STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345357	A. BUILDING _____ B. WING _____	C 05/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEALTH-NEUSE	1303 HEALTH 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 000	INITIAL COMMENTS The survey team entered the facility on 04/24/2025 to conduct a complaint survey and exited on 04/25/2025. Additional information was obtained on 05/05/2025. Therefore, the exit date was changed to 05/05/2025. Event ID#LRI211. The following intake was investigated NC00229545. 1 of 1 complaint allegation resulted in deficiency.	F 000		
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 record review and staff interviews, the facility failed to accurately code the Minimum Data Set (MDS) assessment in the areas of smoking for 1 of 3 residents reviewed for MDS accuracy. Findings included: Resident #1 was admitted to the facility on 01/29/2019 with diagnoses including bipolar with manic delusions. The annual Minimum Data Set (MDS) dated 01/07/2025 had Resident #1 coded as cognitively intact and did not use tobacco. The care plan dated 01/21/2025 had focus of Resident #1 not needing supervision with smoking and will propel self out of facility to smoking area.	F 641	Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice. Resident #1 Minimum Data Set Assessment (MDS) dated 1/7/2025 was modified by the Case Mix Director (CMD) on 4/25/25 to identify tobacco usage. Address how the facility will identify other residents having the potential to be affected by the same deficient practice. All residents with tobacco usage have the potential to be affected. On 5/16/2025 the Case Mix Director and Administrator reviewed all residents last comprehensive assessment to ensure accurate coding of J1300. Address what measures will be put into	6/1/25

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

Electronically Signed | 05/19/2025

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.

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F 641	Continued From page 1 A review of the observation detail list dated 01/21/2025 revealed Resident #1 was observed to be a safe individual smoker that reviewed and understood the smoking policy. An interview with the Case Mix Coordinator was conducted on 04/25/2025 at 9:40 AM. She stated another nurse from the corporate office completed the MDS assessment for Resident #1 when she was out of work. Resident #1 does smoke, and it should have been coded yes for tobacco use. It must have been an oversite. An interview with Director of Nursing (DON) was conducted on 04/25/2025 at 11:47 AM. She stated Resident #1 was a smoker and it should have been coded as her being a tobacco user. The DON also stated they will have someone else review assessments before transmission. An interview with the Administrator was conducted on 04/25/2025 at 12:07 PM. The Administrator stated Resident #1 was a smoker. She also stated that she expected the MDS nurses to code the assessments correctly.	F 641	place or systemic changes made to ensure that the deficient practice will not recur. On 5/14/2025 the Clinical Reimbursement Coordinator RN (CRC) educated the Case Mix Director (CMD) and the MDS Case-Mix Coordinator (CMC) on proper coding of Section J1300 tobacco usage. This education will be added to all newly hired MDS nurses during general orientation. The MDS Case-Mix Nurses will review each other□s MDS section J1300 tobacco usage weekly for accuracy of coding. This review of J1300 will continue 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 MDS review to the 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. Administrator is responsible for POC Date of Compliance: 6/1/2025	
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents.	F 689		6/1/25

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F 689	Continued From page 2 The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to ensure Resident #1 did not smoke inside of the facility in accordance with their smoking policy for 1 of 3 residents sampled for accidents. On 4/13/2025 the resident was observed by staff in the lobby area of the facility lighting and beginning to smoke a cigarette. There were no residents with oxygen in the lobby area and Resident #1 was escorted outside by Nurse #2. The findings included: Resident #1 was admitted to the facility on 1/29/2019 with diagnosis including bipolar with manic delusions. A review of the smoking policy revised 12/12/2024 indicated that no one should be allowed to smoke inside any area of the healthcare center at any time. The care plan dated 1/21/2025 included a focus of Resident #1 not needing supervision with smoking and indicated she could self-propel out of facility to the smoking area. The interventions included that Resident #1 was able to keep her smoking materials in her room in a lock box. The annual Minimum Data Set (MDS)	F 689	Corrective action for the residents found to be affected by the deficient practice. On 4/13/25 the resident affected by the deficient practice was removed from the facility and transported to the emergency room for psychiatric evaluation, then placed on 1-1 when she returned. Prior to the residents return all smoking paraphernalia was removed from the residents room and placed in a secure area on 4/13/25. Corrective action for other residents having the potential to be affected by the same deficient practice. All residents have the potential to be affected. On 4/29/25 the Director of Health Services conducted an audit on all residents who smoke to determine if any smoking paraphernalia was present in their rooms. On 4/29/25 all the residents that smoke were educated on the smoking policy and that going forward all smoking paraphernalia would be kept in a secure area. All smoking paraphernalia was collected from the residents that smoke with their approval and placed in a secure area on 4/29/25 with a sign in/out book.	

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F 689	Continued From page 3 assessment dated 2/02/2025 indicated Resident #1 was cognitively intact and had no behaviors or rejection of care. She was able to transfer herself independently and wheeled self independently in her manual wheelchair. The resident received antipsychotic, antidepressant and antianxiety medication. A review of the observation detail list completed by Nurse #1 dated 1/21/2025 revealed Resident #1 was observed to be a safe smoker who reviewed and understood the smoking policy. An interview with Nurse #1 was conducted on 4/24/2025 at 3:37 PM. The Nurse stated Resident #1 was observed to be a safe and independent smoker on 1/21/2025. Nurse #1 also stated Resident #1 read, understood, and agreed to the smoking policy. A telephone interview with Receptionist was conducted on 4/25/2025 at 9:36 AM. The Receptionist stated she worked evenings and weekends. On Sunday 04/13/2025 she observed Resident #1 light and smoke a cigarette in front of the lobby door. The Resident was not near any other residents with oxygen at the time and Resident #1 was asked by Nurse #2 to go outside and smoke because there was no smoking in the facility. Resident #1 stated that this was her home, and she could smoke where she wanted. Nurse #2 helped escort Resident #1 outside to finish smoking. Nurse #2 asked for Resident #1's smoking materials when she came back in the facility and the resident became combative with the nurse and the police were called. The Receptionist also stated that was the first time she ever witnessed the resident smoking in the building. The Receptionist further stated she had	F 689	Systemic changes made to ensure that the deficient practice will not recur. On 5/12/2025 the Administrator, Director of Health Services, and Clinical Competency Coordinator began education with all staff regarding resident smoking procedures. This includes securing all resident smoking paraphernalia in a secure lock box with resident permission and housing the key with a staff member at all times. Receptionists will house the lock box and assist residents with signing out/in during their shifts, then sign the lock box over to a staff member when the receptionist leaves at the end of the day. The staff member will hold the lock box and keys and sign residents out/in and assist residents with signing out/in during the evening/night shifts. The staff member will then sign the lock box back over to the receptionists when they return the next day. All staff will educated on this procedure by 5/26/2025. Any staff member not educated by 5/26/2025 will be educated prior to their next shift or removed from the schedule until the education is completed. This education has been added to the general new hire orientation and will be completed by the Clinical Competency Coordinator. The Director of Health Services and/or Nurse Managers will monitor this process every shift for one week, then weekly for four weeks, then monthly thereafter. The Admissions Director was educated on 5/12/2025 regarding reviewing the smoking procedures with all new admissions and any smoking	

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F 689	Continued From page 4	F 689		

always observed Resident #1 carry her own cigarettes and lighter.

An interview with Nurse #2 was conducted on 4/25/2025 at 1:10 PM. The Nurse stated she was familiar with Resident #1. She verified she witnessed Resident #1 smoking in the lobby on 4/13/2025, she told Resident #1 she could not smoke in the building, and she helped the resident go outside. She indicated there were no other residents around the lobby area with oxygen tanks. When Resident #1 came back in the facility after smoking, she (Nurse #2) asked for her lighter and cigarettes. Resident #1 refused to give them to her and the resident hit the nurse in the chest area when she was bent over looking for Resident #1's smoking materials. The police were called, and they could not get the materials from the Resident. Resident #1 was sent to the Emergency Room for evaluation due to escalating behaviors and was returned back to the facility and was put on one to one (1:1) supervision. Nurse #2 also stated prior to this 04/13/2025 incident, she had never seen Resident #1 smoke in the building.

Resident #1 was out of the facility during the survey and could not be interviewed or observed.

An interview with the Director of Nursing (DON) was conducted on 4/25/2025 at 1:49 PM. The DON stated residents were not allowed to smoke in the facility at any time. The current smoking policy was to have the residents give their smoking materials to the nurse, but residents who were grandfathered in from the old administration were allowed to keep their smoking materials in a lock box in their rooms. Those residents were care planned and assessed for safe smoking.

paraphernalia, if applicable, will be removed from the resident at the time of admission and placed in the secure lock box upon permission being granted by the resident.

Plans to monitor its Performance to make sure that the solutions are sustained. The Director of Health Services will present the audit for smoking to the Quality Assurance and Performance Improvement Committee monthly until three months of sustained compliance is maintained then Quarterly thereafter. Administrator is responsible for POC.

Date of compliance: 6/1/2025

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F 689	Continued From page 5	F 689		

She indicated that prior to this 04/13/2025 incident, Resident #1 had been allowed to retain her own smoking materials in her lockbox. The DON stated since this incident those privileges were rescinded for all residents who had been grandfathered in to prevent this from happening again.

An interview with the Administrator was conducted on 4/25/2025 at 2:09 PM. The Administrator stated the Receptionist called her on 4/13/2025 and reported that Resident #1 was smoking in the lobby. She told them to call 911, try to get the lighter, and to get her out of the facility. There were no reports of residents in the lobby with oxygen. Nurse #2 was able to get Resident #1 out of the facility to smoke. The Administrator also stated there were no reports of Resident #1 smoking in the facility before 4/13/2025 but since she broke the smoking policy, she would not be able to keep her own smoking materials.

The facility provided a corrective action plan that was not acceptable by the state agency. When addressing how corrective action will be accomplished for other residents found to have been affected by the deficient practice not all smokers were included. Also, the plan did not include who was responsible for the monitoring/audits, specific information regardng what or who they were monitoring, and the frequency and duration of monitoring and audits. Audits and monitoring must be specific to the deficient practice to determine if education and system changes put into place are effective.