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 12/08/2022

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 12/3/22 through 12/8/22. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #HOFK11.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 12/3/22 through 12/8/22. Event ID# HOFK11. The following intakes were investigated : NC00194528, NC00191650, NC00193577, NC00193355, NC00191282, and NC00195384. 7 of 23 allegations were substantiated.	F 000		
F 558 SS=D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on record review, observation and staff interviews, the facility failed to place a resident's call light within reach to allow for the resident to request staff assistance if needed for 2 of 2 residents (Resident #72 and Resident #12) reviewed for accommodation of needs. Findings included: 1. Resident #72 was admitted to the facility on 12-21-20.	F 558	"Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice. Resident # 72 call bell was placed in reach on 12/4/33 and # 12 call bell was placed in reach of the residents on 12/4/22. "Address how the facility will identify other residents having the potential to be	1/3/23

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

Electronically Signed | 12/23/2022

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F 558	Continued From page 1 The quarterly Minimum Data Set (MDS) dated 11-19-22 revealed Resident #72 was severely cognitively impaired. Resident #72 was observed and interviewed on 12-4-22 at 10:30am. The observation revealed Resident #72 was lying in his bed and his call light was laying on the floor behind the bed. Resident #72 stated he if he needed something from staff he was yelling for help. He explained he used to have a "flat button" he could push if he needed help but stated he did not know where the "flat button" was. Another observation occurred with Resident #72 on 12-4-22 at 3:05pm. The observation revealed the resident's call light remained on the floor behind his bed. An interview with Nursing Assistant (NA) #1 occurred on 12-4-22 at 3:30pm. The NA explained she had been working with Resident #72 since 7:00am on 12-4-22. NA #1 said she checked for call light placement each morning when she started her shift and each time, she entered Resident #72's room. The NA stated she had not checked call light placement today (12-4-22) on any of her assigned residents because she "forgot". She discussed the capabilities of Resident #72 and stated he was able to use his call light to request assistance from staff. NA #1 verified Resident #72's call light was on the floor behind his bed and the resident would not have been able to reach the call light. The NA was observed to place the call light around Resident #72's side rail.	F 558	affected by the same deficient practice. The Director of Health Services and Nurse Managers reviewed call bell placement for all resident within the facility on 12//4/22. This identified all other call lights were in place however one was not functioning, and the maintenance director corrected immediately. "Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur. The Director of Nursing, Clinical Competency Coordinator and Nurse Managers educated all staff on proper placement of call bells (to be in the reach of the resident) on 12/21/22. Staff members not educated by 12/23/22 will be removed from the schedule until education is completed. The Call bell placement education has been placed in the general orientation for all newly hired employees. The Department Managers are rounding each morning to validate call bell placement is appropriate for all residents. Call Bells not in place during the rounds will be placed properly and the Administrator and/or Director of Health Services will be notified for follow up with employee assigned to the resident. The Nurses will validate call bell placed each shift for 7 days, then daily for 7 days, then weekly for 4 weeks then biweekly	

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F 558	Continued From page 2 During an interview with Nurse #1 on 12-4-22 at 3:35pm, the nurse explained she "sometimes" checked for call light placement in resident rooms when she entered their room but stated she had not checked any of her assigned residents today (12-4-22) for call light placement. Nurse #1 discussed it was the NAs' responsibility to ensure each resident had their call light in place. She stated Resident #72 was able to use his call light to obtain assistance from staff and was unaware the resident did not have his call light available. Nurse #1 said she guessed Resident #72 would have had to yell if he had needed assistance. The Director of Nursing (DON) was interviewed on 12-5-22 at 9:00am. The DON discussed call light placement being every staff members' responsibility. She stated Resident #72 was able to use his call light to obtain assistance from staff and had not been aware the resident did not have his call light available on 12-4-22. The DON said she expected every staff member who entered a resident room to ensure the resident had access to their call light. The Administrator was interviewed on 12-8-22 at 9:50am. The Administrator discussed daily rounds by the department heads and that they were supposed to be checking for call light placement during their rounds. She said she did not know what had happened and it was not common practice for a resident not to have their call light available. The Administrator stated she expected all residents to always have their call light available. 2. Resident #12 was admitted to the facility on 3-18-22.	F 558	thereafter until continues compliance is maintained. "Indicate 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 Call bell review to the Administrator at the Quality Assurance and Performance Improvement committee monthly for review and revision as needed. "Include dates when corrective action will be completed. Compliance date January 3rd, 2022	

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F 558	Continued From page 3	F 558		

The quarterly Minimum Data Set (MDS) dated 9-19-22 revealed Resident #12 was severely cognitively impaired.

Resident #12 was observed and interviewed on 12-4-22 at 11:35am. The resident was observed sitting up in bed and her call light was on the floor behind her bed and privacy curtain. Resident #12 stated she did not know where her call light was, but she would use it if she had it. The resident said she received help from staff by "using my mouth and yelling."

Another observation of Resident #12 was made on 12-4-22 at 3:15pm. The resident's call light remained in the same position behind her bed and privacy curtain.

An interview with Nursing Assistant (NA) #1 occurred on 12-4-22 at 3:30pm. The NA explained she had been working with Resident #12 since 7:00am on 12-4-22. NA #1 said she checked for call light placement each morning when she started her shift and each time, she entered Resident #12's room. The NA stated she had not checked call light placement today (12-4-22) on any of her assigned residents because she "forgot". She discussed the capabilities of Resident #12 and stated she was able to use her call light to request assistance from staff. NA #1 verified Resident #12's call light was on the floor behind her bed and privacy curtain. She also verified the resident would not have been able to reach the call light. The NA was observed to place the call light over the head of the bed down to Resident #12's right hand.

During an interview with Nurse #1 on 12-4-22 at 3:35pm, the nurse explained she "sometimes"

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F 558	Continued From page 4 checked for call light placement in resident rooms when she entered their room but stated she had not checked any of her assigned residents today (12-4-22) for call light placement. Nurse #1 discussed it was the NAs' responsibility to ensure each resident had their call light in place. She stated Resident #12 was able to use her call light to obtain assistance from staff and was unaware the resident did not have her call light available. Nurse #1 said she guessed Resident #12 would have had to yell if she had needed assistance. The Director of Nursing (DON) was interviewed on 12-5-22 at 9:00am. The DON discussed call light placement being every staff members' responsibility. She stated Resident #12 was able to use her call light to obtain assistance from staff and had not been aware the resident did not have her call light available on 12-4-22. The DON said she expected every staff member who entered a resident room to ensure the resident had access to their call light. The Administrator was interviewed on 12-8-22 at 9:50am. The Administrator discussed daily rounds by the department heads and that they were supposed to be checking for call light placement during their rounds. She said she did not know what had happened and it was not common practice for a resident not to have their call light available. The Administrator stated she expected all residents to always have their call light available.	F 558		
F 584 SS=B	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean,	F 584		1/3/23

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F 584	Continued From page 5	F 584		

comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.

The facility must provide-
§483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible.
(i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk.
(ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft.

§483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior;

§483.10(i)(3) Clean bed and bath linens that are in good condition;

§483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv);

§483.10(i)(5) Adequate and comfortable lighting levels in all areas;

§483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and

§483.10(i)(7) For the maintenance of comfortable sound levels.
This REQUIREMENT is not met as evidenced by:

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F 584	Continued From page 6 Based on observation and staff interviews the facility failed to maintain a clean-living environment for 2 of 2 halls (2nd floor) reviewed for environment. Findings included: Observation of the facility's second floor revealed the following. a. Room 222 was observed on 12-4-22 at 10:30am. The observation revealed the resident's side rail had a brown and green substance on the rail and the wall heating/air unit vent had black, brown and white substances in the vent. A second observation was made on 12-8-22 at 8:10am with the Maintenance Director and the Environmental Manager. The second observation revealed resident's side rail had a brown and green substance on the rail and the wall heating/air unit vent had black, brown and white substances in the vent. The Maintenance Director was interviewed on 12-8-22 at 8:27am. The Maintenance Director explained he usually had been cleaning the wall heat/air unit vents every 60 days but said he had been occupied with other issues and had not been able to clean the vents in all the rooms. The Environmental Manager was interviewed on 12-8-22 at 8:32am. The Environmental Manager explained the housekeeper was responsible to ensure the residents' side rails were clean and free of debris. She stated most of her staff were new and she was in the process of continuing their training.	F 584	"Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice. Room 222 side rails and wall heater/air unit vent was cleaned on by the Housekeeper and Director of Environmental Services validated completion of cleaning on 12/8/22. Room 226 call bell cord, side rail and bathroom ceiling vent were cleaned by the housekeeper and maintenance person on 12/8/22 and validated for cleanliness on 12/8/22 by the Director of Environmental Services and the Director of Maintenance. Room 227 call light cord and side rail was cleaned by the housekeeper on 12/8/22 and the Director of Housekeeping validated the cleanliness on 12/8/22. "Address how the facility will identify other residents having the potential to be affected by the same deficient practice. The Environmental Service Director completed rounds of all rooms on 12/21/22 to determine areas within the rooms that required a deeper cleaning that had been completed by the housekeepers. The Environmental Service Director identified 12 rooms that were affected and provide services to ensure resident room is safe, clean and comfortable. The Maintenance Director completed rounds of the air vents and air conditioning/heater units for cleanliness 12/21/22, 12 rooms identified as a need for deeper cleaning.	

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F 584	Continued From page 7 b. An initial tour of room 226 occurred on 12-4-22 at 10:40am. The initial tour revealed the resident's call light cord, and his side rail had a caked on sticky brown substance and the resident's bathroom ceiling vent contained dust. During a second observation on 12-8-22 at 8:13am with the Maintenance Director and the Environmental Manager, the observation revealed the resident's call light cord, and his side rail had a caked on sticky brown substance and the resident's bathroom ceiling vent contained dust. The Environmental Manager was interviewed on 12-8-22 at 8:32am. The Environmental Manager explained the housekeeper was responsible to ensure the residents' side rails and call light cords were clean and free of debris. She stated she made daily rounds and was aware of the issues with the cleanliness of the resident rooms. The Environmental Manager stated she had been trying to establish a routine with her staff. c. Room 227 was observed on 12-4-22 at 10:45am. The observation revealed a brown substance on the resident's call light cord and his side rail. A second observation was completed on 12-8-22 at 8:15am with the Maintenance Director and the Environmental Manager. The second observation revealed a brown substance on the resident's call light cord and his side rail. The Environmental Manager was interviewed on 12-8-22 at 8:32am. The Environmental Manager explained the housekeeper was responsible to ensure the residents' side rails and call light cords	F 584	"Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur. The Maintenance Director educated and instructed the maintenance assistant on proper cleaning of air vents and air conditioning/heater units within the resident□s room□s on 12/21/22. The education regarding cleaning of air vents and air conditioning/heater units within the resident□s rooms has been added to the general orientation of newly hired Maintenance personnel. The Housekeeping Director educated the housekeeping staff on proper cleaning of residents□ room to include call bell cords and side rails on 12/21/22 date. Housekeeping staff not educated by 12/23/22 will be removed from the schedule until the education has been completed. The education regarding proper cleaning of residents rooms has been added to the general orientation for all newly hired housekeepers. The Maintenance Director will conduct random observations of 10 rooms per day for 5 days, then 10 rooms per week for 4 weeks, then 10 rooms per month to validate that the air vents and air conditioning/heater units within the residents□ rooms are clean. The Housekeeping Director will conduct random audits of 10 rooms per day for 7	

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F 584	Continued From page 8 were clean and free of debris. The Administrator was interviewed on 12-8-22 at 9:50am. The Administrator discussed having a new Environmental Manager and the improvements/changes the Environmental Manager had made since her arrival. She stated she expected residents to have a clean-living environment.	F 584	days, then 10 rooms per week for 4 weeks, then 10 rooms per month to validate the cleanliness of the resident rooms to include the ide rails and call bell cords. "Indicate how the facility plans to monitor its performance to make sure that solutions are sustained; and The Maintenance Director will present the analysis of the air vents and air conditioning/heater units within the residents room□s to the Administrator monthly at the Quality Assurance and Performance Improvement Committee meeting for review and revision as needed. The Housekeeping Director will present the analysis of the resident room cleanliness to include call bell cords and side rails to the Administrator monthly at the Quality Assurance and Performance Improvement Committee meeting for review and revision as needed "Include dates when corrective action will be completed. 1/3/2023	
F 638 SS=D	Qrtly Assessment at Least Every 3 Months CFR(s): 483.20(c) §483.20(c) Quarterly Review Assessment A facility must assess a resident using the quarterly review instrument specified by the State and approved by CMS not less frequently than once every 3 months.	F 638		1/3/23

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F 638	Continued From page 9 This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to complete a quarterly Minimum Data Set (MDS) assessment within the required time frame for 1 of 3 residents reviewed for resident assessments (Resident #63). Findings included: Resident #63 was admitted to the facility on 5/14/21. Record review revealed Resident #63's last comprehensive minimum data set assessment was dated 5/20/22 and last quarterly Minimum Data Set (MDS) assessment was dated 7/22/22. 90 days from that date was 10/20/22. During an interview on 12/5/22 at 1:21 PM the MDS Coordinator stated Resident #63's quarterly minimum data set assessments slipped through the cracks and was not completed on or prior to 10/20/22. During an interview on 12/5/22 at 1:39 PM the Administrator stated Minimum Data Set assessments should be completed timely.	F 638	"Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice-Resident number 63 was completed on 12/6/2022. "Address 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 by the alleged deficient practice. The Case Mix Coordinator / Director conducted a 100% review of all current residents to ensure a quarterly assessment was completed per RAI guidelines. This audit was completed on12/5/2022 and did not identify any other late quarterly assessments. "Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur. The Regional Clinical Reimbursement Consultant (CRC) and/or Senior Nurse Consultant in-serviced the Interdisciplinary Team (IDT) on timely completion of all Minimum Data Set (MDS)assessments according to the Resident Assessment Instrument (RAI) guidelines on 12/22/22. This Education will be provided in new hire orientation for any new Licensed Nurse Assessment Coordinator hired regarding he timely completion of all	

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F 638	Continued From page 10	F 638	Minimum Data Set (MDS) assessments per Center for Medicare and Medicaid Services (CMS)guidelines during general orientation The Case Mix Coordinator will review the Minimum Data Set (MDS)Section Status report in Matrix Care (Assessment due report) daily x 5 days, then weekly x 4 weeks, to assure all assessments are completed and signed within the timeframe. "Indicate 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 Minimum Data Set (MDS)Section Status daily in Matrix Care (the electronic medical record) review to the Administrator monthly at the Quality Assurance and Performance Improvement Committee for review and revision as needed. "Include dates when corrective action will be completed. 1/3/2023	
F 641 SS=E	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	F 641		1/3/23

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F 641	Continued From page 11	F 641		

by:
Based on record review and staff interviews, the facility failed to accurately code the Minimum Data Set (MDS) for Preadmission Screening and Resident Review (Residents #5, #44 and #45) oxygen use (Resident #83) and vision (Resident #2) for 6 of 30 resident records reviewed for MDS accuracy.

Findings included:

1. Resident #5 was admitted to the facility on 11/05/20 with diagnoses that included paranoid schizophrenia.

Resident #5's Preadmission Screening and Resident Review (PASRR) Level II determination letter dated 10/26/22 revealed he had a Level II determination with no expiration date.

The annual Minimum Data Set dated 11/15/22 revealed Resident #5 was coded as no in the Level II PASRR determination section.

An interview on 12/05/22 at 3:10 PM with the MDS Coordinator confirmed she was responsible for coding the PASRR section of the MDS. She confirmed that Resident #5 should have been coded as a Level II PASRR on the MDS and had not done so. She stated she had simply missed it.

An interview on 12/06/22 at 10:43 AM with the Administrator confirmed that MDS Coordinator was responsible for ensuring that the MDS was coded accurately, and she did not know why it had not been done.

2. Resident #44 was admitted to the facility on 6/17/22 with diagnoses that included

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

The Minimum data Set (MDS) modification competed for Residents # 5, # 44, # 45, # 83, # 76 and # 2 on 12/22/2022

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

The Case Mix Director/ Director of Health Services and/or Nurse Managers completed 100% review of MDS for all PASRR_s, residents on oxygen and visual impairment for all active residents to ensure the MDS was coded correctly. The audit identified no residents with inaccurate coding and no resident MDS□s modified to ensure accuracy.

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

The Senior Nurse Consult educated the Interdisciplinary Team (Activities, Social Work, Certified Dietary Manager, Director of Health Services and Administrator) on 12/22/22 regarding accuracy in coding and the (MDS) minimum data set. The education regarding accuracy of the MDS has been added to the general orientation for all newly hired Activity Directors, Social

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F 641	Continued From page 12 schizophrenia. Resident 44's Preadmission Screening and Resident Review (PASRR) Level II determination letter dated 6/16/22 revealed he had a Level II determination with an expiration date of 7/16/22. The admission Minimum Data Set dated 6/23/22 was coded as no in the Level II PASRR determination section. An interview on 12/05/22 at 3:10 PM with the MDS Coordinator confirmed she was responsible for coding the PASRR section of the MDS. She confirmed that Resident #44 should have been coded as a Level II PASRR on the MDS and had not done so. She stated she had simply missed it. An interview on 12/06/22 at 10:43 AM with the Administrator confirmed that MDS Coordinator was responsible for ensuring that the MDS was coded accurately, and she did not know why it had not been done. 3. Resident #45 was admitted to the facility on 6/22/22 with diagnoses that included paranoid schizophrenia. Resident #45's Preadmission Screening and Resident Review (PASRR) Level II determination letter was not available for review but based on the applicant lookup information in the North Carolina Medicaid Uniform Screening Program PASRR history detail, starting on 8/23/22 he was given a Level II determination with an expiration date of 11/21/22. The admission Minimum Data Set dated 6/29/22 was coded as no in the Level II PASRR	F 641	Workers, Certified Dietary Manager, Director of Health Services and Administrator. The Interdisciplinary Team (Social Work, Activities, Case Mix Director, Nurse Managers) will review the electronic medical record during the Assessment Reference date of the current residents to ensure accuracy of the MDS. The newly admitted / readmitted residents will be reviewed at the the facility mornings meeting the next business day to review their PASRR criteria, oxygen usage and visual impairments and coding on MDS. . This will occur daily for 7 days, then weekly for 3 weeks and monthly thereafter. "Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The Case Mix Director will present their analysis of the accuracy of assessment to the Administrator at the monthly Quality Assurance and Performance Improvement Committee for review and revision as needed. "Include dates when corrective action will be completed. January 3, 2023	

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F 641	Continued From page 13	F 641		

determination section.

An interview on 12/05/22 at 3:10 PM with the MDS Coordinator confirmed she was responsible for coding the PASRR section of the MDS. She confirmed that Resident #45 should have been coded as a Level II PASRR on the MDS and had not done so. She stated she had simply missed it.

An interview on 12/06/22 at 10:43 AM with the Administrator confirmed that MDS Coordinator was responsible for ensuring that the MDS was coded accurately, and she did not know why it had not been done.

4. Resident #83 was admitted to the facility on 10/27/22 with diagnoses that included chronic obstructive pulmonary disease and acute and chronic respiratory failure.

Review of physician's orders revealed an order dated 10/29/22 for oxygen at 2 liters per minute via nasal cannula continuous.

The admission Minimum Data Set dated 11/03/22 was not checked as receiving oxygen therapy while a resident section.

Review of physician's orders revealed an order dated 10/29/22 for oxygen at 2 liters per minute via nasal cannula continuous.

An interview on 12/05/22 at 3:10 PM with the MDS Coordinator confirmed she was responsible for coding the oxygen section of the MDS. She confirmed that Resident #83 should have been coded as using oxygen on the MDS. She stated she had simply missed it.

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F 641	Continued From page 14	F 641		

An interview on 12/06/22 at 10:43 AM with the Administrator confirmed that MDS Coordinator was responsible for ensuring that the MDS was coded accurately, and she did not know why it had not been done.

5. Resident #76 was admitted to the facility on 2/1/21. Her active diagnoses included cerebral infarction due to embolism of left middle cerebral artery and diabetes mellitus.

Resident #76's minimum data set assessment dated 10/20/22 revealed she was assessed to have received insulin injections 7 days of the 7 day lookback period.

Resident #76's medication administration record for 10/13/22 through 10/20/22 revealed Resident #76 did not receive any insulin injections.

During an interview on 12/5/22 at 1:28 the MDS Coordinator stated Resident #76 did not receive insulin during the lookback period of the minimum data set assessment dated 10/20/22 and it was marked in error.

During an interview on 12/5/22 at 1:39 PM the Administrator stated the minimum data set assessments should accurately reflect the resident's use of insulin.

6) Resident #2 was admitted to the facility on 5/07/20. Her diagnoses included degenerative myopia bilaterally, macular degeneration and corneal scar and opacity.

A review of the quarterly Minimum Data Set (MDS) assessment dated 10/21/22 revealed Resident #2 was coded as having adequate vision. She was coded as severely cognitively impaired (BIMS score of 04).

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F 641	Continued From page 15 Resident #2 care plan most recently revised on 11/06/22 by the MDS Coordinator revealed a problem of visual function noting she has side vision problems (decreased peripheral vision) related to degenerative myopia bilateral. On 12/5/22 at 11:43 AM Resident #2 was observed turning pages in a book which was on her over the bed table. The book was noted to be upside down. Resident #2 was not aware the book was upside down. On 12/7/22 at 2:30 PM Nurse #4 said there were times during medication pass when Resident #2 would attempt to reach for the cup of water she was offering but would not reach in the correct direction and would reach toward the nurse's voice instead of toward the cup. During an interview on 12/08/22 at 9:11 AM, the MDS Coordinator said she conducted the vision assessment for Resident #2. She said she asked her questions about items in the room such as the sink, the clock on the wall or the dresser. She said she was unsure if Resident #2 used glasses but had noted she had adequate vision. The MDS Coordinator explained she asked other MDS nurses how they completed the assessments and did not consult the RAI (Resident Assessment Instrument -manual with MDS instructions). The MDS Coordinator explained she may need to do more or different testing and should have asked her about seeing fine details.	F 641		
F 644 SS=D	Coordination of PASARR and Assessments CFR(s): 483.20(e)(1)(2) §483.20(e) Coordination.	F 644		1/3/23

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F 644	Continued From page 16 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 staff interviews, the facility failed to request a Preadmission Screening and Resident Review (PASRR) before the expiration date for 2 of 3 residents with a Level II PASRR (Residents #44 and #45). Findings included: 1. Resident #44 was admitted to the facility on 6/17/22 with diagnoses that included schizophrenia. Review of a PASRR Level II Determination Notification letter dated 6/16/22 noted Resident #44 was evaluated and assigned a time-limited Level II PASRR with an expiration date of 7/16/22. Further review revealed in part, a placement determination of nursing facility placement is appropriate for limited nursing	F 644	"Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice. Resident # 44 PASRR (preadmission screening and resident review) was completed on 12/7/22. Resident # 45 PASRR was completed on 12/8/2022. "Address how the facility will identify other residents having the potential to be affected by the same deficient practice. The Social Worker is completing 100% review of all residents PASRR within the facility by 12/23/22. This audit identified no additional residents without a PASRR.	

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F 644	Continued From page 17 facility stay lasting no more than 30 calendar days. It continued to read if the resident is expected to extend beyond the end date, further approval and screening must be obtained through N. C. Medicaid Uniform Screening Program. The admitting facility is responsible for initiating further screening through a Level II evaluation process within 5 calendar days of the PASRR expiration date. An interview on 12/06/22 at 8:37 AM with the Social Worker (SW) confirmed she was responsible for initiating and coordinating Level II PASRR reviews. The SW stated she had not known Resident #44's PASRR expired and had not initiated a follow up. She stated she had not initiated further PASRR screening through the evaluation process. An interview on 12/06/22 at 10:43 AM with the Administrator confirmed that SW was responsible for keeping track of PASRRs and requesting screening when needed before the expiration date. She did not know why it had not been done. 2. Resident #45 was admitted to the facility on 6/22/22 with diagnoses that included paranoid schizophrenia. Review of the N. C. Medicaid Uniform Screening Program PASRR detail history revealed Resident #45 had a PASRR Level II Determination with start date of 8/23/22 and an expiration date of 11/21/22. An interview on 12/06/22 at 8:37 AM with the Social Worker (SW) confirmed she was responsible for initiating and coordinating Level II PASRR reviews. The SW stated she had not	F 644	"Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur. The Social Worker was educated by the facility Administrator on 12/22/22 of the requirements of the PASRR regulation CFR 483.20 (e)(1)(2). This education has been added to the general orientation of all newly hired social workers, The Social Worker begin pulling the PASRR letters on all new admissions upon admission to the facility to validate the PASRR and expiration dates on 12-9-22. This will remain a continuous process for all new admissions. "Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The Social Worker will present the analysis of the PASRR on new admissions audit to the facility Administrator at the monthly Quality Assurance and Performance Improvement Committee for revision and review. "Include dates when corrective action will be completed. 1/3/2023	

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F 644	Continued From page 18 known Resident #45's PASRR expired and had not initiated a follow up evaluation until 12/01/22. An interview on 12/06/22 at 10:43 AM with the Administrator confirmed that SW was responsible for keeping track of PASRRs and requesting screening when needed before the expiration date. She did not know why it had not been done.	F 644		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §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		1/3/23

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F 656	Continued From page 19 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. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to develop and implement an individualized person-centered care plan for 2 of 5 residents (Resident #72 and Resident #34) who were routinely receiving an antidepressant and an antipsychotic medication reviewed for unnecessary medications. Findings included: 1. Resident #72 was admitted to the facility on 12-21-20 with multiple diagnoses that included dementia and schizoaffective disorder. The quarterly Minimum Data Set (MDS) dated 11-19-22 revealed Resident #72 was severely cognitively impaired and received antipsychotic medication 7 out of 7 days and an antidepressant 7 out of 7 days.	F 656	"Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice. Resident # 72 care plan was updated to include antidepressant and antipsychotic medications. Resident # 34 care plan was updated to include antipsychotic medications. "Address how the facility will identify other residents having the potential to be affected by the same deficient practice. The Case Mix Director and Nurse Managers reviewed all residents receiving Antidepressants and antipsychotic medications to validate the residents care plan has been developed and initiated.	

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F 656	Continued From page 20 Resident #72's care plan dated 9-12-22 revealed no goals or interventions related to Resident #72's antidepressant or antipsychotic medications. The MDS Coordinator was interviewed on 12-6-22 at 2:19pm. The MDS Coordinator explained she would typically develop a care plan for an antidepressant medication and a separate care plan for the use of an antipsychotic medication. After reviewing Resident #72's care plan and medications the MDS Coordinator stated she had made an oversite on not having a care plan for Resident #72's antidepressant and antipsychotic medication use. The Director of Nursing (DON) was interviewed on 12-6-22 at 2:49pm. The DON stated she thought there had been something wrong with the facility's computer system not saving goals and interventions to Resident #72's care plan as the reason he was not care planned for his antidepressant and antipsychotic medications. She explained she did not know if the facility had contacted their corporate office to have the computer system issues investigated. The DON also said she expected each resident's care plan to reflect the resident's needs and any high-risk medications. 2. Resident #34 was admitted to the facility on 6-29-15 with multiple diagnoses that included Tourette's disorder. The quarterly Minimum Data Set (MDS) dated 11-4-22 revealed Resident #34 was severely cognitively impaired and received an antipsychotic medication 7 out of 7 days.	F 656	100% of residents reviewed with none requiring development and implementation. "Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur. "The Senior Nurse Consultant provided education regarding development and implementation of person center care plans and ensuring that the goals and interventions include antidepressant and antipsychotic medication, to the Interdisciplinary Team including the social worker, Director of Health Services and Case Mix Director nurses on 12/22/22.This education has been added to the general orientation of newly hired Social Workers, Director of Health Services and Case Mix Directors. "The Case Mix Director and/or Nurse Managers will complete Weekly audits on resident admitted, readmitted or if current residents have a change in their antidepressant and/or antipsychotic drug regime, to validate development and/or implementation of care plan, weekly for four weeks then monthly thereafter. "Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The Case Mix Director will present the findings of the development /	

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F 656	Continued From page 21 Resident #34's care plan dated 12-4-22 revealed no goals or interventions related to his antipsychotic medications. The MDS Coordinator was interviewed on 12-6-22 at 2:19pm. The MDS Coordinator stated when she developed a care plan for antipsychotic medications, she typically would not include interventions other than for the resident to receive the smallest dose possible. After reviewing Resident #34's care plan and medications, the MDS Coordinator stated she had overlooked the resident receiving an antipsychotic medication, so she had not developed any goals or interventions. The Director of Nursing (DON) was interviewed on 12-6-22 at 2:49pm. The DON stated she thought there had been something wrong with the facility's computer system not saving goals and interventions to Resident #34's care plan as the reason he was not care planned for his antipsychotic medications. The DON also said she expected each resident's care plan to reflect the resident's needs and any high-risk medications. The Administrator was interviewed on 12-8-22 at 9:50am. The Administrator stated she had been aware of the issues with the resident care plans and explained it was the MDS Coordinator's responsibility to assure care plans were up to date and accurate. She explained the facility had hired an assistant for the MDS Coordinator. She also said she expected care plans to be accurate and individualized.	F 656	implementation of care plan review to the Administrator monthly at the Quality Assurance and Performance Committee meeting for review and revision as needed "Include dates when corrective action will be completed. January 3, 2022	
F 657 SS=E	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii)	F 657		1/3/23

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F 657	Continued From page 22 §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to hold a quarterly care plan meeting and failed to update the care plan for 2 of 2 residents reviewed for care planning (Resident #84 and Resident #37). Findings included: 1. Resident #84 was admitted to the facility on 3/30/21.	F 657	""Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice. Resident # 84 Care plan meeting was completed on 12/13/2022. Resident # 37 care plan was reviewed on 12/22/22. "Address how the facility will identify other	

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F 657	Continued From page 23 Resident #84's Minimum Data Set (MDS) assessment dated 11/14/22 revealed she was cognitively intact and had no behaviors. A review of Resident #84's chart revealed Resident #84's last care plan meeting was on 5/31/22. During an interview on 12/4/22 at 11:01 AM Resident #84 stated she had not attended a care plan meeting since the end of spring or early summer. During an interview on 12/6/22 at 12:04 PM the MDS Coordinator stated the Social Worker sent out an invitation a week before care plan meeting to invite residents and families. Care plan meetings were to be done every 90 days. She concluded the Social Worker might have more information on if Resident #84 had a care plan meeting since 5/31/22. During an interview on 12/7/22 at 11:31 AM the Social Worker stated the last care plan meeting for Resident #84 was 5/31/22 and Resident #84's next care plan meeting was set for 12/13/22. She concluded she should have had one prior to 12/13/22 but the Social Worker was behind on care plan meetings. During an interview on 12/7/22 at 11:37 AM the Administrator stated care plan meetings should be held quarterly. 2. Resident #37 was admitted to the facility on 11-1-19 with multiple diagnoses that included dementia and unsteadiness on feet. Resident #37's active care plan dated 10-29-22	F 657	residents having the potential to be affected by the same deficient practice. As of 12/8/22, the Minimum Data Set(MDS) nurses reviewed all residents for documentation of a comprehensive care plan meeting with the resident and/or Responsible Party (RP). Of the remaining 99 residents all care plans were reviewed timely and up to date. The Minimum Data Set (MDS) nurses and/or the Social Worker (SW) have completed and mailed care plan meeting letters to all residents and/or Responsible Party (RP) notifying them of scheduled care plan meeting date and time and/or care plans already scheduled. If the facility has not heard from the resident and/or Responsible Party (RP), the Minimum Data Set (MDS) nurses and/or the Social Worker (SW) will follow up with a phone call to schedule a care plan meeting. The Interdisciplinary Team is to review each care plan during the care plan meeting with the resident and/or Responsible Party(RP). "Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur. The Case Mix Coordinator will schedule the comprehensive care plan meeting for resident as assigned quarterly ,annually and with a significant change and distribute the care plan letter invitation to the resident and/or Responsible Party(RP). The Case Mix Coordinator will discuss the assigned care plans daily	

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F 657	Continued From page 24 revealed a problem of the resident having a history of falling due to muscle weakness. The goal documented was Resident #37 would remain free from injury. The interventions were for Resident #37 to wear non-skid socks during the night while in bed and remind the resident to wear both shoes when ambulating. A second goal was added on 12-5-22 for the resident to meet therapy goals. The interventions for the goal were to monitor Resident #37's progress and response to therapy. Review of Resident #37's "event report" dated 11-7-22 revealed Resident #37 had a fall in the facility's dining room while trying to ambulate. The fall was documented as unwitnessed, and Resident #37 complained of mild pain to his left hip. The "event report" documented staff assisted resident back into his wheelchair. The quarterly Minimum Data Set (MDS) dated 11-23-22 revealed Resident #37 was severely cognitively impaired. The MDS also documented the resident needed a wheelchair for ambulation and was documented as having falls, one with a major injury. Nurse #2 was interviewed on 12-7-22 at 12:37pm. Nurse #2 stated she was familiar and usually was assigned to Resident #37. She explained she had not seen any updated interventions on Resident #37's care plan since his fall on 11-7-22 but stated typically the interventions for a resident who falls was for their call bell to be in reach, make sure the resident wears non-skid socks, keep their bed in a low position and increase frequency of rounds. Nurse #2 stated since Resident #37's fall he had not been out of bed, but she had made sure his bed	F 657	during the Interdisciplinary Team (IDT)meeting. The Interdisciplinary Team (IDT)will review each care plan during the care plan meeting with the resident and/or the Responsible Party (RP).The Social Worker (SW) and/or Case Mix Director will review and document via a log all scheduled care plan meetings weekly x 4 weeks and then monthly x 3 months ensuring care plans are conducted quarterly, annually and with a significant change with the resident and/or Responsible Party (RP). In-servicing was conducted on 12/22/2022 with the Interdisciplinary Team (IDT) by the Regional Clinical Reimbursement Consultant (CRC) and/or Senior Nurse Consultant on the care plan meeting process, review and revision of care plans, to include mailing care plan invitation letters quarterly, annually and with a significant change and including the resident and/or Responsible Party (RP)participation of the comprehensive care plan. The education regarding the Care Plan meeting process has been added to the general orientation of newly hired Interdisciplinary team members. In-servicing was conducted on 12/29/2022 and 12/30/2022 by the Director of Health Services and/or Nurse Manager for all Licensed Nurses on updating and reviewing care plan related to when a resident falls after they occur. Any Licensed Nurse not educated by 12/31/2022 will be removed from the schedule until education has been	

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F 657	Continued From page 25 was in a low position and his call light was within reach. The Director of Nursing (DON) was interviewed on 12-7-22 at 1:03pm. The DON explained the management team met every morning and discussed any falls that had taken place the previous day. She said the discussion included making any fall intervention revisions or updates to the resident's care plan. The DON reviewed Resident #37's care plan and stated the only update was made on 12-5-22 for therapy. She further stated Resident #37 should have had revisions or an update made for fall prevention. During an interview with the MDS Coordinator on 12-7-22 at 1:08pm, the MDS Coordinator explained the nurses were responsible for updating the care plan after a resident fall. She further explained she tried to review the care plan during morning meetings to ensure the care plan had been updated but she had not reviewed Resident #37's care plan and was not aware the care plan had not been updated from his fall on 11-7-22. The Administrator was interviewed on 12-8-22 at 9:50am. The Administrator stated she had been aware of the care plan issues and that Resident #37's care plan had not been updated to reflect his fall on 11-7-22. She further stated she expected care plans to be completed timely, be accurate and individualized.	F 657	completed. The education regarding updating and reviewing the care plan after a resident fall has been added to the general orientation for all Licensed Nurses. The Director of Health Care Services and/or Nurse Managers will review all resident who have fallen care plan in the morning meeting Monday through Friday to validate the care plan has been reviewed and/or revised weekly for 2 weeks, then monthly for 3 months then quarterly thereafter. "Indicate how the facility plans to monitor its performance to make sure that solutions are sustained; The Social Worker will present the analysis of the Results of the Care Plan meeting process log will be presented to the Administrator at the Quality Assurance Performance Improvement (QAPI) Committee monthly for review and revision until 3 months of sustained compliance is maintained then quarterly thereafter. The Director of Health Services will present the analysis of the Care plan update and review for residents who have fallen to the Administrator at the Quality Assurance Performance Improvement (QAPI) Committee monthly for review and revision until 3 months of sustained compliance is maintained then quarterly thereafter.	

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F 657	Continued From page 26	F 657	"Include dates when corrective action will be completed. January 3, 2023	
F 791 SS=G	Routine/Emergency Dental Srvcs in NFs CFR(s): 483.55(b)(1)-(5) §483.55 Dental Services The facility must assist residents in obtaining routine and 24-hour emergency dental care. §483.55(b) Nursing Facilities. The facility- §483.55(b)(1) Must provide or obtain from an outside resource, in accordance with §483.70(g) of this part, the following dental services to meet the needs of each resident: (i) Routine dental services (to the extent covered under the State plan); and (ii) Emergency dental services; §483.55(b)(2) Must, if necessary or if requested, assist the resident- (i) In making appointments; and (ii) By arranging for transportation to and from the dental services locations; §483.55(b)(3) Must promptly, within 3 days, refer residents with lost or damaged dentures for dental services. If a referral does not occur within 3 days, the facility must provide documentation of what they did to ensure the resident could still eat and drink adequately while awaiting dental services and the extenuating circumstances that led to the delay; §483.55(b)(4) Must have a policy identifying those	F 791		1/3/23

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F 791	Continued From page 27 circumstances when the loss or damage of dentures is the facility's responsibility and may not charge a resident for the loss or damage of dentures determined in accordance with facility policy to be the facility's responsibility; and §483.55(b)(5) Must assist residents who are eligible and wish to participate to apply for reimbursement of dental services as an incurred medical expense under the State plan. This REQUIREMENT is not met as evidenced by: Based on record review, resident and staff interviews the facility failed to obtain a follow up dental care appointment with a dentist for 1 of 3 residents (Resident #13) reviewed for dental. Resident #13 had complaints of teeth and gum pain from as documented in the care plan from 9/20/22 and to have a follow up with a dentist for a complete exam and x-rays after 10/17/22 dental visit. Findings included: Resident #13 was admitted to the facility on 3-12-20 with multiple diagnoses that included multiple sclerosis and acute kidney failure. The quarterly Minimum Data Set (MDS) dated 9-14-22 revealed Resident #13 was cognitively intact and was documented for a mechanically altered diet. There was no documentation for gum or teeth issues. Resident #13's care plan dated 9-20-22 revealed the resident had discomfort or difficulty chewing related to poor dental status and required a puree consistency diet. The goal for Resident #13 was she would not exhibit signs of malnutrition or	F 791	"Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice. "The facility obtained a dental appointment scheduled on 1/3/22 for Resident # 13. "Address how the facility will identify other residents having the potential to be affected by the same deficient practice. All residents have the opportunity to be affected, The Scheduler reviewed all appointments for the past 6 months to ensure follow up appointments had been scheduled appropriately. No other issues where identified. "Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur. On 12/22/2022 the Director of Nursing Services, Clinical Competency	

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F 791	Continued From page 28 dehydration. The interventions for the goal were to avoid foods that were difficult to chew, inspect mouth for oral abscesses, broken, loose or missing teeth. Review of Resident #13's dental visit dated 10-17-22 at the dental school revealed the resident had a cleaning with instructions for the facility to make an appointment for Resident #13 to have a complete exam, x-rays and follow up with the dentist. Resident #13 was observed and interviewed on 12-5-22 at 8:10am. The resident stated she was not doing well and explained her gums and teeth were hurting. She stated she had gone to the dentist "a couple months ago" and was supposed to have a follow up but said no one had let her know when she was going back. Resident #13 stated she thought she may have an infection in her gums because they hurt. Upon observing Resident #13's teeth and gums, there were no signs of an infection such as swelling, discoloration or drainage. During an interview with the Appointment Scheduler on 12-5-22 at 4:12pm, the Appointment Scheduler explained when a resident went out for an appointment, a form was sent with them for the Physician to write any orders or follow up appointments. She stated when the resident returned from the appointment, the form was given to the nurse who transcribed any orders then gave her the form to make any follow up appointments. The Appointment Scheduler stated she had never received a form from Resident #13's dental appointment on 10-17-22 so she did not know the resident required a follow up appointment and she did not	F 791	Coordinator and/or Nurse Managers began educating the Nurses and scheduler/transportation driver on providing the paperwork from the residents appointment to the nurse on duty, the nurse on duty placed the order in medical record and notifies the scheduler of the appointment to arrange the appointment and transportation. When the resident returned from the appointment, if there is no paperwork, the Nurse will call the provider the resident returned from for instruction and any follow up appointment. Any Nurse, Transportation driver and scheduler not educated by 1/2/2023 will be educated prior to their next scheduled shift. The education on completing appointment / follow up appointment has been added to the general orientation of newly hired Nurses, Transportation drivers and Schedulers. The Director of Nursing Services and/or Nurse Managers will review the completed appointments to validate if return appointments have been scheduled weekly for 4 weeks, then monthly thereafter. "Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The Director of Nursing will present the findings of the return appointment process to the Administrator at the Quality Assurance and Performance Committee meeting monthly for review and revisions as needed.	

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F 791	Continued From page 29 make Resident #13 a follow up appointment. Nurse #3 was interviewed on 12-5-22 at 4:25pm. The nurse explained when a resident returned from an outside appointment, the nurse would be provided the form the resident took with them with any orders or follow up appointments. She stated the nurse would enter any orders into the computer system and write any follow up appointments needed in the appointment book for the Appointment Scheduler. Nurse #3 stated she was not aware of any needed dental follow up for Resident #13. Review of the appointment book revealed no documentation of a needed dental follow up for Resident #13. An interview with Nursing Assistant (NA) #4 occurred on 12-6-22 at 8:40am. The NA stated she had not seen any swelling or drainage from Resident #13's gums but said the resident complained of pain and tenderness when brushing her teeth. NA #4 stated she had informed the nurse (Nurse #4) assigned to Resident #13. During an interview with Nurse #4 on 12-6-22 at 8:44am, the nurse stated Resident #13 often complained of pain to her gums. She stated the Physician had ordered Resident #13 a medicated gel to help relieve her pain and said she had provided the medicated gel to Resident #13. The Administrator was interviewed on 12-8-22 at 9:50am. The Administrator stated when a resident goes out for a dental appointment, the dental office would call to schedule a follow up appointment. She stated after Resident #13	F 791	"Include dates when corrective action will be completed. January 3, 2023	

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F 791	Continued From page 30 returned from her dental appointment on 10-17-22, the dental office did not call for a follow up. The Administrator stated on 12-6-22 Resident #13 had been made a follow up appointment with the Dentist.	F 791		
F 835 SS=E	Administration CFR(s): 483.70 §483.70 Administration. A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility administration failed to provide oversight and leadership to ensure the facility maintained the walk-in freezer in proper working condition to prevent structural damage of the freezer door and the accumulation of ice in the freezer for 8 months. The findings included: This tag is cross referenced to: F 908: Based on observations and interviews with facility staff the facility failed to maintain the walk-in freezer in proper working condition when the exterior door malfunctioned and created the accumulation of ice and ice crystals inside the walk-in freezer for the last eight months for 1 of 1 walk-in freezer. On 12/06/22 at 4:30 PM the Administrator provided a copy of the email verification dated	F 835	"Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice. No resident was identified in this practice. "Address how the facility will identify other residents having the potential to be affected by the same deficient practice. The Administrator submitted a capital expenditure request in November to replace the freezer door. On 12/21/22 the update on the capital expenditure stated it would be 30 to 45 days as the freezer door needed to be specialty made. The facility acquired a Freezer truck on December 22, 2022, to store the freezer items in until the freezer door can be replaced	1/3/23

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F 835	Continued From page 31 12/06/22 from the Maintenance Director via the computerized maintenance log system of the approved authorization for repair of the walk-in freezer door separating at the bottom. She was unable to state why it had taken 8 months to receive the authorization to repair the walk-in freezer door.	F 835	"Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur. On 12/22/2022 the Administrator, Maintenance Director, and Certified Dietary Manager were educated by the Senior Nurse Consultant on identification and timely replacement or alternative equipment provisions for the freezer. The education regarding identification and timely replacement of equipment has been added to the general orientation for newly hired Administrator, maintenance directors and certified dietary managers. The Certified Dietary manager will inspect the freezer door and/or alternate freezer device daily for 5 days, then weekly for 4 weeks then monthly for ice build-up and proper seals. "Indicate how the facility plans to monitor its performance to make sure that solutions are sustained; and The Certified Dietary Manager will present the analysis of the freezer door and/or alternate freezer device to the Administrator monthly at the Quality Assurance and Performance Improvement Committee for review and revision as needed. "Include dates when corrective action will be completed. January 3, 2023	

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F 867 SS=E	QAPI/QAA Improvement Activities CFR(s): 483.75(c)(d)(e)(g)(2)(i)(ii) §483.75(c) Program feedback, data systems and monitoring. A facility must establish and implement written policies and procedures for feedback, data collections systems, and monitoring, including adverse event monitoring. The policies and procedures must include, at a minimum, the following: §483.75(c)(1) Facility maintenance of effective systems to obtain and use of feedback and input from direct care staff, other staff, residents, and resident representatives, including how such information will be used to identify problems that are high risk, high volume, or problem-prone, and opportunities for improvement. §483.75(c)(2) Facility maintenance of effective systems to identify, collect, and use data and information from all departments, including but not limited to the facility assessment required at §483.70(e) and including how such information will be used to develop and monitor performance indicators. §483.75(c)(3) Facility development, monitoring, and evaluation of performance indicators, including the methodology and frequency for such development, monitoring, and evaluation. §483.75(c)(4) Facility adverse event monitoring, including the methods by which the facility will systematically identify, report, track, investigate, analyze and use data and information relating to adverse events in the facility, including how the facility will use the data to develop activities to prevent adverse events.	F 867		1/3/23

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F 867	Continued From page 33	F 867		

§483.75(d) Program systematic analysis and systemic action.

§483.75(d)(1) The facility must take actions aimed at performance improvement and, after implementing those actions, measure its success, and track performance to ensure that improvements are realized and sustained.

§483.75(d)(2) The facility will develop and implement policies addressing:
(i) How they will use a systematic approach to determine underlying causes of problems impacting larger systems;
(ii) How they will develop corrective actions that will be designed to effect change at the systems level to prevent quality of care, quality of life, or safety problems; and
(iii) How the facility will monitor the effectiveness of its performance improvement activities to ensure that improvements are sustained.

§483.75(e) Program activities.

§483.75(e)(1) The facility must set priorities for its performance improvement activities that focus on high-risk, high-volume, or problem-prone areas; consider the incidence, prevalence, and severity of problems in those areas; and affect health outcomes, resident safety, resident autonomy, resident choice, and quality of care.

§483.75(e)(2) Performance improvement activities must track medical errors and adverse resident events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the

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F 867	Continued From page 34 facility. §483.75(e)(3) As part of their performance improvement activities, the facility must conduct distinct performance improvement projects. The number and frequency of improvement projects conducted by the facility must reflect the scope and complexity of the facility's services and available resources, as reflected in the facility assessment required at §483.70(e). Improvement projects must include at least annually a project that focuses on high risk or problem-prone areas identified through the data collection and analysis described in paragraphs (c) and (d) of this section. §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (iii) Regularly review and analyze data, including data collected under the QAPI program and data resulting from drug regimen reviews, and act on available data to make improvements. This REQUIREMENT is not met as evidenced by: Based on record review, and staff interviews the facility's Quality Assessment and Assurance (QAA) Committee failed to maintain implemented procedures and monitor the interventions that the committee put into place following the 11/3/21	F 867	Corrective Action for those Residents found to have been affected No residents were identified in the 2567. The Administrator will review and	

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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 867	Continued From page 35 recertification/complaint survey. This was for 3 deficiencies cited on the current recertification/complaint survey of 12/8/22: 3 deficiencies were cited on the 11/3/21 recertification/complaint survey in the areas of F641 Accuracy of Assessments, F644 Pre-Admission Screening Resident Review (PASSR) and F656 Develop/Implement Comprehensive Care plan. The continued failure of the facility during 2 federal surveys of record shows a pattern of the facility's inability to sustain an effective QAA Findings included: This tag is cross referenced to: F 641 Based on record review and staff interviews, the facility failed to accurately code the Minimum Data Set (MDS) for Preadmission Screening and Resident Review (Residents #5, #44 and #45) oxygen use (Resident #83) and vision (Resident #2) for 6 of 30 resident records reviewed for MDS accuracy. During the 11/3/21 recertification/complaint survey the facility was cited for failing to accurately code the MDS. F 644 Based on record review and staff interviews, the facility failed to request a Preadmission Screening and Resident Review (PASRR) before the expiration date for 2 of 3 residents with a Level II PASRR (Residents #44 and #45). During the 11/13/21 recertification/complaint survey the facility was cited for failing to provide follow-up psychiatric services in accordance with	F 867	complete the electronic education in RELIAS training Quality Assurance / Performance Improvement developing and sustaining a quality culture by 12/27/2022. How the facility will identify other residents having the potential to be affected: All residents have the potential to be affected by this practice. Systemic changes made to ensure that deficient practice will not recur: The Administrator and Director of Health Services initiated reeducation on 12/23/22 on the QAPI process for all staff on the QAA/QAPI Committee with emphasis on identifying areas that may lead to deficiency practice. Education to be completed by 12/28/2022. Administrator will lead Quality Assurance and Performance Improvement meetings with emphasis and focus on ensuring that any areas of non-compliance are addressed to prevent further deficient practices related to accurate completion of the Accuracy of Assessments, Prescreening resident review (PASSAR), and develop/implement comprehensive care plan. Monitoring of performance to make sure that solutions are sustained. Administrator will lead Quality Assurance and Performance Improvement meetings with emphasis and focus on areas that	

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F 867	Continued From page 36 the recommendations and failing to incorporate the recommendations into the comprehensive plan of care. F 656 Based on record review and staff interviews the facility failed to develop and implement an individualized person-centered care plan for 2 of 5 residents (Resident #72 and Resident #34) who were routinely receiving an antidepressant and an antipsychotic medication reviewed for unnecessary medications. During the 11/13/21 recertification/complain survey the facility was cited for failure to develop comprehensive individualized plans of care. In an interview on 12/8/22 at 11:56 AM the Administrator indicated she felt the continued inaccuracy of assessments was due to the fact the facility had only 1 person completing these. She stated she planned to have an additional person assist now. She went on to say she felt the repeat failures in the areas of PASSR and comprehensive care plans were due to inconsistencies in the way they were being completed. The Administrator stated the facility would review its process and put corrective actions in place to address these issues.	F 867	have led to repeated citations and/or deficiencies. This will ensure that the facility has identified areas of non-compliance and are addressed to prevent further deficient practices related to Accuracy of Assessments, Prescreening resident review (PASSAR), and develop/implement comprehensive care plan. At least one member of the regional team that includes the senior nurse consultant, clinical reimbursement consultant, or area vice president will attend QAPI meetings monthly for three months, and then quarterly for three quarters to ensure that any areas leading to deficiency practice identified during clinical and compliance rounds are acted upon by the facility according to QAPI process. The administrator will report to the QAPI committee any areas of non-compliance x3 months and then quarterly x3 quarters for recommendations as needed. Dates when the corrective action will be completed. January 3, 2023	
F 908 SS=E	Essential Equipment, Safe Operating Condition CFR(s): 483.90(d)(2) §483.90(d)(2) Maintain all mechanical, electrical, and patient care equipment in safe operating condition. This REQUIREMENT is not met as evidenced by: Based on observations and interviews with	F 908	"Address how corrective action will be	1/3/23

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F 908	Continued From page 37 facility staff the facility failed to maintain the walk-in freezer in proper working condition when the exterior door malfunctioned and created the accumulation of ice and ice crystals inside the walk-in freezer for the last eight months for 1 of 1 walk-in freezer. The findings included: On 12/04/22 at 10:30 AM the Certified Dietary Manager (CDM) removed a 3-foot-long metal pole which was positioned under the door latch to keep the door to the walk-in freezer closed tightly. Upon entrance to the walk-in freezer an accumulation of ice crystals was observed along the left interior of the freezer. There was also an accumulation of solid ice observed on the left side of the freezer along the outside of the boxes and shelves. There was broken ice on the freezer floor. During the observation on 12/04/22 at 10:30 AM the CDM said she worked on Sundays to remove the ice build up inside the freezer so she could complete the inventory check in preparation for placing the food order on Mondays. She said she used a mallet style hammer to break the ice and then she swept it up for disposal. Upon exiting the walk-in freezer on 12/04/22 at 10:35 AM an observation of the freezer door revealed the metal covering of the door was separated away from the interior structure of the door along the interior lower right side (when facing the door from the interior of the freezer) of the door. Facing the door from the exterior of the freezer revealed both the left and right sides of the lower portions of the door were separated revealing the interior structure of the door.	F 908	accomplished for those residents found to have been affected by the deficient practice. No resident was identified in this practice. "Address how the facility will identify other residents having the potential to be affected by the same deficient practice. The Administrator submitted a capital expenditure request in November to replace the freezer door. On 12/21/22 the update on the capital expenditure stated it would be 30 to 45 days as the freezer door needed to be specialty made. The facility acquired a Freezer truck on 12-22-2022, to store the freezer items in until the freezer door can be replaced. "Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur. On 12/22/2022 the Administrator, Maintenance Director, and Certified Dietary Manager were educated by the Senior Nurse Consultant on identification and timely replacement or alternative equipment provisions for the freezer. The education regarding identification and timely replacement of equipment has been added to the general orientation for newly hired Administrator, maintenance directors and certified dietary managers. The Certified Dietary manager will inspect the freezer door and/or alternate freezer	

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F 908	Continued From page 38 On 12/06/22 at 11:34 AM the Administrator reported she was aware of the need to have the walk-in freezer door replaced and the proposal was completed on 11/03/22 but had not followed up on proposal. She said a new thermostat was installed on 11/17/22. The Administrator said she was able to approve facility expenditures but any expenditure over $500.00 required approval from the regional vice president. She said she would request approval for replacement of the walk-in freezer door. On 12/08/22 at 9:30 AM the CDM said she had used a mallet to remove the ice for the last 8 months. She said she had requested to have the walk-in freezer and walk-in cooler problems corrected by completing a proposal for replacement a few months back but had not received any information back.	F 908	device daily for 5 days, then weekly for 4 weeks then monthly for ice build-up and proper seals. "Indicate how the facility plans to monitor its performance to make sure that solutions are sustained; and The Certified Dietary Manager will present the analysis of the freezer door and/or alternate freezer device to the Administrator monthly at the Quality Assurance and Performance Improvement Committee for review and revision as needed. "Include dates when corrective action will be completed. January 3, 2023	