of any concerns about the skin status of his left armpit. Upon viewing the photographs of Resident #200 supplied by the local police department the Director of Nursing stated a wound of the severity pictured should have been reported to herself as well as the physician or Nurse Practitioner and she was not made aware of the presence of that wound.

During an interview on 10/27/21 at 4:17 PM the Administrator stated she was not aware of any wounds to Resident #200's left armpit. She further stated the Wound Care Nurse was to notify the physician or nurse practitioner of changes to wounds or the presence of new wounds. She stated if the Wound Care Nurse had concerns that a wound was not receiving attention from the physician or nurse practitioner, she should have escalated her concerns to the Administrator and Director of Nursing. She stated the Wound Care Nurse never shared such concerns nor documented such concerns with Resident #200.

The Administrator was notified of the immediate jeopardy on 10/28/21 at 11:03 AM. On 10/29/21 at 2:02 PM the facility provided the following credible allegation of immediate jeopardy removal.

The Removal Plan: F580
· Identify those recipients who have suffered, or are likely to suffer, a serious adverse outcome as a result of the noncompliance; and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEALTH-TRENT	836 HOSPITAL DRIVE NEW BERN, NC 28560

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F 580	Continued From page 10 On 10/27/21 the Director of Nursing was notified by the State Surveyor that Resident #200 (whom expired January 10, 2021) had a wound under his axilla area (armpit) that the Wound nurse stated she had been treating without an order from 9/24/20 through 1/10/21. The Wound nurse stated that she notified the Nurse Practitioner regarding Resident #200's open axilla area and the Nurse Practitioner allegedly stated to the Wound nurse to continue treatments with no order being provided for the treatments. The Wound nurse was unable to provide a date for this notification. The Wound nurse indicated she provided wound treatments to Resident #200 without an order from 9/24/21 through 1/10/21. The Nurse Practitioner stated that she was never notified of any information related to the open axilla area by the facility staff from 9/24/20 through 1/10/21 for Resident #200. When the wound nurse was asked where the documentation regarding treatments and Nurse Practitioner notifications were located the wound nurse stated there was none, she did not document and there was not an order to treat from 9/24/20 through 1/10/21. The wound Nurse failed to complete the weekly body observations that included wound assessments and measurements of the wound status for this same period of time. There is no documentation that the wound nurse notified the Nurse Practitioner related to the order or treatment of the wound identified under the armpit area. The facility was unaware of the wound nurse was providing treatment without a Physician order. The facility was unaware of the Wound nurse's lack of documentation of assessment, measurements of the wound progression, the Wound nurse was providing treatments without orders, and the lack of notification to the	F 580		

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 11/03/2021

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

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F 580	Continued From page 11 physician/nurse practitioner. Upon arrival to facility on 1/10/21 the EMS /police noted the resident's axilla area wound condition as a large open wound under left arm that was extended up inside his body. Officer documented he could see ribs and collar bone through the body that was not bandaged. Resident #200 expired on 1-10-2021. All residents have the potential to suffer a serious adverse outcome as a result of this noncompliance. · Specify the action the entity will take to alter the process or system failure to prevent a serious adverse outcome from occurring or recurring, and when the action will be. The Director of Health Services initiated 100% body audits on all residents within the facility on 10/27/21. This audit reveals no wounds without physician/physician extender notification. The Director of Health Services and/or Nurse Managers began education on 10/27/21 regarding notification to physician and/or physician extender regarding newly identified skin impairments and/or worsening skin impairments for wound treatment orders or all change in conditions (utilizing the Situation, Background, Assessment, Recommendation form when a change in skin impairment or change of condition is noted. This education has been added the Licensed Nurse general orientation upon hire. License Nurses not educated by 10/28/21 will be educated prior to their next scheduled shift. The Director of Health Services and Nurse Managers educated the Certified Nursing Assistants on daily skin checks during personal care. This education includes notification to the	F 580		

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 11/03/2021

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

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F 580	Continued From page 12 nurse of any skin impairment and/or new dressing noted on resident's skin. The Certified Nursing assistant will utilize a body diagram for nurse notification. This education has been added to the Certified Nursing Assistant general orientation upon hire. Certified Nursing Assistants not educated by 10/28/21 will be educated prior to their next scheduled shift. Alleged date of IJ Removal 10/29/21 The credible allegation for Immediate Jeopardy removal was validated on 11/2/21 which removed the Immediate Jeopardy on 10/29/21, as evidenced by staff interviews, in-service record reviews, and observation. The in-services included information on notifying the physician about newly identified skin concerns and worsening of known wounds. The facility's Immediate Jeopardy removal date of 10/29/21 was validated.	F 580		
F 600 SS=K	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or	F 600		12/3/21

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 11/03/2021

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F 600 Continued From page 13

physical abuse, corporal punishment, or involuntary seclusion;
This REQUIREMENT is not met as evidenced by:
Based on staff, physician, nurse practitioner, police officer and emergency medical technician (EMT) interviews, and record review the facility neglected to provide necessary care and services to a resident by failing to effectively assess and monitor an open wound, failing to obtain physician's orders prior to treating the wound, and failing to notify the physician of an open wound that progressively deteriorated from 9/24/20 through 1/10/21. Resident #200 was observed by Emergency Medical Services (EMS) on 1/10/21 with a large tunneling wound under his left arm at the time of death. This was for 1 of 3 residents reviewed for wound care (Resident #200).

Immediate Jeopardy began on 9/24/20 when the Wound Care Nurse failed to notify the physician of the presence of an open wound to Resident #200's left axillary (armpit), administered a discontinued treatment to the wound, and failed to assess and document the status of the wound. Immediate jeopardy was removed on 10/29/21 when the facility provided and implemented an acceptable allegation of Immediate Jeopardy removal. The facility remains out of compliance at a lower scope and severity of "E" (no harm with the potential for more than minimal harm that is not immediate jeopardy) to ensure monitoring systems put in place are effective.

Findings included:

Resident #200 was admitted to the facility on 6/20/20 with diagnoses that included anemia, contracture of the right and left knee, stage II

F 600

"Corrective action will be accomplished for those residents found to have been affected by the deficient practice.
Resident # 200 no longer resides in the facility.

"How the facility will identify other residents having the potential to be affected by the same deficient practice.

The Director of Health Services initiated 100% body audits on all residents within the facility on 10/27/21. This audit reveals no wounds without orders or without physician/physician extender notification.
All residents have the potential to be affected.

"What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur.

The Clinical Competency Coordinator and/or Nurse Management began education on 10/27/21 for Licensed Nurses regarding abuse and neglect with emphasis on provision of care and services, wound care including assessment, measurement, and notification to physician/physician extender. This education included that treatments were not to be provided without a physician□s order and that all provided treatments were to be

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	345371	A. BUILDING ______ B. WING ______	C 11/03/2021

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PRUITTHEALTH-TRENT	836 HOSPITAL DRIVE NEW BERN, NC 28560

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F 600

Continued From page 14

pressure ulcers of the right and left buttock, and Hidradenitis suppurativa (a chronic skin condition featuring skin lesions which develop because of inflammation and infection of sweat glands).

Resident #200's quarterly minimum data set assessment dated 10/22/20 revealed he was assessed as cognitively intact. He required extensive assistance with bed mobility and toilet use. He was totally dependent on staff for dressing and personal hygiene. He had two stage II pressure ulcers present upon admission. He had application of non-surgical dressings, pressure ulcer care, and a pressure reducing device to bed and chair. He also had application of ointment and treatments.

Resident #200's care plan dated 11/26/20 revealed he was care planned to have a pressure ulcer to his sacral area, right axilla, and left and right buttock. There was no mention of a wound to his left armpit. He was also care planned to resist wound treatment care. The interventions included to reiterate the purpose and advantages of treatment for the resident as well as assess his resistance to care.

Review of Resident #200's Treatment Orders and Treatment Administration Records from June 2020 through January 10th, 2021 revealed on 8/20/20 the physician ordered to have Resident #200's left inner armpit cyst, related to hidradenitis, cleansed with normal saline and apply a dry dressing every day. The treatments were performed per orders and he refused on 9/9 through 9/15 of 2020 and again on 9/17 through 9/24 of 2020. This order was discontinued on 9/24/20 by Physician #1 and was transcribed by the Wound Care Nurse.

F 600

documented. This education included that the failure of the facility, its employees, or service providers to provide the care necessary to avoid physical harm constitutes neglect. The Licensed Nurses not educated by 10/28/21 will be educated prior to their next scheduled shift. This education has been added to the general orientation upon hire.

The Clinical Competency Coordinator and/or Nurse Managers began educating the Certified Nursing Assistants that the failure of the facility, its employees, or service providers to provide the care necessary to avoid physical harm constitutes neglect. The Certified Nursing Assistants not educated by 10/28/21 will be educated prior to their next scheduled shift. This education has been added to the general orientation of certified Nursing Assistants.

The Director of Health Services and/or Nurse Managers have reviewed the wound audit conducted on 10/27/21 and reviewed the documentation to ensure residents with skin impairments had an order for treatment to areas with notification to physician and/or physician extender of any new /changed skin impairments. The Director of Health Services and Nurse Managers reviewed residents with wounds to ensure weekly documentation including ongoing assessments with wound measurements are currently in place, documented accurately and physician / physician extender notification. Review of

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 11/03/2021

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

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F 600

Continued From page 15

A physician note dated 9/9/20 by Physician #1 revealed Resident #200's hidradenitis had improved with a course of antibiotics and they would resume antibiotics if the inflammation reoccurred.

Review of physician and nurse practitioner notes from September 2020 through 1/10/21 revealed no mention of any wound to Resident #200's left armpit.

Review of Resident #200's chart revealed between the time of 9/24/20 through 1/10/21 no communication was documented between the facility staff and Physician #1 or Nurse Practitioner #1 related to a wound to Resident #200's left armpit.

A review of Resident #200's weekly skin assessments from 9/23/20 to his time of death (1/10/21) revealed no documentation of a wound to his left armpit. There was no documentation of skin check refusals during this time on the skin check assessments.

A nursing note dated 1/10/21 revealed at 4:45 AM Nurse #5 was alerted by Nurse Aide #3 of a change in Resident #200's breathing. The nurse immediately responded and observed Resident #200 in his usual (due to contractures) fetal position, shallow respirations, unresponsive, and with a faint pulse. 911 was notified by the nurse. Resident #200 was found to be without signs of life, cessation of breathing, and no pulse. Cardiopulmonary Resuscitation (CPR) was initiated. EMS arrived at the facility and called time of death at 5:02 am at the facility.

F 600

documentation identified no residents without wound documentation at this point in time and the current wound observations are accurate. The Director of Health Services and Nurse Managers educated the Licensed Nurses regarding accuracy of weekly body observations to include identification of any dressing noted or skin impairment noted on the resident body. This education has been added the License Nurse general orientation upon hire. License Nurses not educated by 10/28/21 will be educated prior to their next scheduled shift.
The Director of Health Services and/or Nurse Managers began education on 10/27/21 regarding notification to physician and/or physician extender regarding newly identified skin impairments and/or worsening skin impairments for wound treatment orders. This education has been added the License Nurse general orientation upon hire. License Nurses not educated by 10/28/21 will be educated prior to their next scheduled shift.
The Director of Health Services and/or Nurse Managers began education on 10/27/21 regarding notification to Resident responsible party regarding newly identified skin impairments and/or worsening skin impairments and new wound treatment orders. This education has been added the License Nurse general orientation upon hire. License Nurses not educated by 10/28/21 will be educated prior to their next scheduled shift.
The Director of Health Services and

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	345371	A. BUILDING ______ B. WING ______	C 11/03/2021

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PRUITTHEALTH-TRENT	836 HOSPITAL DRIVE NEW BERN, NC 28560

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F 600	Continued From page 16 The EMS record dated 1/10/21 indicated EMS was dispatched to the facility and when they arrived on the scene, they found Resident #200 in bed with caregiver providing CPR. He was pulseless and apneic (cessation of breathing) and was warm to the touch. The nurse (Nurse #5) indicated she found Resident #200 not breathing but with a weak pulse. She called another nurse (Nurse #6) from the downstairs unit (the facility had two stories) to stay with Resident #200 while she called 911. Prior to EMS arrival the resident lost his pulse and CPR was initiated by the staff. He had a large gaping hole in his left armpit that was bleeding. It was agreed by EMS personnel to discontinue CPR and call time of death in the facility at 5:02 AM. The local police department was notified. During an interview on 10/28/21 at 1:03 PM Emergency Medical Technician (EMT) #1 stated he was at the facility on 1/10/21 for Resident #200. EMT #1 further stated the resident had a gaping, open wound to his left underarm and chest which was about three inches in length and two inches in width. He stated there was some drainage from the wound and it presented as an old wound. He stated the wound was not a fresh laceration but had the appearance of being a wound that had been present prior to the initiation of CPR and had been present for some time. This wound was not bandaged and was "wide open." He continued to state even with Resident #200's left arm being held against his body the wound would have been visible to an observer. During an interview on 10/28/21 at 2:00 PM EMT #2 stated he was dispatched to the facility on 1/10/21 for a cardiac arrest for Resident #200. The EMTs identified a wound to his left armpit	F 600	Nurse Managers educated the Certified Nursing Assistants on daily skin checks during personal care. This education includes notification to the nurse of any skin impairment and/or new dressing noted on resident□s skin. The Certified Nursing assistant will utilize a body diagram for nurse notification. This education has been added to the Certified Nursing Assistant general orientation upon hire. Certified Nursing Assistants not educated by 10/28/21 will be educated prior to their next scheduled shift. The Director of Health Services / Nurse Managers are reviewing the residents weekly skin review to ensure physician notification is completed for all new skin impairments or deteriorating skin impairments and ensure the facility, its employees, or service providers are providing the care necessary to avoid physical harm that constitutes neglect This will occur weekly for four weeks then monthly thereafter. The Director of Health Services / Nurse Managers are reviewing the Certified Nurse Aide skin checks completed during resident□s personal care, to ensure the facility, its employees, or service providers are providing the care necessary to avoid physical harm that constitutes neglect, weekly to ensure physician has been notified by the Licensed Nurse of new or worsening skin impairment. This will occur weekly for four weeks then monthly thereafter. "How the facility plans to monitor its	

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F 600	Continued From page 17 that was in-between a golf ball and baseball sized opening. He stated he did not remember the diameter of the tunneling but that the tunneling could be observed. He stated at the very least there was two inches of depth to this wound's tunneling and noted some green pus drainage to the wound as well as bloody clear pink fluid that was on the blanket that had covered the wound as well. He further stated the wound was not an acute laceration and did not present as having acute trauma as a result of CPR. He further stated it had the appearance of a wound that had been present for quite some time. He stated he did not remember any dressing being in place to the wound on his left armpit. He could not recall if there was an odor to that wound. During an interview on 10/28/21 at 2:00 PM EMT #3 stated she remembered walking in Resident #200's room on the morning of 1/10/21. EMT #3 stated she recalled he had a wound to his left armpit and chest area. The EMT stated a golf ball would have fit the wound due to the depth and size of the wound. She further stated she did not remember if the wound to the underarm was bandaged or not. She stated the wound had some drainage, and the wound had some depth but could not recall exactly how deep or the amount of tunneling if any. EMT #3 concluded based on the appearance of the wound to his underarm she did not believe the wound was a result of CPR and had the appearance of a wound that had been present on Resident #200 for some time. The police case narrative dated 1/11/21 revealed Police Officer #1 arrived at the facility in response to a death in the facility on 1/10/21. Police Officer #1 documented he was informed by EMS upon	F 600	performance to make sure that solutions are sustained The Director of Health Services will present the analysis of the Licensed Nurse skin review to ensure the facility, its employees, or service providers are providing the care necessary to avoid physical harm that constitutes neglect to the Quality Assurance and Performance Committee meeting monthly for three months, then quarterly thereafter until six months of continued compliance is sustained. The Director of Health Services will present the analysis of the weekly Certified Nursing Assistant skin check completed during personal care review to ensure the facility, its employees, or service providers are providing the care necessary to avoid physical harm that constitutes neglect to the Quality Assurance and Performance Committee meeting monthly for three months, then quarterly thereafter until six months of continued compliance is sustained. The Clinical Competency Coordinator will present the analyses compliance of employee attendance to the education provided to the Quality Assurance and Performance Committee meeting monthly for three months, then quarterly thereafter until six months of continued compliance is sustained. Date when corrective action will be completed: 12/3/2021	

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	345371	A. BUILDING ______ B. WING ______	C 11/03/2021

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PRUITTHEALTH-TRENT	836 HOSPITAL DRIVE NEW BERN, NC 28560

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F 600	Continued From page 18	F 600		

arrival that it appeared to be a case of neglect based on the deceased's condition and EMS personnel wanted to ensure a report was on file. Resident #200 had one large open wound under his left arm that was "several inches wide and extended up inside his body." The officer documented the open wound that was not bandaged and showed no signs of care. There were additional sores on the resident's side that were smaller but were still noticeable. The officer photographed the body. There were abrasions and sores under his right arm as well though not as pronounced.

During an interview on 10/16/21 at 6:20 PM Police Officer #1 stated he was contacted by his dispatch that EMS had requested an officer respond for an unattended death at the facility. He stated he arrived at 5:03 AM on 1/10/21 and EMS informed him Resident #200 had several open sores on his body that they discovered when they took off his gown. The most notable sore was to his left armpit. The officer observed the area. The gown that was around that area was soaked in a pink fluid. The wound was approximately two inches wide and three inches long. The wound continued into Resident #200's body towards his head which was open and large enough of a cavity that he could visualize inside the resident's body under his armpit. It was approximately 4 inches deep to his collarbone and was approximately 1.5 inches wide. The cavity ran along the outside of his rib cage and ended at his collarbone. The flesh that was visible in the cavity was a whitish pink. There were additional smaller sores located around the wound. He was informed by EMS that this wound did not have any dressing present when they arrived. He stated the staff could not explain why

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	345371	A. BUILDING ______ B. WING ______	C 11/03/2021

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PRUITTHEALTH-TRENT	836 HOSPITAL DRIVE NEW BERN, NC 28560

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F 600	Continued From page 19	F 600		

the wound was not cared for at that time.

Review of the police report photographs taken on 1/10/21 at 5:28 AM at the time of Resident #200's death provided to the surveyor by Police Officer #1 revealed Resident #200 had an open wound under his left armpit. The wound could be observed to be approximately 1.5 inches wide and 2 inches long. Tunneling (Tunneling is when a wound has formed passageways underneath the surface of the skin) could be observed at 12 o'clock. The tunneling was approximately 0.5 inches in diameter from medial (towards the center of the body) to lateral (away from the center of the body) edges of the tunneling and 1 inch in diameter from anterior (towards the front of the body) to posterior (towards the back of the body) edges of the tunneling. This tunneling extended up under his armpit an indeterminant length as the end of the tunneling was outside of the view of the camera. The wound presented as pale pink and the wound bed had yellow slough present (yellow/white material in the wound bed; usually wet but can be dry. It generally has a soft texture. It can be thick and adhered to the wound bed, present as a thin coating, or patchy over the surface of the wound. It consists of dead cells that accumulate in the wound drainage.).

During an interview on 10/26/21 at 4:46 PM Nurse #6 stated she remembered Resident #200. She stated he refused a lot of care, but she did not have him on her caseload often. She further stated she did not really remember the morning when she initiated CPR (1/10/21) on Resident #200 or him passing away. She stated she did not remember lesions under his arms or if they started bleeding while she provided CPR.

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F 600	Continued From page 20 During an interview on 10/26/21 at 3:17 PM Nurse #5 stated she remembered Resident #200. She further stated he was a very quiet gentleman who did not like to be bothered. She further stated she did not specifically remember him passing away on her shift or details of that night (1/10/21). She further stated Resident #200 had open wounds under his arm but could not remember if it was both arms or one arm. She concluded she could not remember the wound's appearance under his arm or arms. During an interview the Wound Care Nurse on 10/26/21 at 9:43 AM stated she remembered Resident #200. She stated she was the Wound Care Nurse at the time he was at the facility, and he was on her caseload. She indicated he refused care at times, explaining he would not allow them to do anything on certain days and other days he would allow treatment to be provided. She indicated she was providing wound care to his left underarm and on 9/24/20 the treatment was discontinued. She revealed she continued to provide care to the wound because it was open. She was unable to recall why the treatment was discontinued by the Nurse Practitioner as the wound had not improved and had not healed at that time. She further revealed that until Resident #200's death (1/10/21) she continued to provide the discontinued treatment without orders. She stated she had not documented this treatment to the left armpit wound in the medical record from 9/24/20 through 1/10/21. The Wound Care Nurse spoke about the treatment she provided. She indicated she cleaned the wound with skin integrity wound cleanser and patted dry and applied a dry dressing. She placed an adhesive foam dressing over this due to the fact it drained a lot. She	F 600		

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PRUITTHEALTH-TRENT	836 HOSPITAL DRIVE NEW BERN, NC 28560

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F 600	Continued From page 21 explained he had purulent drainage and weeping from the wound under his left arm. She further explained the dressing would not stay on due to the drainage from the wound. She revealed she had not completed any assessments or wound measurements of the left armpit wound for Resident #200 from 9/24/20 through 1/10/21. The Wound Care Nurse stated she informed Nurse Practitioner (NP) #1 Resident #200's wound was not healed, that she was completing the treatment without an order, and that the dressing she was using on the wound would not stay on due to the drainage from the wound. This information was from her recollection and she could not recall the exact timeframe she notified NP #1 of this information. The Wound Care Nurse indicated NP #1 informed her (unable to recall a specific date) to keep an eye on the wound and keep her up to date with any changes, but she had not ordered any treatment. She stated that she recalled notifying NP #1 at some point in December 2020 that the wound continued to not heal. She reported NP #1 saw the resident in December 2020 but had not visualized the wound to his left armpit as it had a dressing over it. The Wound Care Nurse reported she observed Resident #200's wound and provided the non-ordered treatment to his left armpit up until his death (1/10/21) and it progressively deteriorated. She indicated that a couple of days before Resident #200's death, his left armpit wound had developed an odor. She indicated the wound was the size of a nickel and was about 0.1 centimeters deep. The Wound Care Nurse reported that she told NP #1 about the size and the odor that had developed. She stated it was concerning to her that the wound had deteriorated in size and developed an odor, yet NP #1 had not ordered any care for the wound.	F 600		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 600	Continued From page 22 She indicated she had not shared this concern with any other staff at the facility. The Wound Care Nurse revealed she had no documentation of any communication with NP #1 related to Resident #200's left armpit wound from 9/24/20 through 1/10/21, and she was unable to provide a date of the last time she visualized the wound. This interview with the Wound Care Nurse (10/26/21 at 9:43 AM) continued. The Wound Care Nurse indicated she worked every Monday through Friday and every other weekend. Nurses for the unit would do the wound care when she was not working. She revealed because there was no physician's order for treatment to Resident #200's open left armpit wound from 9/24/20 through 1/10/21, the staff working when she was not in the facility would not have provided him with treatment. She explained she had not verbally gone to the nurses and informed them of the dressing change she was doing for Resident #200's left armpit wound that was not ordered by the physician. During an interview on 10/26/21 at 10:50 AM Nurse Practitioner #1 stated she remembered Resident #200. She further stated she remembered he had hidradenitis suppurativa especially under his arms. She stated Resident #200 had been given antibiotics a couple of different times when the lesions were infected. She stated he had some scarring which she believed had been from a past surgery for the areas under his arm and she offered to refer him for surgical interventions which he refused. She stated when he first arrived at the facility in June through September of 2020, he always had an odor from those wounds under his arms and the times he did allow her to visualize the wounds,	F 600		

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 11/03/2021

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

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F 600

Continued From page 23

they had drainage. She stated at those times she had put him on antibiotics. She stated he received clindamycin 6/26/20 through 7/9/20. He had Bactrim 6/29/20 through 7/10/20. Bactrim 8/18/20 through 9/1/20. Keflex 6/26/20 through 7/10/20. Keflex 8/18/20 through 9/1/20. She further stated these areas did not typically open very much and were usually raised with a small area that was draining. She stated she did not order the wound treatment to be discontinued due to his refusals. She stated even if a resident refused something every day, she would ensure staff were offering the treatment and would not discontinue it. She continued to state in September 2020 at the conclusion of his antibiotic treatment she had been told the wounds had gotten better. The Wound Care Nurse's interview that indicated she informed Nurse Practitioner #1 she was completing treatments without an order and that the wound had opened and deteriorated was shared with Nurse Practitioner #1. Nurse Practitioner #1 denied ever being notified after September 2020 by the Wound Care Nurse or any other staff at the facility that the wound to Resident #200's left armpit had opened, deteriorated, or was receiving treatments without orders. She stated if the resident's wound under his left arm had opened, she should have been notified and she would have ordered another round of antibiotic treatment and possible referral to surgery for treatment. She also stated she should have been notified the treatments were being done without an order.

Nurse Practitioner #1 provided a signed statement dated 10/28/21 which again attested Nurse Practitioner #1 "was not aware or notified by any staff that [Resident #200's] wound had opened up or gotten worse since the completion

F 600

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	345371	A. BUILDING _______ B. WING _______	C 11/03/2021

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

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F 600	Continued From page 24	F 600		

of antibiotics in September 2020."

During an interview on 10/27/21 at 8:58 AM Physician #1 stated Resident #200 had a condition of hidradenitis which was a chronic problem that was very difficult to control. He further stated the areas to Resident #200's underarms would close and then would rupture and drain. He further stated if one of the wounds was open, he would want to be made aware that the wound was open. The physician indicated he would order antibiotics to attempt to provide treatment to the area and he would leave the area open to allow it to drain better. He stated he was not made aware of any open areas to Resident #200's left armpit and did not know there was a wound to Resident #200's left armpit after September 2020.

During a follow up interview on 10/27/21 at 12:33 PM Physician #1 stated upon review of the photographs supplied by the local police department of the wound to Resident #200's left armpit that he or his nurse practitioner should have been made aware of the presence and severity of such a wound. He further indicated he could not say how quickly a wound such as the one in the photograph could take to develop. He further stated he did not recall discontinuing Resident #200's orders for treatment to his wound on his left armpit but if the nurse had made the recommendation to discontinue the treatment he would have signed off on their recommendation. He further stated he would not have told the Wound Care Nurse to continue administering a discontinued treatment and did not believe Nurse Practitioner #1 would have requested the Wound Care Nurse to continue administering a discontinued treatment as well.

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	345371	A. BUILDING ______ B. WING ______	C 11/03/2021

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 600	Continued From page 25	F 600		

He further stated he did not understand why the Wound Care Nurse would not have gotten an order for treatment of a wound if she had asked. He stated he was unsure if the wound could have developed after his death or how long it would have taken to develop such a wound. The Physician stated he felt the wound had a severe appearance in the photographs and did not know why the Wound Care Nurse did not have measurements, treatment records, and weekly wound assessments if she was following the wound. He stated due to the lack of documentation it was impossible to know if or when the wound was or was not present or the severity of the wound until the time of the photographs by the police department. He stated wounds should be documented and reported to him or the nurse practitioner if there was a need for wound treatment. He expressed he was at a loss as to why the Wound Care Nurse did not request an order for treatment because neither he nor the nurse practitioner would ever deny an order for a wound to be treated. He concluded he would not discontinue wound treatment to a resident even if the resident continually refused treatment except in extenuating circumstances such as hospice and Resident #200 did not meet that criteria at the time.

During an interview on 10/25/21 at 11:34 AM Nurse Aide #5 stated she remembered Resident #200. She stated he required total care, and he did not speak much but he was able to make his needs known when he wanted to. She further stated he would let staff provide activities of daily living care, but he did not like to be bothered most of the time. She continued to state he did have open wounds in one or both underarms and nursing was aware of those wounds. She stated

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 11/03/2021

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 600		F 600		

Continued From page 26
during morning care she was aware of those wounds because she had to take care while cleansing around the wound area. She could not remember if there were ever dressings on his wound under his arm or not.

During an interview on 10/27/21 at 8:42 AM Nurse Aide #1 stated she remembered caring for him leading up to his death. She recalled a wound to one of his armpits that was oozing "something like pus." The nurse aide reported she notified Nurse #5 on multiple occasions (unable to recall specific dates) of the oozing and the nurse went and looked at the wound when notified. She reported she had not recalled seeing the left arm pit wound with a dressing on it at any point in the weeks leading up to his death.

During an interview on 10/27/21 at 11:56 AM Nurse Aide #2 stated she remembered Resident #200 had a wound under one of his arms. She did not remember if there were ever any dressings to the wound she noted under his arm. She stated the area was about the size of a dime with no depth and it had some drainage that was like "pus". This wound was present through the end of his stay in the facility to her knowledge.

During an interview on 10/27/21 at 1:35 PM the Director of Nursing stated if a wound was open or required treatment the wound should be reported to the nurse practitioner or doctor. The doctor had to sign off on all treatments so he would be made aware of treatments. She further stated wound treatment should not be done without an order and if the Wound Care Nurse deemed a wound needed to have continued treatment, she should request the order be continued or changed depending on the situation. She further stated if

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 11/03/2021

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 600	Continued From page 27 the Wound Care Nurse had concerns about wound treatments, lack of response from the nurse practitioner or physician, or concerns about wound care in general the Wound Care Nurse could and should inform the Director of Nursing and escalate her concerns with the wound in question. She stated to her knowledge, Resident #200 was admitted with wounds to his right underarm which eventually closed in September of 2020. He also developed an area under his left arm during his stay that to her knowledge was closed and treatment was completed in September of 2020. She further stated up until his death on 1/10/21 she was not made aware of any concerns about the skin status of his left armpit. She stated the Wound Care Nurse according to the records had discontinued the order to the left armpit as of 9/24/20 and did not document a reason. Upon viewing the photographs of Resident #200 supplied by the local police department the Director of Nursing stated a wound of the severity pictured should have been reported to herself, the physician or Nurse Practitioner, and responsible party and she was not made aware of the presence of that wound. She stated that identified wounds were to be assessed, monitored, and documented. She concluded wound measurements were part of the assessments to follow the wound progress. During an interview on 10/27/21 at 4:17 PM the Administrator stated she was not aware of any wounds to Resident #200's left armpit. She further stated the Wound Care Nurse should not provide treatments without orders. She stated the Wound Care Nurse should acquire wound care orders when she deemed wound treatment was needed. She stated if the Wound Care Nurse had concerns that a wound was not receiving	F 600		

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	345371	A. BUILDING ______ B. WING ______	C 11/03/2021

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 600	Continued From page 28 attention from the physician or nurse practitioner, she should have escalated her concerns to the Administrator and Director of Nursing. She stated the Wound Care Nurse never shared such concerns nor documented such concerns about Resident #200. The Administrator was notified of the immediate jeopardy on 10/28/21 at 9:21 AM. On 10/29/21 at 2:09 PM the facility provided the following credible allegation of immediate jeopardy removal. The Removal Plan: F600 Identify those recipients who have suffered, or are likely to suffer, a serious adverse outcome as a result of the noncompliance; and On 10/27/21 the Director of Nursing was notified by the State Surveyor that Resident #200 (whom expired January 10, 2021) had a wound under his axilla area (armpit) that the Wound nurse stated she had been treating without an order from 9/24/20 through 1/10/21. The Wound nurse stated that she notified the Nurse Practitioner regarding Resident #200's open axilla area and the Nurse Practitioner allegedly stated to the Wound nurse to continue treatments with no order being provided for the treatments. The Wound nurse was unable to provide a date for this notification. The Wound nurse indicated she provided wound treatments to Resident #200 without an order from 9/24/20 through 1/10/21. The Nurse Practitioner stated that she was never notified of any information related to the open axilla area by the facility staff from 9/24/20 through 1/10/21 for Resident #200. When the wound nurse was asked where the documentation regarding treatments and Nurse	F 600		

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	345371	A. BUILDING ______ B. WING ______	C 11/03/2021

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 600	Continued From page 29	F 600		

Practitioner notifications were located the wound nurse stated there was none, she did not document and there was not an order to treat from 9/24/20 through 1/10/21. The wound Nurse failed to complete the weekly body observations that included wound assessments and measurements of the wound status for this same period of time. There is no documentation that the wound nurse notified the Nurse Practitioner related to the order or treatment of the wound identified under the armpit area. The facility was unaware of the wound nurse was providing treatment without a Physician order. Weekly skin assessments from 9/24/20 through 1/10/21 failed to identify Resident #200's open wound to the axilla area.

The facility was unaware of the Wound nurse's lack of documentation of assessment, measurements of the wound progression, the Wound nurse was providing treatments without orders, and the lack of notification to the physician/nurse practitioner. The facility was unaware of the failure of nurses to identify the open wound during weekly skin assessments from 9/24/20 through 1/10/21.

Upon arrival to facility on 1/10/21 the EMS /police noted the resident's axilla area wound condition as a large open wound under left arm that was extended up inside his body. Officer documented he could see ribs and collar bone through the body that was not bandaged. Resident #200 expired on 1-10-2021.

All residents have the potential to suffer a serious adverse outcome as a result of this noncompliance.

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 11/03/2021

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 600	Continued From page 30 Specify the action the entity will take to alter the process or system failure to prevent a serious adverse outcome from occurring or recurring, and when the action will be The Administrator completed a 24-hour report to the State Agency regarding neglect on 10/27/21 when she was notified of the concern regarding the axilla (armpit) wound and no documentation of same. The Wound Nurse was suspended pending investigation on 10/27/21 and terminated on 10/28/21. The wound Nurse was reported to the North Carolina Board of Nursing on 10/28/21 for professional standards violations. The Clinical Competency Coordinator and/or Nurse Management began education on 10/27/21 for Licensed Nurses regarding abuse and neglect with emphasis on provision of care and services, wound care including assessment, measurement, and notification to physician/physician extender. This education included that treatments were not to be provided without a physician's order and that all provided treatments were to be documented. This education included that the failure of the facility, its employees, or service providers to provide the care necessary to avoid physical harm constitutes neglect. The Licensed Nurses not educated by 10/28/21 will be educated prior to their next scheduled shift. This education has been added to the general orientation upon hire. The Clinical Competency Coordinator and/or Nurse Managers began educating the Certified Nursing Assistants that the failure of the facility, its employees, or service providers to provide the care necessary to avoid physical harm constitutes neglect. The Certified Nursing Assistants not	F 600		

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 11/03/2021

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 600	Continued From page 31 educated by 10/28/21 will be educated prior to their next scheduled shift. This education has been added to the general orientation of certified Nursing Assistants. The Director of Health Services initiated 100% body audits on all residents within the facility on 10/27/21. This audit reveals no wounds without orders or without physician/physician extender notification. If any resident is noted without an order for impaired skin integrity the Director of Nursing, Nurse Managers and/or Licensed Nurse will notify the physician and/or physician extender for orders. The Director of Health Services and/or Nurse Managers have reviewed the wound audit conducted on 10/27/21 and reviewed the documentation to ensure residents with skin impairments had an order for treatment to areas with notification to physician and/or physician extender of any new /changed skin impairments. The Director of Health Services and Nurse Managers reviewed residents with wounds to ensure weekly documentation including ongoing assessments with wound measurements are currently in place, documented accurately and physician / physician extender notification. Review of documentation identified no residents without wound documentation at this point in time and the current wound observations are accurate. The Director of Health Services and Nurse Managers educated the Licensed Nurses regarding accuracy of weekly body observations to include identification of any dressing noted or skin impairment noted on the resident body. This education has been added the License Nurse general orientation upon hire. License Nurses not educated by 10/28/21 will be educated prior to	F 600		

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 11/03/2021

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 600	Continued From page 32	F 600		

their next scheduled shift.

The Director of Health Services and/or Nurse Managers began education on 10/27/21 regarding notification to physician and/or physician extender regarding newly identified skin impairments and/or worsening skin impairments for wound treatment orders. This education has been added the License Nurse general orientation upon hire. License Nurses not educated by 10/28/21 will be educated prior to their next scheduled shift.

The Director of Health Services and/or Nurse Managers began education on 10/27/21 regarding notification to Resident responsible party regarding newly identified skin impairments and/or worsening skin impairments and new wound treatment orders. This education has been added the License Nurse general orientation upon hire. License Nurses not educated by 10/28/21 will be educated prior to their next scheduled shift.

The Director of Health Services and Nurse Managers educated the Certified Nursing Assistants on daily skin checks during personal care. This education includes notification to the nurse of any skin impairment and/or new dressing noted on resident's skin. The Certified Nursing assistant will utilize a body diagram for nurse notification. This education has been added to the Certified Nursing Assistant general orientation upon hire. Certified Nursing Assistants not educated by 10/28/21 will be educated prior to their next scheduled shift.

Alleged date of IJ Removal 10/29/21

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 11/03/2021

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 600	Continued From page 33 The credible allegation for Immediate Jeopardy removal was validated on 11/2/21 which removed the Immediate Jeopardy on 10/29/21, as evidenced by staff interviews, in-service record reviews, and observation. The in-services included information on abuse and neglect, skin assessments, wound care documentation, wound care treatments according to physician orders, wound assessments, wound measurements, and notification of wounds and skin conditions to the physician or the physician's extender. The facility's Immediate Jeopardy removal date of 10/29/21 was validated.	F 600		
F 607 SS=D	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(3) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, This REQUIREMENT is not met as evidenced by: Based on staff, physician, nurse practitioner, police officer, and emergency medical technician (EMT) interviews, and record review the facility failed to implement their abuse policy in the areas of identifying, reporting and investigating neglect for 1 of 1 resident reviewed for abuse and neglect (Resident #200).	F 607	"How corrective action will be accomplished for those residents found to have been affected by the deficient practice. Resident # 200 no longer resides in the facility.	12/3/21

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 11/03/2021

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 607 Continued From page 34

Findings included:

A review of the abuse prevention and reporting policy and procedure of the facility dated 9/2012 revealed neglect was the failure to provide goods and services necessary to avoid harm, mental anguish, or mental illness. Anyone witnessing, suspecting, or hearing an allegation of neglect of any resident was to immediately report this to the administrator whether the administrator was on the premises or not. The Administrator would begin an investigation and implement measures necessary to assure the safety and protection of the residents from the actual or alleged perpetrator. In the event the administrator had knowledge that the resident had been neglected, the administrator would report to the department of community health and appropriate law enforcement agency. A 24-hour report was to be completed and faxed to the appropriate health facility regulation department complaint division.

Resident #200 was admitted to the facility on 6/20/20 with diagnoses that included anemia, contracture of the right and left knee, stage II pressure ulcers of the right and left buttock, and Hidradenitis suppurativa (a chronic skin condition featuring skin lesions which develop because of inflammation and infection of sweat glands).

Resident #200's quarterly minimum data set assessment dated 10/22/20 revealed he was assessed as cognitively intact. He had two stage II pressure ulcers present upon admission.

Review of Resident #200's Treatment Orders and Treatment Administration Records indicated Resident #200 had a treatment order for a left

F 607

The Administrator completed a 24-hour report to the State Agency regarding neglect on 10/27/21 when she was notified of the concern regarding the axilla wound and no documentation of same. The Wound Nurse was suspended pending investigation on 10/27/21 and terminated on 10/28/21. The wound Nurse was reported to the North Carolina Board of Nursing on 10/28/2021 for professional standards violations.

"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.

"What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur.

The Clinical Competency Coordinator and/or Nurse Management began education on 10/27/21 for Licensed Nurses regarding abuse and neglect with emphasis on provision of care and services, wound care including assessment, measurement, and notification to physician/physician extender and notification to the Administrator. This education included that treatments were not to be provided without a physician□s order and that all provided treatments were to be documented. This education included that the failure of the facility, its employees, or

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 11/03/2021

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 607

Continued From page 35

inner armpit cyst that was discontinued on 9/24/20. There were no orders after 9/24/20 related to his left armpit wound. Further review of the medical record revealed no documentation of the wound to his left armpit from 9/24/20 through 1/10/21. There were no assessments or measurements of the wound and no reference was made to the wound in the physician or Nurse Practitioner (NP) notes.

A nursing note dated 1/10/21 revealed at 4:45 AM Nurse #5 was alerted by Nurse Aide #3 of a change in Resident #200's breathing. The nurse immediately responded and observed Resident #200 in his usual (due to contractures) fetal position, shallow respirations, unresponsive, and with a faint pulse. 911 was notified by the nurse. Resident #200 was found to be without signs of life, cessation of breathing, and no pulse. Cardiopulmonary Resuscitation (CPR) was initiated. EMS arrived at the facility and called time of death at 5:02 am at the facility.

The EMS record dated 1/10/21 indicated EMS was dispatched to the facility for Resident #200. He had a large gaping hole in his left armpit that was bleeding. It was agreed by EMS personnel to discontinue CPR and call time of death in the facility at 5:02 AM. The local police department was notified.

During an interview on 10/28/21 at 1:03 PM Emergency Medical Technician (EMT) #1 stated he was at the facility on 1/10/21 for Resident #200. EMT #1 further stated the resident had a gaping, open wound to his left underarm and chest which was about three inches in length and two inches in width. He stated there was some drainage from the wound and it presented as an

F 607

service providers to provide the care necessary to avoid physical harm constitutes neglect and must be reported to the Administrator. The Licensed Nurses not educated by 11/30/21 will be educated prior to their next scheduled shift. This education has been added to the general orientation upon hire.

The Clinical Competency Coordinator and/or Nurse Managers began educating the Certified Nursing Assistants, Licensed Nurses, and ancillary staff that the failure of the facility, its employees, or service providers to provide the care necessary to avoid physical harm constitutes neglect and must be reported to the Administrator per policy. The Certified Nursing Assistants, Licensed Nurses and Ancillary staff not educated by 11/30/2021 will be educated prior to their next scheduled shift. This education has been added to the general orientation of Certified Nursing Assistants.
The Administrator maintains a log that identifies allegations of abuse, date and time reported to the Administrator and date and time reported to the State Agency. This log is reviewed by the Corporate Consultant monthly for accuracy in timely reporting.

"How the facility plans to monitor its performance to make sure that solutions are sustained.

The Clinical Competency Coordinator will present the analysis of education

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 11/03/2021

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

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F 607 Continued From page 36

old wound. He stated the wound was not a fresh laceration but had the appearance of being a wound that had been present prior to the initiation of CPR and had been present for some time. This wound was not bandaged and was "wide open." He continued to state even with Resident #200's left arm being held against his body the wound would have been visible to an observer.

During an interview on 10/28/21 at 2:00 PM EMT #2 stated he was dispatched to the facility on 1/10/21 for a cardiac arrest for Resident #200. The EMTs identified a wound to his left armpit that was in-between a golf ball and baseball sized opening. He stated he did not remember the diameter of the tunneling but that the tunneling could be observed. He stated at the very least there was two inches of depth to this wound's tunneling and noted some green pus drainage to the wound as well as bloody clear pink fluid that was on the blanket that had covered the wound as well. He further stated the wound was not an acute laceration and did not present as having acute trauma as a result of CPR. He further stated it had the appearance of a wound that had been present for quite some time. He stated he did not remember any dressing being in place to the wound on his left armpit. He could not recall if there was an odor to that wound.

During an interview on 10/28/21 at 2:00 PM EMT #3 stated she remembered walking in Resident #200's room on the morning of 1/10/21. EMT #3 stated she recalled he had a wound to his left armpit and chest area. The EMT stated a golf ball would have fit the wound due to the depth and size of the wound. She further stated she did not remember if the wound to the underarm was bandaged or not. She stated the wound had

F 607

compliance of the Licensed Nurses, Certified Nursing Assistants, and ancillary Staff regarding abuse reporting to the Quality Assurance and Performance Committee monthly until three months of sustained compliance is maintained then quarterly thereafter.
The Corporate Consultant presents their analysis of timely reporting to the facilities Quality Assurance and Performance Improvement Committee monthly until three months of sustained compliance is maintained then quarterly thereafter.

"Include dates when corrective action will be completed. 12/3/2021

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 11/03/2021

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

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F 607 Continued From page 37 F 607

some drainage, and the wound had some depth but could not recall exactly how deep or the amount of tunneling if any. EMT #3 concluded based on the appearance of the wound to his underarm she did not believe the wound was a result of CPR and had the appearance of a wound that had been present on Resident #200 for some time.

The police case narrative dated 1/11/21 revealed Police Officer #1 arrived at the facility in response to a death in the facility on 1/10/21. Police Officer #1 documented he was informed by EMS upon arrival that it appeared to be a case of neglect based on the deceased's condition and EMS personnel wanted to ensure a report was on file. Resident #200 had one large open wound under his left arm that was "several inches wide and extended up inside his body." The officer documented the open wound that was not bandaged and showed no signs of care. There were additional sores on the resident's side that were smaller but were still noticeable. The officer photographed the body. There were abrasions and sores under his right arm as well though not as pronounced.

During an interview on 10/16/21 at 6:20 PM Police Officer #1 stated he was contacted by his dispatch that EMS had requested an officer respond for an unattended death at the facility. He stated he arrived at 5:03 AM on 1/10/21 and EMS informed him Resident #200 had several open sores on his body that they discovered when they took off his gown. The most notable sore was to his left armpit. The officer observed the area. The gown that was around that area was soaked in a pink fluid. The wound was approximately two inches wide and three inches

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 11/03/2021

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

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F 607	Continued From page 38	F 607		

long. The wound continued into Resident #200's body towards his head which was open and large enough of a cavity that he could visualize inside the resident's body under his armpit. It was approximately 4 inches deep to his collarbone and was approximately 1.5 inches wide. The cavity ran along the outside of his rib cage and ended at his collarbone. The flesh that was visible in the cavity was a whitish pink. There were additional smaller sores located around the wound. He was informed by EMS that this wound did not have any dressing present when they arrived. He stated the staff could not explain why the wound was not cared for at that time.

Review of the police report photographs taken on 1/10/21 at 5:28 AM at the time of Resident #200's death provided to the surveyor by Police Officer #1 revealed Resident #200 had an open wound under his left armpit. The wound could be observed to be approximately 1.5 inches wide and 2 inches long. Tunneling (Tunneling is when a wound has formed passageways underneath the surface of the skin.) could be observed at 12 o'clock. The tunneling was approximately 0.5 inches in diameter from medial (towards the center of the body) to lateral (away from the center of the body) edges of the tunneling and 1 inch in diameter from anterior (towards the front of the body) to posterior (towards the back of the body) edges of the tunneling. This tunneling extended up under his armpit an indeterminant length as the end of the tunneling was outside of the view of the camera. The wound presented as pale pink and the wound bed had yellow slough present (yellow/white material in the wound bed; usually wet but can be dry. It generally has a soft texture. It can be thick and adhered to the wound bed, present as a thin coating, or patchy over the

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 11/03/2021

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

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F 607	Continued From page 39 surface of the wound. It consists of dead cells that accumulate in the wound drainage.). During an interview on 10/26/21 at 3:17 PM Nurse #5 stated she remembered Resident #200. She further stated she did not specifically remember him passing away on her shift or details of that night. She further stated Resident #200 had open wounds under his arm but could not remember if it was both arms or one arm. Nurse #5 could not remember the wound appearance under his arm or arms or if they were present when he died, and she did not have concerns with neglect. She concluded the police came and asked for a few things and left and it was not unusual for police to be called following a code and death. She indicated she was unaware of the EMT and police concerns with neglect for Resident #200. During an interview on 10/26/21 at 4:46 PM Nurse #6 stated she remembered Resident #200. She further stated she did not really remember the morning when she initiated CPR on Resident #200 or him passing away. She stated she could not remember him having wounds under his arms that she was able to visualize or see how deep the wounds were. She was unaware the police came to the facility on 1/10/21 for Resident #200 and was not made aware the EMT and police concerns of neglect for the resident. During an interview on 10/28/21 at 9:55 AM the Director of Nursing stated she was not made aware by EMS, police, or her staff about concerns of neglect with Resident #200 after his death. She further stated after review of the EMS report and police photographs that it was her own opinion at the time prior to his initiation of CPR	F 607		

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 11/03/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 607	Continued From page 40 the area to Resident #200's left armpit was not open because she felt her staff would have reported something to the severity pictured in the police photograph. She stated this was the reason she believed the staff did not report any concerns of neglect for Resident #200. She stated what the staff saw versus what the photos from the police report showed were very different, so she believed the wound had not opened prior to CPR. During an interview on 10/28/21 at 9:32 AM the Administrator stated staff were trained to identify and report abuse and neglect and upon being made aware of Resident #200's status and the concerns identified by EMS and the Police Department, her staff should have identified and reported these concerns and she did not know why staff did not have concerns with neglect. She further stated based on the information provided to her by the Director of Nursing, following her interview with the state, she had suspended the wound care nurse, was currently submitting a 24-hour report for resident neglect, and initiated a 100% head to toe skin audit on all residents. A wound going any length of time untreated, not reported, and not documented was unacceptable.	F 607		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews the facility failed to accurately complete the minimum data set (MDS) assessment in the	F 641	"How corrective action will be accomplished for those residents found to have been affected by the deficient	12/3/21

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 11/03/2021

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

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F 641 Continued From page 41

areas of alarms (Resident #43), Pre-Admission Screening Resident Review (PASARR) (Resident #65) and speech (Resident #3) for 3 of 25 residents whose MDS were reviewed.

Findings included:

1. Resident #43 was admitted to the facility on 06/29/2015 with a diagnoses of aphasia (loss of ability to express or understand speech due to brain damage).

A review of Resident #43's quarterly MDS assessment dated 08/18/2021 revealed Resident #43 had both short and long term memory problems. He demonstrated continuous inattention. He had physical behaviors directed towards others 1-3 days of the 7 day look back period of the assessment. Resident #43 had no wandering behaviors during the assessment period. He was independent with locomotion on and off his unit after staff set up. He used a wheelchair (WC) for mobility. Resident #43 did not use a wander/elopement alarm.

A review of the quarterly elopement risk assessment for Resident #43 dated 8/18/2021 revealed he was at high risk for wandering and continued the wander guard program.

A review of Resident #43's current care plan last revised on 10/18/2021 revealed a focus area initiated on 06/29/2015 of wandering. The goal was for Resident #43 to wander safely within specified boundaries. An intervention was wander guard to right wrist.

On 10/27/2021 at 2:28 PM an observation of Resident #43 revealed he had a wander

F 641

practice.

Resident # 43 MDS assessment has been updated to reflect the use of a wander elopement alarm.
Resident # 3 no longer resides in the facility.
Resident # 65 MDS assessment has been updated to reflect the state level PASARR 2 process to have a serious mental health illness or related condition.

"How the facility will identify other residents having the potential to be affected by the same deficient practice.

On 11/18/2021 the Interdisciplinary Team began reviewing 100% of the MDS assessments to validate accuracy of the assessments, areas identified have been corrected.

"What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur.

The Interdisciplinary team will be educated on 11/24/2021 by the Clinical Reimbursement Consultant regarding accuracy of MDS Assessments. This education has been added to the general orientation for all newly hired Interdisciplinary Team members.

The Case Mix Director and Interdisciplinary team is reviewing all MDS assessments for accuracy prior to signing as correct and submitting.

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 11/03/2021

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 641

Continued From page 42

guard/elopement alarm bracelet present on his right wrist. An attempt to interview Resident #43 at that time was unsuccessful.

On 10/27/2021 at 2:49 PM an interview with the MDS nurse indicated she completed the alarm section of Resident #43's MDS assessment dated 08/18/2021 indicating he did not use a wander/elopement alarm. She stated Resident #43 had been using a wander/elopement alarm at the time of the assessment and she completed the section inaccurately. She went on to say she would correct this.

On 10/29/2021 at 9:53 AM an interview with the Director of Nursing (DON) indicated resident's MDS assessments should accurately reflect their status and the care they were receiving.

2. Resident #65 was admitted to the facility on 09/19/2018 with diagnoses including seizures, psychotic disorder with delusions due to known physiological condition and paranoid personality disorder.
Review of Resident #65's medical record revealed he had a level II Preadmission Screening and Resident Review (PASARR) dated 07/02/2019 with no expiration date.

The annual minimum data set assessment (MDS) for Resident #65 dated 07/30/2021 revealed he was not currently considered by the state level II PASARR process to have a serious mental illness or related condition. Resident #65's cognition was moderately impaired. He had no hallucinations, delusions, or behaviors in the 7-day look back period for this assessment.

On 10/28/2021 at 1:38 PM an interview with

F 641

The Social Service Director with the Interdisciplinary team review admission / readmission MDS□s to ensure the behaviors / changes in behavior are accuracy assessed.

The Clinical Reimbursement Consultant will review the new / readmission, quarterly, annual, significant change assessments for accuracy of coding weekly for four weeks, bi-weekly for two months, and monthly for three months.

"How the facility plans to monitor its performance to make sure that solutions are sustained.

The Case Mix Director will present the analysis of the Clinical Reimbursement Consultant review to the Quality Assurance and Performance Committee meeting monthly for review and revisions as needed. The analysis will be presented monthly until three months of sustained compliance then quarterly thereafter.

"Include dates when corrective action will be completed. 12/3/2021

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 11/03/2021

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 641	Continued From page 43	F 641		

Resident #65's social worker (SW) indicated Resident #65 had been determined by the state level II PASARR process to have a serious mental illness or related condition on 07/02/2019.

On 10/28/2021 at 1:49 PM in an interview the MDS nurse stated she completed the PASARR section of Resident #65's MDS dated 07/30/2021 indicating he was not currently considered by the state level II PASARR process to have a serious mental illness or related condition. She went on to say this was incorrect and she must have missed it.

On 10/29/2021 at 9:53 AM an interview with the Director of Nursing (DON) indicated resident's MDS assessments should accurately reflect their status and the care they were receiving.
3. Resident # 3 was admitted to the facility on 3/4/21. Her diagnoses included traumatic subdural hemorrhage and mixed receptive-expressive language disorder.

The quarterly Minimum Data Set (MDS) dated 10/18/21 indicated Resident #3 had clear speech, was understood and was able to understand. She was coded as moderately cognitively impaired.

A progress note written by the Certified Dietary Manager (CDM) dated 3/8/21 reported the CDM interviewed Resident #3 on "3/5/21 for likes and dislikes, she can nod her head yes /no but unsure is she really understands the question."

A review if the dental exam documentation completed on 7/27/21 read "Denies pain by shaking head 'no' ."

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 11/03/2021

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

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F 641	Continued From page 44 On 10/27/21 at 2:15 PM the Social Worker (SW) stated during the resident ' s quarterly assessment the Resident #3 did not speak to her. The SW said Resident #3 could nod her head and she pointed, but she had never heard Resident #3 speak a word. On 10/28/2110:15 AM the MDS nurse reported she completed the quarterly MDS dated 10/18/21 and the resident did speak to her, but it was softly. She added Resident #3 could say words but could not carry on a conversation. On 10/28/21 from 10:17 AM until 10:30 AM the MDS nurse was observed to attempt to get Resident #3 to speak. Resident #3 made a grunting noise, but she was not able to speak. During the observation the MDS nurse asked the resident on different attempts to say 3 different words but the resident was not able to say any of the words. On 10/28/21 at 10:37 AM Nurse Aid #6 stated she had worked with Resident #3 many times and had never heard her speak. On 10/28/21 at 10:30 AM Nurse #7 stated she had worked with Resident #3 numerous times as she was on her assignment on the days when Nurse #7 worked. Nurse #7 said she had never heard Resident #3 speak. On 10/28/21 at 10:35 AM Unit Manager #1 stated she had never heard Resident #3 speak. On 10/28/21 at 10:35 AM the Director of Nursing (DON) said she had not heard Resident #3 speak. She felt the MDS dated 10/18/21 was coded incorrectly.	F 641		

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 11/03/2021

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

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F 644 SS=E	Coordination of PASARR and Assessments CFR(s): 483.20(e)(1)(2) §483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes: §483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care. §483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment. This REQUIREMENT is not met as evidenced by: Based on record review and resident, staff and physician interviews the facility failed to provide follow-up psychiatric services by a psychiatrist in accordance with Pre-Admission Screening and Resident Review (PASARR) level II determination and evaluation report recommendations and failed to incorporate these recommendations into the resident's comprehensive care plan for 1 of 5 residents reviewed for PASARR level II. (Resident #65) Findings included: Resident #65 was admitted to the facility on 09/19/2018 with diagnoses including major depressive disorder, psychotic disorder with	F 644	"How corrective action will be accomplished for those residents found to have been affected by the deficient practice. Resident #65 was referred to the Mental Health for psychiatric services. Resident # 65 stated he was feeling well and refused psychiatric services on November 2, 2021. Resident # 65 care plan has been updated to identify the psychiatric refusal. "How the facility will identify other residents having the potential to be affected by the same deficient practice.	12/3/21

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 11/03/2021

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

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F 644 Continued From page 46

delusions due to known physiological condition and paranoid personality disorder.

Review of Resident #65's PASARR level II Determination Notification dated 07/02/2019 revealed he was assessed to be a PASARR level II resident. It further revealed this PASARR level II determination had no expiration date. The notification indicated Resident #65 was to receive follow-up psychiatric services by a psychiatrist.

A review of the annual Minimum Data Set (MDS) assessment for Resident #65 dated 07/30/2021 revealed he was assessed with no Level II PASARR. Resident #65's cognition was moderately impaired. He had no hallucinations, delusions, or behaviors in the 7-day look back period for this assessment. He was assessed as not receiving psychological therapy.

A review of Resident #65's current care plan dated 10/15/2021 revealed he was not care planned for his level II PASARR status.

A review of Resident #65's medical record revealed he had not been seen for psychiatric services by a psychiatrist during his stay in the facility following the PASAAR level II Determination Notification dated 07/02/2019.

On 10/29/2021 at 8:08 AM an interview with Resident #65 indicated he recalled seeing a psychiatrist several years ago but did not think he had seen a psychiatrist since his admission to the facility. He stated he was feeling well and not having any problems.

On 10/29/2021 at 9:17 AM an interview with Resident #65's social worker (SW) indicated she

F 644

The Social Service Director and MDS Coordinator have reviewed 100% of all PASARR level 2s to ensure all recommendations have been followed and corrected as indicated.

"What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur.

The Administrator educated the Social Services Director and Case Mix Coordinator regarding PASARRs Level 2 and psychiatric service referrals and comprehensive care plan reviews. This education has been added to the general orientation for newly hired Social workers and the Interdisciplinary team.
11/23/2021

The Administrator is conducting weekly reviews of Level 2 PASARRS weekly for four weeks then bi-weekly for four weeks then monthly until three months of sustained compliance is maintained, then quarterly thereafter.

"How the facility plans to monitor its performance to make sure that solutions are sustained.

The Administrator will present the analysis of the Level 2 PASARR review to the Quality Assurance and Performance Improvement Committee for review and revisions, monthly until three months of sustained compliance is maintained then quarterly thereafter.

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 11/03/2021

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 644	Continued From page 47 received the PASAAR level II Determination Notification letter for Resident #65 dated 07/02/2019 with no expiration date. She stated she should have obtained a psychiatric referral from Resident #65's physician for Resident #65 to be seen by a psychiatrist. She stated she reviewed Resident #65's medical record and could find no evidence a psychiatric referral had been obtained for Resident #65. She further indicated she did not know why she had not obtained a psychiatric referral for Resident #65 and would do so now. The SW reported Resident #65's level II PASARR determination recommendations should have been incorporated into his comprehensive plan of care. On 10/29/2021 at 9:51 AM in an interview the Director of Nursing (DON) indicated she would expect Resident #65's level II PASAAR recommendations to be incorporated into his comprehensive plan of care. In a follow-up interview on 10/29/2021 at 9:53 AM the DON further indicated Resident #65's SW should have followed through with obtaining a referral for Resident #65 to be seen by a psychiatrist for psychiatric services. On 10/29/2021 at 10:35 AM a telephone interview with Resident #65's facility physician (Physician #1) indicated if the PASAAR Level II Determination Notification dated 07/02/2019 revealed Resident #65 was to be seen for follow-up psychiatric services by a psychiatrist than a referral for psychiatric services should have been obtained. He stated Resident #65 had no history of self-harm or harm to others. He further indicated he did not think the delay in receiving psychiatric services caused Resident #65 any harm. He went on to say he would initiate	F 644	"Include dates when corrective action will be completed. 12/3/2021	

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	345371	A. BUILDING ______ B. WING ______	C 11/03/2021

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

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F 644	Continued From page 48 a psychiatric consult for Resident #65 immediately. On 10/29/2021 at 11:06 AM an interview with the Administrator indicated if it was a PASARR level II determination that Resident #65 was to receive psychiatric services he should have received them.	F 644		
F 656 SS=E	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the	F 656		12/3/21

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	345371	A. BUILDING ______ B. WING ______	C 11/03/2021

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

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F 656	Continued From page 49 resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on observations, resident and staff interviews, and record review the facility failed to develop comprehensive individualized plans of care in the areas of advance directives (Resident #52), behaviors (Resident #98), epilepsy/seizures (Resident #65), pressure ulcers (Resident #79), pacemaker (Resident #74), activities of daily living (Resident #95), and contracture (Resident #80) for 7 of 25 residents reviewed for comprehensive care plans. Findings included: 1. Resident #74 was admitted to the facility on 4/29/2021 with diagnoses that included acute congestive heart failure. A review of a physician order dated 4/29/2021 revealed pacemaker take apical pulse (the part of the heart where the beat is heard the loudest) daily for one full minute. Report irregularities in rate and rhythm, and observe pacemaker site for redness, swelling or pain as needed. A quarterly Minimum Data Set (MDS) assessment dated 10/4/2021 revealed Resident	F 656	"How corrective action will be accomplished for those residents found to have been affected by the deficient practice. The Interdisciplinary Team has updated the Comprehensive Care plans for resident #52, #98, #65, #95, #74,#79, #80 to reflect the resident person-centered care. "How the facility will identify other residents having the potential to be affected by the same deficient practice. The Interdisciplinary Team conducted a review of 100% resident care plans for comprehensive person-centered care plans. Resident comprehensive care plans have been updated as indicated. "What measures will be put into place or systemic changes made to ensure that	

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 11/03/2021

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

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F 656 Continued From page 50

#74 was severely cognitively impaired. Per MDS he had an active diagnosis of heart failure.

The active care plan, last reviewed on 8/29/2021, revealed there was no care plan that addressed Resident #74's pacemaker.

A review of the Medication Administration Record for the month of October 2021 revealed Resident #74's physician's order for apical pulses remained active and were completed as ordered.

During an interview with the MDS Nurse on 10/28/2021 at 2:00 pm, she stated she was aware Resident #74 had a pacemaker. The MDS Nurse acknowledged Resident #74's pacemaker was not mentioned on his care plan and that this should have been addressed.

On 10/29/2021 at 11:14 am during an interview the Director of Nursing (DON) stated Resident #74's pacemaker should have been addressed on the care plan.

2. Resident #95 was admitted on 9/23/2021 to the facility with diagnoses that included chronic obstructive pulmonary disease (COPD).

The admission Minimum Data Set (MDS) assessment dated 10/14/2021 revealed Resident #95 was severely cognitively impaired. He required extensive assistance of 1 with all activities of daily living (ADL) except was independent with meals.

The active care plan, initiated on 9/29/2021, revealed there was no plan of care that addressed Resident #95's ADL needs.

F 656

the deficient practice will not recur.

The Clinical Reimbursement Consultant has educated the Interdisciplinary team on 11/24/21 regarding comprehensive person-centered care plans. This education has been added to the general orientation of newly hired Interdisciplinary Team members.

The Clinical Reimbursement Consultant will review the baseline care plans of new admissions for development of a person center care plan and comprehensive care plans developed on admission, annually and with significant changes.

"How the facility plans to monitor its performance to make sure that solutions are sustained.

The Clinical Reimbursement Consultant will provide the facility Quality Assurance and Performance Committee meeting an analysis of their review of the baseline and initial / annual / significant change person centered care plan review monthly until three consecutive months of compliance is sustained then quarterly thereafter.

"Dates when corrective action will be completed. 12/3/2021

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 11/03/2021

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

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F 656	Continued From page 51	F 656		

During an interview with the MDS Nurse on 10/28/2021 at 2:00 pm, she stated she thought she had a care plan for Resident #95' s ADL care. She stated it was an oversite and there should have been a care plan to address his needs.

On 10/28/2021 at 11:14 am the Director of Nursing stated the MDS Nurse was responsible for the care plans. She then stated she had not known how he was missed for an ADL care plan. She further stated there should have been a care plan to address Resident #95's daily ADL needs.

3. Resident #80 was admitted to the facility on 11/01/2016 with diagnoses that included cerebrovascular disease affecting the left non-dominant side.

A record review revealed a diagnosis of left hand contracture on 2/19/2019.

The quarterly Minimum Data Set (MDS) assessment dated 10/08/2021 revealed she was severely cognitively impaired. Per MDS she had a functional limitation on one side of the upper and lower extremity.

The active care plan, last reviewed on 8/29/2021, revealed no plan of care that addressed Resident #80's left hand contracture.

During an observation and interview with Resident #80 on 10/27/2021 at 10:00 am, she was resting in bed with her left arm outside of the covers. Her left hand was noted to be in a closed position. She stated she could not open her left hand or use the left arm. She then stated her hand and arm have been in that condition for a long time.

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 11/03/2021

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 656		F 656		

Continued From page 52

The MDS Nurse stated on 10/28/2021 at 2:00 pm during an interview she was aware Resident #80 had a left hand contracture. She said she thought it was addressed on the care plan. The care plan was reviewed with the MDS Nurse and she verified it was not on the care plan and that it should have been.

During the interview with the Director of Nursing on 10/28/2021 at 11:14 am she stated the MDS Nurse was responsible for the care plans. She said Resident #80's care plan should have included her left hand contracture.
4. Resident #98 was admitted to the facility on 6/10/21 with diagnoses which included epilepsy disorder and schizophrenia.

Resident #98's quarterly Minimum Data Set (MDS) dated 10/15/21 revealed he was cognitively intact and was independent or supervision for most activities of daily living.

Review of the comprehensive care plan for Resident #98 last revised 10/15/21 revealed no care plan intervention or focus for schizophrenia behaviors or epilepsy.

An interview on 10/27/21 at 8:13 AM with the MDS Nurse revealed she was responsible for entering the care plan information. She stated Resident #98 should have been care planned for behaviors and potential for seizures and she had just missed it.

An interview on 10/29/21 at 11:51 AM with the Administrator revealed it was her belief that care plans should be accurate.

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 11/03/2021

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

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F 656	Continued From page 53	F 656		

5. Resident #79 was admitted to the facility on 9/30/21 with diagnoses which included Diabetes Mellitus and a stage 2 sacral pressure ulcer.

Resident #79's admission Minimum Data Set (MDS) dated 9/30/21 revealed he had severe cognitive impairment and was totally dependent on staff for activities of daily living. He was coded to have had a stage 2 sacral pressure ulcer that was present on admission.

Review of the comprehensive care plan for Resident #79 last revised 10/09/21 revealed no care plan intervention or focus for pressure ulcers.

An interview on 10/27/21 at 8:13 AM with the MDS Nurse revealed she was responsible for entering the care plan information. She stated Resident #79 should have been care planned for pressure ulcers and she had just missed it.

An interview on 10/29/21 at 11:51 AM with the Administrator revealed it was her belief that care plans should be accurate.
#6 Resident #52 was admitted to the facility on 6/5/19. Her diagnoses included Diabetes, hypertension, and cardiovascular accident (CVA).

A progress note dated 8/17/21 written by the Social Worker documented Resident #52 continued to have a Do Not Resuscitate status.

The October 2021 Physician orders indicated Resident #52 had a Do Not Resuscitate status.

The quarterly Minimum Data Set (MDS) dated 10/19/21 revealed Resident #52 was readmitted from the hospital on 7/28/21. She was severely

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 11/03/2021

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 656	Continued From page 54	F 656		

cognitively impaired. She required extensive or total assistance with activities of daily living.

The current care plan revealed Resident #52 had two different code statuses. One care plan had been initiated on 6/5/19 and noted Resident #52 "wishes to be a full code." Another care plan which had been initiated on 7/22/21 noted Resident #52 had "wishes to be a DNR (Do Not Resuscitate), allow natural death, do not attempt resuscitation." Both had been edited by the MDS nurse on 9/4/21 and continued to be active care plans.

On 10/28/21 the MDS nurse stated Resident #52 was a DNR and not a full code. The MDS nurse added the care plan had an error because the full code problem should not be on the current care plan. She said the care plan should not have both DNR and full code.
7. Resident #65 was admitted to the facility on 09/19/2018 a diagnosis of seizures.

The annual Minimum Data Set assessment (MDS) for Resident #65 dated 07/30/2021 revealed his cognition was moderately impaired. Seizure disorder or epilepsy was listed in the active diagnoses.

A review of the physician's orders for Resident #65 revealed a current order for levetiracetam (an anticonvulsant medication to treat seizures) 500 milligrams by mouth twice daily last initiated on 12/09/2019.

Review of the current care plan for Resident #65 dated 10/15/2021 revealed no identification or incorporation of his seizures.

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 11/03/2021

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

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F 656	Continued From page 55 On 10/28/2021 1:13 PM an interview with the MDS nurse indicated Resident #65 had a diagnosis of seizures. She stated this should have been incorporated in his comprehensive plan of care. On 10/29/2021 at 9:51 AM an interview with the Director of Nursing (DON) indicated she would expect Resident #65's diagnosis of seizures to be incorporated in his comprehensive plan of care.	F 656		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) 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, record review and resident and staff interviews the facility failed to provide nail care for 2 of 6 residents reviewed for activities of daily living (ADL). (Resident #90 and Resident #80) Findings included: 1. Resident #90 was admitted to the facility on 10/02/2020 with diagnoses including hemiplegia (paralysis on one side of the body) following non-traumatic intracranial hemorrhage (bleeding into the brain), muscle weakness, contracture (tightening of the muscle and tendon that causes joints to become very stiff and prevents normal movement) of the left hand and wrist, and diabetes mellites type 2.	F 677	"How corrective action will be accomplished for those residents found to have been affected by the deficient practice. Resident # 90 nails were trimmed on 10/26/21, Resident # 80 nails were trimmed on 10/29/2021. "How the facility will identify other residents having the potential to be affected by the same deficient practice. On 10/29/21 the Director of Nursing, Nurse Managers and Licensed Nurses began reviewing 100% of the resident□s nails for ensure appropriate length and cleanliness.	12/3/21

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 11/03/2021

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 677

Continued From page 56

A review of the annual Minimum Data Set (MDS) assessment for Resident #90 dated 10/10/2021 revealed he was cognitively intact. Resident #90 had no behaviors or rejection of care during the 7 day look back period of the assessment. He required the extensive assistance of one person for bathing and personal hygiene. He had functional limitation in range of motion to his upper and lower extremity on one side.

A review of the current care plan for Resident #90 last revised on 09/21/2021 revealed a focus area dated 10/03/2020 of ADL decline requires assistance due to hemiplegia and hemiparesis. The goal was for Resident #90 to have his ADL needs met with the required assistance from staff. An intervention was to set-up Resident #90 for ADL.

On 10/25/2021 at 2:27 PM an observation of Resident #90 revealed his left hand was contracted. The fingernails of his left hand were not visible.

A review of Resident #90's medical record from 07/01/2021 through 10/25/2021 did not reveal any information regarding when Resident #90 had his fingernails last trimmed.

On 10/26/2021 at 2:45 PM an observation of Resident #90 revealed his left hand was contracted. The fingernails of his left hand were not visible. An interview with Resident #90 at that time indicated he received his bath that morning. He stated the nursing assistant (NA) washed his left hand. He further indicated she had not trimmed the fingernails of his left hand as a nurse had to do that. Resident #90 went on to say his family member trimmed the fingernails of his right

F 677

"What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur.

On 11/22/21 the Director of Nursing and/or Clinical Competency Coordinator began educating the Certified Nursing Assistants and Licensed Nurses on completion of nail care during daily personal grooming and notification to Licensed Nursing for nails they are unable to trim. This education has been added to the general orientation for all Certified Nursing Assistant�s and Licensed Nurses upon hire.

The Director of Nursing and/or Clinical Competency Coordinator began educating the Licensed Nurses on 11/22/2021 regarding observing nails during their weekly skin checks and trimming nails as required.

The Director of Health Services and Nursing Leadership complete a weekly review of 25% resident nails to ensure nails are being trimmed and cleaned. The nail care review will occur weekly for four weeks then monthly until three months of sustained compliance is met, then quarterly.

"How the facility plans to monitor its performance to make sure that solutions are sustained.

The Director of Nursing will present the analysis of the nail care review to the

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 11/03/2021

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 677	Continued From page 57 hand but could not trim the fingernails of his left hand because it was contracted. He stated he could not recall when the fingernails of his left hand had last been trimmed. Resident #90 further indicated he was satisfied with the length of the fingernails on his right hand but he could not use his left arm or hand and could not see whether the fingernails of his left hand needed to be trimmed. On 10/26/2021 at 2:57 PM an observation of the fingernails of Resident #90's left hand with NA #2 revealed they extended ¼ to ½ inch beyond the tip of each finger. An interview with NA #2 at that time indicated she assisted Resident #90 with his bath that morning, had washed his left hand, and had noticed the fingernails of his left hand needed trimming. She stated she could not trim Resident #90's fingernails because he had diabetes. NA #2 stated she would normally notify the nurse if a resident's fingernails needed trimming but she didn't usually work with Resident #90 and had not notified his nurse that day. On 10/26/2021 at 3:09 PM an observation of the fingernails of Resident #90's left hand was conducted with Nurse #8. In an interview with Nurse #8 at that time she stated the fingernails of Resident #90's left hand extended ¼ to ½ inch beyond the tip of each finger and needed to be trimmed. She further indicated she was assigned to care for Resident #90 that day. She stated she regularly cared for him. Nurse #8 went on to say Resident #90 had diabetes and nursing assistants were not allowed to trim his fingernails. She stated she usually checked the fingernails of diabetic residents weekly to see if they needed trimming. She stated she had not checked Resident #90's fingernails that week. Nurse #8	F 677	Quality Assurance and Performance Committee monthly for review and revision as needed. "Include dates when corrective action will be completed. 12/3/2021	

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 11/03/2021

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

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F 677	Continued From page 58	F 677		

further indicated she could not recall when she had last checked or trimmed Resident #90's fingernails

On 10/26/2021 at 3:25 PM an observation of the fingernails of Resident #90's left hand was conducted with the Director of Nursing (DON). In an interview at that time the DON stated the fingernails of Resident #90's left hand extended at least ¼ inch beyond the tip of each finger and needed to be trimmed. She further indicated the nursing assistants were not allowed to trim Resident #90's fingernails as he had diabetes. She went on to say she expected NA's providing ADL care to report to the resident's nurse or to her if a resident needed their nails trimmed and the NA's were unable to do so. The DON stated she trimmed resident's fingernails weekly. She stated she last trimmed Resident #90's fingernails about a month ago.

2. Resident #80 was admitted to the facility on 11/01/2016 with diagnoses that included cerebrovascular disease affecting the left non-dominant side.

The quarterly Minimum Data Set (MDS) assessment dated 10/08/2021 revealed she was severely cognitively impaired. She required extensive assistance with personal hygiene, and total assistance with bathing. The MDS was coded no rejection of care for the 7 day look back assessment period. Per the MDS she had functional range of motion limitations on one side of the upper and lower extremity.

A care plan last reviewed on 10/15/2021 revealed no plan of care that focused on Resident #80's activity of daily living or contracture.

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 11/03/2021

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 677	Continued From page 59	F 677		

An observation on 10/26/2021 at 10:00 am revealed Resident #80's left hand was in a closed position with the pinky and middle finger nails approximately one-half inch in length. The finger nails were touching the palm of her hand while in the closed position. The rest of her fingers were closed tightly in her hand and could not be seen.

During an interview with Resident #80 on 10/27/2021 at 11:00 am, she stated it have been a long time since she was able to open her hand. She then stated her fingernails on the left hand have not been cut in a while. She was unable to tell the last time her fingernails were cut.

An observation on 10/28/2021 at 3:00 pm revealed Resident #80's fingernails on her left hand were still long and touched the palm of her left hand.

On 10/28/2021 at 3:45 pm during an interview with Nurse Aide (NA) #7 she stated fingernail care was usually done with the baths by the NAs. She stated she informed the nurses when a resident needed nail care. The NA stated she was not aware Resident #80's nails needed cutting.

During an observation of Resident #80's fingernails on her left hand with Nurse #8 on 10/28/2021 at 4:00 pm, she stated the resident's nails were long and should have been cut to keep the nails from digging into her hand. She stated the NAs cuts the nondiabetic residents fingernails and the nurses cuts the diabetic residents fingernails. She also said the NAs usually informed the nurses when a resident fingernails needed to be cut by a nurse. She stated she was not informed by the NAs that Resident #80's fingernails needed cutting.

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 11/03/2021

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 677	Continued From page 60 The Director of Nursing stated on 10/29/2021 at 11:14 am during an interview she heard Resident #80's fingernails on her contracted hand were long . She then stated her fingernails should have been cut by the NAs or the nurses. The Administrator stated on 10/29/2021 at 1:45 pm the facility had two nurses that cut the resident's fingernails when needed. She stated the NAs should have been monitoring Resident #80's fingernails and informed the nurses when they needed to be cut.	F 677		
F 684 SS=K	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on staff, physician, nurse practitioner, police officer and emergency medical technicians (EMT) interviews, and record review the facility failed to obtain physician's orders prior to treating a wound and failed to identify, assess, and monitor a wound to determine the need for medical treatment for an open wound that progressively deteriorated from 9/24/20 through 1/10/21. Resident #200 was identified by Emergency Medical Technicians (EMT) and police on 1/10/21 to have a large tunneling wound	F 684	"Identify those recipients who have suffered, or are likely to suffer, a serious adverse outcome as a result of the noncompliance, and. Resident # 200 no longer resides in the facility. "How the facility will identify other residents having the potential to be affected by the same deficient practice.	12/3/21

F 684 Continued From page 61
under his left arm at the time of death with no observed dressing present. This was for 1 of 3 residents reviewed for wound care (Resident #200).

Immediate Jeopardy began on 9/24/20 when Resident #200's wound to his left axillary (armpit) opened and the Wound Care Nurse administered a discontinued treatment to the wound and failed to assess and document the status of the wound. During this time, staff failed to identify, report, and document this wound on weekly skin assessments. Immediate jeopardy was removed on 10/29/21 when the facility provided and implemented an acceptable allegation of Immediate Jeopardy removal. The facility remains out of compliance at a lower scope and severity of "E" (no harm with the potential for more than minimal harm that is not immediate jeopardy) to ensure monitoring systems put in place are effective.

Findings included:

Resident #200 was admitted to the facility on 6/20/20 with diagnoses that included anemia, contracture of the right and left knee, stage II pressure ulcers of the right and left buttock, and hidradenitis suppurativa (a chronic skin condition featuring skin lesions which develop because of inflammation and infection of sweat glands).

Resident #200's quarterly minimum data set assessment dated 10/22/20 revealed he was assessed as cognitively intact. He required extensive assistance with bed mobility and toilet use. He was totally dependent on staff for dressing and personal hygiene. He had two stage II pressure ulcers present upon admission. He

F 684

The Administrator completed a 24-hour report to the State Agency regarding neglect on 10/27/21 when she was notified of the concern regarding the axilla wound and no documentation of same. The Wound Nurse was suspended pending investigation on 10/27/21 and terminated on 10/28/21. The wound Nurse was reported to the North Carolina Board of Nursing on 10/28/2021 for professional standards violations.

The Director of Health Services initiated 100% body audits on all residents within the facility on 10/27/21. This audit reveals no wounds without physician/physician extender notification. If any resident is noted without an order for impaired skin integrity the Director of Nursing, Nurse Managers and/or Licensed Nurse will notify the physician and/or physician extender for orders.
All residents have the potential to suffer a serious adverse outcome as a result of this noncompliance.

"What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur.

The Director of Health Services and/or Nurse Managers have reviewed the wound audit conducted on 10/27/21 and reviewed the documentation to ensure residents with skin impairments had an order for treatment to areas. The Director of Health Services and Nurse Managers reviewed residents with wounds to ensure

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 11/03/2021

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 684 Continued From page 62

had application of non-surgical dressings, pressure ulcer care, and a pressure reducing device to bed and chair. He also had application of ointment and treatments.

Resident #200's care plan dated 11/26/20 revealed he was care planned to have a pressure ulcer to his sacral area, right axilla, and left and right buttock. There was no mention of a wound to his left armpit. He was also care planned to resist wound treatment care. The interventions included to reiterate the purpose and advantages of treatment for the resident as well as assess his resistance to care.

Review of Resident #200's Treatment Orders and Treatment Administration Records from June 2020 through January 10th, 2021 revealed he was ordered on 8/20/2020 to have his left inner armpit cyst, related to hidradenitis, cleansed with normal saline and apply a dry dressing every day. This order was discontinued on 9/24/2020. The order was discontinued by Physician #1 and transcribed by the Wound Care Nurse.

A review of the physician and Nurse Practitioner (NP) notes from 9/24/20 through 1/10/21 revealed no reference to Resident #200's left armpit wound.

Further review of the medical record revealed no documentation of the wound to his left armpit from 9/24/20 through 1/10/21. There were no assessments or measurements of the wound.

A review of Resident #200's weekly skin assessments from 9/23/20 to his time of death (1/10/21) revealed no documentation of a wound to his left armpit. There was no documentation of

F 684

weekly documentation including ongoing assessments including wound measurements are currently in place and documented. Review of documentation identified no residents without documentation at this point in time.

The Director of Health Services and/or Nurse Managers began education on 10/27/21 regarding weekly skin observations and documentation in the electronic health record of same. When a new skin impairment is noted, the Licensed nurse will complete the wound documentation in the electronic medical record that includes description and measurement of area ,and contact the physician/physician extender for orders, regarding newly identified skin impairments and/or worsening skin impairments for wound treatment orders. This includes that the assessments and measurements were necessary as a monitoring tool to determine if there are any changes in the wound that would require a change in the treatment plan. This education has been added to the License Nurse general orientation upon hire. Any Licensed Nurse will not be allowed to work after 10/28/21 until they receive the education. The new Wound Nurse and the Nurse Practitioner are meeting weekly to discuss and review all residents with wounds.
The Director of Health Services and/or Nurse Managers began education on 10/27/21 regarding completing weekly skin observation and wound management notes including description and

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 11/03/2021

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 684

Continued From page 63

skin check refusals during this time on the skin check assessments.

On 12/18/20 a skin check completed by Nurse #1 indicated Resident #200 had alterations in skin. There was no further documentation.

On 12/26/20 a skin check completed by Nurse #3 indicated Resident #200 had alterations to his skin. The comment note indicated the skin alteration was to the resident's sacrum.

On 1/2/21 a skin check completed by Nurse #4 indicated Resident #200 had no alterations to his skin.

A nursing note dated 1/10/21 revealed at 4:45 AM Nurse #5 was alerted by Nurse Aide #3 of a change in Resident #200's breathing. The nurse immediately responded and observed Resident #200 in his usual (due to contractures) fetal position, shallow respirations, unresponsive, and with a faint pulse. 911 was notified by the nurse. Resident #200 was found to be without signs of life, cessation of breathing, and no pulse. Cardiopulmonary Resuscitation (CPR) was initiated. EMS arrived at the facility and called time of death at 5:02 AM at the facility.

The EMS record dated 1/10/21 indicated EMS was dispatched to the facility for Resident #200. He had a large gaping hole in his left armpit that was bleeding. It was agreed by EMS personnel to discontinue CPR and call time of death in the facility at 5:02 AM. The local police department was notified.

During an interview on 10/28/21 at 1:03 PM Emergency Medical Technician (EMT) #1 stated

F 684

measurements of skin impairments weekly. This education has been added the License Nurse general orientation upon hire. Any Licensed Nurse will not be allowed to work after 10/28/21 until they receive the education.

The Director of Health Services and Nurse Managers educated the Certified Nursing Assistants on daily skin checks during personal care. This education includes notification to the nurse of any skin impairment and/or new dressing noted on resident□s skin. The Certified Nursing assistant will utilize a body diagram for nurse notification. This education has been added to the Certified Nursing Assistant general orientation upon hire. Any Certified Nursing Assistant will not be allowed to work after 10/28/21 until they receive the education.

The Clinical Competency Coordinator/RN is responsible for ensuring education is completed prior to the start of any Licensed Nurse and/or Certified Nursing Assistant working the floor after 10/28/21. The Director of Health Services and/or Nursing Leadership review the weekly skin observations to validate all areas identified have physician notification, treatments orders are written, wound is monitored for changes weekly for four weeks then monthly thereafter.

"How the facility plans to monitor its performance to make sure that solutions are sustained; and

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 11/03/2021

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 684

Continued From page 64

he was at the facility on 1/10/21 for Resident #200. EMT #1 further stated the resident had a gaping, open wound to his left underarm and chest which was about three inches in length and two inches in width. He stated there was some drainage from the wound and it presented as an old wound. He stated the wound was not a fresh laceration but had the appearance of being a wound that had been present prior to the initiation of CPR and had been present for some time. This wound was not bandaged and was "wide open." He continued to state even with Resident #200's left arm being held against his body the wound would have been visible to an observer.

During an interview on 10/28/21 at 2:00 PM EMT #2 stated he was dispatched to the facility on 1/10/21 for a cardiac arrest for Resident #200. The EMTs identified a wound to his left armpit that was in-between a golf ball and baseball sized opening. He stated he did not remember the diameter of the tunneling but that the tunneling could be observed. He stated at the very least there was two inches of depth to this wound ' s tunneling and noted some green pus drainage to the wound as well as bloody clear pink fluid that was on the blanket that had covered the wound as well. He further stated the wound was not an acute laceration and did not present as having acute trauma as a result of CPR. He further stated it had the appearance of a wound that had been present for quite some time. He stated he did not remember any dressing being in place to the wound on his left armpit. He could not recall if there was an odor to that wound.

During an interview on 10/28/21 at 2:00 PM EMT #3 stated she remembered walking in Resident #200's room on the morning of 1/10/21. EMT #3

F 684

Include dates when corrective action will be completed.

The Director of Health Services will present the analysis of the weekly skin observations to validate all areas identified have physician notification, treatments orders are written, to the Quality Assurance and Performance Committee monthly until three months of sustained compliance is maintained then quarterly thereafter.

The Clinical Competency Coordinator will present the analysis of education compliance of the Licensed Nurses regarding weekly skin observation and documentation in wound management notes including description and measurements and physician notification weekly to the Quality Assurance and Performance Committee monthly until three months of sustained compliance is maintained then quarterly thereafter.

The Clinical Competency Coordinator will present the analysis of education compliance of the Certified Nursing Assistants regarding on daily skin checks during personal care to the Quality Assurance and Performance Committee monthly until three months of sustained compliance is maintained then quarterly thereafter.

Date when corrective action will be completed: 12/3/2021

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 11/03/2021

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 684	Continued From page 65 stated she recalled he had a wound to his left armpit and chest area. The EMT stated a golf ball would have fit the wound due to the depth and size of the wound. She further stated she did not remember if the wound to the underarm was bandaged or not. She stated the wound had some drainage, and the wound had some depth but could not recall exactly how deep or the amount of tunneling if any. EMT #3 concluded based on the appearance of the wound to his underarm she did not believe the wound was a result of CPR and had the appearance of a wound that had been present on Resident #200 for some time. The police case narrative dated 1/11/21 revealed Police Officer #1 arrived at the facility in response to a death in the facility on 1/10/21. Police Officer #1 documented he was informed by EMS upon arrival that it appeared to be a case of neglect based on the deceased's condition and EMS personnel wanted to ensure a report was on file. Resident #200 had one large open wound under his left arm that was "several inches wide and extended up inside his body." The officer documented the open wound that was not bandaged and showed no signs of care. There were additional sores on the resident's side that were smaller but were still noticeable. The officer photographed the body. There were abrasions and sores under his right arm as well though not as pronounced. During an interview on 10/16/21 at 6:20 PM Police Officer #1 stated he was contacted by his dispatch that EMS had requested an officer respond for an unattended death at the facility. He stated he arrived at 5:03 AM on 1/10/21 and EMS informed him Resident #200 had several	F 684		

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 11/03/2021

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 684	Continued From page 66 open sores on his body that they discovered when they took off his gown. The most notable sore was to his left armpit. The officer observed the area. The gown that was around that area was soaked in a pink fluid. The wound was approximately two inches wide and three inches long. The wound continued into Resident #200's body towards his head which was open and large enough of a cavity that he could visualize inside the resident's body under his armpit. It was approximately 4 inches deep to his collarbone and was approximately 1.5 inches wide. The cavity ran along the outside of his rib cage and ended at his collarbone. The flesh that was visible in the cavity was a whitish pink. There were additional smaller sores located around the wound. He was informed by EMS that this wound did not have any dressing present when they arrived. He stated the staff could not explain why the wound was not cared for at that time. Review of the police report photographs taken on 1/10/21 at 5:28 AM at the time of Resident #200's death provided to the surveyor by Police Officer #1 revealed Resident #200 had an open wound under his left armpit. The wound could be observed to be approximately 1.5 inches wide and 2 inches long. Tunneling (Tunneling is when a wound has formed passageways underneath the surface of the skin.) could be observed at 12 o'clock. The tunneling was approximately 0.5 inches in diameter from medial (towards the center of the body) to lateral (away from the center of the body) edges of the tunneling and 1 inch in diameter from anterior (towards the front of the body) to posterior (towards the back of the body) edges of the tunneling. This tunneling extended up under his armpit an indeterminant length as the end of the tunneling was outside of	F 684		

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 11/03/2021

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 684	Continued From page 67	F 684		

the view of the camera. The wound presented as pale pink and the wound bed had yellow slough present (yellow/white material in the wound bed; usually wet but can be dry. It generally has a soft texture. It can be thick and adhered to the wound bed, present as a thin coating, or patchy over the surface of the wound. It consists of dead cells that accumulate in the wound drainage.).

During an interview on 10/26/21 at 9:43 AM the Wound Care Nurse stated she remembered Resident #200. She stated she was the wound care nurse at that time, and he was on her caseload. She indicated she was providing wound care to his cyst to his left underarm and on 9/24/20 the treatment was discontinued but she continued to provide care to the wound because it was open. She was unable to recall why the treatment was discontinued by the Nurse Practitioner on 9/24/20 as the wound had not improved and had not healed at that time. She revealed that until his death (1/10/21) she continued to provide the discontinued treatment without orders. She stated she had not documented this treatment to the wound in the medical record from 9/24/20 through 1/10/21. She indicated she had not completed any assessments or wound measurements from 9/24/20 through 1/10/21. She visualized the wound and provided the non-ordered treatment to his left armpit up until his death and it was progressively deteriorating till his death on 1/10/21. The Wound Care Nurse indicated she worked every Monday through Friday and every other weekend and the nurses for the unit complete the wound care when she was not working. She stated because there was no physician's order for the treatment the staff working when she was not in the facility would not

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 11/03/2021

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 684	Continued From page 68	F 684		

have known to do the dressing change to the left armpit of Resident #200. She stated she had not verbally gone to the nurses and informed them of the dressing change she was doing for him that was not ordered by the physician. She stated a couple of days before his death his left armpit wound had developed an odor. She stated it was concerning to her that the wound had deteriorated in size and developed an odor and she notified Nurse Practitioner #1 verbally, but Nurse Practitioner #1 did not write a new order or do anything for the wound. She stated she did not share this concern with anyone or document the interactions or concerns.

During an interview on 10/26/21 at 10:50 AM Nurse Practitioner #1 stated she remembered Resident #200. She stated in September 2020 Resident #200 completed antibiotic treatment and she had been told the wounds had gotten better. She indicated she had not known Resident #200's wound progressively deteriorated from 9/24/20 through 1/10/21 nor had she known the Wound Care Nurse was completing treatments without orders. She stated that orders were to be obtained prior to treatments being completed. The Wound Care Nurse's interview that indicated she informed NP #1 she was completing treatments without an order and that the wound had opened and deteriorated was shared with NP #1. She denied ever being notified after September 2020 by staff at the facility that the wound to Resident #200's left armpit had opened, deteriorated, or was receiving treatments without orders. NP #1 was informed that no assessments or measurements of the wound were completed from 9/24/20 through 1/10/21 despite the Wound Care Nurse being aware of the wound. She stated that identified wounds

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 11/03/2021

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 684	Continued From page 69	F 684		

were to be assessed and monitored. She indicated without documented assessments there was no way to ascertain if there were changes in the wound that would require a change in the treatment plan.

During an interview on 10/27/21 at 12:33 PM with Physician #1 the Wound Care Nurse's interview in which she reported that she completed treatments with no physician's order from 9/24/20 through 1/10/21 as well as her statement that she completed no assessments or measurement of the wounds throughout this same time period were reviewed with the physician. He stated that orders were to be obtained prior to treatments being completed and identified wounds were to be assessed, monitored, and documented. He stated wound measurements were part of the assessment. He indicated without assessments and measurements there was no way to determine if there were changes in the wound that would require a change in the treatment plan. He further stated he was unable to understand why the Wound Care Nurse would not have gotten an order for treatment of a wound and why she would not have completed wound assessments and measurements in order to monitor the wound's status. He indicated that neither he nor the nurse practitioner would ever deny an order for a wound to be treatment. The police report photographs of the wound to Resident #200's left armpit (taken 1/10/21) were reviewed with Physician #1 during interview. He stated he was unsure if the wound could have developed after his death or how long it would have taken to develop such a wound. The Physician stated he felt the wound had a severe appearance in the photographs and had reiterated he had not known why the wound care

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 11/03/2021

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 684	Continued From page 70	F 684		

nurse had no measurements, treatment records, or weekly wound assessments if she was following the wound. He stated due to the lack of documentation it was impossible to know if and when the wound was or was not present or the severity of the wound until the time of the photographs by the police department.

During an interview on 10/27/21 at 1:35 PM the Director of Nursing stated wound treatment should not be done without and order and if the wound care nurse deemed a wound needed to have continued treatment, she should request the order be continued or changed depending on the situation. Identified wounds were to be assessed, monitored, and documented. She concluded wound measurements were part of the assessments in order to follow the wound progress.

During an interview on 10/27/21 at 10:32 AM Nurse #1 stated she did skin check for Resident #200 but did not remember him very well. She stated from September 2020 through December 2020 Resident #200 was on her assignment for weekly skin checks. She stated she did not remember why she checked yes for skin alteration on 12/18/20. She stated she did not identify any wounds under his arms during her skin assessments of the resident and if she had noted any wounds to his armpits, she would have documented it and notified the wound nurse. She stated if he had refused his weekly skin assessments, she would have documented the assessment as refused, therefore he did not refuse his weekly skin assessments as she had documented them as completed. She stated a full head to toe skin check included observing the skin of a resident from top to bottom and then

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 11/03/2021

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PRUITTHEALTH-TRENT	836 HOSPITAL DRIVE NEW BERN, NC 28560

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F 684	Continued From page 71	F 684		

turning the resident to check the skin on their back. She stated she usually observed under the arm for skin assessments but could not remember in Resident #200's case if she observed under his arm during his skin assessment.

During an interview on 10/27/21 at 11:44 AM Nurse #3 stated she did remember Resident #200. She stated she did a skin check on 12/26/20 and noted he had a pressure ulcer wound to his sacrum. Resident #200 was able to raise his arms and she did not identify any wound under his left arm. She further stated had she identified any alterations to his skin under his left arm and armpit she would have documented it on her skin assessment and notified the wound care nurse. The nurse stated if Resident #200 had refused his skin check she would have documented the skin check as refused. She stated because she documented his skin check as complete, he did not refuse his skin assessment on 10/26/20.

During an interview on 10/27/21 at 12:30 PM Nurse #4 stated she did a skin check on Resident #200. She stated she could not remember the date but if the documented date was 1/2/21 then that was when she did the skin check. She stated if she documented no alterations in skin that meant that he did not have any wounds present. She further stated she did not identify any wound to his left underarm or she would have documented the wound and notified the wound care nurse. She stated she could not remember if there were dressings on his left armpit or not but if she saw issues with his skin, she would have documented them. She stated he did not refuse the skin assessment, or she would not have

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 11/03/2021

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

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F 684	Continued From page 72	F 684		

documented the skin check as complete.

During an interview on 10/28/21 at 9:55 AM The Director of Nursing stated if a wound was present under Resident #200's arm at the time they did their skin assessments, it should have been documented and reported to the wound care nurse and nurse on the hall who would be responsible for notifying the Physician, responsible party, and Director of Nursing. If the wound was present at the time of these skin checks she did not know why they did not identify the wound.

The Administrator was notified of the immediate jeopardy on 10/28/21 at 2:49 PM. On 10/29/21 at 12:51 PM the facility provided the following credible allegation of immediate jeopardy removal.

The Removal Plan: F684
Identify those recipients who have suffered, or are likely to suffer, a serious adverse outcome as a result of the noncompliance, and.

On 10/27/21 the Director of Nursing was notified by the State Surveyor that Resident #200 (whom expired January 10, 2021) had a wound under his axilla area (armpit) that the Wound nurse stated she had been treating without an order from 9/24/20 through 1/10/21. The Wound nurse stated that she notified the Nurse Practitioner regarding Resident #200's open axilla area and the Nurse Practitioner allegedly stated to the Wound nurse to continue treatments with no order being provided for the treatments. The Wound nurse was unable to provide a date for this notification. The Wound nurse indicated she provided wound treatments to Resident #200

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 11/03/2021

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

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F 684 Continued From page 73 F 684

without an order from 9/24/21 through 1/10/21. The Nurse Practitioner stated that she was never notified of any information related to the open axilla area by the facility staff from 9/24/20 through 1/10/21 for Resident #200. When the wound nurse was asked where the documentation regarding treatments and Nurse Practitioner notifications were located the wound nurse stated there was none, she did not document and there was not an order to treat from 9/24/20 through 1/10/21. The wound Nurse failed to complete the weekly body observations that included wound assessments and measurements of the wound status for this same period of time. There is no documentation that the wound nurse notified the Nurse Practitioner related to the order or treatment of the wound identified under the armpit area. The facility was unaware of the wound nurse was providing treatment without a Physician order.
The facility was unaware of the Wound nurse's lack of documentation of assessment, measurements of the wound progression, the Wound nurse was providing treatments without orders, and the lack of notification to the physician/nurse practitioner.
Upon arrival to facility on 1/10/21 the EMS /police noted the resident's axilla area wound condition as a large open wound under left arm that was extended up inside his body. Officer documented he could see ribs and collar bone through the body that was not bandaged. Resident #200 expired on 1-10-2021.
All residents have the potential to suffer a serious adverse outcome as a result of this noncompliance.

Specify the action the entity will take to alter the process or system failure to prevent a serious

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 11/03/2021

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PRUITTHEALTH-TRENT	836 HOSPITAL DRIVE NEW BERN, NC 28560

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F 684		F 684		

Continued From page 74
adverse outcome from occurring or recurring, and when the action will be complete

The Administrator completed a 24-hour report to the State Agency regarding neglect on 10/27/21 when she was notified of the concern regarding the axilla wound and no documentation of same. The Wound Nurse was suspended pending investigation on 10/27/21 and terminated on 10/28/21. The wound Nurse was reported to the North Carolina Board of Nursing on 10/28/2021 for professional standards violations.
The Director of Health Services initiated 100% body audits on all residents within the facility on 10/27/21. This audit reveals no wounds without physician/physician extender notification. If any resident is noted without an order for impaired skin integrity the Director of Nursing, Nurse Managers and/or Licensed Nurse will notify the physician and/or physician extender for orders. The Director of Health Services and/or Nurse Managers have reviewed the wound audit conducted on 10/27/21 and reviewed the documentation to ensure residents with skin impairments had an order for treatment to areas. The Director of Health Services and Nurse Managers reviewed residents with wounds to ensure weekly documentation including ongoing assessments including wound measurements are currently in place and documented. Review of documentation identified no residents without documentation at this point in time.

The Director of Health Services and/or Nurse Managers began education on 10/27/21 regarding weekly skin observations and documentation in the electronic health record of same. When a new skin impairment is noted, the Licensed nurse will complete the wound

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 11/03/2021

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

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F 684	Continued From page 75 documentation in the electronic medical record that includes description and measurement of area ,and contact the physician/physician extender for orders, regarding newly identified skin impairments and/or worsening skin impairments for wound treatment orders. This includes that the assessments and measurements were necessary as a monitoring tool to determine if there are any changes in the wound that would require a change in the treatment plan. This education has been added to the License Nurse general orientation upon hire. Any Licensed Nurse will not be allowed to work after 10/28/21 until they receive the education. The new Wound Nurse and the Nurse Practitioner are meeting weekly to discuss and review all residents with wounds. The Director of Health Services and/or Nurse Managers began education on 10/27/21 regarding completing weekly skin observation and wound management notes including description and measurements of skin impairments weekly. This education has been added the License Nurse general orientation upon hire. Any Licensed Nurse will not be allowed to work after 10/28/21 until they receive the education. The Director of Health Services and Nurse Managers educated the Certified Nursing Assistants on daily skin checks during personal care. This education includes notification to the nurse of any skin impairment and/or new dressing noted on resident ' s skin. The Certified Nursing assistant will utilize a body diagram for nurse notification. This education has been added to the Certified Nursing Assistant general orientation upon hire. Any Certified Nursing Assistant will not be allowed to work after 10/28/21 until they receive the education.	F 684		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEALTH-TRENT	836 HOSPITAL DRIVE NEW BERN, NC 28560

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F 684	Continued From page 76 The Clinical Competency Coordinator/RN is responsible for ensuring education is completed prior to the start of any Licensed Nurse and/or Certified Nursing Assistant working the floor after 10/28/21. Alleged date of IJ Removal 10/29/21 The credible allegation for Immediate Jeopardy removal was validated on 11/2/21 which removed the Immediate Jeopardy on 10/29/21, as evidenced by staff interviews, in-service record reviews, and observation. The in-services included information on providing wound care treatments according to physician orders, wound assessments, wound measurements, and identification of new wounds and skin assessments. The facility's Immediate Jeopardy removal date of 10/29/21 was validated.	F 684		
F 726 SS=K	Competent Nursing Staff CFR(s): 483.35(a)(3)(4)(c) §483.35 Nursing Services The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e).	F 726		12/3/21

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 11/03/2021

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F 726	Continued From page 77 §483.35(a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. §483.35(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs. §483.35(c) Proficiency of nurse aides. The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. This REQUIREMENT is not met as evidenced by: Based on staff, physician, nurse practitioner, police officer and emergency medical technician (EMT) interviews, and record review the facility nursing staff failed to demonstrate competency and skill sets to effectively manage a resident ' s wound and to report a change in wound condition to the physician for evaluation of a wound that progressively deteriorated for more than a 3-month period of time. Resident #200 was identified by Emergency Medical Technicians (EMT) and police on 1/10/21 to have a large tunneling wound under his left arm at the time of death with no observed dressing present. This was for 1 of 3 residents reviewed for wound care (Resident #200). Immediate Jeopardy began on 9/24/20 when Resident #200's wound to his left axillary (armpit) opened and the Wound Care Nurse administered a discontinued treatment to the wound and failed	F 726	"How corrective action will be accomplished for those residents found to have been affected by the deficient practice. Resident # 200 no longer resides in the facility. The Administrator completed a 24-hour report to the State Agency regarding neglect on 10/27/21 when she was notified of the concern regarding the axilla wound and no documentation of same. The Wound Nurse was suspended pending investigation on 10/27/21 and terminated on 10/28/21. The wound Nurse was reported to the North Carolina Board of Nursing on 10/29/2021 for professional standards violations.	

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 11/03/2021

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

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F 726

Continued From page 78

to assess and document the status of the wound according to her training. During this time, staff trained on skin assessments failed to identify, report, and document this wound on weekly skin assessments. Immediate jeopardy was removed on 10/30/21 when the facility provided and implemented an acceptable allegation of Immediate Jeopardy removal. The facility remains out of compliance at a lower scope and severity of "E" (no harm with the potential for more than minimal harm that is not immediate jeopardy) to ensure monitoring systems put in place are effective.

Findings included:

This tag is cross referenced to:

Tag F580 - Based on staff, physician, nurse practitioner, and police officer interviews, and record review the facility failed to notify the physician of an open wound that progressively deteriorated from 9/24/20 through 1/10/21. This failure resulted in the resident receiving no physician evaluation of the wound and no physician ordered treatments to the wound. Resident #200 was identified by Emergency Medical Services (EMS) and police on 1/10/21 to have a large tunneling wound under his left arm at the time of death with no observed dressing present. This was for 1 of 3 residents reviewed for wound care (Resident #200).

Tag F600 - Based on staff, physician, nurse practitioner, police officer and emergency medical technician (EMT) interviews, and record review the facility neglected to provide necessary care and services to a resident by failing to effectively assess and monitor an open wound, failing to

F 726

"How the facility will identify other residents having the potential to be affected by the same deficient practice

The Director of Health Services initiated 100% body audits on all residents within the facility on 10/27/21. This audit reveals no wounds without physician/physician extender notification. If any resident is noted without an order for impaired skin integrity the Director of Nursing, Nurse Managers and/or Licensed Nurse will notify the physician and/or physician extender for orders. All residents have the potential to be affected.

The Director of Health Services and/or Nurse Managers have reviewed the wound audit conducted on 10/27/21 and reviewed the documentation to ensure residents with skin impairments had an order for treatment to areas with notification to physician and/or physician extender of any new /changed skin impairments. The Director of Health Services and Nurse Managers reviewed residents with wounds to ensure weekly documentation including ongoing assessments with wound measurements are currently in place, documented accurately and physician / physician extender notification. Review of documentation identified no residents without wound documentation at this point in time and the current wound observations are accurate.

"What measures will be put into place or systemic changes made to ensure that

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 11/03/2021

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

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F 726	Continued From page 79 obtain physician ' s orders prior to treating the wound, and failing to notify the physician of an open wound that progressively deteriorated from 9/24/20 through 1/10/21. Resident #200 was observed by Emergency Medical Services (EMS) on 1/10/21 with a large tunneling wound under his left arm at the time of death. This was for 1 of 3 residents reviewed for wound care (Resident #200). Tag F684 - Based on staff, physician, nurse practitioner, police officer and emergency medical technicians (EMT) interviews, and record review the facility failed to obtain physician ' s orders prior to treating a wound and failed to identify, assess, and monitor a wound to determine the need for medical treatment for an open wound that progressively deteriorated from 9/24/20 through 1/10/21. Resident #200 was identified by Emergency Medical Technicians (EMT) and police on 1/10/21 to have a large tunneling wound under his left arm at the time of death with no observed dressing present. This was for 1 of 3 residents reviewed for wound care (Resident #200). During an interview on 10/28/21 at 3:26 PM Nurse #3 stated when she was hired, she was trained on weekly skin checks. She further stated they were to do a head-to-toe assessment. She stated she would start with the resident ' s head and observe the integrity of the skin to the resident ' s head. She stated while checking their head she would palpate their neck to check their glands. She stated and then they would have the resident raise their arms and observe the skin under their arms. Then she would inspect their chest and then peri-area and groin. Then she would check legs and feet. Then the resident	F 726	the deficient practice will not recur. The Director of Health Services and Nurse Managers educated the Licensed Nurses regarding accuracy of weekly body observations to include identification of any dressing noted or skin impairment noted on the resident body. This education has been added the License Nurse general orientation upon hire. License Nurses not educated by 10/28/21 will be educated prior to their next scheduled shift. The Director of Health Services and/or Nurse Managers began education on 10/27/21 regarding weekly skin observations and documentation in the electronic health record of same. When a new skin impairment is noted, the Licensed nurse will complete the wound documentation in the electronic medical record that includes description and measurement of area ,and contact the physician/physician extender for orders, regarding newly identified skin impairments and/or worsening skin impairments for wound treatment orders. This includes that the assessments and measurements were necessary as a monitoring tool to determine if there are any changes in the wound that would require a change in the treatment plan. This education has been added to the License Nurse general orientation upon hire. Any Licensed Nurse will not be allowed to work after 10/28/21 until they receive the education. The new Wound Nurse and the Nurse Practitioner are	

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 11/03/2021

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

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F 726

Continued From page 80

would be turned over and they would check the back and the gluteal fold and legs. She stated she performed the skin assessment on 12/26/20 and noted his skin issue to Resident #200 ' s sacrum. Upon being informed of the wound care nurse ' s description of the wound as well as the description by police and EMT at the time of his death she stated she did not recall identifying such a wound. She further stated she could not explain why the wound would not have been documented in her assessment if it had been present. She denied having any knowledge of the presence of or beginning of a wound to his left underarm in her skin assessment she completed on 12/26/20.

During an interview on 10/28/21 at 4:42 PM Nurse #4 stated she was trained how to complete head to toe skin assessments. She further stated she would start with observations of the head, and then move to the front of the resident, then shoulders, then back, then legs and feet, and finally arms and hands. She stated she would have documented if Resident #200 refused to raise his arms so if she did not document refusal, she would have observed under his arms for skin integrity. She further stated she had no idea how she could have missed a wound as it was described by the wound care nurse, EMTs, and responding police officer. She stated the only wound she identified Resident #200 with on 1/2/21 was the wound under his buttock which she would not note this wound in her skin assessment because it was a pressure ulcer already being treated and it was up to the wound care nurse to document those measurements and treatments.

During an interview on 10/28/21 at 10:24 AM the

F 726

meeting weekly to discuss and review all residents with wounds.

The Director of Health Services and/or Nurse Managers began education on 10/27/21 regarding completing weekly skin observation and wound management notes including description and measurements of skin impairments weekly. This education has been added the License Nurse general orientation upon hire. Any Licensed Nurse will not be allowed to work after 10/28/21 until they receive the education.

The Director of Health Nursing and/or RN Nurse Managers have validated, (by observation) the 10/27/21 skin observations completed by the License Nurses for comprehensive assessment and accuracy. No discrepancies where identified. The Clinical Competency Coordinator, Director of Health Services and RN Managers are observing all Licensed Nurse□s on 10/29/21 complete skin observation to validate competency of the comprehensive assessment and for accuracy of the assessment. Licensed Nurses not deemed competent will be re-educated and reevaluated to validate competency prior to completing further skin assessments. Licensed Nurse will not be allowed to work after 10/29/21 until they have been observed and validated for competency of the comprehensive assessment and for accuracy of the assessment .

The Clinical Competency Coordinator/RN

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 11/03/2021

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

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F 726	Continued From page 81 Wound Care Nurse indicated she began working with wounds at the facility in June 2020. She indicated she received training at the facility on how to identify, assess, evaluate, monitor, and document skin conditions. This training was completed for her in 6/2020 when she took the position of wound care nurse. When asked why she had not implemented this training for Resident #200 ' s left arm pit wound she indicated she had no reason she chose not to. She acknowledged that she should have assessed and evaluated the open wound to his left armpit, monitored the wound ' s status, and documented this in the medical record in accordance with her training. The Wound Care Nurse reported she was trained to acquire orders for wound care prior to providing treatment. She stated she had no reason why she provided the treatment without an order. She revealed she had not asked the physician or nurse practitioner for orders and that she knew she should have. She stated she was aware she should have completed all these steps due to her training at the time it was happening and had no reason she did not follow her training. The skin assessments completed from the 9/24/20 through 1/10/21 that all failed to identify Resident #200 ' s left arm pit wound were reviewed with the Wound Care Nurse. The Wound Care Nurse stated she would have identified a wound of that size on a skin assessment but could not speak to how the other nurses missed the wound. During an interview on 10/28/21 at 1:28 PM Staff Development Coordinator #1 stated she was the Staff Development Coordinator (SDC) from 2019 through November 2020. When staff were hired, they were provided education on wound treatments and documentation of treatments. She	F 726	is responsible for ensuring education and evaluation of competency is completed prior to the start of any Licensed Nurse and/or Certified Nursing Assistant working the floor after 10/29/21. "How the facility plans to monitor its performance to make sure that solutions are sustained. The Director of Health Services will present the analysis of the weekly skin observations to validate all areas identified have physician notification, treatments orders are written, to the Quality Assurance and Performance Committee monthly until three months of sustained compliance is maintained then quarterly thereafter. The Clinical Competency Coordinator will present the analysis of education compliance of the Licensed Nurses regarding weekly skin observation and documentation in wound management notes including description and measurements and physician notification weekly to the Quality Assurance and Performance Committee monthly until three months of sustained compliance is maintained then quarterly thereafter. Date when corrective action will be completed: 12/3/2021	

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 11/03/2021

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

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F 726	Continued From page 82 stated they had a skills observation checkoff for skin assessments that were done with staff upon orientation as well. Staff were educated on notification of changes of residents to the physician and responsible party to include incidents involving skin concerns on an as needed basis. They also educated staff on not providing treatments without orders, not obtaining orders for needed skin treatments, and education on wound care documentation on an as needed basis. She stated she believed the last time any of these issues were needed to be in-serviced was back in 2019 and did not have those records immediately available. She stated the new SDC had done some in-services since 1/10/2021 on the topic of wound care. This in-service was due to a new policy that had been initiated by corporate and did not have anything to do with any concerns identified with the care provided in the facility. During an interview on 10/28/21 at 1:35 PM Staff Development Coordinator #2 stated she had provided in-services since 1/10/2021 on the topic of wound care. This in-service was due to a new policy that had been initiated by corporate and did not have anything to do with any concerns identified with the care provided in the facility. During an interview on 10/28/21 at 9:32 AM the Administrator stated it was her expectation that staff would follow their training to perform full head to toe skin assessments and that they would identify, and report concerns of skin integrity. During an interview on 10/28/21 at 9:55 AM The Director of Nursing stated nursing staff were trained on skin checks and Nurse #1, Nurse #3,	F 726		

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	345371	A. BUILDING ______ B. WING ______	C 11/03/2021

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

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F 726	Continued From page 83	F 726		

and Nurse #4 received skin assessment training. She further stated if a wound was present under Resident #200 ' s arm at the time they did their skin assessments, it should have been documented and reported to the Wound Care Nurse and nurse on the hall who would be responsible for notifying the Physician, responsible party, and Director of Nursing. If the wound was present at the time of these skin checks she did not know why they did not identify the wound. The Wound Care Nurse had been trained that identified wounds were to be assessed, monitored, documented, and treatment was to be provided according to physician ' s orders. She did not understand why the wound care nurse did not follow her training.

The Administrator was notified of the immediate jeopardy on 10/29/21 at 9:36 AM. On 10/29/21 the facility provided the following credible allegation of immediate jeopardy removal.

The Removal Plan: F726
Identify those recipients who have suffered, or are likely to suffer, a serious adverse outcome as a result of the noncompliance; and

On 10/27/21 the Director of Nursing was notified by the State Surveyor that Resident #200 (whom expired January 10, 2021) had a wound under his axilla area (armpit) that the Wound nurse stated she had been treating without an order from 9/24/20 through 1/10/21. The Wound nurse stated that she notified the Nurse Practitioner regarding Resident #200 ' s open axilla area and the Nurse Practitioner allegedly stated to the Wound nurse to continue treatments with no order being provided for the treatments. The Wound nurse was unable to provide a date for

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 11/03/2021

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

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F 726	Continued From page 84 this notification. The Wound nurse indicated she provided wound treatments to Resident #200 without an order from 9/24/21 through 1/10/21. The Nurse Practitioner stated that she was never notified of any information related to the open axilla area by the facility staff from 9/24/20 through 1/10/21 for Resident #200. When the wound nurse was asked where the documentation regarding treatments and Nurse Practitioner notifications were located the wound nurse stated there was none, she did not document and there was not an order to treat from 9/24/20 through 1/10/21. The wound Nurse failed to complete the weekly body observations that included wound assessments and measurements of the wound status for this same period of time. There is no documentation that the wound nurse notified the Nurse Practitioner related to the order or treatment of the wound identified under the armpit area. The facility was unaware of the wound nurse was providing treatment without a Physician order. Weekly skin assessments from 9/24/20 through 1/10/21 failed to identify Resident #200 ' s open wound to the axilla area. The facility was unaware of the Wound nurse ' s lack of documentation of assessment, measurements of the wound progression, the Wound nurse was providing treatments without orders, and the lack of notification to the physician/nurse practitioner. The facility was unaware of the failure of nurses to identify the open wound during weekly skin assessments from 9/24/20 through 1/10/21. Upon arrival to facility on 1/10/21 the EMS /police noted the resident ' s axilla area wound condition as a large open wound under left arm that was extended up inside his body. Officer documented he could see ribs and collar bone through the	F 726		

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	345371	A. BUILDING ______ B. WING ______	C 11/03/2021

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

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F 726	Continued From page 85 body that was not bandaged. Resident #200 expired on 1-10-2021. All residents have the potential to have suffered a serious outcome as a result of this noncompliance. Specify the action the entity will take to alter the process or system failure to prevent a serious adverse outcome from occurring or recurring, and when the action will be complete. The Administrator completed a 24-hour report to the State Agency regarding neglect on 10/27/21 when she was notified of the concern regarding the axilla wound and no documentation of same. The Wound Nurse was suspended pending investigation on 10/27/21 and terminated on 10/28/21. The wound Nurse was reported to the North Carolina Board of Nursing on 10/29/2021 for professional standards violations. The Director of Health Services initiated 100% body audits on all residents within the facility on 10/27/21. This audit reveals no wounds without physician/physician extender notification. If any resident is noted without an order for impaired skin integrity the Director of Nursing, Nurse Managers and/or Licensed Nurse will notify the physician and/or physician extender for orders. The Director of Health Services and/or Nurse Managers have reviewed the wound audit conducted on 10/27/21 and reviewed the documentation to ensure residents with skin impairments had an order for treatment to areas with notification to physician and/or physician extender of any new /changed skin impairments. The Director of Health Services and Nurse Managers reviewed residents with wounds to ensure weekly documentation including ongoing	F 726		

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	345371	A. BUILDING ______ B. WING ______	C 11/03/2021

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PRUITTHEALTH-TRENT	836 HOSPITAL DRIVE NEW BERN, NC 28560

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F 726	Continued From page 86 assessments with wound measurements are currently in place, documented accurately and physician / physician extender notification. Review of documentation identified no residents without wound documentation at this point in time and the current wound observations are accurate. The Director of Health Services and Nurse Managers educated the Licensed Nurses regarding accuracy of weekly body observations to include identification of any dressing noted or skin impairment noted on the resident body. This education has been added the License Nurse general orientation upon hire. License Nurses not educated by 10/28/21 will be educated prior to their next scheduled shift. The Director of Health Services and/or Nurse Managers began education on 10/27/21 regarding weekly skin observations and documentation in the electronic health record of same. When a new skin impairment is noted, the Licensed nurse will complete the wound documentation in the electronic medical record that includes description and measurement of area ,and contact the physician/physician extender for orders, regarding newly identified skin impairments and/or worsening skin impairments for wound treatment orders. This includes that the assessments and measurements were necessary as a monitoring tool to determine if there are any changes in the wound that would require a change in the treatment plan. This education has been added to the License Nurse general orientation upon hire. Any Licensed Nurse will not be allowed to work after 10/28/21 until they receive the education. The new Wound Nurse and the Nurse Practitioner are meeting weekly to discuss and review all residents with wounds.	F 726		

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	345371	A. BUILDING ______ B. WING ______	C 11/03/2021

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

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F 726	Continued From page 87 The Director of Health Services and/or Nurse Managers began education on 10/27/21 regarding completing weekly skin observation and wound management notes including description and measurements of skin impairments weekly. This education has been added the License Nurse general orientation upon hire. Any Licensed Nurse will not be allowed to work after 10/28/21 until they receive the education. The Director of Health Nursing and/or RN Nurse Managers have validated, (by observation) the 10/27/21 skin observations completed by the License Nurses for comprehensive assessment and accuracy. No discrepancies where identified. The Clinical Competency Coordinator, Director of Health Services and RN Managers are observing all Licensed Nurse ' s on 10/29/21 complete skin observation to validate competency of the comprehensive assessment and for accuracy of the assessment. Licensed Nurses not deemed competent will be re-educated and reevaluated to validate competency prior to completing further skin assessments. Licensed Nurse will not be allowed to work after 10/29/21 until they have been observed and validated for competency of the comprehensive assessment and for accuracy of the assessment . The Clinical Competency Coordinator/RN is responsible for ensuring education and evaluation of competency is completed prior to the start of any Licensed Nurse and/or Certified Nursing Assistant working the floor after 10/29/21. Alleged date of IJ Removal 10/30/21 The credible allegation for Immediate Jeopardy removal was validated on 11/2/21 which removed	F 726		

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	345371	A. BUILDING ______ B. WING ______	C 11/03/2021

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

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F 726	Continued From page 88 the Immediate Jeopardy on 10/29/21, as evidenced by staff interviews, in-service record reviews, and observation. The in-services included information on providing wound care treatments according to physician orders, wound assessments, wound measurements, and identification of new wounds and weekly skin assessments. The facility ' s Immediate Jeopardy removal date of 10/30/21 was validated.	F 726		
F 805 SS=D	Food in Form to Meet Individual Needs CFR(s): 483.60(d)(3) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(3) Food prepared in a form designed to meet individual needs. This REQUIREMENT is not met as evidenced by: Based on observations and interviews with facility staff and the consulting dietitian the facility failed to provide the correct consistency of food to 1 (Resident #3) of 5 residents reviewed for nutrition. The findings included: Resident #3 was admitted to the facility on 3/4/21. Her diagnoses included traumatic subdural hemorrhage, mixed receptive-expressive language disorder and diabetes. The quarterly Minimum Data Set dated 10/18/21 indicated Resident #3 understood and was able to understand. She was coded as moderately cognitively impaired. She required extensive	F 805	"How corrective action will be accomplished for those residents found to have been affected by the deficient practice. Resident #3 no longer resides in the facility. "How the facility will identify other residents having the potential to be affected by the same deficient practice. The Dietary Supervisor monitored the tray line to ensure all residents received the correct diet texture. All residents have the potential to be affected.	12/3/21

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 11/03/2021

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

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F 805

Continued From page 89

assistance with most activities of daily living except she was dependent on staff for toileting and independent with eating. She received a mechanically altered diet.

The October 2021 Physician orders revealed the current diet for Resident #3 was regular puree.

A dietary note written on 10/18/21 by the Dietary Manager revealed Resident #3 continued to receive a regular pureed diet.

During a meal observation on 10/25/21 at 12:25 PM Resident #3 ' s lunch meal tray was on her over the bed table. Resident #3 was feeding herself. The meal tray ticket identified Resident #3 was on a regular puree diet. The meal tray included pureed okra. The pureed okra contained visible pieces of okra.

On 10/25/21 at 12:35 PM Unit Manager stated she observed Resident #3 ' s lunch meal tray and she could see the pieces of okra. She removed the plate containing the okra.

On 10/25/21 at 12:40 PM the Administrator stated it was a concern to have visible pieces of okra in the pureed item. She added Resident #3 was known to consume whole pieces of food by taking the food from other resident ' s trays or food items brought in by her family.

On 10/25/21 at 12:47 PM the Dietary Manager said pureed foods should not have visible pieces of food if it was pureed correctly.

The Speech Therapist was interviewed on 10/27/21 at 1:30 PM. She stated Resident # 3 required a pureed diet because she did not chew

F 805

"What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur.

The Certified Dietary Manager began educating the Certified Nursing Assistants on 11/23/2021 regarding how to read a meal card and how to know what the consistency of the diet should look like to ensure resident is given correct consistency. This education has been added to the general orientation of newly hired Certified Nursing Assistants.

The Speech Therapist is conducting an education to the dietary employees on 12/1/2021 regarding diet textures (regular, chopped, pureed, mechanical soft, nectar thick and honey liquids) . This education will include the reason a resident may be ordered an altered diet consistency. This education has been added to the general orientation of newly hired dietary employees.

The Certified Dietary Manager reviewed the policy regarding diet textures with the dietary staff on 11/23/2021. This education has been added to the general orientation of newly hired dietary employees.

The Certified Dietary Manager began education to the Dietary Staff on 11/23/2021 regarding reading and following the spreadsheet given per meal to prevent the wrong texture of foods being served to the resident. This education has been added to the general

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 11/03/2021

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

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F 805	Continued From page 90 the foods even when instructed to do so. She swallowed foods whole. During an interview with the consulting dietitian on 10/28/21 at 9:00 AM she stated Resident #3 was on a pureed diet and the pureed foods should not have any pieces in them.	F 805	orientation of newly hired dietary employees. The Dietary Supervisor/Cook is monitoring the pureed food prior to placing on tray line for texture accuracy, alternating meal times, four times per week for four weeks, then bi-weekly for two months, then monthly thereafter. The Certified Dietary Manager is performing spot checks of meal trays delivered to the units for texture and consistency daily for two meals per day for one week, then ten trays per week for four weeks, then 10 trays per month for three months. "How the facility plans to monitor its performance to make sure that solutions are sustained. The Certified Dietary Manager will present the analysis of the spot checks performance to the Quality Assurance and Performance Committee monthly until three months of sustained compliance is sustained then quarterly thereafter. The Certified Dietary Manager will present the analysis of the Dietary Supervisors tray line review to the Quality Assurance and Performance Committee monthly until three months of sustained compliance is sustained then quarterly thereafter. Include dates when corrective action will be completed. 12/3/2021	

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 11/03/2021

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

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F 842	Continued From page 91	F 842		
F 842 SS=E	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners,	F 842		12/3/21

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 11/03/2021

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

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F 842 Continued From page 92

medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512.

§483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use.

§483.70(i)(4) Medical records must be retained for-
(i) The period of time required by State law; or
(ii) Five years from the date of discharge when there is no requirement in State law; or
(iii) For a minor, 3 years after a resident reaches legal age under State law.

§483.70(i)(5) The medical record must contain-
(i) Sufficient information to identify the resident;
(ii) A record of the resident's assessments;
(iii) The comprehensive plan of care and services provided;
(iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State;
(v) Physician's, nurse's, and other licensed professional's progress notes; and
(vi) Laboratory, radiology and other diagnostic services reports as required under §483.50.
This REQUIREMENT is not met as evidenced by:
Based on staff interviews and record review the facility failed to document wound care treatments and assessments for 1 of 3 residents reviewed for wound care (Resident #200).

Findings included:

Resident #200 was admitted to the facility on 6/20/20 with diagnoses that included anemia,

F 842

"How corrective action will be accomplished for those residents found to have been affected by the deficient practice.

Resident #200 no longer resides in the facility.

"How the facility will identify other

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 11/03/2021

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

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F 842

Continued From page 93

contracture of the right and left knee, stage II pressure ulcers of the right and left buttock, and Hidradenitis suppurativa (a chronic skin condition featuring skin lesions which develop because of inflammation and infection of sweat glands).

Resident #200's quarterly minimum data set assessment dated 10/22/20 revealed he was assessed as cognitively intact. He required extensive assistance with bed mobility and toilet use. He had two stage II pressure ulcers present upon admission. He had application of non-surgical dressings, pressure ulcer care, and a pressure reducing device to bed and chair.

Review of Resident #200's Treatment Orders and Treatment Administration Records from June 2020 through January 10th, 2021 revealed he was ordered on 8/20/2020 to have his left inner armpit cyst, related to hidradenitis, cleansed with normal saline and apply a dry dressing every day. This order was discontinued on 9/24/2020. The order was discontinued by Physician #1 and transcribed by the Wound Care Nurse. There were no further treatments documented for his left armpit wound.

A review of the physician and Nurse Practitioner (NP) notes from 9/24/20 through 1/10/21 revealed no reference to Resident #200's left armpit wound.

Further review of the medical record revealed no documentation of the wound to his left armpit from 9/24/20 through 1/10/21. There were no assessments or measurements of the wound.

A nursing note dated 1/10/21 revealed at 4:45 AM Nurse #5 was alerted by Nurse Aide #3 of a

F 842

residents having the potential to be affected by the same deficient practice.

The Director of Health Services initiated 100% body audits on all residents within the facility on 10/27/21. This audit reveals no wounds without physician/physician extender notification. If any resident is noted without an order for impaired skin integrity the Director of Nursing, Nurse Managers and/or Licensed Nurse will notify the physician and/or physician extender for orders.

"What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur.

"The Director of Health Services and/or Nurse Managers have reviewed the wound audit conducted on 10/27/21 and reviewed the documentation to ensure residents with skin impairments had an order for treatment to areas. The Director of Health Services and Nurse Managers reviewed residents with wounds to ensure weekly documentation including ongoing assessments including wound measurements are currently in place and documented. Review of documentation identified no residents without documentation at this point in time.

"The Director of Health Services and/or Nurse Managers began education on 10/27/21 regarding weekly skin observations and documentation in the electronic health record of same. When a

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 11/03/2021

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 842 Continued From page 94

change in Resident #200's breathing. The nurse immediately responded and observed Resident #200 in his usual (due to contractures) fetal position, shallow respirations, unresponsive, and with a faint pulse. 911 was notified by the nurse. Resident #200 was found to be without signs of life, cessation of breathing, and no pulse. Cardiopulmonary Resuscitation (CPR) was initiated. EMS arrived at the facility and called time of death at 5:02 am at the facility.

The EMS record dated 1/10/21 indicated EMS was dispatched to the facility for Resident #200. He had a large gaping hole in his left armpit that was bleeding. It was agreed by EMS personnel to discontinue CPR and call time of death in the facility at 5:02 AM. The local police department was notified.

The police case narrative dated 1/11/21 revealed Police Officer #1 arrived at the facility in response to a death in the facility on 1/10/21. Resident #200 had one large open wound under his left arm that was "several inches wide and extended up inside his body." The officer documented the open wound that was not bandaged and showed no signs of care.

During an interview on 10/26/21 at 9:43 AM the Wound Care Nurse stated she remembered Resident #200. She stated she was the wound care nurse at that time, and he was on her caseload. She indicated she was providing wound care to his cyst to his left underarm and on 9/24/20 the treatment was discontinued but she continued to provide care to the wound because it was open. She was unable to recall why the treatment was discontinued by the Nurse Practitioner on 9/24/20 as the wound had not

F 842

new skin impairment is noted, the Licensed nurse will complete the wound documentation in the electronic medical record that includes description and measurement of area ,and contact the physician/physician extender for orders, regarding newly identified skin impairments and/or worsening skin impairments for wound treatment orders. This includes that the assessments and measurements were necessary as a monitoring tool to determine if there are any changes in the wound that would require a change in the treatment plan. This education has been added to the License Nurse general orientation upon hire. Any Licensed Nurse will not be allowed to work after 10/28/21 until they receive the education. The new Wound Nurse and the Nurse Practitioner are meeting weekly to discuss and review all residents with wounds.

"The Director of Health Services and/or Nurse Managers began education on 10/27/21 regarding completing weekly skin observation and wound management notes including description and measurements of skin impairments weekly. This education has been added the License Nurse general orientation upon hire. Any Licensed Nurse will not be allowed to work after 10/28/21 until they receive the education.

"The Director of Health Services and Nurse Managers educated the Certified Nursing Assistants on daily skin checks during personal care. This education

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F 842	Continued From page 95 improved and had not healed at that time. She revealed that until his death (1/10/21) she continued to provide the discontinued treatment without orders. She stated she had not documented this treatment to the wound in the medical record from 9/24/20 through 1/10/21. She indicated she had not completed any assessments or wound measurements from 9/24/20 through 1/10/21. During an interview on 10/27/21 at 12:33 PM with Physician #1 the Wound Care Nurse's interview in which she reported that she completed treatments with no physician's order from 9/24/20 through 1/10/21 as well as her statement that she completed no assessments or measurement of the wounds throughout this same time period were reviewed with the physician. He stated that orders were to be obtained prior to treatments being completed and identified wounds were to be assessed, monitored, and documented. He stated wound measurements were part of the assessment. He indicated without assessments and measurements there was no way to determine if there were changes in the wound that would require a change in the treatment plan. He stated due to the lack of documentation it was impossible to know if and when the wound was or was not present or the severity of the wound until the time of the photographs by the police department. During an interview on 10/27/21 at 1:35 PM the Director of Nursing stated wounds were to be assessed, monitored, and documented. Wound care treatment was to be documented as well. She concluded wound measurements were part of the assessments in order to follow the wound progress.	F 842	includes notification to the nurse of any skin impairment and/or new dressing noted on resident□s skin. The Certified Nursing assistant will utilize a body diagram for nurse notification. This education has been added to the Certified Nursing Assistant general orientation upon hire. Any Certified Nursing Assistant will not be allowed to work after 10/28/21 until they receive the education. "The Clinical Competency Coordinator/RN is responsible for ensuring education is completed prior to the start of any Licensed Nurse and/or Certified Nursing Assistant working the floor after 10/28/21. "The Director of Health Services and/or Nursing Leadership review the weekly skin observations to validate all areas identified have physician notification, treatments orders are written, wound is monitored for changes weekly for four weeks then monthly thereafter. "How the facility plans to monitor its performance to make sure that solutions are sustained. The Director of Health Services will present the analysis of the weekly skin observations to validate all areas identified have physician notification, treatments orders are written, to the Quality Assurance and Performance Committee monthly until three months of sustained compliance is maintained then	

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F 842	Continued From page 96	F 842	quarterly thereafter. The Clinical Competency Coordinator will present the analysis of education compliance of the Licensed Nurses regarding weekly skin observation and documentation in wound management notes including description and measurements and physician notification weekly to the Quality Assurance and Performance Committee monthly until three months of sustained compliance is maintained then quarterly thereafter. The Clinical Competency Coordinator will present the analysis of education compliance of the Certified Nursing Assistants regarding on daily skin checks during personal care to the Quality Assurance and Performance Committee monthly until three months of sustained compliance is maintained then quarterly thereafter. "Include dates when corrective action will be completed. 12/3/2021	