STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345357	A. BUILDING _____ B. WING _____	C 01/25/2018

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PRUITTHEALTH-NEUSE	1303 HEALTH DRIVE NEW BERN, NC 28560

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F 000	INITIAL COMMENTS The survey team entered the facility on 1/10/18 to conduct a complaint survey and was unable to return to the facility on 1/12/18 due to one surveyor available to do the 2 dayer and could not complete 7 45 day intakes. The survey team returned to the facility on 01/21/18 and completed the survey on 1/25/18. Event ID YTMQ11#	F 000		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by:	F 761		2/21/18

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

Electronically Signed | 02/15/2018

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F 761	Continued From page 1 Based on observations and staff interviews, the facility failed to secure a stock bottle of ferrous sulfate (100 hall cart) and faild to secure 1 (200 hall) of 4 medications carts. Findings include: 1. On 1/22/2018 at 04:09 PM Nurse #1 was observed preparing medications. The nurse locked the medication cart, leaving a bottle of Ferrous sulfate 325 milligram (mg) tablets on top of the cart. She then entered a resident room. An interview with Nurse #1 was conducted on 1/22/2018 at 4:10 PM. The nurse stated she should not have left the bottle of Ferrous sulfate on top of the medication cart unattended. The nurse then unlocked the medication cart and placed the medication into the cart. An interview with the Director of Nursing (DON) was conducted on 1/24/2018 at 9:45 AM. The DON stated medications should be secured in the medication cart when unattended. 2. On 1/23/18 at 3:20 PM, the 200 hall medication cart was observed in the hall parked between rooms 211 and 215. The medication cart lock mechanism was observed in the unlocked position (a red dot on the side of the lock is visible when the cart is in the unlocked position). No staff were observed in the hall. On 1/23/18 at 3:23 PM Nurse #2 was observed walking in the hall toward the cart. The nurse stated she should not have left the medication cart unlocked and the cart should have been locked when she left the cart. The nurse then opened the top drawer of the medication cart and verified the cart was unlocked.	F 761	This plan of Correction constitutes the facilities written allegation of compliance for the deficiencies cited. However, submission of this plan of correction is not an admission that deficiencies exist or that one was cited correctly. This plan of correction is submitted to meet requirements established by federal and state law. Process that lead to the deficiency 1. The nurse left the bottle of iron on top of the cart because she forgot to lock it up, due to being distracted by a resident. 2.The nurse walked away from the med cart for 3 minutes while it was unlocked, and returned to lock it after she was distracted by a phone call at the nurse□s station. Process for implementing a plan of correction for specific deficiency All nurses were in-serviced by the Clinical Competency Coordinator on the proper securing of medications by 02/15/2018, those nurses that were on leave during this time will be in-serviced prior to being able to return to work and new hires during orientation. Develop a monitoring tool for the Director of Nursing/Nurse Managers to utilize during med-pass times to observe the nurses securing medications prior to distancing themselves out of eyesight. Monitoring to ensure effectiveness of	

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F 761	Continued From page 2 An interview with the Director of Nursing (DON) was conducted on 1/24/2018 at 9:45 AM. The DON stated she expected the nurse to lock the medication cart when they leave the cart.	F 761	POC The Director of Nursing/Nurse Managers will monitor 3 nurses during their med pass each week for 4 weeks, then 2 nurses each week for 3 weeks. If the requirement is met during this 7 week period, the monitoring will be completed, if not it will continue at 2 nurses each week until the standard is met for 3 consecutive weeks. The findings from the monitoring will be brought to the monthly QAPI meeting for review and recommendations as needed. This will ensure that the medication storage requirement is met and maintained. Title of person responsible for implementing the POC Director of Nursing/Nurse Manager	
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents	F 812		2/21/18

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F 812	Continued From page 3 from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to thaw raw beef at a level below precooked sliced meat and to label opened food items stored in 1 of 1 walk-in refrigerator. The findings included: An observation on 1/21/17 at 3:36 PM during the initial kitchen tour revealed a package of raw ground beef, located in a sheet pan on the upper shelf of a rolling rack was thawing. Below the raw meat, 4 packages of precooked meat in another sheet pan were thawing on the next shelf of the rolling rack. This observation on 1/21/18 at 3:36PM during the initial kitchen tour also revealed an opened container of vanilla pudding on the top shelf of the stationary shelving unit without a label on it and an opened container of banana pudding on the 2nd shelf was also unlabeled. During an interview on 1/21/18 at 3:55 PM Dietary Aide #1 stated the raw ground beef should be below the already cooked meat and the containers of opened foods should be labeled. During an interview on 1/21/18 at 5:17PM the Dietary Manager stated the raw ground beef should have been below the already cooked meats and all opened items should have a label with the date it was opened on it.	F 812	Process that lead to the deficiency 1. The dietary aide placed the raw meat in the refrigerator above pre-cooked meats because the cook did not realize that the meat under it was pre-cooked. 2.The dietary aide placed the pudding in the cooler without labeling it because she thought she had placed the date label on the plastic wrap but forgot to peel the label off and stick it on the can. Process for implementing a plan of correction for specific deficiency All dietary employees were in-serviced by the Dietary Manager on the proper storage and labeling of food by 02/15/2018, any employees that were absent or on leave during this time will be educated prior to being able to return to work and new hires during orientation. Developed a monitoring tool for the Dietary Manager/Kitchen Supervisor to utilize to ensure that food is labeled and stored appropriately. Monitoring to ensure effectiveness of POC Dietary Manger/Kitchen Supervisor will	

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F 812	Continued From page 4	F 812	audit the refrigerators daily for 1 week for proper food storage and labeling, then 3 times weekly for 3 weeks for proper food storage and labeling, then 2 times weekly for 4 weeks. The findings from the monitoring will be brought to the monthly QAPI meeting for review and recommendations as needed. This will ensure that the food storage and labeling requirements are met and maintained. Title of person responsible for implementing the POC Dietary Manger/Kitchen Supervisor	
F 867 SS=D	QAPI/QAA Improvement Activities CFR(s): 483.75(g)(2)(ii) §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews, the facility's Quality Assessment and Assurance (QAA) Committee failed to maintain implemented procedures and monitor interventions previously put in place. This failure was related to non-compliance at the regulatory grouping of 483.80 on three consecutive annual recertification surveys. A deficiency in the area of infection control at the regulatory grouping of 483.80 was cited during the facility's 4/28/16 annual recertification survey, recited during the facility's 1/19/17 annual recertification survey, and	F 867	Process that lead to the deficiency 1. The QA team failed to identify that there was an issue with infection control in the facility. Process for implementing a plan of correction for specific deficiency The QA team will continue to meet monthly and address any instances of noncompliance in any areas of the facility. Education will continue to be scheduled	2/21/18

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F 867	Continued From page 5 was cited again on the current 1/25/18 annual recertification survey. The facility's continued failure during the recertification surveys showed a pattern of the facility's inability to sustain an effective QAA program. Findings Included: This tag is cross referenced to: 483.80: Infection Prevention and Control: Based on observations, interviews with staff and record review, the facility failed to clean a glucometer per manufacturer's recommendation for 1 of 2 observations (Resident #153 and #79). 483.80 was originally cited during the April 2016 recertification survey for failing to clean a glucometer per manufacturer's instructions. 483.80 was again cited during the January 2017 recertification survey for failing to perform proper hand hygiene during incontinent care. During an interview on 1/25/17 at 9:59 AM the Staff Development Coordinator stated she was not here during the 2016 annual recertification and had not been a part of that plan of correction. She further stated she could not remember what the plan of correction was for last year's deficiency but believed that education was provided about hand hygiene. The Staff Development Coordinator stated the previous deficiency in 2017 was related to hand hygiene and not glucometer cleaning and was why the concern had not been identified or addressed. During an interview on 1/25/18 at 11:55 AM the Administrator stated that because last year's	F 867	for any areas that are required. Focus areas will be reviewed monthly and removed from the focus two months after substantial compliance is achieved. All nurses were also in-serviced by the Clinical Competency Coordinator on the proper disinfecting of glucometers by 02/15/2018 any employees that were absent or on leave will be educated prior to being able to return to work and new hires during orientation. Monitoring to ensure effectiveness of POC Any identified areas of concern for those that are out of compliance will be in-serviced on and monitoring tools will be developed to ensure that substantial compliance is maintained. If the monitoring tools identify that the identified concerns are still present, then remedial training will be provided to the employee to ensure appropriate competency. Title of person responsible for implementing the POC The Administrator will develop the plans to achieve substantial compliance and the QA team will work in unison to help identify concerns that need to be monitored. Monitoring tools will be utilized by the department manager in the area which the concern was noted.	

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F 867	Continued From page 6 deficiency was a result of non-compliance with hand hygiene, glucometer cleaning was not addressed in the 2017 plan of correction. He further stated this could have contributed to the deficiency repeat.	F 867		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;	F 880		2/21/18

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F 880	Continued From page 7 (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which 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; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observations, interviews with staff and record review, the facility failed to clean a glucometer per manufacturer's recommendation for 1 of 2 observations (Resident #153 and #79).	F 880	Process that lead to the deficiency 1. The nurse was fully able to verbalize the correct procedure for disinfecting the	

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F 880	Continued From page 8 Findings included: Glucometer manufacturer recommendations for cleaning and disinfecting were reviewed. The glucometer manufacturer recommended the germicidal and disinfectant wipes which the facility used. The manufacturer instructions noted "allow the surface of the meter to remain wet at room temperature for the contact time listed on the wipe's directions for use. Wipe all external areas of the meter including both front and back surfaces until visibly wet." The germicidal and disinfectant product used by the facility recommended varied times for the level of disinfection desired. Instructions included "use enough wipes for the treatment surface to remain visibly wet for the contact time listed below. Let air dry. Gross filth must be removed prior to disinfecting. Killing Clostridium difficile spores: pre-clean hard non porous surfaces by removing gross filth. Wipe surface to be disinfected. Use enough wipes for treated surface to remain visibly wet for 3 minutes. Let air dry. Pathogen/contact time: Bacteria/30 seconds, Viruses/1 minute, Clostridium difficile/3 minutes." A continuous observation was conducted of Nurse #1 on 1/22/2018 from 4:09 PM to 4:51 PM. On 1/22/2018 at 4:09 PM Nurse #1 was observed performing a glucometer check on Resident #153. The nurse brought the glucometer out of the room and placed it on the top of the medication cart. She then wiped the glucometer with an alcohol swab and placed the glucometer into a clean cup. When asked about the cleaning process for the glucometer, Nurse #1 stated she had been instructed to wipe the glucometer with	F 880	glucometer, but the nurse became distracted and nervous while being observed by the surveyor and forgot to use the bleach wipe prior to entering the room to obtain the FSBS. Process for implementing a plan of correction for specific deficiency All nurses were in-serviced by the Clinical Competency Coordinator on the proper disinfecting of glucometers by 02/15/2018 any employees that were absent or on leave will be educated prior to being able to return to work and new hires during orientation. Developed a monitoring tool for the Director of Nursing/Clinical Competency Coordinator to utilize to ensure that all glucometers are disinfected appropriately each time. Monitoring to ensure effectiveness of POC The Director of Nursing/Clinical Competency Coordinator will monitor 4 nurses each week for 4 weeks to ensure that they are correctly disinfecting the glucometers after each use, then 2 nurses each week for 4 weeks. The findings from the monitoring will be brought to the monthly QAPI meeting for review and recommendations as needed. This will ensure that the glucometers are disinfected appropriately and the infection control requirement is met and maintained. Title of person responsible for	

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F 880	Continued From page 9 alcohol and then wipe again with a bleach wipe. The nurse stated she would get the bleach wipe (stored on the medication cart) the next time she unlocked the medication cart. On 1/22/18 at 4:45 PM Nurse #1 was observed to remove the glucometer from the cup. The nurse then entered Resident #79's room with the glucometer in her hand. Nurse #1 was stopped and asked about the cleaning process. The nurse stated she had been unaware she had not cleaned the glucometer with a bleach wipe. Nurse #1 returned to the medication cart, retrieved a bleach wipe, rubbed the glucometer for a few seconds and stated the glucometer only needed to dry for a few seconds. She then entered resident 79's room and completed the glucometer check. On 1/22/2018 at 4:51 PM Nurse #1 returned to the medication cart. She wiped the glucometer with an alcohol swab and placed the glucometer on the top of the cart. She then retrieved a bleach wipe and wiped the glucometer for a few seconds and placed it into a clean cup. An interview with Nurse #1 was conducted on 1/22/2018 at 4:51 PM. The nurse stated the Director of Nursing (DON) and the Staff Development Coordinator (SDC) had instructed her to wipe the glucometer with alcohol and then wipe with the bleach wipe for a few seconds and let air dry which only takes a few moments. An interview with the SDC nurse was conducted on 1/24/2018 at 8:45 AM. The SDC stated nurses were instructed to clean the glucometer with an alcohol wipe and then disinfect with a bleach wipe	F 880	implementing the POC Director of Nursing/Clinical Competency Coordinator	

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F 880	Continued From page 10 until the surface of the glucometer is wet. The glucometer then must air dry for a few minutes. An interview was conducted on 1/24/2018 at 3:27 PM with the DON. The DON stated the bleach germicidal disinfectant wipe recommendation indicated the glucometer should remain wet for 3 minutes. The DON stated the recommendations for disinfecting the glucometer had not been followed.	F 880		