CENTER	S FOR MEDICARE &	MEDICAID SERVICES					D. 0938-0391
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			DNSTRUCTION		E SURVEY PLETED
		345357	B. WING			04	/28/2016
-	ROVIDER OR SUPPLIER			1303	EET ADDRESS, CITY, STATE, ZIP CODE 3 HEALTH DRIVE W BERN, NC 28560		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 156 SS=B	RIGHTS, RULES, SE The facility must infor and in writing in a lan- understands of his or regulations governing responsibilities during facility must also prov notice (if any) of the S §1919(e)(6) of the Ac made prior to or upon resident's stay. Rece any amendments to it writing. The facility must infor entitled to Medicaid b of admission to the nu- resident becomes elig- items and services the facility services under which the resident ma other items and service inform each resident of the items and service (i)(A) and (B) of this s The facility must infor at the time of admissi the resident's stay, of facility and of charges under Medicare or by The facility must furni legal rights which incl	m the resident both orally guage that the resident her rights and all rules and resident conduct and the stay in the facility. The ide the resident with the State developed under t. Such notification must be admission and during the ipt of such information, and t, must be acknowledged in m each resident who is enefits, in writing, at the time ursing facility or, when the gible for Medicaid of the at are included in nursing the State plan and for ay not be charged; those ces that the facility offers dent may be charged, and s for those services; and when changes are made to s specified in paragraphs (5) ection. m each resident before, or on, and periodically during services available in the s for those services, a for services not covered the facility's per diem rate.	F	156			5/24/16
LABORATORY	DIRECTOR'S OR PROVIDER/S	SUPPLIER REPRESENTATIVE'S SIGNATURE			TITLE		(X6) DATE

Electronically Signed

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.

DEPARTMENT OF HEALTH AND HUMAN SERVICES.

05/11/2016

PRINTED: 05/16/2016 FORM APPROVED

	-	D HUMAN SERVICES MEDICAID SERVICES				FORM): 05/16/2016 APPROVED). 0938-0391
STATEMENT (OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING _	CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345357	B. WING		_	04/2	28/2016
NAME OF PI	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, S	TATE, ZIP CODE	-	
PRUITTHE	ALTH-NEUSE		1303 HEALTH DRIVE NEW BERN, NC 28560				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 156	funds, under paragraf A description of the re- for establishing eligibit the right to request an 1924(c) which determ non-exempt resource- institutionalization and spouse an equitable sc cannot be considered toward the cost of the medical care in his or down to Medicaid elig A posting of names, a numbers of all pertine groups such as the Si agency, the State lice ombudsman program advocacy network, an unit; and a statement complaint with the Sta agency concerning re- misappropriation of re- facility, and non-comp directives requiremen The facility must infor name, specialty, and physician responsible The facility must prom- written information, ar applicants for admissi information about how Medicare and Medica	equirements and procedures lity for Medicaid, including assessment under section ines the extent of a couple's is at the time of d attributes to the community share of resources which available for payment institutionalized spouse's her process of spending ibility levels. Addresses, and telephone ent State client advocacy tate survey and certification nsure office, the State , the protection and d the Medicaid fraud control that the resident may file a ate survey and certification sident abuse, neglect, and esident property in the oliance with the advance ts. m each resident of the way of contacting the for his or her care.	F 156				

Facility ID: 923514

If continuation sheet Page 2 of 34

		D HUMAN SERVICES MEDICAID SERVICES				FORI	D: 05/16/2016 M APPROVED D. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345357	B. WING			04	/28/2016
NAME OF PI	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
PRUITTHE	ALTH-NEUSE				03 HEALTH DRIVE EW BERN, NC 28560		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 156	Continued From page	2	F 1	56			
	by: Based on interviews facility failed to notify responsible person by Medicare coverage w residents reviewed. (F #168). The findings included 1. Resident #17's Mea 3/1/16. Review of Res non-coverage letter d "Attempts were made and/or family member twice on 2/25/16 and no answer and no voi evidence that a certifin notifying Resident #11 was ending. During an interview of Business Office Mana mailed but the letters mail. During an interview of Minimum Data Set (M called three times and could not get in touch During an interview of	 certified letter that as ending for two of three Resident #17 and Resident dicare coverage ended on sident #17's Medicare ated 3/1/16, read in part, to contact the resident through telephone calls, once on 2/26/16. There was cemail." There was no ed letter was mailed 7 that medicare coverage h 4/28/2016 at 1:57 PM, the uger revealed letters were were not sent by certified h 4/28/2016 at 3:25 PM, the IDS) Coordinator stated she d she mailed a letter when with them. h 4/28/2016 at 3:29 PM, the 			What Corrective action will be accomplished for the residents found thave been affected by the deficient practice? F156- Resident # 17 & 168 were mailed certified copy of the Medicare notice of non-coverage on 5/10/2016. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? All residents/responsible parties will be notified in writing of Medicare coverage ending, by presenting the document in person and requiring a signature or via certified mail by the Social Worker. What measures will be put in place or what systemic changes will be made to ensure that the deficient practice will ne reoccur? The MDS coordinator, Financial Counselor and Social Worker have be in-serviced on 4/28/2016 by the Administrator as to the correct proceded How will the corrective action be monitored to assure that the deficient practice will not reoccur, i.e., what qua assurance program will be put in place	ed a f he e a o o ot en ure.	

Event ID: 41Q111

Facility ID: 923514

If continuation sheet Page 3 of 34

	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION		E SURVEY IPLETED
		345357	B. WING		04/28/2016	
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
	ALTH-NEUSE			1303 HEALTH DRIVE		
PRUITING	ALIH-NEUSE			NEW BERN, NC 28560		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION (CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 156	Continued From pag	e 3	F 15	6		
				monitoring to assure continued	I	
		ledicare coverage ended on Resident #168's Medicare		compliance.		
		dated 3/17/16, read in part,		The list of residents that have I	been issued	
		e to contact the responsible		letters of non-coverage will be		
		nd a message was left to call I6 at 11:00 AM Resident		and brought to the monthly QA be monitored for continued cor		
	-	ospital. Resident #168 was		be monitored for continued cor	npliance.	
	out of the facility grea	ater than twenty four hours				
		e-evaluate. On 3/14/16,				
		evaluations, Resident #168 d therapy services and				
		pick up the resident." There				
		t a certified letter was mailed				
	notifying Resident #1 was ending.	68 that medicare coverage				
		on 4/28/2016 at 1:57 PM, the ager revealed letters were				
		s were not sent by certified				
		on 4/28/2016 at 3:25 PM, the MDS) Coordinator stated she				
		she mailed a letter when				
	she could not get in t					
	During an interview of	on 4/28/2016 at 3:29 PM, the				
	Administrator revealed	ed he did not know that the				
	letter had to be maile					
F 281 SS=D	483.20(k)(3)(i) SERV PROFESSIONAL ST	/ICES PROVIDED MEET ANDARDS	F 28			5/24/16
		d or arranged by the facility nal standards of quality.				
	This REQUIREMEN	T is not mat as suidenand				

Facility ID: 923514

If continuation sheet Page 4 of 34

PRINTED: 05/16/2016 FORM APPROVED

		MEDICAID SERVICES		LE CONSTRUCTION	OMB NO. 0938-039 (X3) DATE SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	· ,		COMPLETED
		345357	B. WING		04/28/2016
IAME OF PR	OVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
RUITTHE	ALTH-NEUSE			1303 HEALTH DRIVE NEW BERN, NC 28560	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE COMPLETIO
F 281	Continued From page	e 4	F 28	1	
	by: Based on observatio and staff interviews, t a physician 's order f Medication Administra April 2016 MAR for 1 weight loss (Resident reviewed receiving in #68) and failed to cor resulting in a resident medication for 1 of 1 wrong medication (Re follow physician 's or prevent further contra reviewed for range of findings included: 1. Resident #170 was 1/11/16 and had a dia COPD (Chronic Obstr and Anorexia. The Care Area Asses revealed the resident following hospitalizati COPD and was oxyge revealed the resident with eating. Review of the physici order dated 3/1/16 for twice a day. The resident 's Care Supplement as ordered Review of the March Administration Record supplement was give Review of the April 20 for Standard 2.0, 120	ns, record review, resident the facility failed to carry over from the March 2016 ation Record (MAR) to the of 3 residents reviewed for t #170) and 1 of 1 resident halation therapy (Resident rectly identify a resident t receiving the wrong resident who received the esident #55) and failed to ders to apply a splint to actures for 1 of 1 resident motion (Resident #18) The s admitted to the facility on agnosis of Pneumonia, ructive Pulmonary Disease) ssment (CAA) dated 1/15/16 was recently admitted on for pneumonia and en dependent. The CAA required set up help only an ' s orders revealed an r Standard 2.0, 120 milliliters Plan updated 3/1/16 read: " ed. " 2016 Medication d (MAR) revealed the		 What Corrective action will be accomplished for the residents four have been affected by the deficient practice? Resident #170 on 4/27/2016 the supplement was immediately place on the April Medication Administrat Record (MAR) and was given. Resident #55 the physician was immediately notified as well as the on 1/11/16. The resident was mon throughout the shift for any side eff related to receiving the wrong med and none were noted. Resident #18 on 4/28/16 she had h splint applied immediately upon dis that the splint was not on, and three nails were trimmed. Resident # 68 was discharged from facility, the nystatin order could not restarted because the resident was discharged, however, per MD asse prior to discharge physician noted for ashes were present on her body. How will you identify other resident having the potential to be affected for same deficient practice and what corrective action will be taken? The Director of Health Services and Nurse management performed a 10 	t ed back ion family itored rects ication her scovery e finger that no ss by the d

Facility ID: 923514

If continuation sheet Page 5 of 34

FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION COMPLETED A. BUILDING 345357 B. WING 04/28/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1303 HEALTH DRIVE **PRUITTHEALTH-NEUSE NEW BERN, NC 28560** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (X4) ID ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 281 Continued From page 5 F 281 (DON) stated in an interview that new orders were on current MAR. Any order were faxed to the pharmacy and they entered the discovered to be missing from the MAR new orders on the MAR for the following month. was placed on the MAR immediately. The DON stated when the upcoming month 's MARs were received from the pharmacy, 2 The Director of Health Services and nurses checked the MARs against the physician ' Nurse Management performed a 100% s orders for the past month. The DON stated the audit on 4/29/16 of residents with orders pharmacy did not put the order on the April 2016 for splints and range of motion to ensure MAR and the 2 nurses that checked the MAR orders were being carried out. Any missed the order. identified concerns were addressed with On 4/28/16 at 8:13 AM Resident #170 stated in the MD and/or a Rehab referral made. an interview he had several bouts of pneumonia and urinary tract infections since in the facility and The Director of Health Services and had lost weight. The Resident stated they were Nurse management performed a giving him a supplement but they had stopped it medication audit of all new admits from and stated: " I don ' t know what that ' s about. " 4/1/16 to present for order transcription On 4/28/16 at 10:42 AM the Unit Supervisor accuracy. The Director of Health Services stated in an interview she did the second check and Nurse management performed an on the April 2016 MAR for Resident #170. The audit of all new physician s orders for Supervisor stated she would have checked the transcription accuracy from 4/28/2016 new orders back to the first of March but forward. Any identified concerns were apparently did not see the order for the addressed with the MD. supplement. On 4/28/16 at 11:00 AM, Nurse #1 stated in an What measures will be put in place or interview that she checked the April 2016 MAR what systemic changes will be made to for Resident #170 against the new physician 's ensure that the deficient practice will not orders for March 2016. The Nurse stated she did reoccur? not see the order for the supplement. 2. Resident #55 was admitted to the facility on Education began on 4/29/16 by the 1/7/16 for rehabilitation after having a total right Clinical Competency Coordinator for shoulder replacement. The resident did not have Licensed nurses on order transcription a diagnosis of a thyroid disorder. including but not limited to supplements, The Admission Minimum Data Set (MDS) splints, and new admissions. Education Assessment dated 1/14/16 revealed the resident will be added to new hire orientation and was cognitively intact, had minimal hearing staff not completing the training will be difficulty and clear speech. The MDS revealed the educated prior to the start of the next resident was understood by others and scheduled shift. understood others. Review of a medication error report dated 1/11/16 Education began on 4/28/16 by the

FORM CMS-2567(02-99) Previous Versions Obsolete

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Facility ID: 923514

If continuation sheet Page 6 of 34

FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION COMPLETED A. BUILDING 345357 B. WING 04/28/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1303 HEALTH DRIVE **PRUITTHEALTH-NEUSE NEW BERN, NC 28560** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (X4) ID ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 281 Continued From page 6 F 281 at 6:30 AM revealed a nurse went in to give Clinical Competency Coordinator for Synthroid (thyroid medication) 100 micrograms to Licensed nurses on Medication a resident and called the resident 's name and administration including but not limited to the resident said yes and the nurse administered the 5 rights, medication errors, order the Synthroid. The report revealed the nurse transcription, medication reconciliation at realized she had given the medication to the the end of each month. Education will be wrong resident. added to new hire orientation and staff not A nurse 's note dated 1/11/16 at 7:30 AM completing the training will be educated revealed Resident #55 had received medication prior to the start of the next scheduled ordered for the resident 's roommate. The note shift. revealed the physician 's assistant and a family member was notified as well as the Assistant Education began on 4/28/16 by the Director of Nursing. Clinical Competency Coordinator for On 4/27/16 at 4:00 PM the Director of Nursing Licensed and non-licensed nursing staff stated in an interview she spoke with Nurse #2 on proper splinting and following all and went over resident identification during a physicians orders as well as making all medication pass with the nurse. The DON stated nursing staff aware that it is the the physician was notified and the physician told responsibility of the treatment nurse to her the medication would not hurt the resident. ensure that the splint is applied and On 4/27/16 at 6:10 PM Nurse #2 stated in an removed according to physicians orders. interview she went in the resident 's room around Education will be added to new hire 5:30 AM and saw only one name on the door and orientation and staff not completing the there was a resident in the first bed. The Nurse training will be educated prior to the start stated it was dark and the curtain was pulled of the next scheduled shift. between the 2 beds. The Nurse stated she ask the resident in the first bed if she was (name of Supplement orders will be monitored on 5 resident) and the resident said yes. The Nurse residents to include new and current stated she told the resident she had her synthroid orders each week for 6 weeks then 3 medication. The Nurse stated the resident looked residents each week for 4 weeks by the a little puzzled and she asked Resident #55 if she Director of Health Service/Unit Managers. took thyroid medication and the resident said yes. The Nurse stated the resident sat up and took the New admission orders and new medication. The Nurse stated she later realized physician s orders to include there was a resident in the second bed and asked transcription to the MAR, will be monitored that resident her name and realized she had Monday through Friday by the Unit given the Synthroid to the wrong resident. The Managers and week-ends by the Nurse stated she notified the physician, the Supervisor for 2 months. responsible party and the assistant director of nursing. The Nurse managers will monitor the

FORM CMS-2567(02-99) Previous Versions Obsolete

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Facility ID: 923514

If continuation sheet Page 7 of 34

			0/00 1/0			
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345357	B. WING		04/28/2016	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
PRUITTHI	EALTH-NEUSE			1303 HEALTH DRIVE NEW BERN, NC 28560		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETIO	
F 281	5/5/2011 with diagnost encephalopathy, han vascular accident, dia aphasia and Alzheime The most recent quar Set (MDS) dated 4/8/ had short and long te severely impaired dai She required extensive mobility, personal hyg with bathing. The ME was assessed as hav range of motion in the extremities on both si The resident 's care the resident had decr motion) related to cor lower extremities. The hand/wrist orthosis 12 for positioning and joi tolerate. The care pla reviewed on 4/21/16. Physician 's orders w	admitted to the facility on sees that included metabolic d joint contracture, cerebral abetes mellitus II, dysphagia, er 's dementia. terly review Minimum Data 16 indicated Resident #18 rm memory problems and ly decision making skills. ve assistance with bed giene and total assistance DS indicated resident #18 ring functional limitation in e upper and lower des of the body. plan dated 3/16/15 indicated eased ROM (range of ntractures to upper and e interventions included left 2 hours on and 12 hours off nt integrity as resident will n was documented as	F 28		eks plints nt juality ace for be y QA gs will	
	tolerate. The care pla reviewed on 4/21/16. Physician 's orders w an order dated 8/3/15 wear left hand/ wrist of hours on and 12 hour for positioning and joi A record review of the	n was documented as vere reviewed and revealed is that the resident was to porthosis (orthotic device) 12 rs off, (9AM on) (9 PM off) nt integrity. Medication Administration prough April 27, 2016 was				

If continuation sheet Page 8 of 34

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 05/16/2016 MAPPROVED D. 0938-0391
STATEMENT (OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		E CONSTRUCTION	(X3) DATE	
		345357	B. WING			04/	28/2016
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
PRUITTH	EALTH-NEUSE				1303 HEALTH DRIVE NEW BERN, NC 28560		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 281	documentation that the documented as applie 9 PM from April 1 thro On 4/26/16 at 1:09 PM observed lying in bed or rolled wash cloth o On 4/27/16 at 10:42 A resident # 18 was obs an orthosis device or hand. On 4/28/16 at 9:13 A observed lying in bed or rolled wash cloth o During an interview of Director of Nursing sta Resident #18 to wear On 4/28/16 at 9:41 AN assistant stated that r did not return to put th She indicated it was r responsible for putting On 4/28/16 at 9:46 AI that the resident was restorative caseload. assistants on the hall device on the residen On 4/28/16 at 9:34 AN restorative NA should 4. Resident #68 was a 3/10/16 with diagnose Disease (Stage III), A Dementia. Review of the Admiss (MDS) Assessment d	he orthosis device was ed at 9 AM and removed at ough April 27, 2016. M resident # 18 was without an orthosis device in her left hand. AM, 1:38 PM and 4:30 PM served lying in bed without rolled wash cloth on her left M resident # 18 was without an orthosis device in her left hand. n 4/28/16 at 9:36 AM the ated that she expected the orthosis device daily. M the resident ' s nursing morning she was busy and he device on the resident. Not clear who was g the device on the resident. M the restorative NA stated not no longer on the She indicated that nursing were educated to put the	F	281			

Facility ID: 923514

If continuation sheet Page 9 of 34

	-	D HUMAN SERVICES MEDICAID SERVICES				FORM): 05/16/2016 1 APPROVED 0. 0938-0391
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, <i>'</i>	PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345357	B. WING		_	04//	28/2016
NAME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, S	TATE, ZIP CODE		
PRUITTHE	ALTH-NEUSE			1303 HEALTH DRIVE NEW BERN, NC 28560			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 281	3/10/16 documented a ointment three times a breast area and Kena day. Review of the March 2 Administration Record ointment was applied Kenalog cream was a until it was changed to 3/24/16. Review of the Physici 3/23/16 documented 3 Intertrigo (a yeast infe folds) and the Nystati and the Kenalog crea PRN. Review of the April 20 Administration Record order for Nystatin oint Review of the Physici 4/6/16 documented R distress, had no skin no pruritus. Her skin rashes. During an interview w 04/25/2016 4:55PM h identify a few charts o errors and the facility staff on 4/28/16 and 4	ng Physician's orders dated an order for Nystatin a day to underneath the log cream three times a 2016 Medication d revealed the Nystatin three times per day and the upplied three times per day o PRN (as needed) on an's progress note dated a diagnosis of Candida ection that occurs in skin n ointment would continue m would be changed to 216 Medication d revealed there was no	F 2				
F 282 SS=D	had been started. 483.20(k)(3)(ii) SERV PERSONS/PER CAR		F 2	82			5/24/16

Facility ID: 923514

If continuation sheet Page 10 of 34

FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION COMPLETED A. BUILDING 345357 B. WING 04/28/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1303 HEALTH DRIVE **PRUITTHEALTH-NEUSE NEW BERN, NC 28560** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ID (X5) COMPLETION (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 282 Continued From page 10 F 282 The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff What Corrective action will be interviews the facility failed to follow the care plan accomplished for the residents found to for the application of a splint for one of one have been affected by the deficient residents (#18) reviewed for range of motion. practice? Resident #18 was admitted to the facility on 5/5/2011 with diagnosis that included metabolic F282- For resident #18 on 4/28/16 she encephalopathy, hand joint contracture, cerebral had her splint applied immediately upon vascular accident, diabetes mellitus II, dysphagia, discovery that the splint was not on, and aphasia and Alzheimer 's dementia. three finger nails were trimmed. The most recent guarterly review Minimum Data Set (MDS) dated 4/8/16 indicated Resident #18 How will you identify other residents having the potential to be affected by the had short and long term memory problems and severely impaired daily decision making skills. same deficient practice and what She required extensive assistance with bed corrective action will be taken? mobility, personal hygiene and total assistance with bathing. The MDS indicated resident #18 The Director of Health Services and was assessed as having functional limitation in Nurse Management performed a 100% audit on 4/29/16 of residents with orders range of motion in the upper and lower extremities on both sides of the body. for splints and range of motion to ensure The resident 's care plan dated 3/16/15 and last orders were being carried out. Any identified concerns were addressed with updated on 4/21/16 indicated the resident had decreased ROM (range of motion) related to the MD and/or a Rehab referral made. contractures to upper and lower extremities. The interventions included left hand/wrist orthosis 12 What measures will be put in place or hours on and 12 hours off for positioning and joint what systemic changes will be made to ensure that the deficient practice will not integrity as resident will tolerate. Physician 's orders were reviewed and revealed reoccur? an order dated 8/3/15 that the resident was to wear left hand/ wrist orthosis (orthotic device) 12 Education began on 4/29/16 by the hours on and 12 hours off, (9AM on) (9 PM off) Clinical Competency Coordinator for

FORM CMS-2567(02-99) Previous Versions Obsolete

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Facility ID: 923514

If continuation sheet Page 11 of 34

FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION COMPLETED A. BUILDING 345357 B. WING 04/28/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1303 HEALTH DRIVE **PRUITTHEALTH-NEUSE NEW BERN, NC 28560** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (X4) ID ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 282 Continued From page 11 F 282 for positioning and joint integrity. Licensed nurses on order transcription A record review of the Medication Administration including but not limited to supplements, Record for January through April 27, 2016 was splints, and new admissions. Education conducted. The April MAR showed will be added to new hire orientation and documentation that the orthosis device was staff not completing the training will be documented as applied at 9 AM and removed at educated prior to the start of the next 9 PM from April 1 through April 27, 2016. scheduled shift. On 4/26/16 at 1:09 PM resident #18 was observed lying in bed without an orthosis device Education began on 4/28/16 by the or rolled wash cloth on her left hand. Clinical Competency Coordinator for Licensed and non-licensed nursing staff During an interview with the restorative nursing assistant on 4/26/16 at 1:59 PM she stated that on proper splinting and following all resident #18 was no longer on the restorative physicians orders as well as making all case load. She stated that the NA 's on the hall nursing staff aware that it is the were responsible for putting splints on the responsibility of the treatment nurse to residents. ensure that the splint is applied and On 4/27/16 at 10:42 AM, 1:38 PM and 4:30 PM removed according to physicians orders. resident #18 was observed lying in bed without an Education will be added to new hire orthosis device or rolled wash cloth on her left orientation and staff not completing the hand. training will be educated prior to the start On 4/28/16 at 9:13 AM resident #18 was of the next scheduled shift. observed lving in bed without an orthosis device or rolled wash cloth on her left hand. The Nurse managers will monitor the During an interview on 4/28/16 at 9:34 AM Nurse residents with splints and ROM orders #6 stated that the restorative nursing assistant daily x 2 weeks then weekly x 4 weeks was responsible for putting the splint device on then monthly thereafter to ensure splints residents. and ROM are being completed as In an interview with the DON on 4/28/16 at 9:36 ordered. AM she stated that she expected resident #18 to have her orthosis device on. She stated that the How will the corrective action be restorative NA was responsible for putting the monitored to assure that the deficient device on the resident. practice will not reoccur, i.e., what quality During an interview on 4/28/16 at 9:41 AM assurance program will be put in place for nursing assistant #7 she stated that morning she monitoring to assure continued was busy and did not return to put the device on compliance. the resident. She indicated it was not clear who was responsible for putting the device on the The results from the monitoring will be resident. reviewed and brought to the monthly QA During an interview on 4/28/16 at 9:51 AM the meeting by the DHS, and the findings will

FORM CMS-2567(02-99) Previous Versions Obsolete

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Facility ID: 923514

If continuation sheet Page 12 of 34

					OMB NO. 0938-03
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		(X3) DATE SURVEY COMPLETED
		345357	B. WING		04/28/2016
NAME OF P	ROVIDER OR SUPPLIER		5	STREET ADDRESS, CITY, STATE, ZIP CODE	
PRUITTHE	EALTH-NEUSE			1303 HEALTH DRIVE NEW BERN, NC 28560	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE COMPLETIC
F 282	Therapy Manager sta released from restora department would be	ted that after a resident is tive case load the nursing notified and the nursing all would then be responsible	F 282	be discussed and continue moniton needed to continue compliance.	pring as
F 312 SS=D	483.25(a)(3) ADL CA DEPENDENT RESID A resident who is una daily living receives th	RE PROVIDED FOR	F 312		5/24/16
	by: Based on observation family interviews, the care for 1 of 5 depend Activities of Daily Livit to provide a shower for residents reviewed for (Resident #52). Ex.1 Resident #18 was add 5/5/2011 with diagnost encephalopathy, hand vascular accident, dia aphasia and Alzheime The most recent quar Set (MDS) dated 4/8/ had short and long te severely impaired dai She required extensiv	r Activities of Daily Living mitted to the facility on sis that included metabolic d joint contracture, cerebral abetes mellitus II, dysphagia,		 What Corrective action will be accomplished for the residents for have been affected by the deficier practice? F312- The nails of resident# 18 we immediately trimmed. Resident # received his shower on 4/28 on th shift. How will you identify other resider having the potential to be affected same deficient practice and what corrective action will be taken? A 100% audit of fingernails in the finals that were in need of trimming 4/28/2016. Residents identified we have a stransmission of the taken is that were in need of trimming 4/28/2016. 	nt ere 52 e 7-3 hts I by the facility Health any g on

Facility ID: 923514

If continuation sheet Page 13 of 34

FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY IDENTIFICATION NUMBER AND PLAN OF CORRECTION COMPLETED A. BUILDING 345357 B. WING 04/28/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1303 HEALTH DRIVE **PRUITTHEALTH-NEUSE NEW BERN, NC 28560** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (X4) ID ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 312 Continued From page 13 F 312 was assessed as having functional limitation in immediately. The shower schedule was range of motion in the upper and lower revised on 4/29/2016 to include make-up extremities on both sides of the body. times each day so if a resident misses a Review of the CNA Care Intervention Record shower then it can be made up on the Form dated 1/29/16 listed bathing as total care next shift, as the resident will allow. with showers, hair wash and trim fingernails/toenails with bath. What measures will be put in place or On 4/27/16 at 4:30 PM resident #18 was what systemic changes will be made to observed lying in bed. Three fingernails on her ensure that the deficient practice will not left hand were observed 1/4 inch long with broke reoccur? and jagged edges. On 4/28/16 at 9:36 AM resident #18 was All resident s fingernails will be observed lying in bed. Three fingernails on her monitored weekly by the unit managers left hand were observed 1/4 inch long with broke for 4 weeks to ensure compliance, then and jagged edges. they will be checked on each shower day During an interview with the Director of Nursing thereafter. on 4/28/16 at 9:36 AM she stated that she expected resident fingernails to be trimmed. The Senior Care Partner will conduct During an interview on 4/28/16 at 9:41 AM weekly rounds on 5 residents each week nursing assistant #7 stated that she usually would for 5 weeks to ensure that residents trim her fingernails after her bath. She stated that received their showers as indicated in the she was busy that day and did not get to finish. shower schedule, then on 3 residents for 3 weeks. The nursing staff in-service began on 4/28/16 by the Clinical Competency Ex. 2 Coordinator on maintaining appropriate nail length and following the shower Resident #52 was admitted to the facility on schedule and what to do in the event of a 2/2/09 and re-admitted on 4/12/12 with diagnoses missed shower as well as being added to including Cerebrovascular Accident with the new hire orientation process. Staff Hemiplegia, Contractures, Aphasia, Congestive that did not attend the in-service will be Heart Failure (CHF), Chornic Kidney Disease and educated prior to the next scheduled shift. History of Pressure Ulcers. . How will the corrective action be Review of the most recent guarterly Minimum monitored to assure that the deficient Data Set Assessment dated 1/19/16 identified practice will not reoccur, i.e., what quality Resident #52 as having short and long term assurance program will be put in place for memory problems and severly imparierd in monitoring to assure continued making daily decisions. He was totally dependent compliance.

FORM CMS-2567(02-99) Previous Versions Obsolete

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Facility ID: 923514

FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING 345357 B. WING 04/28/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1303 HEALTH DRIVE **PRUITTHEALTH-NEUSE NEW BERN, NC 28560** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ID (X5) COMPLETION (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 312 Continued From page 14 F 312 on two persons for bathing. The results of the monitoring will be Review of the Care Plan dated 4/12/12 and last reviewed and brought to the monthly QA updated on 2/4/16 listed the Problem: potential by the DHS and the findings will be for skin breakdown due to diagnoses of discussed and any changes implemented Congestive Heart Failure, Diabetes, Atrial to maintain compliance. Fibrillation, History of ulcer to sacrum, Bedfast, Incontinent, requires assist with bed mobility, bilateral upper extremity contractures, neck contractures and poor intake. Approaches to meeting the goal of no skin breakdown by next review included, in part: shower/bed bath as scheduled. According to the shower schedule book review, Resident #52 received showers on Monday and Thursday on the 7am - 3pm shift. Observations were made over the four day survey period. Resident #52 was observed clean an dry and without odors. Resident #52 was bedfast. During an observation of incontinent care. Resident #52 was noted to have no skin breakdown on his buttocks area, but did have a healed area of previous pressure. During a family interview on 4/26/16 at 2:30pm it was stated on 4/21/16 Resident #52 did not receive his scheduled shower. The family member stated she was told the lift batteries were not working. The family member further stated on Friday 4/22/16 and Saturday 4/23/16 she had asked for Resident #52 to receive a shower. She stated it was not until Sunday before the shower was given. During an interview on 4/27/16 at 2:23pm with Nursing Assistant #4 she stated that she did not give Resident #52 a shower on 4/21/16 because

FORM CMS-2567(02-99) Previous Versions Obsolete

DEPARTMENT OF HEALTH AND HUMAN SERVICES

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIP	LE CONSTRUCTION	· · ·	E SURVEY
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	3	CON	PLETED
		345357	B. WING		04/28/2016	
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
PRUITTHE	EALTH-NEUSE			1303 HEALTH DRIVE NEW BERN, NC 28560		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	IOULD BE	(X5) COMPLETIO DATE
F 312	the lift batteries were thought night shift did which made the lifts u During an interview w 4/27/16 at 10:30am s should be charged fo is dead the storage u batteries and you cou During an interview w 4/28/16 at 8:42am sh Resident #52 on Frice bathed him and dress it takes about an hour family member told he showered. She state shower on that day ar and said once a resid s hard to get them in. During an interview w 4/28/16 at 9am she s Resident #52 on Satu member asked her if he did not get shower stated that she never would not shower Re would try to work him could never work in h were scheduled for sl During a follow up int Assistant #5 on 4/27/ you get a lift to use ar you take that battery	not working. She stated she I not charge the batteries unuseable the next day. vith Nursing Assistant #5 on he stated that the lifts r day shift and if they battery nit had " a million " uld get one from there. vith Nursing Assitant #3 on e stated she did have lay, 4/22/16 and she had sed him first thing, because r to do his care, and then the er that she wanted him d that she had others to nd could not squeeze him in lent misses a shower day it ' vith Nursing Assistant #2 on tated that she did work with urday 4/23/16 and the family she could shower him since red Thursday or Friday. She told the family member she sident #52 but that she in. She stated that she im because other residents howers that day.	F 31	2		

Facility ID: 923514

If continuation sheet Page 16 of 34

TATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO	INSTRUCTION	(X3) DAT	E SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		· · ·	IPLETED
		345357	B. WING		0,	4/28/2016
NAME OF PI	ROVIDER OR SUPPLIER		STRE	ET ADDRESS, CITY, STATE, ZIP COL		
PRUITTHE	EALTH-NEUSE		1303 NEW			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETIO DATE
		e 16 en the battery runs low or /s batteries ready to go in	F 312			
	rooms with batteries. During an interview w 4/27/16 at 3:56pm sh showers are only give there just are not end showers. She further not get done on a sch usually cannot be ma because other reside stated Resident #52 of Sunday, 4/24/16. During an interview w on 4/28/16 at 11:17ar doesn't get a shower scheduled, then any st that shower. There an		F 315			5/24/16
SS=D	Based on the residen assessment, the facil resident who enters t indwelling catheter is resident's clinical con catheterization was n who is incontinent of treatment and service	it's comprehensive ity must ensure that a				
		is not met as evidenced				

Facility ID: 923514

If continuation sheet Page 17 of 34

FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION COMPLETED A. BUILDING 345357 B. WING 04/28/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1303 HEALTH DRIVE **PRUITTHEALTH-NEUSE NEW BERN, NC 28560** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (X4) ID ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 315 Continued From page 17 F 315 Based on observation, record review and staff What Corrective action will be interviews the facility failed to prevent accomplished for the residents found to contamination of an indwelling urinary catheter by have been affected by the deficient allowing the drainage spout to rest on the floor for practice? 1 of 1 sampled residents with a urinary catheter (Resident #100). F315- Resident # 100 had her catheter Resident #100 was admitted to the facility on bag replaced immediately after notification 1/5/15 and had a diagnosis of Neurogenic that the spout had come into contact with Bladder. the floor The Care Area Assessment for Indwelling Urinary How will you identify other residents Catheter dated 8/6/15 revealed the resident had a having the potential to be affected by the urinary catheter and would be care planned to same deficient practice and what prevent urinary tract infections (UTIs). corrective action will be taken? The resident 's Care Plan dated 8/6/15 revealed the resident used an indwelling urinary catheter A 100% audit of all catheters was done on related to a neurogenic bladder and was at risk 5/2/2016 by the Director of Health for UTIs. Services/Unit Managers to ensure that no The Quarterly Minimum Data Set (MDS) dated catheters were found on the ground or 1/21/16 revealed the resident was cognitively any contaminated surfaces. Identified intact, required extensive assistance with concerns related to catheters were activities of daily living and had an indwelling corrected immediately. urinary catheter. On 4/25/16 at 4:05 PM Resident #100 was What measures will be put in place or observed lying in bed. The urinary drainage bag what systemic changes will be made to was hanging on the lower part of the bed. The ensure that the deficient practice will not drainage spout was clamped but was not secured reoccur? and was observed lying directly on the floor. During the observation the resident stated she The DHS/Unit Managers will make rounds had a urinary tract infection and did not feel good. to observe all catheters on two days each week for 8 weeks to ensure continued On 4/25/16 at 4:52 PM the resident was observed lying in bed. The catheter spout of the urinary compliance. drainage bag was clamped but was not secured and was observed resting directly on the floor. Nursing staff were in-serviced on On 4/28/16 at 1:43 PM the Infection Control catheters and prevention of UTIs Nurse stated in an interview the urinary drainage associated with catheter contamination spout should not be on the floor. and the education began on 4/28/16 by On 4/28/16 at 3:03 PM the Director of Nursing the Clinical Competency Coordinator as stated in an interview the urinary drainage spout well as being added to the new hire should be secured and that being on the floor orientation process. Staff not attending will

FORM CMS-2567(02-99) Previous Versions Obsolete

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Facility ID: 923514

If continuation sheet Page 18 of 34

	DF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION	OMB NO. 0938-03 (X3) DATE SURVEY COMPLETED			
	Contraction		A. BUILDING					
		345357	B. WING		04/28/2016			
	ROVIDER OR SUPPLIER		1	STREET ADDRESS, CITY, STATE, ZIP CODE 1303 HEALTH DRIVE				
_			N	NEW BERN, NC 28560				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETIC			
F 315	Continued From page	e 18	F 315					
	was an infection cont	rol issue.		be educated prior to next scheduled s	hift.			
				How will the corrective action be monitored to assure that the deficient practice will not reoccur, i.e., what qua				
				assurance program will be put in place monitoring to assure continued compliance.	e for			
				The results of the monitoring will be reviewed and brought to the monthly by the DHS and the findings will be discussed and any changes implement to maintain compliance.				
F 318 SS=D	483.25(e)(2) INCREA IN RANGE OF MOTI	ASE/PREVENT DECREASE ON	F 318		5/24/16			
	resident, the facility n with a limited range c	t and services to increase or to prevent further						
		is not met as evidenced						
	interviews the facility device for one of one range of motion.	ns, record review and staff failed to apply an orthosis residents (#18) reviewed for		What Corrective action will be accomplished for the residents found have been affected by the deficient practice?	to			
	5/5/2011 with diagno: encephalopathy, han vascular accident, dia aphasia and Alzheim	mitted to the facility on sis that included metabolic d joint contracture, cerebral abetes mellitus II, dysphagia, er ' s dementia. rterly review Minimum Data		F318- For resident #18 on 4/28/16 she had her splint applied immediately up discovery that the splint was not on, a three finger nails were trimmed.	on			

Event ID: 41Q111

Facility ID: 923514

If continuation sheet Page 19 of 34

FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION COMPLETED A. BUILDING 345357 B. WING 04/28/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1303 HEALTH DRIVE **PRUITTHEALTH-NEUSE NEW BERN, NC 28560** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (X4) ID ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 318 Continued From page 19 F 318 Set (MDS) dated 4/8/16 indicated Resident #18 How will you identify other residents had short and long term memory problems and having the potential to be affected by the severely impaired daily decision making skills. same deficient practice and what She required extensive assistance with bed corrective action will be taken? mobility, personal hygiene and total assistance with bathing. The MDS indicated resident #18 The Director of Health Services and was assessed as having functional limitation in Nurse Management performed a 100% audit on 4/29/16 of residents with orders range of motion in the upper and lower extremities on both sides of the body. for splints and range of motion to ensure The resident 's care plan dated 3/16/15 and last orders were being carried out. Any updated on 4/21/16 indicated the resident had identified concerns were addressed with decreased ROM (range of motion) related to the MD and/or a Rehab referral made. contractures to upper and lower extremities. The interventions included left hand/wrist orthosis 12 What measures will be put in place or hours on and 12 hours off for positioning and joint what systemic changes will be made to integrity as resident will tolerate. ensure that the deficient practice will not Physician 's orders were reviewed and revealed reoccur? an order dated 8/3/15 that the resident was to wear left hand/ wrist orthosis (orthotic device) 12 Education began on 4/29/16 by the hours on and 12 hours off, (9AM on) (9 PM off) Clinical Competency Coordinator for Licensed nurses on order transcription for positioning and joint integrity. A record review of the Medication Administration including but not limited to supplements, splints, and new admissions. Education Record for January through April 27, 2016 was conducted. The April MAR showed will be added to new hire orientation and documentation that the orthosis device was staff not completing the training will be documented as applied at 9 AM and removed at educated prior to the start of the next scheduled shift. 9 PM from April 1 through April 27, 2016. On 4/26/16 at 1:09 PM resident # 18 was observed lying in bed without an orthosis device Education began on 4/28/16 by the Clinical Competency Coordinator for or rolled wash cloth on her left hand. During an interview with the restorative nursing Licensed and non-licensed nursing staff assistant on 4/26/16 at 1:59 PM she stated that on proper splinting and following all when resident #18 was in the restorative program physicians orders as well as making all she wore an orthosis device on her left hand. nursing staff aware that it is the She stated that the resident was no longer on the responsibility of the treatment nurse to restorative case load and the NA 's on the hall ensure that the splint is applied and removed according to physicians orders. were responsible for putting splints on the residents. Education will be added to new hire On 4/27/16 at 10:42 AM, 1:38 PM and 4:30 PM orientation and staff not completing the

FORM CMS-2567(02-99) Previous Versions Obsolete

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Facility ID: 923514

If continuation sheet Page 20 of 34

FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY IDENTIFICATION NUMBER AND PLAN OF CORRECTION COMPLETED A. BUILDING 345357 B. WING 04/28/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1303 HEALTH DRIVE **PRUITTHEALTH-NEUSE NEW BERN, NC 28560** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (X4) ID ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 318 Continued From page 20 F 318 resident # 18 was observed lying in bed without training will be educated prior to the start an orthosis device or rolled wash cloth on her left of the next scheduled shift. hand During an interview on 4/28/16 at 8:28 Am the The Nurse managers will monitor the Therapy Manger stated that when resident #18 residents with splints and ROM orders was discharge from therapy in July 2015 she was daily x 2 weeks then weekly x 4 weeks able to tolerate the orthosis device on her left then monthly thereafter to ensure splints hand/ wrist. She stated that staff were educated and ROM are being completed as on passive range of motion and application of the ordered. device. How will the corrective action be On 4/28/16 at 9:13 AM resident # 18 was observed lying in bed without an orthosis device monitored to assure that the deficient or rolled wash cloth on her left hand. practice will not reoccur, i.e., what quality During an interview on 4/28/16 at 9:34 AM Nurse assurance program will be put in place for #6 stated that the restorative nursing assistant monitoring to assure continued was responsible for putting the splint device on compliance. residents. In an interview with the Director of Nursing on The results from the monitoring will be 4/28/16 at 9:36 AM she stated that she expected reviewed and brought to the monthly QA resident #18 to have her orthosis device on. She meeting by the DHS, and the findings will stated that the restorative NA was responsible for be discussed and continue monitoring as putting the device on the resident. needed to continue compliance. During an interview on 4/28/16 at 9:41 AM nursing assistant #7 stated that morning she was busy and did not return to put the device on the resident. She indicated it was not clear who was responsible for putting the device on the resident. During an interview on 4/28/16 at 1:15 PM Nurse #7 stated that he thought the restorative nursing assistant was responsible for applying the orthosis device on resident #18. F 325 483.25(i) MAINTAIN NUTRITION STATUS F 325 5/24/16 UNLESS UNAVOIDABLE SS=D Based on a resident's comprehensive assessment, the facility must ensure that a resident -(1) Maintains acceptable parameters of nutritional

FORM CMS-2567(02-99) Previous Versions Obsolete

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Facility ID: 923514

If continuation sheet Page 21 of 34

CENTERS FOR MEDICARE & MEDICAID SERVICES TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 04/28/2016	
ND PLAN OF CORRECTION IDENTIFICATION NUMBER:							
		NAME OF PROVIDER OR SUPPLIER PRUITTHEALTH-NEUSE					
1303 HEALTH DRIVE NEW BERN, NC 28560							
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX (EACH CORRECTIVE ACTION SHO		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ULD BE COMPLETI	
F 325	Continued From page	e 21	F	325			
	status, such as body unless the resident's demonstrates that thi	weight and protein levels, clinical condition					
	This REQUIREMENT is not met as evidenced by: Based on record review, staff and resident interviews the facility failed to administer a nutritional supplement for 1 of 3 residents reviewed for weight loss (Resident #170). The findings included: Resident #170 was admitted to the facility on 1/4/16 and had a diagnosis of Pneumonia, Chronic Respiratory Failure, COPD (Chronic Obstructive Pulmonary Disease) Urinary Retention and Anorexia. A Nutritional Screening and Assessment Form dated 1/11/16 signed by the consulting dietician noted the resident weighed 179 pounds. The assessment revealed the resident consumed 25% of his meals, was within his ideal body weight of 160-199 pounds and would continue to monitor. The Care Area Assessment (CAA) dated 1/15/16 for Nutrition revealed the resident received a NAS (no added salt) regular consistency diet and had no difficulty chewing or swallowing. The CAA revealed the resident 's weight was 179 pounds and was at risk for weight changes related to COPD with oxygen use and pneumonia. The resident 's Care Plan dated 1/15/16 noted the resident was at risk for weight changes				What Corrective action will be accomplished for the residents found to have been affected by the deficient practice? F325- For resident #170 on 4/27/2016 f supplement was immediately placed ba on the April Medication Administration Record (MAR) and was given. How will you identify other residents having the potential to be affected by th same deficient practice and what corrective action will be taken? The Director of Health Services and Nurse management performed a 100% audit on 5/2/16 of residents with supplements orders to ensure orders were on current MAR. Any order discovered to be missing from the MAF was placed on the MAR immediately. What measures will be put in place or what systemic changes will be made to ensure that the deficient practice will no	the ack ne	

Facility ID: 923514

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION COMPLETED A. BUILDING 345357 B. WING 04/28/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1303 HEALTH DRIVE **PRUITTHEALTH-NEUSE NEW BERN, NC 28560** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (X4) ID ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 325 Continued From page 22 F 325 resident ample time to eat due to shortness of Education began on 4/29/16 by the Clinical Competency Coordinator for breath. A Nutritional Screening and Assessment Form Licensed nurses on order transcription dated 1/21/16 signed by the consulting dietician including but not limited to supplements, revealed the resident 's current body weight was splints, and new admissions. Education 174 pounds and was down 5 pounds since will be added to the new hire orientation admission. The assessment revealed the resident and the staff not completing the training would be offered a snack and hydration three will be educated prior to the start of the times a day and monitored for significant next scheduled shift. changes. Review of the resident 's weekly weight record Supplement orders will be monitored on 5 revealed a weight of 166 on 2/15/16. residents to include new and current The most recent Minimum Data Set (MDS) orders each week for 6 weeks then 3 Assessment (Quarterly) dated 2/29/16 revealed residents each week for 4 weeks by the the resident was cognitively intact and required Director of Health Service/Unit Managers. set up help, supervision and encouragement with eating. How will the corrective action be There was a physician 's order dated 3/1/16 for monitored to assure that the deficient Standard 2.0 (nutritional supplement), 120 practice will not reoccur, i.e., what quality milliliters twice a day. assurance program will be put in place for On 3/1/16 the resident 's Care Plan was updated monitoring to assure continued and directed staff to provide supplements as compliance. ordered and to monitor weights per policy and as ordered. The results from the monitoring will be Review of the Medication Administration Record reviewed and brought to the monthly QA (MAR) for March 2016 revealed a handwritten meeting by the DHS, and the findings will order for Standard 2.0, 120millilites twice a day be discussed and continue monitoring as and the MAR revealed the nutritional supplement needed to continue compliance. was given as ordered. Review of the resident 's weekly weight record revealed the following weights: 3/2/16 160 pounds. 3/9/16 167 pounds. 3/23/16 163 pounds. 3/30/16 160 pounds. Review of the MAR for April 2016 revealed no entry for Standard 2.0, 120 milliliters twice a day and there were no physician 's orders to discontinue the nutritional supplement. Review of the resident 's weekly weight record revealed the following weights: 4/6/16 163

FORM CMS-2567(02-99) Previous Versions Obsolete

If continuation sheet Page 23 of 34

	S FOR MEDICARE 8				OMB NO. 0938-03
TATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345357 NAME OF PROVIDER OR SUPPLIER			(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED
		B. WING	04/28/2016		
		STREET ADDRESS, CITY, STATE, ZIP CODE		'E	
PRUITTHEALTH-NEUSE			130 NE		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRE PREFIX (EACH CORRECTIVE ACTION SH TAG CROSS-REFERENCED TO THE APF DEFICIENCY)		N SHOULD BE COMPLETIO
F 325	Continued From page	ge 23	F 325		
	pounds. 4/13/16 16	-			
		PM the Dietary Supervisor			
		w she went around the facility			
		ts a snack at 10 AM and 2			
		r stated they prepared a cart sistants offered snacks at 8			
		r stated she had never been			
	able to get Residen	t #170 to accept a snack.			
		PM the Director of Nursing			
	(DON) stated in an interview that new orders were faxed to the pharmacy and entered on the				
		narmacy and entered on the ng month. The DON stated			
		month 's MARs were			
		harmacy, 2 nurses checked			
	-	new orders for the resident.			
		e pharmacy did not put the			
		016 MAR and the 2 nurses			
		AR missed the order. AM Resident #170 stated in			
		several bouts of pneumonia			
		ections since admission to the			
		weight. The Resident stated			
		n a supplement but they had			
	stopped it.				
		2 AM the Unit Supervisor w she did the second check			
		AR for Resident #170. The			
	-	he would have checked the			
	new orders back to	the first of March but			
	apparently did not s	see the order for the			
	supplement.	AM Nuroo #1 stated in an			
) AM, Nurse #1 stated in an hecked the April 2016 MAR			
		igainst the new physician 's			
		06. The Nurse stated she did			
	not see the order fo	r the supplement.			
			— — — — — — — — — —		E/04/40
F 333	483.25(m)(2) RESI	DENTS FREE OF	F 333		5/24/16

Facility ID: 923514

If continuation sheet Page 24 of 34

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING 345357 B. WING 04/28/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1303 HEALTH DRIVE **PRUITTHEALTH-NEUSE NEW BERN, NC 28560** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ID (X5) COMPLETION (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 333 Continued From page 24 F 333 The facility must ensure that residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced bv: Based on record review and staff interviews, the What Corrective action will be facility failed to ensure a medication was accomplished for the residents found to administered as ordered by the physician for 1 of have been affected by the deficient 6 sampled residents (Resident #200). The practice? findings include: F333-For resident # 200 the Duoneb order was clarified on 4/25/2016 to read Resident #200 was admitted to the facility on 4/8/16 with diagnoses including End Stage every 4 hours and was given around the Chronic Obstructive Pulmonary Disease, Anxiety, clock every four hours. Chronic Pain Syndrome and Hospice status. How will you identify other residents Review of the Admission Minimum Data Set having the potential to be affected by the (MDS) Assessment dated 4/15/16 identified same deficient practice and what Resident #200 as moderately impaired cognitively corrective action will be taken? with a Brief Interview of Mental Status score of 12 and receiving Oxygen. The Director of Health Services and Nurse management performed a Review of the Care Plan dated 4/20/16 listed the medication audit of all new admissions Problem as: Diagnosis of Chronic Obstructive from 4/1/16 to present for order Pulmonary Disease, reports of frequent shortness transcription accuracy. The Director of of breath and Oxygen ordered. The documented Health Services and Nurse management approaches to meeting the goal of maintaining performed an audit of all new physician s optimal breathing and oxygen level within orders for transcription accuracy from constraints of a terminal diagnosis included, in 4/28/2016 forward. Any identified concerns were addressed with the MD. part, give medications as ordered. Review of the form FL2, used on admission to What measures will be put in place or document the physician's orders listed the what systemic changes will be made to following order: Duoneb 0.5milligrams - 3 ensure that the deficient practice will not milligrams - 3 milliliters inhalation every 4 hours reoccur? (Duoneb is a bronchodilator that relaxes muscles in the airways and increases air flow to the lungs). Education began on 4/28/16 by the

FORM CMS-2567(02-99) Previous Versions Obsolete

Facility ID: 923514

If continuation sheet Page 25 of 34

FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION COMPLETED A. BUILDING 345357 B. WING 04/28/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1303 HEALTH DRIVE **PRUITTHEALTH-NEUSE NEW BERN, NC 28560** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (X4) ID ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 333 Continued From page 25 F 333 Clinical Competency Coordinator for Review of the Medication Administration Record Licensed nurses on Medication dated 4/8/16 documented an order for Duoneb administration including but not limited to 0.5milligrams - 3 milligrams - 3 milliliters the 5 rights, medication errors, order inhalation every 4 hours. Futher review revealed transcription, medication reconciliation at the medication had been signed as given 6 times the end of each month. Education will be since admission. The resident had been residing added to new hire orientation and staff not in the facility 17 days (4/8/16 through 4/25/16) completing the training will be educated and per order was to have received 102 doses. prior to the start of the next scheduled shift. During a facility tour on 4/25/16 at 3:22PM Resident #200 was observed to be lying in her New admission orders and new bed with the head of the bed up 45 degrees. She physician s orders to include was observed to be sweating and had grimacing transcription to the MAR, will be monitored on her face. The State surveyor asked how she Monday through Friday by the Unit was doing and she replied she was having trouble Managers and week-ends by the breathing and wished she could have her Registered Nurse for 8 weeks. Duoneb. She had Oxygen on at 2.5liters via How will the corrective action be nasal cannula. The State surveyor left the room to enquire from the nurse regarding Duoneb. monitored to assure that the deficient practice will not reoccur, i.e., what quality During an interview with Nurse #4 on 04/25/2016 assurance program will be put in place for 3:26PM she stated the resident had not asked for monitoring to assure continued any PRN (as needed) meds except for Tylenol for compliance. a fever. Otherwise she had not received any PRN meds. When asked about the Duoneb 0.5 inhaler The results from the monitoring will be every four hours order Nurse #4 stated "that is reviewed and brought to the monthly QA PRN". Nurse #4 was shown the Medication meeting by the DHS, and the findings will Administration Record for April 2016 and asked if be discussed, and changes implemented the order read "PRN?" The MAR revealed the to maintain compliance. order did not read PRN. During an interview with Nurse #5 on 4/25/16 at 3:30PM, who had entered the conversation to clarify the medication order, she stated the order seemed a bit confusing; however, Resident #200 did have an order for Morphine to help with her shortness of breath.

FORM CMS-2567(02-99) Previous Versions Obsolete

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Facility ID: 923514

If continuation sheet Page 26 of 34

FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING ___ 345357 B. WING 04/28/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1303 HEALTH DRIVE **PRUITTHEALTH-NEUSE NEW BERN, NC 28560** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ID (X5) COMPLETION (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) Continued From page 26 F 333 F 333 During an interview with the Director of Nursing (DON) on 04/25/2016 3:43PM she stated that MDS Coordinator took off the admitting orders on 4/8/16. During an interview with the MDS Coordiantor on 04/25/2016 3:43:50 PM she stated she did not call and clarify the medication order as to if it was every four hours or every four hours (PRN) as needed. During a follow up interview with the DON on 04/25/2016 3:44PM she stated she would re-write the order with the number of times to give the medication and do a medication error form. She stated it was her expectation that medications be given as ordered. During an interview with the Administrator on 04/25/2016 4:55PM he stated the pharmacist did identify a few charts on 4/20/16 with transcription errors and the facility was planning to in-service staff on 4/28/16 and 4/29/16, but no chart audits had been started. He stated Resident #200s chart had most likely not been reviewed by the Pharmacist since admission. During an interview with the Physician's Assistant on 04/27/2016 10:15AM she stated that she did not believe there was any negative outcome for Resident #200 by not receiving the Duoneb every four hours. F 425 483.60(a),(b) PHARMACEUTICAL SVC -F 425 5/24/16 ACCURATE PROCEDURES, RPH SS=D The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in

FORM CMS-2567(02-99) Previous Versions Obsolete

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Facility ID: 923514

If continuation sheet Page 27 of 34

FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION COMPLETED A. BUILDING 345357 B. WING 04/28/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1303 HEALTH DRIVE **PRUITTHEALTH-NEUSE NEW BERN, NC 28560** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ID (X5) COMPLETION (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 425 Continued From page 27 F 425 §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. This REQUIREMENT is not met as evidenced by: Based on record review, staff and pharmacist What Corrective action will be interviews the pharmacy failed to add a new order accomplished for the residents found to for a supplement on the April 2016 Medication have been affected by the deficient Administration Record for 1 of 6 residents whose practice? medications were reviewed (Resident #170). The F425- For resident #170 on 4/27/2016 the findings included: Resident #170 was admitted to the facility on supplement was immediately placed back 1/11/16 with a diagnosis of Pneumonia and on the April Medication Administration Chronic Obstructive Pulmonary Disease (COPD). Record (MAR) and was given. Review of the resident 's medical record revealed the resident had experienced weight How will you identify other residents having the potential to be affected by the loss since admission to the facility and on 3/1/16 there was a physician 's order for Standard 2.0 same deficient practice and what corrective action will be taken? (nutritional supplement), 120 milliliters twice a day. The entry was observed to be hand written on the March 2016 Medication Administration The Director of Health Services and Record (MAR) and initialed as given twice a day. Nurse management performed a 100% Review of the April 2016 MAR revealed no entry audit on 5/2/16 of residents with

FORM CMS-2567(02-99) Previous Versions Obsolete

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Facility ID: 923514

If continuation sheet Page 28 of 34

FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION COMPLETED A. BUILDING 345357 B. WING 04/28/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1303 HEALTH DRIVE **PRUITTHEALTH-NEUSE NEW BERN, NC 28560** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (X4) ID ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 425 Continued From page 28 F 425 for Standard 2.0 to be given. supplements orders to ensure orders The Director of Nursing (DON) stated in an were on current MAR. Any order interview on 4/27/16 at 3:39 PM the pharmacy did discovered to be missing from the MAR not enter the supplement on the April 2016 MAR was placed on the MAR immediately or the monthly physician 's orders and when the nurses checked the April MARs at the end of What measures will be put in place or March they missed it as well. what systemic changes will be made to On 4/28/16 at 10:28 AM Pharmacist #1 stated in ensure that the deficient practice will not an interview their pharmacy entered new orders reoccur? for medications and their medical records department entered orders for supplements. The Education began on 4/29/16 by the Pharmacist stated the order sheet faxed to the Clinical Competency Coordinator for pharmacy on 3/1/16 for Resident #170 had an Licensed nurses on order transcription order following the Standard 2.0 for a controlled including but not limited to supplements, substance. The Pharmacist stated the order splints, and new admissions. Education sheet was marked control and did not get sent to will be added to new hire orientation and medical records for them to enter the supplement staff not completing the training will be into the system for the April 2016 MAR. The educated prior to the start of the next Pharmacist stated the order should have been scheduled shift. sent to their medical records department where the supplement order would have been entered Supplement orders will be monitored on 5 residents to include new and current into the system. orders each week for 6 weeks then 3 residents each week for 4 weeks by the Director of Health Service/Unit Managers. How will the corrective action be monitored to assure that the deficient practice will not reoccur, i.e., what quality assurance program will be put in place for monitoring to assure continued compliance. The results from the monitoring will be reviewed and brought to the monthly QA meeting by the DHS, and the findings will be discussed and continue monitoring as needed to continue compliance.

FORM CMS-2567(02-99) Previous Versions Obsolete

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Event ID: 41Q111

Facility ID: 923514

If continuation sheet Page 29 of 34

FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING 345357 B. WING 04/28/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1303 HEALTH DRIVE **PRUITTHEALTH-NEUSE NEW BERN, NC 28560** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ID (X5) COMPLETION (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 441 Continued From page 29 F 441 F 441 483.65 INFECTION CONTROL, PREVENT F 441 5/24/16 SPREAD, LINENS SS=D The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it -(1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.

FORM CMS-2567(02-99) Previous Versions Obsolete

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Facility ID: 923514

If continuation sheet Page 30 of 34

FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER COMPLETED A. BUILDING 345357 B. WING 04/28/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1303 HEALTH DRIVE **PRUITTHEALTH-NEUSE NEW BERN, NC 28560** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (X4) ID ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 441 Continued From page 30 F 441 This REQUIREMENT is not met as evidenced by: What Corrective action will be Based on observations, record review and staff interviews the facility failed to clean a glucometer accomplished for the residents found to after use for 1 of 1 residents observed to receive have been affected by the deficient a finger stick blood sugar (Resident #88). practice? The facility policy dated July 10, 2015 titled Blood Glucose Monitoring, Long-term Care under The nurse in question cleaned the Introduction stated: " If one device (blood glucometer according to policy glucose monitor) must be used to monitor several immediately after the state surveyor residents, it must be cleaned and disinfected after walked away and went back into the every use to prevent carryover of blood and conference room. infectious agents. " The facility's undated Skills Competency How will you identify other residents Checklist for blood glucose equipment cleaning having the potential to be affected by the same deficient practice and what read: " Clean the outside of the blood glucose meter, use a lint free cloth dampened with soapy corrective action will be taken? water or isopropyl alcohol. Disinfect the meter with a bleach solution wipe. " Education began on 4/29/16 by the CCC On 4/25/16 at 12:15 PM. Nurse #3 was observed for Licensed nurses on how and when to to unlock the medication cart and remove a clean the glucometer. Education will be glucometer (device to check finger stick blood added to new hire orientation and staff not sugars), lancet and alcohol wipe from the cart. completing the training will be educated The nurse was observed to enter the room of prior to the start of the next scheduled shift. Resident #88 and check a finger stick blood sugar on the resident. The nurse was observed to return to the medication cart and place the All license nurses will perform a glucometer in the top drawer of the cart and competency skills checklist on the correct locked the cart. The nurse was asked when she cleaning of a glucometer prior to the start of the next scheduled shift. would clean the glucometer. The Nurse stated the glucometers were cleaned on night shift with alcohol and normal saline. The Nurse stated if What measures will be put in place or there was blood on the glucometer she would what systemic changes will be made to wipe it off but did not clean the glucometer ensure that the deficient practice will not between residents. The Nurse stated she reoccur? received training on cleaning the glucometer in orientation and was trained as stated in her The DHS or Unit Manager will observe

FORM CMS-2567(02-99) Previous Versions Obsolete

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Facility ID: 923514

If continuation sheet Page 31 of 34

CENTERS FOR MEDICARE & MEDICAID SERVICES TATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345357		(X2) MULTIPLI	(X3) DATE SURVEY COMPLETED			
		A. BUILDING				
		B. WING		04/28/2016		
NAME OF PROVIDER OR SUPPLIER PRUITTHEALTH-NEUSE			STREET ADDRESS, CITY, STATE, ZIP CODE			
				1303 HEALTH DRIVE NEW BERN, NC 28560		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRE PREFIX (EACH CORRECTIVE ACTION SHO TAG CROSS-REFERENCED TO THE APP DEFICIENCY)		BE	(X5) COMPLETIC DATE
F 441 F 514 SS=D	(DON) stated in an in supposed to clean th with alcohol and blea On 4/25/16 at 12:35 I interview she got ner have been to clean th wipes after each use not clean the glucom stick blood sugar on observed but had nov On 4/25/16 12:50 PM Coordinator who was Nurse stated in an init trained in orientation alcohol, then bleach a use. On 4/27/16 at 4:07 P interview that Nurse a glucometer before an glucometer. 483.75(I)(1) RES RECORDS-COMPLE LE The facility must main resident in accordance standards and practice accurately document systematically organi The clinical record m information to identify resident's assessment services provided; the	PM the Director of Nursing therview the nurses were e glucometer after each use ch wipes. PM, Nurse #3 stated in an vous and her answer should be glucometer with bleach . The Nurse stated she did eter after checking a finger Resident #88 while being w cleaned the glucometer. I the Staff Development also the Infection Control terview the nurses were to clean the glucometer with and let dry between each M the DON stated in an #3 should have cleaned the ad after using the ETE/ACCURATE/ACCESSIB thatin clinical records on each we with accepted professional ces that are complete; ed; readily accessible; and zed. ust contain sufficient y the resident; a record of the nts; the plan of care and	F 441	 and document on 3 nurses each week 4 weeks, then 2 nurses each week for weeks to ensure that the proper procedure for glucometer cleaning is adhered to. How will the corrective action be monitored to assure that the deficien practice will not reoccur, i.e., what quassurance program will be put in place monitoring to assure continued compliance. The results from the monitoring will reviewed and brought to the monthly meeting by the DHS, and the findings be discussed and changes implement to maintain compliance. 	t lality ce for QA s will nted	5/24/16

Facility ID: 923514

If continuation sheet Page 32 of 34

	S FOR MEDICARE &				
TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345357		(X2) MULTI A. BUILDIN	(X3) DATE SURVEY COMPLETED		
		B. WING		04/28/2016	
NAME OF PROVIDER OR SUPPLIER PRUITTHEALTH-NEUSE			STREET ADDRESS, CITY, STATE, ZIP COD		ODE
				1303 HEALTH DRIVE NEW BERN, NC 28560	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT) CROSS-REFERENCED TO TH DEFICIENC'	ON SHOULD BE COMPLETI HE APPROPRIATE DATE
F 514	Continued From page	e 32	F 5	14	
	This REQUIREMENT is not met as evidenced by: Based on document review, observations and staff interviews the facility failed to ensure medical records were not falsified to make it appear as if a hand/wrist orthosis device was on one of one sampled residents (#18) reviewed for range of motion. Resident #18 was admitted to the facility on 5/5/2011 with diagnosis that included metabolic encephalopathy, hand joint contracture, cerebral vascular accident, diabetes mellitus II, dysphagia, aphasia and Alzheimer 's dementia. The most recent quarterly review Minimum Data Set (MDS) dated 4/8/16 indicated Resident #18 had short and long term memory problems and severely impaired daily decision making skills. She required extensive assistance with bed mobility, personal hygiene and total assistance			What Corrective action will accomplished for the reside have been affected by the opractice? For resident #18 on 4/28/16 clarified/revised to read spli each day as tolerated by the How will you identify other r having the potential to be aff same deficient practice and corrective action will be take Director of Health Services Management performed a 1 Medication Administration F residents receiving splinting	ents found to deficient b the order was nt on 6 hours e resident. residents ffected by the what en? and Nurse 100% audit of Records for
	was assessed as have range of motion in the extremities on both si The resident 's care updated on 4/21/16 in decreased ROM (ran contractures to upper interventions included hours on and 12 hour integrity as resident w Physician 's orders w an order dated 8/3/15 wear left hand/ wrist of hours on and 12 hour for positioning and join	ides of the body. plan dated 3/16/15 and last ndicated the resident had ge of motion) related to and lower extremities. The d left hand/wrist orthosis 12 rs off for positioning and joint will tolerate. were reviewed and revealed to that the resident was to porthosis (orthotic device) 12 rs off, (9AM on) (9 PM off)		What measures will be put i what systemic changes will ensure that the deficient pra- reoccur? All residents receiving splint monitored daily for two wee times a week for three week a week for three weeks to e they are documented appro DHS/Unit Managers. Educa 4/29/16 by the CCC for Lice on signing MAR/TAR after s treatment is completed. Edu added to new hire orientation completing the training will	be made to actice will not ting will be ks then three ks, then once ensure that opriately by the ation began on ensed nurses service or ucation will be on and staff not

Facility ID: 923514

If continuation sheet Page 33 of 34

FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION COMPLETED A. BUILDING ___ 345357 B. WING 04/28/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1303 HEALTH DRIVE **PRUITTHEALTH-NEUSE NEW BERN, NC 28560** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (X4) ID ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 514 Continued From page 33 F 514 was conducted. The April MAR showed shift. documentation that the orthosis device was documented as applied at 9 AM and removed at How will the corrective action be 9 PM from April 25 through April 27, 2016. monitored to assure that the deficient On 4/26/16 at 1:09 PM resident # 18 was practice will not reoccur, i.e., what quality observed lving in bed without an orthosis device assurance program will be put in place for or rolled wash cloth on her left hand. monitoring to assure continued During an interview with the restorative nursing compliance. assistant on 4/26/16 at 1:59 PM she stated that resident #18 was no longer on the restorative The results from the monitoring will be reviewed and brought to the monthly QA case load. She stated that the NA 's on the hall were responsible for putting splints on the meeting by the DHS, and the findings will residents be discussed and continue monitoring as On 4/27/16 at 10:42 AM, 1:38 PM and 4:30 PM needed to continue compliance. resident # 18 was observed lying in bed without an orthosis device or rolled wash cloth on her left hand. On 4/28/16 at 9:13 AM resident # 18 was observed lying in bed without an orthosis device or rolled wash cloth on her left hand. During an interview on 4/28/16 at 9:34 AM Nurse #6 stated that the restorative nursing assistant was responsible for putting the splint device on residents. During an interview on 4/28/16 at 1:15 PM Nurse #7 stated that he could not remember when he saw the splint during his shift but he signed the MAR that the splint was on the resident.

FORM CMS-2567(02-99) Previous Versions Obsolete

DEPARTMENT OF HEALTH AND HUMAN SERVICES